A Transcendental Phenomenological Study Exploring How Licensed Marriage and Family Therapists Describe the Emotional Impact of the COVID-19 Pandemic

by

Melissa Lund

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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Abstract

The purpose of this qualitative, phenomenological study was to describe the experiences of Licensed Marriage and Family Therapists (LMFT) in private practice during the COVID-19 pandemic. The study was viewed through the lens of resilience theory, which suggests that an individual's ability to adapt and overcome adverse experiences is based on their individual level of resilience. Eight LMFTs varying in demographics, such as age, gender, and ethnicity, as well as length of time in practice participated in individual interviews exploring their lived experiences during the pandemic. The study's questions aimed to gain a better understanding of the emotional impact of the pandemic, how the therapists described the emotional impact on their personal and professional lives, and how they described the feelings associated with stress. Themes that emerged based on participants' lived experiences included recognition of the need for a healthy work/life balance as well the recognition of feelings of fear, anger, and uncertainty during the pandemic.

Keywords: Resilience, COVID-19, stress, burnout, licensed marriage and family therapist

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Dedication

This dissertation is dedicated to my partner in life, Michael, who encouraged and supported me. His confidence in my abilities kept me moving forwards in those moments that I had doubts. He has been my rock throughout this journey, keeping me grounded and focused.

This dissertation is also dedicated to my family. My mom, Mickey, tirelessly listened to me drone on and on about the process. My daughter, Amanda, has been a consistent source of support. And my grandchildren, Emery and JT, for whom I wanted to show that through perseverance and hard work anything is possible. I am eternally grateful to have these individuals in my life who love me unconditionally and provide unwavering support.

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List of Abbreviations

Coronavirus disease (COVID-19)

Emergency Medical Technicians (EMT)

Emergency Room (ER)

Institutional Review Board (IRB)

Licensed Marriage and Family Therapist (LMFT)

Marriage and Family Therapy (MFT)

Posttraumatic Stress Disorder (PTSD)

CHAPTER ONE: INTRODUCTION

Overview

The COVID-19 (coronavirus), discovered in December of 2019, quickly spread across the world, ultimately resulting in stay-at-home orders for most of the United States in March of 2020. The unknown nature of this virus created uncertainty, anxiety, stress, and fear throughout diverse populations. Various professions were profoundly affected as well. Some found themselves out of work. Some found themselves working harder than ever before. For example, many small businesses and most restaurants were instructed to close their doors to reduce the spread of the virus, whereas it was necessary for essential employees to continue in their roles, including first responders who, because of the nature of the virus, often were given more work and longer hours.

This chapter serves to provide an overview from a historical, social, and theoretical perspective of the relevant literature pertaining to the lived experiences and impact of previous natural disasters as well as the current COVID-19 pandemic on first responders in general, and more specifically on licensed marriage and family therapists. This review revealed a gap in the literature, which formed the foundation for the present study.

Background

Historical

The entire world was impacted by the outbreak of the COVID-19 virus in early 2020. While everyone was affected to some extent, various populations experienced the pandemic in different ways. With stay-at-home orders in place in much of the world, many hospitality industries, such as restaurants and hotels, incurred significant losses resulting from declines in occupancy (Al-Mughairi et al., 2022). This led to many individuals being out of work and higher

unemployment rates (Al-Hasni, 2021). Other types of workers such as office workers had to reorganize and many found ways to work from home as the pandemic dragged on (Mehta, 2021; Yeo & Li, 2022). Due to the nature of the global crisis, essential employees, including front line workers like firefighters, emergency medical technicians, doctors, and nurses, were highly needed and most continued to perform their professional duties, oftentimes working even longer hours than pre-pandemic (Jun et al., 2020). The uncertainty of the virus, fear of infection and health issues, and lockdowns with possible resultant isolation created an increased need for mental healthcare providers, including licensed marriage and family therapists (LMFTs) (Ashcroft et al., 2021).

For example, many LMFTs in private practice experienced an increased demand for care that led to multiple challenges, both professionally and personally (Aafjes-van Doorn et al., 2022). Professionally, the rapid transition from in-person sessions to online virtual sessions was for many a new, unknown, anxiety-producing task (Machluf et al., 2021). For some, the increased caseload produced longer hours and increased stress (Ashcroft et al., 2021). For others, however, with the stay-at-home orders in place, some clinicians initially had a significant decrease in clients, leading to financial loss (Jacome et al., 2021) and uncertainty, which affected both their professional and personal lives. In addition, many clinicians struggled with personal and familial challenges very similar to those of their clients: isolation, personal losses, and health concerns (Aafjes-van Doorn et al., 2022).

The world has experienced a variety of natural disasters including weather-related disasters, such as tornados, hurricanes, flooding, and earthquakes (Bentley et al., 2021; Clay & Greer, 2019; Johannesson et al., 2015; Lee & First, 2022; Wu et al., 2009; Xu & Feng, 2012). The world has also experienced disastrous pandemics including the Russian flu, Spanish flu,

SARS-CoV or severe acute respiratory syndrome, Swine flu, and most recently SARS-CoV-2, more commonly known as COVID-19 (Piret & Boivin, 2021). Each natural disaster has consequences—sometimes they are minimal but often they are profound. However, the COVID-19 pandemic specifically had significant effects on the majority of the workforce population, including those who provide mental health services such as LMFTs.

Social

Oftentimes the effects of natural disasters and/or pandemics are profound but fairly localized to a town, state, country, or region. However, the effects of COVID-19 were felt by everyone worldwide in various areas and to varying degrees. For example, for many people the virus significantly affected their employment in diverse ways, creating challenges both professionally (Cronin et al., 2021; Hardy et al., 2021; Lee, 2020; Levy et al., 2021; Machluf et al., 2021; Patterson et al., 2021) and personally. According to the American Speech-Language-Hearing Association (2021) the majority of speech-language pathologists, university-based professionals, and students surveyed reported difficulty balancing personal and professional responsibilities, and many audiologists, speech-language pathologists, and university-based professionals reported a reduction in work hours and/or income.

Additionally, mental health changes and challenges have been reported (Fisher et al., 2021). It was reported that a survey of high school students in the spring of 2020 revealed an increase in depression and anxiety symptoms, stress and worry, and loneliness (Gazmararian et al., 2021). The social implications of the COVID-19 virus have also been profound for many. Chandiramani (2020) stated that many people experienced psychological problems such as fear and isolation. Others have experienced emotional manifestations such as frustration, anger, depressive symptoms, and stress, including job-related stress (Chatzittofis et al., 2021; Jun et al.,

2020; Marey-Sarwan et al., 2021). While COVID-19 is a recent phenomenon, it is evident by the current research that this pandemic has had significant and lasting consequences.

Theoretical

The leading theory providing the framework for the presented study was resilience theory. Resilience theory is grounded in the concept that an individual's ability to adapt and overcome adverse experiences is based on their individual resilience. Both adversity and positive adaptation must be apparent for resilience to be noted (Fletcher & Sarkar, 2013). Resilience theory is a strength-based approach (Zimmerman, 2013). As cited by Fletcher and Sarkar (2013), strengths that serve as protective factors and that help individuals to adapt and cope with adverse experiences include characteristics such as positive emotions (Tugade & Fredrickson, 2004), self-efficacy (Gu & Day, 2007), spirituality (Bogar & Hulse-Killacky, 2006), self-esteem (Kidd & Shahar, 2008), and positive affect (Zautra et al., 2005). Martinez-Marti and Ruch (2017) found that "the three individual strengths that showed the largest correlations with resilience were hope, zest, and bravery" (p. 116). Resilience theory was an appropriate approach for the presented study as the intent of the study is to better understand the experiences of LMFTs during COVID-19 and what role resilience played in their coping during that time.

Situation to Self

The motivation for conducting this presented research arose from my own experience as a licensed marriage and family therapist in private practice at the onset of the COVID-19 pandemic. As an LMFT, I have an ethical responsibility to do no harm and as such have to be able to compartmentalize my own challenges and fully engage with each client in order to provide the best possible care. I wanted to better understand how clinicians experienced the pandemic, how they describe the stress they experienced, and how their own resilience impacted

their ability to cope with the professional and personal challenges created in their lives due to the pandemic. My motivation increased with the recommendation by Agnello and Giubellini (2021) for future studies of how psychotherapists, while providing very important and necessary services, remained in the background of other healthcare professionals and that primarily doctors and nurses were identified as the heroes of the pandemic. It was of interest to me to explore if mental healthcare professionals were impacted by this or even experienced these feelings.

Problem Statement

Current studies have explored individuals' work-related experiences during the COVID-19 pandemic (Chandiramani, 2020; Humer et al., 2020). Studies of multiple healthcare providers including nurses, nurse managers, and physicians have also been performed (Arcadi et al., 2021; Bhattacharya & Prakash, 2021; Chatzittofis et al., 2021; Jun et al., 2020; Muz & Erdogan Yuce, 2021; White, 2021). Specific to licensed marriage and family therapists, significant focus has been on examining the challenges faced by mental health providers related to the transition from face-to-face sessions to virtual/online therapy (Cronin et al., 2021; Hardy et al., 2021; Levy et al., 2021; Machluf et al., 2021; McBeath et al., 2020; Salcuni et al., 2020). Also investigated have been some personal struggles of therapists including loss of income (Amorin-Woods et al., 2021; Ashcroft et al., 2021; Patterson et al., 2021), familial stressors (Amorin-Woods et al., 2020), and burnout (Kotera et al., 2021). Mention was also made about the difficulty of the need for an immediate transition from therapist role to parent role when working from home during the lockdown (McBeath et al., 2020).

In light of is already known, what is lacking is qualitative research examining the lived experiences of licensed marriage and family therapists during the COVID-19 pandemic related to any personal struggles they did experience while continuing to be present and engaged with

clients, but also remaining unnoticed and unacknowledged as front line or essential workers. Additionally, Patterson et al. (2021) suggests consequences of COVID-19 such as isolation, general and boundary uncertainty, and burnout—which is comprised of emotional exhaustion and depersonalization (Kotera et al., 2021)—could lead to increased moral distress in clinicians. Therefore, Agnello and Giubellini (2021) recommended further research be conducted to investigate this phenomenon.

The goal of this transcendental phenomenological study was to examine the phenomenon of stress and varied emotions experienced by licensed marriage and family therapists during the COVID-19 pandemic and to explore their perception of continuing to provide care for clients while remaining unnoticed and/or unacknowledged as essential workers; the study also aimed to investigate how they describe the feelings they associated with the stress experienced both personally and professionally during that time.

Purpose Statement

The purpose of this phenomenological study was to explore and better understand the lived experiences of licensed marriage and family therapists in private practice in San Diego County during COVID-19 related to stress and the level of resilience as a means of coping with the stress. The lived experiences of the LMFTs were generally defined as how they describe the emotional impact as essential healthcare workers during the pandemic and what stress means to them.

Significance of the Study

The COVID-19 pandemic was felt across the world. For many, it became a time of greater need for support and understanding by mental healthcare providers (Ashcroft et al., 2021). However, LMFTs and other mental healthcare providers were not immune to the effects

of the virus as they continued to provide these needed services. This research study aimed to provide valuable insight into how the COVID-19 pandemic impacted the lives of licensed marriage and family therapists, to what extent, if any, it impacted their ability to function as mental healthcare providers, and how their own resilience aided in this. Understanding this can help improve how mental healthcare providers approach client care and self-care should another natural disaster occur. This information is beneficial to a wide spectrum of mental health providers, including but not limited to licensed professional counselors, licensed clinical social workers, licensed mental health counselors, and psychologists.

Research Questions

The following research questions guided this transcendental phenomenological study.

Central Research Question: How do licensed marriage and family therapists (LMFT) describe the emotional impact on one's personal and professional life as essential healthcare workers during the COVID-19 pandemic?

Guiding Question: How do LMFTs describe the feelings they associated with stress during the COVID-19 pandemic?

Definitions

1. *Resilience* – One's ability to adapt and overcome or "bounce back from" adverse experiences, trauma, or other life altering events based on one's individual resilience (Zimmerman, 2013).
2. *COVID-19* - A respiratory disease caused by SARS-CoV-2, a coronavirus that began in 2019 (Centers for Disease Control and Prevention, 2021).
3. *LMFT* – Acronym for Licensed Marriage and Family Therapist.

4. *Burnout* – Burnout is a state of exhaustion that can occur when one experiences prolonged stress or fatigue, either mental, emotional, physical, or any combination of such (Ashcroft et al., 2021; Jacome et al., 2021; Sklar et al., 2021).
5. *Posttraumatic stress disorder* – A mental health condition in which an individual has experienced a traumatic event and continues to have significant symptoms that last more than a month after the event which cause distress and functional impairment (American Psychiatric Association, 2013).

Summary

Effects of the worldwide COVID-19 pandemic were widespread and impacted many people in both personal and professional ways (Bortnick, 2021; Hofbauer et al., 2020). Healthcare providers as front line and essential workers were profoundly affected by the pandemic, in part due to the uncertainty and potential lethality of the virus (Arcadi et al. 2021; Chatzittofis et al., 2021; Jun et al., 2020; Muz & Erdogan Yuce, 2021; White, 2021). The purpose of this study was to investigate and better understand the lived experiences of licensed marriage and family therapists while they performed as essential workers during the COVID-19 pandemic.

CHAPTER TWO: LITERATURE REVIEW

Overview

This chapter serves to present a literature review of previous research based on similar aspects of the research questions and the theoretical framework to better understand the essential concepts of the current qualitative phenomenological study. Literature reviewed includes articles and books exploring the lived experiences of essential workers at the time of COVID-19, including physicians, nurses, and psychotherapists. Also included is literature specific to psychotherapists and the necessary changes required to continuing providing services.

These experiences and changes presented many challenges and required strength and flexibility of these professionals. The theory upon which the current research was based is resilience theory, a strength-based approach, which contends that how one deals with adversity is of greater importance than the adversity itself (Zimmerman, 2013). The population specific to the current study was Licensed Marriage and Family Therapists (LMFT), and the study explored emotional resiliency in the face of a global pandemic.

This critical review of sources includes a history of resilience theory, challenges faced by various professions—including physicians, nurses, and psychotherapists/therapist —at the onset of COVID-19 and during the subsequent lockdowns, personal emotional toll, professional concerns, and difficulties faced when needing to make abrupt work-related changes. The literature review is necessary to better understand what role level of resiliency played for essential workers when facing the adversity of a global pandemic. Finally, the current study and gaps in the literature related specifically to LMFTs, emotional toll during adversity, and resilience are discussed.

Theoretical Framework

Background of Resilience Theory

This study was based on the resilience theory concept. Resilience has been the focus of many research studies and this theory was chosen to guide the study due to the significance of the research findings. Resilience theory is founded on the concept of a person's ability to adapt and overcome adverse experiences, trauma, or other life altering events based on one's individual resilience (Zimmerman, 2013).

Norman Garmezy, a clinical psychologist often considered a pioneer of resilience research dating from the early 1970s, was the lead researcher in Project Competence, a crucial landmark study in the field of resilience (Masten et al., 2011). Garmezy et al. (1984) describes resilience as the ability to recover from a stressful or adverse event and to maintain healthy behaviors that enable a person to positively cope with the event (Masten et al., 2011). For one to be resilient, they must demonstrate proficient functioning in spite of and in the face of stressful situations. Garmezy et al. (1984) sought to better comprehend protective and risk factors in children identified as stress-resistant. It was found that children with family stability and cohesion appeared to be more socially engaged, more competent, and less likely to exhibit disruptive behaviors when under high levels of stress as compared to children with low family stability and cohesion. It was concluded that resilience was associated with a low number of risk factors and a higher number of protective factors, whereas lack of resilience was associated with a lower number of protective factors and a higher number of risk factors.

According to Rolf et al. (1990) Garmezy viewed resilience from an ecological standpoint, believing there were multiple influences on one's resilience. Garmezy identified ecological factors on an individual level, a family level, and those external to the family such as

a teacher, a social worker, or a larger community including a church or club (Rolf et al., 1990). Factors at the individual level could include one's temperament, cognitive skills, and the manner in which one copes with new situations. Factors at the familial level could include family cohesion, feelings of warmth and concern, and the presence of a caring adult (Masten & Garmezy, 1985). Families with higher levels of resilience are better able to adapt in a crisis, maintain functioning, and ultimately survive a crisis, often growing and becoming stronger as a family in the process (Black & Lobo, 2008).

Michael Rutter (2006), a professor of child psychiatry, defines resilience as the integration of experiences involving serious risk with at least a moderately positive psychological aftereffect in the face of those experiences. In a study comparing children in an underprivileged area of London with a more well-off area and associated risk factors, it was found that the more risk factors children were exposed to, the more likely they were to suffer from a psychiatric disorder and/or to experience poorer outcomes (Rutter, 1979). Rutter performed a longitudinal study comparing adoptees who did not suffer institutional deprivation as orphans and adoptees who did. The findings revealed that there was a greater chance for the adopted children who experienced institutional deprivation to develop psychological difficulties and exhibit disinhibited behavior than for those who did not. It was also noted that this behavior continued into adolescence. However, disinhibited behavior did not emerge in the adoptees who did not experience deprivation, even into adolescence (Rutter et al., 2007).

Based on his research, Rutter (2012) postulates that resilience is an individual's typical adaptation to circumstances if they have been given the right resources, and that differences such as personality, genetics, and temperament can make one more or less susceptible to changes in the environment—including traumatic circumstances—which produce differences in the

response to various protective and risk factors. Rutter views resilience over the course of the lifespan and states it may be more or less evident at various times and in response to some risks but not others, with a child demonstrating resilience at one point and lacking resilience at another. Rutter (2012) identifies exposure to low-level challenge or risk, labeled as "steeling effect" events, as a protective factor (p. 337). These events are an important aspect of normal development and can lead to greater coping skills and resilience, and avoidance of such events is more likely to "increase vulnerability rather than promote resilience" (Rutter, 2013, p. 477). Another protective factor identified by Rutter is the significance of social relationships, such as social support and family cohesion.

Building and maintaining one's level of resilience is particularly important for those working in professions in which exposure to vicarious trauma is highly likely and ongoing, in addition to their own personal challenges. In examining professional growth and posttraumatic resilience, it was found that professional counselors who volunteered and assisted individuals affected by Hurricane Katrina and Hurricane Rita and who also had been personally impacted by the hurricanes had significantly higher professional growth than counselors who had not been personally affected by the hurricanes (Lambert & Lawson, 2013). It has also been reported that professional counselors who fostered resilience may have increased levels of compassion satisfaction, were better able to reduce work stressors, and were able to increase their sense of purpose. Possibly this is because professional counselors may view their work as empowering clients in their time of need, thus contributing to a greater sense of purpose. It was noted that increased resiliency was found in counselors "who reframed clinical difficulties as a natural part of the therapeutic process" (Litam et al., 2021, p. 391).

As a student of Garmezy and clinical psychologist, Ann Masten (2014) defines resilience as “the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development” (p. 6). Positive adaptation of developmental tasks is described as meeting the expectation of a particular society or culture for various ages and situations —for example, children going to school. Systems involved in successful adaptation include attachment relationships, families, emotional self-regulation, arousal and behavior, pleasure in mastery motivational systems, education systems, cultural belief and religion, and spirituality systems (Masten et al., 2009). These systems are referred to as fundamental human adaptation systems. Masten also postulates there are protective factors that contribute to one’s resilience and these protective factors function at an individual, familial, and community level (Masten et al., 2009). Also identified are potential risk factors that can interfere with resilience and can lead to negative outcomes. Some of these risk factors include low socio-economic status, maltreatment, abuse, and low birth weight.

Garmezy, Rutter, and Masten have all made important contributions to the study of resilience. They each describe various protective factors that contribute to increased resilience, such as family stability and cohesion and social support (Garmezy et al., 1984; Masten et al., 2009; Rutter, 2013). They all describe resilience as an ability to adapt to and overcome challenging circumstances, and this shared theme guided the present research.

Research on Resilience in the Aftermath of Natural Disasters

Resilience is a normal process and behavior in response to traumatic situations. Humans have an incredible capacity for resilience and can adapt to and overcome significant life stressors. Posttraumatic stress disorder has been a well-researched and documented consequence of trauma due to natural disasters (Johannesson et al., 2015; Wu et al., 2009).

However, resilience has also been demonstrated throughout the course of history in the aftermath of natural disasters, and research has shown long-term resilience to be a common outcome.

The 2001 World Trade Center attacks resulted in posttraumatic stress disorder (PTSD) symptoms in a significant number of police first responders (Liu et al., 2014; Pietrzak et al., 2014). In a longitudinal study, Pietrzak et al. (2014) found that a majority of the participants (77.8%) were described as being on a resilient trajectory. It was found that adolescents who witnessed and survived the 2016 tornado disaster in Yancheng City, China, reported an initial decrease in resilience in the first 6-9 months after the disaster but experienced an increase in resilience in 9-18 months post-disaster (An et al., 2020). Moreover, a randomized survey of hospital employees who were exposed to the SARS virus outbreak in 2003 revealed that only 10% of employees had severe PTSD symptoms three years post-epidemic (Wu et al., 2009). More generally, a long-term survey of natural disaster survivors has shown that survivors with a high level of resilience tended to have fewer PTSD symptoms (Yang & Bae, 2022). While a survey of psychotherapists (Aafjes-van Doorn et al., 2020) found that the participants reported experiencing moderate to high levels of vicarious trauma during the COVID-19 pandemic, Brillon et al. (2022) found that mental health workers "were significantly more resilient than other workers" (p. 613).

Natural disasters can have adverse consequences, such as posttraumatic stress (Johannesson et al., 2015; Liu et al., 2014; Pietrzak et al., 2014; Wu et al., 2009). However, those with higher levels of resilience tend to have fewer PTSD symptoms or to better adapt and overcome, showing decreasing PTSD symptoms over time (An et al., 2020; Wu et al., 2009). With the findings of Brillon et al. (2022), it may be that licensed marriage and family therapists,

as mental health workers, have a higher level of resilience and, therefore, experienced less adverse consequences and negative lasting effects of the COVID-19 pandemic.

Research on Resilience Across Various Occupational Populations

Various occupational populations have increased exposure to disasters and traumatic events. Well-known examples include first responders such as firefighters, law enforcement officers, paramedics, emergency medical technicians (EMTs), and those involved in search and rescue (Cornell Law School, n.d.). These individuals are those who immediately respond and are first on the scene of emergencies or disasters, and they may be witness to any number of traumatic situations. In addition, essential workers in the medical field such as emergency room (ER) physicians, nurses, support staff, and critical care nurses in trauma centers and emergency rooms are on the frontlines during disasters and also have increased exposure to traumatic events (Carleton et al., 2017; Pietrzak et al., 2014; Stogner, 2020; Wu et al., 2009).

Doyle et al. (2021) examined the effects of occupational stress on levels of anger and sought to determine whether one’s level of resiliency could have a mediating effect between occupational stress and maladaptive anger. On self-report measures of occupational stress, psychiatric symptoms, and resilience completed by 201 first responder participants it was found that resiliency can have a mediating effect on the stress that one experiences from one’s occupation (2021). Velichkovsky (2009) analyzed the relationships between experienced stress, the presence of a variety of stressors, and the index of stress resilience (ISR), and also examined the index of stress resilience as a possible moderator of the stressor-stress relationship. Velichkovsky (2009) found that people with higher values on the ISR experienced lower levels of health problems related to stress, as well as enhanced work performed.

Resilience During a Pandemic as Experienced in First Responders

First responders are those who are first on the scene of emergencies or disasters, often witnessing any number of traumatic situations, as mentioned previously (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Due to the frequent exposure to traumatic events, many of these workers experience significant stress (Carleton et al., 2017). These exposures may also result in adverse mental health consequences, such as acute stress, posttraumatic stress, substance abuse, and depression (Benedek et al., 2007). During a pandemic first responders may also experience additional occupational stress as a consequence of increased exposure to hazards. It was noted that police officers may have been more significantly impacted by stressors experienced during the recent pandemic because they were essential workers and were unable to shelter at home (Stogner et al., 2020). The outbreak of HIV in the 1980s provides an example of a similar time in history in which law enforcement officers may have experienced increased stress due to a pandemic (Stogner et al., 2020).

Pink et al. (2021) assessed levels of psychological distress among first responders, healthcare professionals, and healthcare staff, and also sought to determine if there was a difference in the level of psychological distress within these groups. Also assessed was whether levels of resilience moderated the psychological impact of the COVID-19 virus pandemic. This research has shown that significantly higher levels of resilience were found in first responders, specifically police and fire and rescue workers, in comparison to healthcare workers and the general population (Pink et al., 2021). It may be that resiliency plays a mediating role and serves as a protective factor against occupational stress (Doyle et al., 2021).

Resilience During a Pandemic as Experienced in the Medical Field

Medical providers such as emergency room physicians, nurses, and support staff played a significant role as essential workers during the course of the COVID-19 pandemic. Studies

have shown high levels of burnout among healthcare workers during the pandemic (Forycka et al., 2022; Luceno-Moreno et al., 2022; Serrao et al., 2021). Many healthcare workers reported increased levels of frustration and anger, as well as depressive and posttraumatic stress disorder symptoms (Chatzittofis et al., 2021; Jun et al., 2020; Marey-Sarwan et al., 2021). Additionally, higher levels of stress have been reported by nursing staff as compared to doctors, likely due to the "more direct and continuous contact with patients, therefore being at a higher risk of contracting the COVID-19 disease" (Luceno-Moreno et al., 2022, p. e122).

Research has shown varying degrees of resilience within various populations of healthcare workers. It has been shown that medical students demonstrated low levels of resilience and difficulty maintaining emotional well-being (Forycka et al., 2022), whereas other studies indicate that professional healthcare workers, including those who worked in a variety of roles within primary healthcare, emergency services, and inpatient services, showed moderate or high levels of resilience (Serrao et al., 2021). In an effort to explore resilience as having a potential mediating role in the relationship between depression and burnout, Serrao et al. found that healthcare workers reported high levels of work fatigue, exhaustion, and personal and client burnout, but also had moderate or high levels of psychological resilience. It was noted that a higher level of resilience "seems to partially mediate the relationships amongst depression and all dimensions of burnout" (p. 10). Interestingly, among all physicians, anesthesiologists showed higher levels of resilience and emergency physicians showed lower levels of overall resilience (Douillet et al., 2021). It was also found that older healthcare workers had higher levels of resilience than those who were younger (Luceno-Moreno et al., 2022).

Resilience During a Pandemic as Experienced by Psychotherapists/Counselors

Those who work in a mental health capacity, such as psychotherapists, licensed professional counselors, licensed marriage and family therapists, and those in other helping professions also may experience increased stress during a natural disaster such as a pandemic (Carleton et al., 2017; Doyle et al., 2021; Litam et al., 2021). The nature of these professionals' jobs involves listening to clients without taking on the emotional burden and pain of their clients' stories. Mental and behavioral health workers are engaged and present with their clients and may themselves experience increased stress when working with those who have been traumatized by natural disasters (Cronin et al., 2021; Hardy et al., 2021; Kotera et al., 2021; Levy et al., 2021; McBeath et al., 2020; Smith & Gillon, 2021). As a consequence of increased stress, mental health providers may experience vicarious trauma, compassion fatigue, and ultimately burnout (Litam et al., 2021). It has also been noted that providing disaster counseling can further increase stress (Litam et al., 2021). Mental health providers who responded to Hurricanes Rita and Katrina were found to demonstrate two times the rate of vicarious trauma and compassion fatigue compared to mental health provider members of the American Counseling Association in the general population (Lambert & Lawson, 2013). During the COVID-19 pandemic mental health providers suffered the same effects of pandemic-related restrictions, isolation, personal losses, and health concerns (Aafjes-van Doorn et al., 2022). These experiences also led to an increased likelihood of vicarious trauma in therapists.

Many studies have been conducted on therapists' experience of transitioning from face-to-face therapy to online therapy, particularly working with couples and families (Cronin et al, 2021; Hardy et al, 2021; Lee 2020; Levy et al., 2021; Machluf et al., 2021), and there has been some research conducted on the experiences of other clinicians, such as nurses, nurse managers, physicians (psychiatrists), and medical family therapists (Patterson et al., 2021). However, to

date there is little research on the lived experiences of licensed marriage and family therapists and how the trauma of the pandemic impacted them personally. Some clinicians wondered if their own personal worries even deserved attention (Patterson et al., 2021).

Lived experiences needing further exploration include how mental healthcare professionals showed up, engaged with, and were present for their clients while being challenged with the same struggles presented by the COVID-19 virus pandemic that their clients and the majority of the population were struggling with (Amorin-Woods et al., 2020; Lee, 2020). Additionally, possible life changes such as loss of income, resultant stress due to that loss of income, and changes in work/life balance (Kotera et al., 2021) may have had an emotional impact on them. Agnello and Giubellini (2021) recommend future studies in this area, particularly on how psychotherapists, while providing very important and necessary services, remained in the background of the health professionals as primarily doctors and nurses were identified as the heroes of the pandemic. Previous research by Brillon et al. (2022), found mental health providers "were significantly more resilient than other workers" (p. 613). With these studies in mind, it is clearly important to conduct further research on the emotional impacts of COVID-19 on LMFTs and how, if at all, the level of their resilience affects their ability to manage these emotional impacts.

Related Literature

Existing literature examines multiple challenging facets created by the outbreak of the Coronavirus (COVID-19), particularly as it relates to continuing to work during state and national stay-at-home orders intended to slow the spread of the virus. The effects of this "lockdown" have been widespread. Psychological problems experienced by many included fear and isolation (Chandiramani, 2020). It was also reported that many individuals felt increased

job insecurity and spent less time engaged in professional activities (Basyouni & El Keshky, 2021). This resulted in a decline in the meaning of work and as such work was viewed as less important (Humer et al., 2020). It was also noted that due to the duration and uncertainty of this virus as compared to other similar pandemics, the scale of COVID-19 was intensified (Chakraborty, 2020).

Those considered essential workers—healthcare providers in particular—were profoundly impacted during the pandemic and faced many professional and personal challenges, including staff shortages, increased work shifts, fear for their own safety and health, and changes in the way healthcare was administered. A substantial amount of literature exists exploring the experiences of nurses, including critical care nurses, nurse managers and nurse assistant managers, and other front line healthcare professionals (Arcadi et al. 2021; Chatzittofis et al., 2021; Jun et al., 2020; Muz & Erdogan Yuce, 2021; White, 2021). A tremendous amount of compassion and resiliency was (and is still) required for healthcare professionals, including mental healthcare providers, to provide the care that patients needed during this time (Amorin-Woods et al., 2020; Ashcroft et al., 2021; Lee, 2020).

Literature also exists examining challenges faced by mental healthcare providers in regards to transitioning from face-to-face therapy to virtual/online therapy (Cronin et al., 2021; Hardy et al., 2021; Levy et al., 2021; Machluf et al., 2021; McBeath et al., 2020; Salcuni et al., 2020). The problem is a lack of qualitative research exploring the personal and professional struggles of Licensed Marriage and Family Therapists during the pandemic. Some of these struggles may include, but may not limited to, a decreased caseload with subsequent loss of income, personal financial concerns, familial stressors such as needing to be more involved with their children's school work, being available for clients, and continuing to be present and

engaged, yet primarily remaining unnoticed and unacknowledged as front line or essential workers (Agnello & Giubellini, 2021).

Emotional Impact of Manmade and Natural Disasters

Man-made disasters, such as mass shootings and terrorist attacks, and natural disasters, such as weather-related disasters like floods, earthquakes, hurricanes, tornadoes, wildfires, and widespread pandemics can have catastrophic consequences on the lives of those who experience them (Forresi et al., 2020; Knez et al., 2021). There can be a loss of life, homes, personal items, and loss of community. Experiencing or being witness to any of these traumatic events can have a significant impact on a person and significantly affect one's emotional functioning (Dai & Wang, 2020; Galea et al., 2002; Philippe & Houle, 2020).

An evaluation of tweets posted following the terrorist attacks in London in March and June of 2017 (Dai & Wang, 2020) "revealed elevated attentions of the violence and detected clusters of negative emotions, such as fear, sadness, and anger in the aftermath of these disasters" (p. 10). It was also found that the symptoms of stress due to the terrorist attacks were felt by society "far beyond the city where the attacks occurred" (p. 10). Galea et al. (2002) surveyed adults living close to the World Trade Center in New York City five to eight weeks after the September 11th terrorist attack. They found an increase in posttraumatic stress symptoms and depressive symptoms that were approximately twice the baseline values. Survivors of bomb attacks in India even several years after the blasts reported psychological symptoms including sadness and depression, anxiety, irritability, lack of concentration, and posttraumatic symptoms including nightmares and flashbacks of the events (Hussain & Sarma, 2016).

Those who experience and survive a natural disaster may experience significant emotional consequences, both short- and long-term. A study by Knez et al. (2021) found that "feelings of anxiety, rage and emotional strength were present in both the first hours of the catastrophe and one year after" (p. 6). Other studies performed post weather-related natural disasters have shown adverse emotional responses (Acierno et al., 2007; Davis et al., 2010; Ruggiero et al., 2012). In an effort at understanding the psychological sequelae of hurricanes, a study by Acierno et al. (2007) revealed hurricane survivors who participated in the study may be "negatively emotionally affected" and the "effects of the hurricanes on emotional functioning may have been significant" (p. 106). Based on their 2012 study of adults in counties affected by Hurricane Ike, Ruggiero et al. (2012) found negative mental health consequences; 5.9% met criteria for probable posttraumatic stress disorder, 9.3% met criteria for generalized anxiety, and 4.5% met criteria for a major depressive episode (p. 28). Evaluation of the psychological impact of Hurricane Katrina found increased levels of stress and anxiety in university students approximately 2.5 months after the event (Davis et al., 2010).

A study by Xu & Feng (2012) investigating the impact of emotional distress after experiencing an earthquake found that during the first two weeks following the earthquake 98.46% of respondents reported one or more major psychiatric symptoms (p. 286). It was also reported that while many had apparent recovery after one year, over half the initial respondents continued to show "three or more symptoms of emotional distress" (p. 287). In a systematic review of the mental health impact of tornadoes, Lee and First (2022) identified "PTSD, anxiety, depression, suicidal thoughts, and alcohol and drug abuse in children, adolescents, and adults" (p. 8) as negative effects of tornadoes on mental health. Clay and Greer (2019) found

that 27.9% of participants in their study reported poor mental health after experiencing a 2013 tornado. First and Houston (2022) found an association between exposure to a tornado and exposure related to COVID-19 with higher levels of posttraumatic stress symptoms and depression.

Emotional Impact of COVID-19 Virus

The worldwide spread of the COVID-19 virus had an emotional impact on many for a variety of reasons. For some, the enforced stay-at-home orders and confinement caused negative emotions and distress (Miragall et al., 2021). A study of medical science students that compared levels of depression prior to and one year after COVID-19 revealed deterioration of mental health and significantly increased levels of depression, including suicidal ideation (Mirhosseini et al., 2022). In another study, Ramiz et al. (2021) found a significant increase in anxiety symptoms in those with such symptoms prior to the lockdowns, an increase in emotional distress, and a decrease in self-rated mental health. Meda et al. (2021) found that the lockdown due to the pandemic was seemingly responsible for a 2-point median increase in Beck Depression Inventory-2 (BDI-2) scores and increased depressive symptoms (p.75) among students surveyed. A review and meta-analysis of the general population (Salari et al., 2020) found the prevalence of stress, anxiety, and depression as a result of the COVID-19 pandemic at 29.6%, 31.9%, and 33.7% respectively (p. 4).

Impact of COVID-19 Virus on Healthcare Professionals

Since the outbreak of the COVID-19 pandemic in early 2020, many studies have been performed exploring the impact of the virus on various professions. Front line or essential workers, in particular healthcare professionals, were especially hard-hit professionally and personally since the onset of the virus (Arcadi et al., 2021; Chatzittofis et al., 2021; Jun et al.,

2020; Muz & Erdogan Yuce, 2021). Nurses caring for patients during the pandemic reported themes of the fear of the unknown and uncertainty (Arcadi et al. 2021), as well as fear of contagion and contamination (Jun et al., 2020; Muz & Erdogan Yuce, 2021). They also reported a change in their tasks and feeling the need to become a surrogate family member to patients because no visitors were allowed (Arcadi et al., 2021). Many reported depression, frustration, and anger during the pandemic (Jun et al., 2020), as well as posttraumatic stress disorder symptoms (Chatzittofis et al., 2021).

Critical care nurses also reported psychological challenges of fear, anxiety and stress, increased work shifts, increased fatigue, and exhaustion due to increased caseloads, long hours and burnout (Jun et al., 2020), professional discrimination, increased concern regarding job prospects, and lack of adequate training. Other challenges experienced by critical care nurses included inadequate staffing, lack of personal protective equipment (Jun et al., 2020), poor communication, and health protocols not being followed (Chegnin et al., 2021). Nurse managers and assistant nurse managers reported struggling with finding support and with finding ways to cope with the burden they felt they were carrying (White, 2021).

Nurses who had personally been infected with and recovered from the COVID-19 virus reported professional prejudice, feeling there was less inquiry about their wellbeing during their illness, as well as less time off in comparison to professionals in other roles. Additionally, they reported not being asked how they were doing in their recovery. They also reported lack of understanding at work, inadequate resources, lack of personal protective equipment, inadequate staffing of nurses, and an increased workload. On a personal level they reported increased financial difficulties due to loss of work because of illness (Radfar et al., 2021).

There were, however, a few positive findings that healthcare professionals—nurses in particular—reported during the course of the COVID-19 pandemic. They reported feeling professionally more supported by nursing groups (Arcadi et al., 2021), feeling increased work pride and commitment to the profession, and feeling more appreciated by society overall (Chegnin et al., 2021).

Healthcare professionals as first responders were highly impacted at the outbreak of and during the course of the COVID-19 pandemic, both professionally and personally. Professionally, many struggled with fear and anxiety (Arcadi et al. 2021; Jun et al., 2020; Muz & Erdogan Yuce, 2021), as well as increased workload and burnout (Jun et al., 2020). Many struggled with finding support (White, 2021) and financial difficulties (Radfar et al., 2021). However, first responders have been shown to have higher levels of resiliency (Douillet et al., 2021; Luceno-Moreno et al., 2022; Pink et al., 2021; Serrao et al., 2021). It has also been found that resilience may play a mediating role against occupational stress (Doyle et al., 2021; Pink et al., 2021), and may serve as a moderator of the stressor-stress relationship (Velichkovsky, 2009).

Impact of COVID-19 Virus on Mental Healthcare Professionals

While not as widely identified as frontline workers, mental healthcare professionals, including psychiatrists, psychologists, therapists, and counselors, remained essential providers during the COVID-19 pandemic. With an increase in depression and anxiety symptoms compared to the previous year (Abbott, 2021), there was an increased demand for mental healthcare (Ashcroft et al., 2021) and need for mental healthcare providers to continue seeing clients. However, many of these providers had the same personal struggles related to the pandemic and subsequent stay-at-home orders as the rest of world, including uncertainties and

anxiety (Lee, 2020). The unpredictable nature of the virus contributed to feelings of confusion and fear (Amorin-Woods et al., 2020). Many also had professional struggles, including the rapid transition from face-to-face therapy to online therapy, ethical and confidentiality concerns, and burnout.

Stress Related to Transition to Online Therapy. While the COVID-19 pandemic is a recent event primarily hitting the United States and the world in early 2020, there is already considerable literature regarding the need to transition from in-person or face-to-face therapy to virtual or online therapy, also referred to as teletherapy (Wiederhold, 2020). This transition brought about several professional challenges for mental healthcare providers as they worked to continue to see their clients. Many providers had limited experience providing therapy in this manner prior to the pandemic (Machluf et al., 2021). This may have contributed to increased professional self-doubt (Aafjes-van Doorn et al., 2021) that was reported by therapists. The therapist's own attitudes and beliefs about teletherapy, as well as their theoretical orientation, contributed to a reported increase in interruption of treatment (Salcuni et al., 2020). Some therapists may have felt their theoretical orientation would not be as effective in an online format—for example, play or art therapy. Therapists also reported feeling unsure and anxious about providing therapy online and feeling disconnected from their clients (Cronin et al., 2021). However, clinicians have an ethical obligation to: 1) do no harm, and 2) not abandon clients. Therefore, on the whole, most mental healthcare professionals remained committed to seeing clients and transitioned to providing online therapy services.

Many couples' therapists reported not being eager to continue teletherapy when the pandemic was over; they did concede that providing online therapy had a positive effect on their attitude (Machluf et al., 2021). They also believed that telehealth therapy was better than clients

not receiving any therapy services at all but rejected the notion that nothing was lost utilizing this form of treatment (Agnello & Giubellini, 2021). However, by one year after the onset of the pandemic, most clients—nearly 80%—had returned to in-person sessions (Humer et al., 2021).

Other concerns for mental healthcare providers in transitioning to teletherapy services included privacy issues (Cronin et al., 2021; Hardy et al., 2021; Levy et al., 2021). With the stay-at-home order many therapists were no longer seeing clients in their offices, which led to clients needing to find a place, typically within their own homes, that offered some level of privacy and maintained confidentiality (McBeath et al., 2020). Family therapists expressed specific concern regarding providing a safe space for family members during therapy and consideration of possible adaptations, such as sitting in separate rooms, were an option (Levy et al., 2021). Environmental adaptation included increased anxiety regarding managing risk, ensuring safety, and potential ethical considerations, as well as a varying sense of control (Smith & Gillon, 2021).

Many clinicians as well followed the stay-at-home order and worked from home seeing clients. This too presented a challenge as therapists needed to find a private place within their homes to maintain client privacy and confidentiality. For example, it may have been difficult for therapists with young children to find a place in the home that was quiet and far enough away from the typical noise children make. It also may have been challenging for young children to understand that while mom or dad was in that room, they could not disturb them.

Due to limited experience with teletherapy (Machluf et al., 2021), many therapists were ill-prepared for the rapid transition to providing online therapy. Clinicians not aware of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) may have utilized a platform that was not compliant with this requirement, risking client privacy and

confidentiality. While there are a variety of platforms available for online communication, it is imperative that clinicians choose one that maintains client privacy and confidentiality.

Another frequently reported concern was technological challenges (Chen et al., 2020; Cronin et al., 2021; Hardy et al., 2021; McBeath et al., 2020; Spiller, 2021) and how technology may affect the therapeutic relationship (Smith & Gillon, 2021). Technological issues can include things such as proper functioning of the audio or video. Clinicians may not have been well-versed in technology of this sort and may not have been able to help the client(s) navigate issues that arose. Sessions may have been interrupted by “freezing” of the video or a slow internet connection, or it may have been suddenly disconnected and dropped altogether, contributing to interference in therapy and possible frustration for the therapist and the client.

As with technology of any sort that is connected to the internet, such as a desktop, laptop, tablet, or cell phone, privacy and confidentiality cannot be 100% guaranteed. Of course, as mentioned previously, the clinician will want to do due diligence and utilize the safest and most compliant platform possible; however, any of these devices can be hacked. Therefore, clinicians have an ethical obligation to inform clients of these possible limitations of confidentiality (Cronin et al., 2021; Harding et al., 2021; McBeath et al., 2020).

Regardless of whether the client was being seen virtually or in-person wearing a face mask (Humer et al., 2021), it was also necessary for clinicians to be creative when delivering online therapy (Ashcroft et al., 2021). Making use of hand gestures and exaggerated facial expressions were ways in which to increase connection with clients (Cronin et al., 2021), as creating a therapeutic bond was another reported challenge with online therapy (Machluf et al., 2021). Managing conflict when providing services to couples and families was another reported

struggle for therapists (Levy et al., 2021; Machluf et al., 2021). It may have been more difficult to control the session, as sometimes there is a brief delay online, whereas in person it is easier for the clinician to interrupt a rising conflict.

Safety concerns, emergency issues, and crisis intervention and management were frequently reported with the transition to online therapy (Chen et al., 2020; Hardy et al., 2021; Smith & Gillon, 2021). When there is a crisis situation in a face-to-face office setting, for example a highly suicidal client, the clinician is well-prepared and equipped to provide and/or arrange for the level of care needed to keep the client safe. However, challenges arise when providing online therapy in a situation such as this. It may have been that the client was not at home and did not or would not identify their location. They may have been pulled over in a parking lot for their session and the clinician may not have known where to send help if it were deemed necessary.

It was also noted that therapy services may have pivoted to crisis work due to consequences of the pandemic, such as the loss of a loved one, job loss, or exacerbation of relationship difficulties (McBride et al., 2020). The stay-at-home order resulted in a dramatic change in routines and family dynamics. Difficult relationships may have become even more challenging with possibly increased fighting, stress, and anxiety. Abusive relationships may have become more abusive due to close proximity of the individuals. It may also have been more difficult to discuss and formulate a safety plan with an individual in an abusive relationship while the abuser was in the home with the client. It may also have been more difficult for the client to execute a safety plan as well.

Clients struggling with substance misuse and use disorders may have been more inclined to relapse due to the nature of the pandemic and the resultant isolation. The lockdown and

disruption in routines and in-person support services for those struggling with use disorders led to an increase in substance misuse and overdose (Arnold, 2020). Social distancing, isolation, and financial stressors could have contributed to individuals self-medicating and using substances while alone (Arnold, 2020). It was also noted that internet addiction rose among the general public during the COVID-19 pandemic (Li et al., 2021). This too could be attributed in part to the stay-at-home order with resultant isolation and lack of work for many individuals, and may have been a trauma response.

There were, however, some benefits from this transition to teletherapy. Therapists reported working online had actually enhanced their clinical skills such as engaging in reflective practice, listening, and developing increased attentiveness skills (Smith & Gillon, 2021). It was also noted that online sessions served to provide greater convenience, flexibility and comfort for both the therapist and the couples (Hardy et al., 2021). It was no longer necessary for the client to live in close proximity to the clinician's office and the provider could see clients throughout the state in which they were licensed (McBeath et al., 2020). Therapists remained committed to providing services and continued to find ways to increase connection with their clients (Cronin et al., 2021).

Stress Induced Burnout of Mental Healthcare Providers During COVID. Burnout, or a state of exhaustion that can occur when one experiences prolonged stress or fatigue (Ashcroft et al., 2021; Jacome et al., 2021; Sklar et al., 2021), can occur when one experiences prolonged stress or exhaustion, either mental, emotional, physical, or any combination of those. Due to the nature of uncertainty of the virus, burnout could potentially have been high in any profession during the pandemic. However, burnout has especially been an area of concern for mental healthcare providers during the course of the COVID-19 pandemic. With the increased

need for mental healthcare (Ashcroft et al., 2021) and mental health providers struggling with the stress, anxiety, depression, trauma, and other symptoms due to or exacerbated by the virus, identifying causes and recognizing symptoms of burnout is imperative in an effort at reducing risk of burnout to clinicians.

Literature has specifically identified one contributing factor related to clinician burnout as telepressure (Kotera et al., 2021). Telepressure is the perceived requirement to check and respond quickly to messages received from clients (Kotera et al., 2021). Most mental health providers are empathetic to the needs of clients and, of course, want to help them. The stressors, uncertainty, and confusion of the pandemic may have worsened some clients' symptoms, and while they had not been in crisis previously, the pandemic may have created a crisis situation. This could have led to a perceived pressure to respond quickly to these clients.

Other factors contributing to clinician burnout include health issues, income reduction (Jacome et al., 2021), and increased patient load (Ashcroft et al., 2021). While at the onset of the pandemic many clinicians had a dramatic decrease in patient load, as previously noted there was an increased need for mental healthcare services as the pandemic continued, which led to an increase in patient load and an increase in work hours for many mental health providers. Furthermore, increased work changes, such as changing work setting—for example, from private practice to a community clinic—changing teams, or changing tasks were associated with increased levels of burnout among mental health providers (Sklar et al., 2021).

Vicarious trauma is a trauma that can be the result of repeated exposure to others' trauma. Mental healthcare professionals can be at increased risk for vicarious trauma as the nature of their work is often being exposed to clients' traumatic events. Moderate to high levels of vicarious trauma were reported in therapists during the COVID-19 virus. Therapists of

younger age and/or those with less clinical experience were found to experience higher levels of vicarious trauma. Increased vicarious trauma was associated with greater distress, tiredness, and decreased competence and confidence (Aafjes-van Doorn et al., 2020). Vicarious trauma and the related distress can be a contributing factor to clinician burnout.

Psychological symptoms from burnout can include feelings of guilt, anxiety, and frustration. High levels of burnout have also been associated with increased depression and stress (Jacome et al., 2021). If a clinician is struggling with their own negative psychological symptoms, they may struggle to stay present and engaged with clients. Clinicians may also have negative attitudes towards their clients if they lack their own emotional resources and lack the ability to show empathy and understanding (Ensari, 2021).

It is imperative, therefore, that clinicians practice self-care in an effort at minimizing the risk of burnout, for better mental health for themselves and for the benefit of their clients. Some self-care recommendations for reducing burnout include stress reduction and increasing self-care strategies, which may include eating a healthy diet, getting regular exercise, engaging in meditation, taking regular breaks, and getting proper sleep (Ensari, 2021).

Stress Related to Personal and Family Challenges During COVID-19. Physicians (psychiatrists) and medical family therapists reported challenges during the coronavirus pandemic that contributed to feelings of moral distress. Some of these challenges included social isolation and a sense of lack of control and confusion (Patterson et al., 2021). Many clinicians also experienced therapist fatigue (McBeath et al., 2020) due to increased client caseload as the pandemic wore on, a significantly increased amount of time spent on a computer providing teletherapy sessions, and possibly experiencing their own family and personal stressors. Just as the rest of the world did, mental healthcare providers also struggled

with separation from loved ones, isolation, confusion, and fear (Amorin-Woods et al., 2021; Amorin-Woods et al., 2020). Isolation can be particularly difficult because humans recognize that they are interconnected and interdependent, and that maintaining relationships is vitally important (Amorin-Woods et al., 2020).

The uncertainty of the pandemic raised existential issues of death and dying, nothingness, the unknown, wonder, identity, and freedom (Spiller, 2021) that impacted nearly everyone worldwide. Mental healthcare professionals were not immune to these concerns. The COVID-19 virus did not discriminate. While different age groups were at higher risk, there was no guarantee that one would have a mild case or would survive if infected. There was, of course, also the fear of loved ones becoming infected and perhaps succumbing to the virus. Many freedoms previously enjoyed and perhaps taken for granted, such as dining inside a local restaurant, going to visit one's neighbor, or taking a flight across the country to visit a family member were no longer allowed.

Many clinicians initially struggled with a rapid decline in clients due to the stay-at-home orders, which resulted in financial concerns with a decline in income (Amorin-Woods et al., 2021, Patterson et al., 2021). These financial concerns could have contributed to additional stress, anxiety and depressive symptoms. Therapists who experienced threats to their own livelihood may have had decreased ability to access coping resources of their own, yet needed to continue to support clients and help them manage their emotions (Lombana, 2021). This potentially could have been very challenging and could also have contributed to an increased likelihood of burnout as well.

Challenges also included the proximity of family while seeing clients from home, which resulted in difficulty finding a private space in their home (Cronin et al., 2021; Hardy et al.,

2021; Levy et al., 2021; McBeath et al., 2020). As mentioned previously, this could have been particularly challenging for clinicians with young children, school-age children who were at home completing online classes due to statewide school closures, or if there were many family members living in their home. This not only represented a potential privacy and/or confidentiality issue (Cronin et al., 2021; Hardy et al., 2021) but could also have proven to be distracting from the therapy session if there was considerable noise on the other side of the door or if there were other interruptions. It also may have been challenging to ignore what was going on in the household while in session. For example, a therapist may have heard children fighting or crying. Even if they were being appropriately supervised or were old enough to care for themselves, it may have been difficult to tune some things out.

There was also reported difficulty quickly switching roles, such as going from therapist to parent, for those clinicians with children at home (McBeath et al., 2020). When working from home clinicians may have had difficulty finding adequate time to transition from a therapist mindset to a parent mindset or spouse mindset, as this may have been accomplished on the travel home from the office prior to the stay-at-home order. A clinician may need time to process the content of the session, practice detached concern, and not let the material affect them throughout the rest of the day or affect how they engage with their family members or loved ones.

Man-made and natural disasters can cause short-term and long-lasting emotional consequences (Acierno et al., 2007; Davis et al., 2010; Hussain & Sarma, 2016; Knez et al., 2021; Ruggiero et al., 2012). The COVID-19 pandemic is one such event that had consequences worldwide, affecting various sectors of the workforce. One job sector particularly hard hit has been healthcare providers such as doctors and nurses (Arcadi et al. 2021; Jun et al., 2020; Muz & Erdogan Yuce, 2021; Radfar et al., 2021; White, 2021), but also mental health providers such as

psychologists, counselors, and therapists (Aafjes-van Doorn et al., 2020; Cronin et al., 2021; Hardy et al., 2021; Jacome et al., 2021; Kotera et al., 2021; Levy et al., 2021; McBeath et al., 2020; Smith & Gillon, 2021). Some therapists have experienced increased stress due to transitioning to online therapy (Machluf et al., 2021) and technological challenges that arose with this transition (Chen et al., 2020; Cronin et al., 2021; Hardy et al., 2021; McBeath et al., 2020; Spiller, 2021). Others experienced increased stress due to social isolation and a sense of lack of control and confusion (Patterson et al., 2021), therapist fatigue (McBeath et al., 2020), and burnout (Kotera et al., 2021). However, the longer-lasting effects of the COVID-19 pandemic still remain to be seen.

Summary

Recent research has shown that some occupations, such as those working as first responders, place individuals at greater risk of increased stress when working within a pandemic (Carleton et al., 2017; Doyle et al., 2021; Litam et al., 2021). It is necessary for those working in these occupations to develop greater levels of resilience, as it has been shown that resilience can have a mediating effect on stress (Doyle et al., 2021) and individuals with a higher degree of resilience may have fewer negative effects of occupational stress (Reicherts & Pihet, 2000). First responders have been shown to have significantly higher levels of resilience than healthcare workers and the general population (Pink et al., 2021). Therefore, in light of studies that have revealed higher levels of resilience corresponding with lower levels of occupational stress, it is important for qualitative research to be conducted to understand the emotional impact of working through a pandemic as an essential healthcare worker.

For most, mental healthcare providers were considered essential workers and were at the frontlines for many individuals and families struggling with the challenges encountered during

the COVID-19 pandemic. Much research has been done to understand the impacts of the pandemic on essential healthcare workers (Arcadi et al. 2021; Chatzittofis et al., 2021; Chegnin et al., 2021; Jun et al., 2020; Muz & Erdogan Yuce, 2021; White, 2021). Additionally, studies have been conducted to understand the increased stress placed on mental healthcare providers in making a sudden shift from in-person to telehealth services (Cronin et al., 2021; Hardy et al., 2021; Kotera et al., 2021; Levy et al., 2021; McBeath et al., 2020; Smith & Gillon, 2021), as well as psychological symptoms of burnout due to increased stress (Aafjes-van Doorn et al., 2020; Jacome et al., 2021). However, what is lacking in the literature is understanding how licensed marriage and family therapists (LMFT) describe the emotional impact as essential healthcare workers during the COVID-19 pandemic. The present study explored how licensed marriage and family therapists describe working as essential healthcare workers during the COVID-19 pandemic and analyzed any themes that presented themselves.

CHAPTER THREE: METHODS

Overview

The purpose of this chapter is to introduce the research methodology for this qualitative phenomenological study regarding how licensed marriage and family therapists (LMFT) describe the emotional impact as essential healthcare workers during the COVID-19 pandemic. This approach builds upon existing literature of phenomenological studies regarding the lived experiences of licensed marriage and family therapists who experienced work and personal stress during a natural disaster.

Design

As previously stated, this study was a qualitative study. Qualitative research is an appropriate methodology when the researcher's purpose is to discover and gain insight on prominent issues (Creswell, 2007). The study was guided by the desire to better understand the lived experiences of licensed marriage and family therapists (LMFT) during the COVID-19 pandemic and the emotional impact on them as essential healthcare workers during that time. This research design chosen for this study was a transcendental phenomenological study. Based upon Pietkiewicz and Smith's (2014) recommendations, a small sample size of 8 to 15 LMFTs was utilized. This allowed for detailed analysis of each interview.

Phenomenology can be described as the study of phenomena manifested in the experiences of people and how these people perceive, understand, and give meaning to such phenomena. Creswell and Poth (2018) put it simply as the "common meaning for several individuals of their lived experiences" of a phenomenon (p. 75). This description of the lived experience includes what was experienced and how it was experienced (Creswell & Poth, 2018; Moustakas, 1994). Moran (1999) describes phenomenology as emphasizing the "attempt to get to

the truth of the matter" (p. 4).

The origin of phenomenology dates back to the early 20th century and specifically to the writings of Edmund Husserl. His "understanding of phenomenology grew out of his attempt to understand the nature of mathematical and logical truths" (Moran, 1999, p. 10). Husserl advanced a descriptive phenomenological research design (Connelly, 2010). This type of design is based on the descriptions of lived experiences provided by individuals.

Transcendental phenomenology is a research methodology that seeks to further understand human experience (Moustakas, 1994). This method is "focused less on the interpretations of the researcher and more on a description of the experiences of participants" (Creswell & Poth, 2018, p. 78). This method was selected for this study as a description of the participants' experiences, instead of attempts at interpretation by the examiner, provided greater ability for the examiner to bracket their own personal and professional relationship to the phenomenon and minimize any potential bias (Moustakas, 1994).

Research Questions

This study sought to build a theory in answer to the following research questions:

Central Research Question: How do licensed marriage and family therapists (LMFT) describe the emotional impact on their personal and professional lives as essential healthcare workers during the COVID-19 pandemic?

Guiding Question: How do LMFTs describe the feelings they associated with stress during the COVID-19 pandemic?

Setting

The research was conducted via live interviews on the Zoom online platform due to the researcher's location being different than that of the population being studied and the

participants' locations, with the participants living and working in the County of San Diego in California. The researcher was located in their private therapy office while the participants were located either in their private therapy offices or their own homes during the interviews. The participants were encouraged to choose a location in which they were most comfortable sharing information related to their experience with the phenomenon in question.

Participants

Brinkman and Kvale (2015) describe the semi-structured interview technique as "attempts to understand the world from the subjects' point of view, to unfold the meaning of their experience, to uncover their lived world" (p. 3). This therapist population was determined by the individual therapists' ability and willingness to participate in the interview process and to discuss their perceptions and experiences as practicing providers during the time of the COVID-19 pandemic outbreak. The qualitative phenomenological design reduces the participants' "experiences to a central meaning or the 'essence' of the experience" (Creswell & Poth, 2018, p. 314), and as the experiences of the participants was the focus of this study, a research interview design was utilized to best achieve the desired information.

The participant sample included 8 licensed marriage and family therapists (LMFTs) in the State of California, County of San Diego, of any gender, age, and ethnicity with the caveat that the participants were able to speak English; this was because the researcher only speaks English and no interpreters were available. Specific criteria needed to be met by the participants. These criteria included: 1) must be a licensed marriage and family therapist, 2) each LMFT must have been in a private practice setting, and 3) each LMFT must have been practicing prior to outbreak of the COVID-19 pandemic (i.e. earlier than January 2020 or before). Along with much of the country, the State of California, and the County of San Diego specifically, issued a stay-at-

home order at the outbreak of the COVID-19 virus. While therapists were considered essential workers during this time, many clinicians in private practice chose or were forced to discontinue in-person sessions and transition to online sessions only. As such, the participants were private practice therapists who continued to see clients during this time period.

Purposeful sampling was utilized to "intentionally sample a group of people that can best inform the researcher" (Creswell & Poth, 2018, p. 148) about the phenomenon being studied. This provided a homogenous sampling. Participants were recruited through a convenience sampling method. This was done through simply inviting therapists in private practice in San Diego County to participate. Those who agreed to participate were then scheduled for an interview. Additionally, those therapists who did agreed to an interview were asked if they knew of any other therapists who might be interested in participating in this research study. This form of recruiting is known as the snowball sampling technique (Merriam & Tisdell, 2016).

Procedures

Institutional Review Board (IRB) approval was requested and obtained prior to the beginning of this research study. The Director of Clinical Training of the MFT Program at Azusa Pacific University in San Diego, CA was contacted as she had previously offered to help recruit participants for this study. The next step in the process was to contact the therapists whose names were provided to the researcher to inquire about their willingness to participate in the study. Those who wanted to participate were given an Informed Consent (Appendix A). The Informed Consent included details of how the data would be collected (i.e., through an individual interview) and acknowledgment that the interview would be recorded. Once signed the informed consent was returned to the researcher and this provided approval for their participation. Appointment times were then offered to schedule a virtual online interview via the Zoom video

conferencing platform.

Interviews were held individually by the researcher. As these were semi-structured interviews, the length of the interview varied depending on the participants' engagement with an expected minimum of 30 minutes, but with an understanding that each may last longer (DiCicco & Crabtree, 2006). McFarland-Morris (2020) found semi-structured interviews tend[s] to last approximately 40 minutes. Smith et al. (2022) indicated a semi-structured interview "tend to occupy between 45 to 90 minutes of conversation" (p. 57). Interviews for the present study were scheduled for one hour. Each interview was recorded and the researcher took some notes by hand when necessary to gather the purest information. The study participants were asked a series of questions in this semi-structured interview that were intended to better elucidate the research topic. The participants were encouraged to answer the questions as candidly as they could.

As one of the final steps of the present research, after all the interviews had been completed and the data had been collected, the data were analyzed. In an effort to bring to light the entire essence of the studied phenomenon (Peoples, 2021), the data were analyzed by "organizing the data, coding, organizing themes, representing the data, and forming an interpretation of them" (Creswell & Poth, 2018, p. 181).

The Researcher's Role

The researcher's role in this qualitative study was to serve as the primary instrument through which information was obtained from the study participants via interview questions. The researcher had no relationship with the therapists who agreed to participate in the research study.

The researcher is herself a licensed marriage and family therapist who was practicing in San Diego County at the time of the COVID-19 virus outbreak. This study was motivated by the researcher's desire to better understand the personal and professional emotional impact on other

LMFTs in private practice during that time period. As the study was a transcendental phenomenological study, the researcher was the "primary instrument" (Chan et al., 2013, p. 3) and needed to bracket out her own experience, or "engage in disciplined and systematic efforts to set aside prejudgments regarding the phenomenon" (Moustakas, 1994, p. 22). Chan et al. (2013) state that "the ability to be aware of one's own values, interests, perceptions and thoughts becomes a prerequisite before we can set aside the things that influence the research process" (p. 3). It is also recommended that the concept of bracketing be kept "in the researcher's mind throughout the research process" (Chan et al., 2013, p. 3). The researcher did not share any personal opinions or beliefs about the phenomenon at any point during the interview process.

Data Collection

The method of data collection utilized within this transcendental phenomenological qualitative study consisted of: 1) individual in-depth, semi-structured interviews with the research participants, and 2) researcher notes taken during these interviews. Such individual interviews are considered a standard procedure utilized in this type of qualitative study (Creswell & Poth, 2018) as they strive to more clearly understand the research participants' point of view and to disclose and better appreciate how they interpret their experiences (Kvale & Brinkman, 2009). According to Giorgi (1997) "questions are generally broad and open-ended so that the subject has sufficient opportunity to express his or her viewpoint extensively" (p. 245). Open-ended questions "leave the participant free to respond in whatever way" they choose (Magnusson & Marecek, 2015). This form of questioning works nicely to "elicit rich, full, and complex accounts from the participants" (Magnusson & Marecek, 2015, p. 46). Therefore, the researcher asked open-ended questions, as this approach allowed the research participant to provide as much information as they chose with as many details as they wished. Additionally, the questions

were asked in language, vocabulary, and verbiage familiar to the participants so as to reduce the likelihood of hinderance caused by use of theoretical terms (Brenner, 1994). While at times it may have been necessary and appropriate to use "technical terms in the field" (Rubin & Rubin, 2011, p. 132), ordinary, easily understood language was implemented. The interviews were scheduled via Zoom or other online platforms to permit the researcher the ability to observe and take note of the participants' facial expressions or other significant body language.

Interview Schedule

Icebreaker Questions

1. What do you like most about living in San Diego?
2. What do you like most about being a therapist?

Personal and Professional Impact Questions

3. How would you describe resilience in your own words?
4. How would you describe your level of resilience?
5. Describe how your level of resilience helped or failed to help your ability to successfully manage the emotional impact of the pandemic.
6. Talk to me about any struggles you experienced due to the COVID-19 virus outbreak.
7. Tell me how COVID affected your professional life, if at all.
8. Describe the aspects of your professional life that changed due to the pandemic, if at all.
9. Of any changes that you did experience in your professional life, which would you say was the most significant and why?
10. Talk to me about how you coped with these changes in your professional life?
11. Talk to me about how COVID-19 affected your personal life.
12. Describe how your personal life changed during the pandemic, if at all.

13. Of any changes that you did experience in your personal life, which would you say was the most significant and why?
14. Talk to me about how you coped with these changes in your personal life.
15. Talk to me about how, if at all, the pandemic affected your work/life balance.
16. Tell me how you coped with any work/life balance changes.

Stress Related Questions

17. Tell me about how stress affected your ability to continue in your practice.
18. Describe any personal and family challenge(s) you faced due to stress.
19. Tell me about any other change(s) in life stressors you experienced during the pandemic.
20. Talk to me about how these changes affected you.
21. Describe any difference(s) in your ability to cope with stress during the pandemic than prior to the outbreak of COVID.
22. Describe the feelings you associate with the stress you experienced during COVID.
23. We have discussed a lot of material today. I do not have any further questions for you. Do you have anything else you would like to add or any questions for me?

Questions one and two were icebreaker questions, allowing the participants to become more familiar with the interview process and more comfortable with the interviewer.

Resilience has been described as the ability to adapt to and overcome adverse or traumatic experiences or other life-altering events (Zimmerman, 2013). Questions three and four provided the participants an opportunity to identify and reflect on their own ability to adapt to adverse experiences and their level of resilience.

Questions five through eight were created to expound upon previous research regarding psychotherapists/counselors' professional experiences at the onset of the COVID-19 pandemic

(Aafjes-van Doorn et al., 2022; Cronin et al., 2021; Hardy et al., 2021; Lee, 2020; Levy et al., 2021; Litam et al., 2021; Machluf et al., 2021). Question nine allowed the participants to discuss their ability to cope with (level of resilience) this adverse experience.

Questions ten through twelve were created to gain further insight into the lived experiences of clinicians and how the trauma of the pandemic affected them personally, as to date there is little research in this area (Patterson et al., 2021). Questions thirteen and fifteen allowed the participants to express their view of their ability to cope with (level of resilience) any challenges in their personal life due to the pandemic.

Questions sixteen through nineteen allowed the participants to describe any stress-related challenges experienced during the initial outbreak and immediate aftermath of the COVID-19 pandemic (Brillon et al., 2022; Chen et al., 2020; Kotera et al., 2021). Question twenty examined the participants' view of their level of resiliency and allowed the participants to describe any differences noticed. Question 21 aimed to uncover the feelings the participants associated with any stress experienced during the pandemic. The questions were formulated keeping in mind the transcendental phenomenological research design of examining the lived experiences and essence of such experiences (Creswell & Poth, 2018).

Data Analysis

Peoples (2021) describes the goal of transcendental phenomenology to be bringing to light the essence of the entirety of a phenomenon. Moustakas' (1994) recommendations for analyzing phenomenological data procedures were used in this research study. According to Creswell & Poth (2018) data analysis consists in "organizing the data, coding, organizing themes, representing the data, and forming an interpretation of them" (p. 181).

The researcher avoided insertion of their own personal bias and/or judgments. The practice of setting aside one's personal experiences is referred to as bracketing or Epoche (Chan et al., 2013; Moustakas, 1994). This setting aside of one's judgment allows for greater understanding of the participants' experiences. However, Creswell and Poth (2018) also indicate the researcher "relies on intuition, imagination, and universal structures" (p. 315) to derive an understanding of the experience.

Familiarization

The researcher began data analysis by familiarizing herself with the data received from each interview. This was done by immersing herself into the data (Braun & Clarke, 2021). Immersion took place by transcribing the interviews verbatim and then performing a preliminary verbatim read-through (Creswell & Poth, 2018) of all the data obtained. Additionally, the researcher listened to the audio recordings of the data. She then re-read the dataset several times to obtain familiarization with the information (Ravitch & Carl, 2015). During the re-reading of the data she developed a "list of significant statements" (Creswell & Poth, 2018) and highlighted quotes that were pertinent to the participants' experiences of the phenomenon under investigation.

Categorization

Data were categorized according to topics. This step of creating listings and preliminary groupings is part of the horizontalization process described by Moustakas (1994). Merriam and Tisdell (2016) describe horizontalization as "the process of laying out all the data for examination and treating the data as having equal weight" (p. 27). This horizontalization process was useful in creating themes of the participants' experiences. The transcripts were organized into highlighted quotes or statements of significance. These significant statements were used to

write textural and structural descriptions of the phenomenon, which helped provide a better understanding of how the participants experienced the phenomenon (Creswell & Poth, 2018). This was done to organize the information into specific manageable sections and facilitate categorization further on in the coding process.

Coding

After completion of re-reading the data transcripts, familiarizing myself with the dataset, and putting topics into sections, the researcher began coding the data. In qualitative analysis, a code is typically "a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldana, 2021). The researcher coded the "meaning units" (Moustakas, 1994, p. 122), including the previously organized highlighted quotes and/or statements of significance. These codes were then summarized and clustered (Moustakas, 1994) based on commonality (Saldana, 2021).

Theming

The clusters were then categorized into larger themes and entered into an Excel spreadsheet to review and compare the context of the participants' experiences, highlighting themes that emerged. A theme is described as "an extended phrase or sentence that identifies what a unit of data is about and/or what it means" (Saldana, 2021, p. 257). The thematic statements were compared across the data sets in an effort to reach the experienced essence of the phenomenon by the participants. The researcher was looking across the individual datasets, or Personal Experiential Themes (PETs), for any patterns of similarities or differences (Smith et al., 2022). In doing this, she was be looking to generate a set of "shared or unique features of the experience" (Smith et. al., 2022, p. 100) or Group Experiential Themes (GETs) with an aim of identifying any overarching themes shared by the participants. An overarching theme can include

a number of themes and can demonstrate a "broader conceptual idea" that anchors ideas together (Braun & Clark, 2021, p. 86).

Trustworthiness

It is of utmost importance to address trustworthiness in qualitative research. According to Lincoln and Guba (1985) the four criteria utilized in establishing trustworthiness in a qualitative study include credibility, dependability, transferability, and confirmability. Trustworthiness has also been used to mean "validity, credibility, and believability of our research—as assessed by the academy, our communities, and our participants" (Harrison et al., 2001, p. 324). Merriam and Tisdell (2016) describe what makes a study trustworthy is "the researcher's careful design of the study, applying standards well developed and accepted by the scientific community" (p. 238).

Credibility

Credibility deals with the belief by the research participant that the researcher portrayed their perceptions accurately (Bloomberg & Volpe, 2019). The researcher sought to establish credibility by actively listening to the participants and by memoing and taking extensive notes during the interview process (Creswell & Poth, 2018). She also sought to establish credibility through member checking, or feedback from the participants themselves (Motulsky, 2021). Member checking allows for the participants to review the accuracy of the data, and the validity procedure then shifts to the participants rather than the researcher (Creswell & Miller, 2000). Participants were provided a summary of their individual interview, as well as the results of the overall data analysis. They were provided an opportunity to review the data and verify the accuracy of the findings. They were encouraged to notify the researcher of any inaccuracies or missing information to be corrected.

Dependability and Confirmability

Dependability is similar to reliability in that they both pertain to whether a study can consistently be replicated over time (Bloomberg & Volpe, 2019). The researcher worked to increase dependability by making sure the process was clearly documented, logical, and traceable (Bloomberg & Volpe, 2019). This was accomplished by carrying out the interviews in a consistent manner while allowing the participants ample opportunity to describe their experiences of the phenomenon. After careful analysis and interpretation of the data, the researcher, as mentioned previously, provided the opportunity for the participants to review their individual interviews as well as the overall data analysis for any corrections.

In an effort to ensure the data were free of researcher bias or assumptions and, therefore, to enhance confirmability, an internal audit trail was maintained (Carcary, 2020). The use of an audit trail included maintaining a journal of the research activities, documenting procedures used and observations made during the interviews, and documenting analysis of the data (Creswell & Miller, 2000). This helped to make the research design transparent and provided "details of the data collection, analysis, reduction, and synthesis, the researcher's theoretical, methodological, and analytical choices, and interpretations that led to the research findings" (Wolf, 2003, as cited in Carcary, 2020, p. 167). Memoing of ideas, short phrases, or key concepts was utilized in order to "synthesize" the data (Creswell & Poth, 2018), As previously mentioned, member checking was implemented to confirm accuracy of the data collected from the participants.

Additionally, an external audit trail was utilized. An external audit trail consists of having a second party not previously involved in this study evaluate the procedures, data analysis, and the reported findings to assess the study's accuracy (Peoples, 2021), with a goal of confirming the study's findings (Carcary, 2020).

Transferability

Transferability refers to the ability to transfer or generalize the research findings to other populations, contexts, or studies. Peoples (2021) indicates that insights from lived experiences of the study participants "may be similar to insights about other populations with similar experiences" (p. 85). Put another way, Bloomberg and Volpe (2019) state, "it is likely that the lessons learned in one setting might be useful to others" (p. 205). When evaluating transferability, considerations included the setting, the participants and their experiences, as well as the research procedures (Peoples, 2021). To ensure transferability, efforts were made to provide sufficient rich, thick descriptions (Lincoln & Guba, 1985) of these points. Merriam and Tisdell (2016) explain that rich, thick descriptions help readers to "contextualize the study" (p. 257) so that readers can decipher "the extent to which their situations match the research context, and, hence, whether findings can be transferred" (p. 257). Researchers in counseling centers or emergency management personal may be able to utilize this study's finding in the future.

Ethical Considerations

When research is being conducted on human participants, great care should be taken in considering ethical concerns. Approval from the IRB was procured prior to initiation of any research. Additionally, the details of the research and data collection process were discussed with the participants and consent forms provided. Confidentiality was maintained by keeping participants anonymous and replacing individuals' names with pseudonyms. All handwritten notes were maintained in a locked filing cabinet behind a locked door and all computer generated data were password protected. The researcher was only person who had access to all of the information.

As a licensed marriage and family therapist who experienced the same phenomenon being researched, the researched worked to maintain a neutral stance and remain unbiased by keeping an open mind and engaging in active listening as the participants shared their own experiences.

Summary

The purpose of the present research was to gain a better understanding of how licensed marriage and family therapists experienced the emotional impact of being essential workers during the COVID-19 pandemic and what the stress they experienced means to them. Currently, little research exists in this area. This qualitative transcendental phenomenological study took place in the form of semi-structured interviews via a Zoom online platform of LMFTs living and practicing in San Diego County at the onset of the COVID-19 pandemic.

CHAPTER FOUR: FINDINGS

Overview

This transcendental phenomenological study aimed to explore and better understand the lived experiences of licensed marriage and family therapists in private practice during COVID-19 related to stress and level of resilience as a means of coping with the stress. The following research question guided this study: How do licensed marriage and family therapists (LMFT) describe the emotional impact on their personal and professional lives as essential healthcare workers during the COVID-19 pandemic? This chapter includes participant descriptions, data collection, data analysis and results, including narrative descriptions of the eight participants, common themes identified across the eight participants, evidence of trustworthiness, and a chapter summary.

Prior to beginning the research, approval was obtained from the Institutional Review Board (IRB) and informed consent was collected and filed. A combination of purposeful sampling, convenience sampling, and snowball sampling (Merriam & Tisdell, 2016) methods were utilized to recruit participants and "best inform the researcher" (Creswell & Poth, 2018, p. 148) about the phenomenon being studied. Semi-structured interviews were conducted using open-ended questions, allowing the research participants to provide as much information as they chose with as many details as they desired. The researcher actively listened to the participants and took extensive notes during the interview process to establish credibility (Creswell & Poth, 2018).

Data analysis began with familiarization of the data received (Braun & Clarke, 2021). This took place by transcribing the interviews verbatim, performing a verbatim read-through of the data, and recording reflexive notes for each data set (Creswell & Poth, 2018). The datasets

were re-read several times to obtain familiarization (Ravitch & Carl, 2015). During this re-reading, a list of significant statements was developed (Creswell & Poth, 2018) and pertinent quotes related to the participants' experiences of the phenomenon were highlighted. The coding process began by assigning a short phrase to the significant statements that symbolically assigned an essence-capturing attribute to the data (Saldana, 2021). These "meaning units" (Moustakas, 1994, p. 122) were then summarized and clustered (Moustakas, 1994) based on commonality (Saldana, 2021). These clusters were categorized into themes, entered into an Excel spreadsheet, and reviewed for phrases or sentences that identified what they meant (Saldana, 2021). The thematic statements were compared across all of the data sets looking or any patterns of similarities or differences (Smith et al., 2022). Overarching themes shared by the participants were identified.

Each participant was provided a summary of their individual interview as well as the results of the overall data analysis for review. This is called member checking and provided the participants an opportunity to review the data and verify the accuracy of the findings (Creswell & Miller, 2000).

All datasets, notes, and spreadsheets were provided to a Licensed Marriage and Family Therapist familiar with qualitative research for review. This served as a peer review of the material, the analysis, and the results. This LMFT found the data to be comprehensible and informative with no request for additional information or clarification.

Participants

All participants had previously given consent for the use of pseudonyms in place of their real names, and all were assigned pseudonyms to maintain participant confidentiality. All participants worked in the capacity of a Licensed Marriage and Family Therapist at the time of

the COVID-19 pandemic. Table 1 reflects the demographics of participants reported at the time of their participation with their identified gender, age, and race and/or ethnicity. Participants were in the age range of 34 to 76 years old, of which 7 identified as female and 1 identified as male.

Table 1

Summary of Participant Demographics

Name (Pseudonym)	Ethnicity	Gender	Age
George	Caucasian	Male	66
Brenda	Black	Female	63
Carly	Caucasian	Female	34
Susy	Caucasian	Female	63
Vanessa	Hispanic	Female	52
Patrice	Black	Female	58
Terri	Caucasian	Female	76
Lois	Caucasian	Female	54

George

George is a 66-year-old Caucasian male. He is retired from his previous profession and currently works as a Licensed Marriage and Family Therapist. He does so to serve others and for personal fulfillment. He specializes in marital counseling, anxiety, and grief. George is married with adult children and grandchildren.

Brenda

Brenda is a 63-year-old Black female. She is 30 years into her career as a Licensed Marriage and Family Therapist. Brenda specializes in trauma and posttraumatic stress, anxiety, and depression. Brenda is also an author and inspirational speaker. Brenda is married with college-aged and adult children.

Carly

Carly is a 34-year-old Caucasian female who is married with one middle-school-aged child. She works as a Licensed Marriage and Family Therapist who specializes in trauma, stress, and anxiety, and also works as a college instructor.

Susy

Susy is a 63-year-old Caucasian female. She works as a Licensed Marriage and Family Therapist two days a week and describes her and her husband as semi-retired, stating she continues as an LMFT because she finds helping people extremely rewarding. Susy specializes in grief counseling, as well as marital and pre-marital counseling. Susy has adult married children.

Vanessa

Vanessa is a 52-year-old Hispanic female. She is a Licensed Marriage and Family Therapist who specializes in trauma and posttraumatic stress, as well as anxiety. Vanessa is married with adult children and explains that her husband has been the primary wage earner, which provided reassurance at the time of COVID.

Patrice

Patrice is a 58-year-old Black female. She is a Licensed Marriage and Family Therapist who specializes in anxiety, depression, and trauma. Patrice is married with adult children.

Terri

Terri is a 76-year-old, married Caucasian female. She explained that she began her career as a Licensed Marriage and Family Therapist later in life and continues to see clients for the joy of helping others. Terri specializes in trauma, grief, anxiety, depression, and addiction. Terri is married with adult children and grandchildren.

Lois

Lois is a 54-year-old Caucasian female. She is a Licensed Marriage and Family Therapist who specializes in anxiety, depression, and parenting issues, and has a special passion for working with the LGBTQ+ community. Lois is married with adult children.

Results

Themes were discovered and developed by conducting individual interviews. The themes that emerged were directly related to the central research question: "How do licensed marriage and family therapists (LMFT) describe the emotional impact on their personal and professional lives as essential healthcare workers during the COVID-19 pandemic?" and the guiding research question: "How do LMFTs describe the feelings they associated with stress during the COVID-19 pandemic?" The themes describing the emotional impact of COVID-19 on the LMFTs' personal and professional lives included: (a) A newly discovered ability to slow down, take a break, and/or the need to reprioritize what was most important in one's life, (b) The realization of significant differences in belief about the pandemic and a subsequent divisiveness, and (c) A pressure to do what the LMFT felt was right for the client. The themes describing the feelings associated with stress during the pandemic included: (a) Frustration with the unknown of the virus and how to respond, (b) Fear amidst the uncertainty of circumstances, (c) Anger at the changes in how people were treating each other

Theme One: The Ability to Slow Down

The first theme that became evident was a newly discovered ability to slow down, to take a break, and/or the need to reprioritize what was most important in life. This theme was shared by all participants at the time of the individual interviews, which took place March through May of 2023, approximately three years after the outbreak of the COVID-19 pandemic. Each participant described in various ways how the stay-at-home order put into place to slow the

spread of the virus provided them an unexpected opportunity to reflect on their own schedules, relationships, and capacities and allowed them the chance make changes in these areas.

During the interview George explained that he had retired from a previous profession and currently works as an LMFT for the fulfillment, not the money, and he was not depending on the income from working as a therapist. When the stay-at-home order was put into place, he did not experience significant financial stress, but actually discovered an ability to slow down. He described his experience at the onset of the COVID pandemic as follows:

> Well, for me at the very beginning it was a nice opportunity. I was at two different sites and I just, working three days, two sites, and I just like, this is ridiculous. I don't need to do this. So I dropped one of the sites and went to two days. I think COVID spoiled me in some ways because it was like, you know, I used to have a contest with myself, how many clients can I see today? And there were times when I would do eight or ten clients in a day. Yeah, and it was just silly. So it's just, so I think, COVID just kind of spoiled me into saying, you know, four or five is a nice number. I don't need to do any more than that. And, I think it kind of made me realize that for me, I did not need that many and a little extra money didn't matter. I guess maybe I hadn't really put it together, but that probably would be one of the things that COVID did, you know, I didn't need to see that many clients.

From the onset of COVID to the time of the study interview, George continues to see clients but while maintaining a lighter schedule and not having a contest with himself to see how many clients he can put into his schedule. Vanessa also did not have financial stressors but did have her own family losses during the pandemic. She described her reduced caseload and ability

to be home more as one way she was able to keep herself healthy and subsequently she had the ability to be there for her clients:

> Well, one of the positives about COVID is I was home more. I did take time off, obviously, when my sister passed away, so there's that. But because the workload was reduced, I was not needing to commute. I mean, I had a very short commute anyhow, but there wasn't the back and forth. So meditation, journaling, prayer, talking with family, going for walks, so really getting back to, there was a lot of calm, although there was stress, there was a lot of calm too around it too. Yeah, meditation and prayer were a huge part.

Brenda also described that she was not the primary breadwinner and, therefore, did not have financial stressors due to the lockdown. Brenda, unlike many others, found that she thrived during COVID. She went on to explain the reason she thrived may be partially due to her personality as an introvert who reenergizes during her alone time. Brenda describes her experience as follows:

> At the outbreak, first, I was thrilled. You get traffic and to see empty streets was like amazing! Then that sense of, because I had been going so much that to have things slow down, felt really good. I'm an introvert, so I thrived on being home. That's why I'm like, I should be saying more stress, but I was like, I didn't have to deal with traffic. I didn't have to deal with a bunch of people that I was…I had a friend, not another therapist, but a friend who was an extrovert and she was dying. And I could just like, aww, and inside I was like doing cartwheels. So I think that's why I'm stress, stress, no, you know, that I was very happy.

Brenda went on further to describe her realization of the ability to slow down as a means to self-care by enforcing boundaries:

> I know therapists were going through burnout. I think in that respect I did set a boundary on how many clients I would take and I developed strength in that particular skill. I'm only going to work these hours. I went from okay I'll work four days a week, got everybody into three days, stopped working so many evenings, got it down to two evenings. So I did do that self-care because I would have really lost my mind. Even though I'm back in the office I still practice this, whereas my last I would see a 7:00 p.m. client, sometimes an 8:00 o'clock, my last one now is 5:00. Yeah, I'm really working towards making my last client at 4:00, and not taking any more after, working a half day on Wednesday and being okay with that. And I think probably that skill did develop during COVID.

Carly, a very busy mother of a 3rd grader at the time of the COVID outbreak, also found the transitions a welcome break and time for reflection on familial and life priorities. When asked about the emotional impact of the pandemic, Carly described her realization of how much she liked her family.

> I, thankfully, discovered that I really liked my husband and kid. That was a cool surprise. And I was like, okay, you guys don't suck, especially because we were in a very hectic season of life before that where there wasn't a lot of connection, not a lot of time together. So, to go from almost no time together to so much time together, I think we already kind of had a little bit more of a positive view because the home portion of it was supportive enough.

When asked how her personal life changed because of the pandemic, Carly described how she and her family reevaluated and reprioritized what was important in their lives:

> I think it's almost positive in that it allowed my husband and I to kind of, again, reevaluate our own values. We got very clear on what our values were and realized that we were living at a very frantic pace that does not suit our temperaments, our personalities, like we're both real introverted, and by being like, having all of that pulled away, we were like, how did we do this every weekend? Like, how are we gone all day on Sundays doing whatever and then having to come into a work week completely unrested. So I think that helped us to recognize our own capacities instead of this hustle mentality of you go, go, go one meeting to the next. Now, years later, we are very selective and we're like we can do one big social thing a weekend. And it can't be several days in a row. I think being more selective with our energy and realizing it's okay for us to have different boundaries, it's okay to for us to recognize that we have limited capacity. We definitely prioritized physical health along with mental health. My husband and I are now avid hikers. We were not before that (COVID). We liked it, but I think for us in prioritizing time as a family, prioritizing getting outside, trying to find a way to get out of the house safely, and hiking was the first one.

Susy worked part time as she and her husband were nearing retirement and were financially secure. She described that her practice has limited space and usually is full as even prior to the outbreak of COVID she only worked two days. However, she also described her experience with her practice slowing down due to the restrictions during COVID as almost feeling like a break:

> Well, I had quite a few clients that did not want to be seen over Zoom and so my practice definitely shrunk during that time, but because I am not financially supporting, it didn't matter to me, I didn't really care. I mean, it was kind of almost like a break for me to be honest with you. So that was kind of a positive, but I can see how that would be difficult for someone that's trying to pay their bills. That would have been very scary.

Susy also noticed a benefit to the shutdowns due to COVID on an even more personal level:

> There were things that affected me personally. One is in some ways it was good because my husband and I had more time together, we were home together more. It was just kind of more relaxing in that because, you know, if I did have clients, they were online and I could do it from home. That was great.

Patrice's experience during the pandemic helped her realize the need for a holistic approach to taking better care of herself, including her own mental health and taking time off:

> I now work very hard to take better care of my mental health through a really strong morning routine, I take care of my body, I go on dates with my husband more. I slow down enough to take care of me. And so I would think that year three what's come out of it the most is I've created the balance for myself. I make sure to take a week off every now and then instead of plowing through and not taking time because clients need me. Or I would make it so it didn't impact them, like Thursday to Sunday, you know, now it's like, nope, Monday through Friday, we're taking a whole week off. I work out more, I've changed the way I eat and nutrition. I really dove into a balanced life and figuring out what that looks like for me.

Terri, noting that, "You know, I have a husband who pays for the expenses," so the "month or two I took off" at the start of COVID "wasn't really impactful. It was a break." Lois,

having coincidentally scheduled vacation the week after the initial shut-down beginning March 13th, indicated she "took a little extra time off just in general." She found it "helpful that I wasn't scrambling today to try to figure out how to do my sessions today." Lois also described how the changes in response to COVID became longstanding changes:

> Well, to be honest there were a lot of perks. So, I was used to getting up at 5:15…I loved not having to do that anymore. And it's been a pledge to myself ever since that I very rarely wake up before 7:00 a.m. So I really liked not having the commute. I really liked getting to sleep in. I really liked working out of my home.

Lois also made another permanent change in order to create a healthier work/life balance which was to change her contract work with the school district noting, "to be kind to myself I reduced that workload the following school year." She ultimately retired from that work at the end of the school year after that.

So while COVID and the response to the virus caused many challenges and many changes for most of the population, these participants each identified and put into place positive changes that they have maintained for three years at the time of these interviews.

Theme Two: Differences in Beliefs regarding COVID

Another theme that was discovered through the data and related to the emotional impact of COVID-19 on the LMFTs' personal and/or professional lives was the realization of significant differences in beliefs about the pandemic and, in some cases, subsequent divisiveness. The participants relayed a variety of experiences in both their personal and professional lives that illustrated these differences. George and his family held similar beliefs about the virus and believed if they kept a "small circle" while continuing to get together and support each other that

they would not have a significant risk of catching or spreading COVID. However, George did note challenges of the community's view of the virus:

> I think early on we all realized that there was going to be a whole variety of responses to COVID. So, I think early on I just said, even though this is going to be my stance, I respect you, and it even came out with clients too. If you're going to wear a mask, I'll wear a mask. Later on when we had live staff meetings we wore masks. It was more of a meeting, a community standard rather than feeling that anyone was disrespectful. I think we all went the extra mile of being extra cautious when we were in a group, but alone, not so much. I felt very free to go on living my life without a mask.

Tragically, Brenda had some losses of loved ones during the pandemic, and while not from COVID, it was during this time period. Brenda personally experienced differing views of the virus when the time came to attend the funeral of a loved one:

> My son came home from college with COVID, which none of us knew was COVID. It just seemed like a bad cold. And so that became a problem because even though we finished, you know, all passed, symptom-free, my brother freaked out about it, "you have COVID, you need a negative test." I was like, we don't have COVID! So my brother did not come to my dad's service. So that's how COVID impacted us personally like that.

According to Brenda, "That was just my brother at the worst time ever." She did not report experiencing other instances of differing views of the pandemic affecting her life, personally or professionally.

Like Brenda, Carly experienced familial difficulties due to the virus. For her, the differences in views caused significant and longstanding turmoil, division, and alienation that still affected her at the time of the interview. Carly described her experience:

> I think a disparity between how seriously people took it really brought up a lot of kind of relational ruptures personally and professionally. So some people that were a lot more cautious, guarded, wanted to have stronger boundaries in place, wanted to have respect for social distancing and that sort of thing. And then we've had other people that went again both extremes of being very overly cautious to the people that were not cautious at all, thought it was all a hoax, didn't think it was real, and having to see the coworkers and the family members, like where they fell into each camp of like, oh, this is not what I would expect. This is not what I would have expected of you. And honestly, even now seeing some, like personally and family, like rupture of seeing different sides of our own family with how far they went on one extreme or the other. We've completely re-evaluated our relationships with people.

Carly noticed division in multiple areas of her life including with coworkers or other therapists, family members, and individuals and families within her church. Similar to Carly, Susy experienced some family challenges regarding their varying views on the virus, family gatherings, and the vaccine. She described some of these challenges as follows:

> Then the difficulty, there were some family difficulties with people that were very, you know, pro-vaccine, against vaccine, should we get together, shouldn't we? When things opened up a little bit, we had a couple weddings. There were definitely family issues, who has been vaccinated, who's been tested, did they get tested to come to the wedding, that kind of stuff.

When considering these family difficulties, Susy explained that she has a very close, tightknit family. However, they did experience some challenges during COVID. When discussing her feelings around these challenges, she explained:

> I would say there was frustration and at times being probably angry about it, hurt with maybe some things that were said. But my husband and I were on the same page, so we would just kind of process it together and be able work through it. And being able to say, okay, it's okay. We don't have to all agree and be loving towards each other and kind of move forward with that. My son and his wife were not on the same page with us but we really worked through it. They did not agree with us on stuff. It was hard and it was frustrating but we just, I think being on the same page with my husband made all the difference.

Vanessa, too, felt the impact of differing beliefs surrounding COVID and the struggle of how to manage these differences. Since her husband is immunocompromised, they had to consider these varying beliefs in ways that others perhaps did not. Vanessa described some of their concerns and questions that arose during this time:

> So there were several losses during that time and my husband is immunocompromised, so trying, there was a lot of distance. A lot of important things would come up and we'd have to miss out. Or there were different beliefs around COVID, if you should wear a mask or not. So just juggling everybody's different beliefs around it and because of the losses we would have funerals and, you know, should we be having a get-together?

Patrice described the impact of the differing views surrounding COVID as being profound in her life. Quite early in the pandemic she related she noted "big differences in belief systems around COVID." This was exemplified by the fact that she decided to go back to in-person sessions in the building where she leased an office and where others had differing views about whether it was appropriate to return to in-person or not. She described her experience as follows:

> Everybody that you thought were good friends and positive colleagues suddenly was like, wait, you're not talking to me? Why? And you're creating pressure? Why? And you're sending out emails that you should just be talking to me about. There was, I mean it was drama on a different level. It was just more like covert drama. You know, it's like, wow, so all of a sudden, all you guys are meeting and whispering in one of the office and I'm not allowed in.

She described how with these differing views "you start to see the division and the amount of pressure" and she realized it was "time for me to get of here." And, that is what she did. She was able to move into another building where she did not feel the pressure of having the same views and opinions as the other therapist renters. Terri noticed that people had different beliefs surrounding COVID as well, stating, "You know, everybody had their own process, right," referring to the differences in how and when clients returned to in-office sessions and whether they chose to wear a mask.

Lois described how her own views could have caused some challenges and internal struggles. She explained that she had "consulted with some colleagues that had COVID denier clients" and that for her that she considered herself "fortunate that I didn't have any" because "I think that would have been really hard for me." She further explains:

> I did feel like a lot of issues I had at that time is like that social justice thread within me that says you know if someone doesn't see something as urgent or as like foundationally necessary as I do, inside it's a little bit hard for me. So, if I had just, for whatever reason, been seeing people who didn't believe that this was true, I think I would have had a much harder time, like how can I convince you that this is real? That would have been like really, really challenging for me.

Each participant indicated a felt sense of division on some level. For some it affected their personal life with friends and family members. For others, it affected their professional life, and sometimes in very unexpected ways, such as feeling the need to move to another building. However, each one of them came to understand that they had to do what they felt was best for themselves.

Theme Three: Need to Do What Was Right for the Client

A felt pressure to do what the LMFT felt was right for the client, which sometimes brought about concerns in the therapist, was the third theme that emerged related to the emotional impact of COVID-19 on LMFTs. Concerns ranged from fear of spreading the virus to fear of loss of licensure. During our interview, George indicated that he really had no interest in doing sessions remotely and that technology and logistics "was the biggest challenge." However, he recognized that clients had a need for continued therapy, so he "learned Zoom reluctantly" in order to continue therapy with some as this was the right thing to do for his clients. Nonetheless, doing so caused him some feelings of confusion and shame. George elaborated:

> I would say there was a lot of confusion for me at the beginning. I began to understand online was the only option and it was very confusing because no one really knew what platform was secure. And then the BBS came out with, well you know, anything, any platform will do. We'll give a free pass to everything right now and then later on, we'll start hammering it out because nobody really knew. And then the question being asked amongst the therapists was which platform are you using and I didn't really want to share because I don't even know if the BBS is approving it or not. There was a secrecy and a little bit of shame.

Some therapists had their own concerns about the virus and going back to in-person sessions but also felt a responsibility to their clients. Carly elaborated on her experience:

> I think, that came with being a first responder to where I'm like, I'm very nervous about going in and also feeling I had clients that wanted to come in person. But I remember my biggest fear being, you know, clients that have family members that were immunocompromised. I was so anxious every day with the clients that I met with. My biggest fear was not for myself or my family, but that I would pass it along to someone that was not as healthy or was more vulnerable. And so there was also this overwhelming sense of responsibility. I wanted to support my clients, but I was terrified to support some of my clients. My biggest fear was spreading it. But having a lot of conversations with clients like, okay, if you're comfortable coming and I am comfortable coming, so be it.

Like Carly, Susy also struggled with whether or not to see clients in person. However, for Susy the concern was not being effective with her clients while both people wearing masks was mandated for in-person sessions. She explained her frustration:

> Well, so how can you do therapy with a mask on? You can't. And people were, if I have to wear a mask, I'm not coming into the office. But again, that, and they didn't want to do online. If I was supporting my family that would have been really frustrating knowing that those guidelines were keeping me from doing my job because people, how in the world can you do therapy when you're both wearing masks? I did my own thing. It doesn't feel good saying that to you because I just feel like there's really not justification of doing your own thing. But, I really did right by my clients. It's kind of one of those legal/ethical, right? Like if they're going to discontinue therapy or not benefit from it

> because of those barriers, then it's a disservice to them. You know, they tell us to do no harm, but we also want to do benefit.

She summarized her thoughts by saying, "The mandates that were put on were more harmful to our clients than anything else and kept us from really doing a good job of being able to be there for our clients. That's what I noticed."

Vanessa also found it important to do right by her clients. In her case, she was very aware of her own struggles due to personal losses during the pandemic and aware of the potential for transference. In describing her difficulties, she stated:

> I had about four losses that first year of COVID. So it was trying to maintain my own emotions, working through my emotions. It was so interesting how we can just put our emotions to the side during sessions and in between I remember just feeling so tired inside, and really watching to make sure I'm still professional, but I'm also going through this with them so I get it. I just wanted to make sure I was constantly keeping myself in check. And then there were moments where I remember I could feel myself getting tearful in session, and so I think just trying to keep myself healthy so that I could also be there for clients.

Similar to Susy's experience, Patrice found that online platforms did not serve her clients well and that to do right by them she needed to be in-person. She described how she came to understand this:

> Going home for a while made me realize I don't like doing this through Zoom. It may be convenient but I can't read anybody because I only see their head. It didn't feel like the work that I had been trained to do, you know. I started coming back in because I just realized the client population I served being online and being on Zoom was not serving

> them well. They weren't leaving their homes, they were sinking, so I decided to come back. But the pressure because, I was renting space, you know, there was a whole group of us there, and, of course, you start to see the division and the amount of pressure.

Terri's experience was very much like Patrice's in that she chose to go back into the office for in-person sessions relatively quickly after the stay-at-home orders had been put into place. She explained:

> I think I took about a month off and then I slowly opened up back at the office and I was surprised how many people wanted to see me in person. I was just really surprised at the number of people that wanted to be in person and that all of them wanted to take their mask off. I always met them with a mask on. They always came with a mask on. And I would say, if you're comfortable taking the mask off, I'm fine with that and if you're not, we can leave them on. Everyone, 100% took their masks off. I was shocked. I mean, how do you do therapy with a mask on? You need to be able to see a person's face.

When discussing providing therapy remotely, Brenda found that in order to best serve her clients she needed to develop new skills:

> I think what pops in my mind right now was my ability. I missed not being in the room with my clients because from head to toe I'm looking for all cues, body language, and I only had half information to work with. So that was challenging for me and so I had to develop language for myself to say or even when my clients would cry and I couldn't hand them a tissue. So I would try to find ways to connect with them through the screen. Those were skills I had not needed before that I had to develop. It was like how can I make this work, to look past the screen to the person on the other side of the screen? How

> can I connect with you so you feel seen, so you feel heard, so you don't feel distant? It just was a different way.

As a play therapist, Lois faced unique challenges in the transition from face-to-face to remote work. She explained that she had to be "creative and think outside the box" in order to provide the best, most effective therapy with children. She described one such occasion:

> There was this one day I was working with a kid and I ran over to my closet because this is my oldest kid's old bedroom and there's a bag of old stuffed animals in there. I just got stuffed animals out and I was like you go get your favorite stuffed animals and we acted out a story about when friends don't get along and someone's mean and how did they communicate and I had some stuffed animals on my shoulder and I felt so happy at the end. There were moments like that where you found a way to make it work and really connect with the client remotely. You had to be creative and it paid off. The creativity and thinking outside the box led to some really neat moments.

It was evident that all the therapists interviewed took very seriously the needs of their clients to continue to receive care. They also took very seriously how to best serve them, whether it was in-person or remotely via a telehealth platform. They all wanted to do what was right for their clients.

Themes Related to Emotions Experienced due to Stress

In an effort at better understanding the emotions experienced due to the stressors of COVID, the guiding question, "How do licensed marriage and family therapists describe the feelings they associated with stress during the COVID-19 pandemic?" was posed to the interviewees. In addition to the three themes described above stemming from the first research

question, the following three themes, themes four through six, emerged from this guiding question.

Theme Four: Frustration with the Unknowns of the Virus and How to Respond

The fourth theme that emerged from the interview data and the first theme related to the guiding question that identified the feelings LMFTs associated with stress during the pandemic was frustration. This frustration related to the response to the COVID virus and subsequent mandates including the stay-at-home, mask requirements, and social distancing mandates. During the interview George described himself as trying to be "patient with the process of everyone determining how we're going to respond to COVID and what the new rules are going to look like." He continued:

> I think that early on the biggest struggle was how we're going to respond to it. And it was made more difficult because there were so many layers that we're dealing with. We are dealing with the federal response, which was, you know, kind of unknown and haphazard. The state response, which was a little bit heavy-handed, and then the county response, which tended to mimic the state pretty closely. And then just the whole idea of once we were determined to be essential workers or in the medical area, and then qualified to get the vaccine. I'd say three or four months, maybe six months, it was just everybody trying to figure out what we were going to do. And all of those levels of bureaucracy and concerns needed to be addressed. And so I'm way down at the bottom.

Susy shared a feeling of frustration regarding the restrictions due to COVID. For her, it was not only the frustration of the restrictions but also the frustration of not being able to help as she had prior to the pandemic:

> The biggest struggles for me were the limitations that were put on us by the healthcare system, supposed to wear masks, you know closing the office. So maybe not being able to practice in a way that we've been able to practice in the past. I think those things were the most frustrating to me. I mean it was a totally new experience at that point. I had quite a few clients that did not want to be seen over Zoom. I would say 80% of mine did not want to go online. They wanted to be in person in the office. And they didn't want to wear a mask and I didn't want to wear a mask. I think that was probably the frustration of not being able for those that didn't want to go online, feeling like I wasn't able to help them.

Terri also expressed a felt sense of frustration. Her frustration came from what she believed to be misinformation regarding the virus itself and whether or not the virus actually rose to the level of a pandemic or if there was an overreaction in the information provided to the public.

> I was frustrated at, just my personal opinion, but the fear that was kind of shoved at us, right? We were taught to be afraid initially or told to be afraid at the very beginning, just the idea that they kept talking about it as a worldwide pandemic. And I just kept doing research, that's how I dealt with it. I kept looking up other pandemics and other experiences over the past hundred years, and I'm like this is not a pandemic.

So, while Terri experienced frustration with the information that was provided to the public regarding the pandemic, the virus and the deaths due to the pandemic, Lois's frustration stemmed from individuals who did not take the recommended precautions and seemingly did not view COVID as a serious potential threat. For Lois, she felt frustration "when I was going to the store and having people in there with no masks on or just hearing deniers, and that was harder for me."

Patrice expressed frustration in a much different way, a very personal way. She described how she experienced COVID and the racial tensions at that time as a woman of color:

> The biggest frustration for me was that it was just all the division was so apparent that I had to learn, like I am in my 50s trying to figure out how to find my voice and whether or not it's worth it for me to fight. Because I don't think most people realize that it was almost back to back, right. It was like COVID and then George Floyd happened. And so if you're in that world, then I was dealing with, you're an Uncle Tom, you're a traitor to your own race. So I had that pressure. I was the representative token Black in the office, right? So it was a whole new world for me. It was like, now you guys are going to walk around me eggshells, even though we've been together for the last two years? And you're walking around like eggshells thinking that you need to prove to me and you're coming up to me apologizing for your White privilege and I'm looking at you like dude you are 20-somethging years old, I am in my 50s. Don't I make more money than you? I'm not sure what kind of privilege you think you have. Yeah, it's a concept not a reality but it was people coming up, I'm so sorry I didn't realize how much White privilege I have. And I'm just like, I just want to come to work and take care of my clients.

Patrice's experience was much more complex than other participants. For her, the societal events during that time lead to frustration due to others' assumptions of her beliefs and, at times, judgment because of the beliefs she held. This resulted in significant frustration, whereas Vanessa and Carly both described experiencing a slight sense of frustration. This frustration was related to their perception of how the general public failed to view therapists as first responders. Vanessa explained her frustration:

> They talked about the nurses, and don't get me wrong. I remember having this

> conversation with my husband that, don't get me wrong, teachers and nurses and doctors, oh my goodness, you know, like bow down to them. But I honestly did feel like therapists did not get seen or heard or acknowledged. It almost did feel like we were first responders to some degree. Maybe not first first, but definitely right behind. We were right behind the front line and it was tough. And again, you know, same things on the news. The nurses, teachers, they should be acknowledged and recognized, but they always got these like gifted things, so like what about us? Like, even if it was at the Padres game, all the nurses got, you know, free Padres tickets. I'm like, what about the therapists? And there was just no other than amongst us in our field, we talked about it. I think we were kind of ghost front liners, like we're the kind of those ghost spirits in the background of the chaos, but we're still having to carry the chaos for a lot of people. And so we were very invisible and we kind of have to because of confidentiality reasons. Who was going to hold that? And I think that's the thing. Who was holding the therapist?

Carly recognized there was some confusion as to what category therapists fell into at the initial outbreak of COVID. This confusion caused some frustration, but the lack of recognition of therapists as front line workers was a source of frustration as well.

> I think we were front line workers but it wasn't globally recognized. Like, we saw a lot of praise for people that are considered first responders, essential workers. There was even debate within, like, by employment of, are we considered essential? Are we allowed to stay open? Therapists, I felt, kind of fell into a gray area where we were kind of considered essential, but the way that they even phrased on the CDC website of like, well, behavioral health and it's like okay, well, where do we fully fall into that? And I remember getting a notice from a car dealership of, oh hey, first responders can get a free

> oil change and I was like, do I count? There was always ambiguity around therapy, counselor, whatever it is, and does that count as medical health? And we're like, yes, we know that it is. But I think we absolutely were first-line responders. I think that emotionally and physically we very much were on the same level as frontline workers but we're a little bit dismissed.

Brenda also experienced frustration on a very personal level. Losing both parents during the pandemic, not due to COVID but during COVID, caused not only sadness and grief, but also frustration:

> I lost both parents nine months apart during COVID. And not from COVID, interestingly enough. My mom had a massive stroke and my brother found her. Because of COVID we couldn't go to the hospital with her. And the ambulance driver wrote my brother's phone number down wrong and so we didn't know where she was. And because she had fallen, they have this security thing for elder abuse that they give them pseudonyms, so in case the family member hurt them, they can't call to find them. So even though we were calling, they were like, oh no, she's not here. I mean it was a mess and all that was due to not being able to go with her because of COVID.

Fortunately, even with the COVID protocols in place, Brenda and her brother were finally able to see their mother and spend a little bit of time with her prior to her passing.

The frustrations that were felt by the participants varied; however, all the frustrations centered around COVID. For some participants the restrictions that were put into place in an effort at containing the virus made it difficult to practice as they had prior to the outbreak of the virus, such as the inability to see clients in person and the mask mandate. For Brenda, this restriction made it extremely difficult to see her ill mother before her passing. For other

participants, frustration stemmed from different beliefs about the virus or assumptions about how one should respond to the virus.

Theme Five: Fear Amidst the Uncertainty of the Circumstances

The fifth theme that emerged from the interview data and the second theme related to the feelings LMFTs associated with stress during the pandemic was fear. Several of the participants described experiencing fear, mostly in the initial phase or outbreak of COVID. Lois remembered initially having fears about getting sick and also having fears about what it would be like going back to the office, worrying about "could I get sued if I get somebody sick? What if I get somebody sick and they die?" She then explained that "when we pretty much figured out we were like, oh, we're not going back to the office for like a year, then that fear went down because we were only doing telehealth." Terri described a transition of emotions beginning with fear, turning into anger, and ultimately feeling apathy:

> I think at the very beginning it was fear. Just the idea that they kept talking about it as a worldwide pandemic…you know, and then it went from fear to anger…and then from the anger, it was more of an apathy about it.

Vanessa explained that even though "luckily, financially, I was completely fine, but I think there was a fear of finances going down to about half my caseload." Vanessa also recalled "there was a constant fear, do we have COVID? Do we have symptoms? We're coughing." Patrice explained the fear that she experienced due to her decision to go back in office when most of her colleagues continued to use online platforms:

> So, because professionally I was terrified I was going to lose my license during that time, always in a state of anxiety for fear of losing my license, just because of the political climate. And I am more of a conservative therapist, so that climate was, especially when I

> was there with all those people (other therapists) with me, you know, I lived under this cloud of fear. So personally, I didn't have a fear like, I'm going to get COVID and I'm going to get sick and die. That's probably why I could go back so fast. But I did have a lot of anxiety during that time because I was constantly afraid that somebody was going to find a reason that I was not like towing the line, line by line, step by step, right? And I was going to end up losing my license because I was like if you're comfortable without a mask, I will take my mask off. If you need me to wear a mask, I'll put my mask on. I wasn't doing it for me. I was doing it for the comfort of my clients.

Carly also did not have a significant fear of catching the virus or health concerns. Her fear surrounded how the uncertainty of the pandemic was going to affect her way of living in the short-term and for the long-term. She explained:

> I think that fear and that uncertainty of, again, I'm like, I might never be able to go to a movie ever again? Concerts are a thing of the past. Like can I even go out to a restaurant ever again? So a lot of the fear around that and definitely fear around, being really worried about food for the first time. The fear of I don't know when those things are going to come back in stock. And in the event that they don't, my family's whole diet had to change, too. Those little things of just not knowing when that resource is going to be available. So a lot of fear, a lot of anxiety, obviously, and again, a lot of that loss of control and feeling helpful because so many things were happening.

Stemming from various reasons, these therapists expressed a shared feeling of fear at some point in time during the pandemic. While in most cases this fear was quite short-lived, it was nonetheless present at some point in time during the pandemic.

Theme Six: Anger Stemming from Peoples' Treatment of Each Other

The sixth theme that emerged from the interview data and the third theme related to the feelings LMFTs associated with stress during the pandemic was anger. The reasons behind the anger varied from participant to participant, but many remembered feeling angry at how they themselves had been treated or how people in general had been treated. Susy felt angry due to information about COVID and restrictions that were put into place:

> I remember at times being angry when we were being told one thing about COVID, and either reading information that was, or studies that kind of proved that not to be true. I mean, when I look back and I think of all of the, just the whole idea of wearing masks, I mean just the whole idea. And now they say, yeah, masks don't really work. That makes me angry when I think of what was said, some of it knowingly, some of it maybe not knowingly, but I think most knowingly. That makes me angry.

Susy also recalled also feeling angry over how people treated people because of the information that was provided:

> I would say anger over watching people be so ugly and negative towards others. Like, you know, some therapists calling other therapists, you know. To me I'm like you can believe what you want to believe but don't tell me I'm killing other people because I'm not wearing a mask and then they find out masks don't work anyway.

Carly had her own experience of being treated differently due to her own response to the pandemic. Carly explained that when the church she and her family attend transitioned to in-person but outside, "we were watching on Zoom with a live stream." However, she states, "by not going, people assumed the worst of us." She continued, "people that we've known for decades treated us like strangers because we weren't showing up." Carly felt angry because she

and her family were "being ostracized needlessly" because not going to church in-person meant "you're against us or you're too cautious or you're reacting too strongly."

Patrice stated that as a Black woman, she had a unique experience during COVID that many did not because of the concurrent racial tensions the U.S. was experiencing. It was during the early stages of COVID that Breonna Taylor, a 26-year-old Black woman, was shot and killed when police officers raided her apartment, apparently mistaking her apartment for one involved in a drug dealing operation. Shortly after the outbreak of COVID, George Floyd, a 46-year-old Black man, was killed by a Minneapolis police officer while being detained during the course of his arrest. The deaths of these two Black individuals stoked racial tensions all over the country. Patrice's beliefs did not align with those of others, particularly her White colleagues. Patrice explained the anger she felt during that time as follows:

> I think there was some anger. It's kind of like I was angry, but not like I'm ready to burn down a house kind of anger. It was just like a realization that it's like, I don't even think you guys realize how racist you sound. Like, what you're telling me is very racist. Like, the mere fact that you're saying that it's because of the color of my skin I have to vote for a particular party, otherwise, I am an Uncle Tom or I am a traitor to my race makes no sense and you don't realize that's a racist statement. And so there was a lot of anger there. It was more like, I don't know, righteous anger…You don't get to tell me that I can't use my voice.

Terri described a progression of her feelings during the pandemic. Terri, having researched previous pandemics in history, felt full information was not being provided to the public. She explained the frustration she experienced and that this frustration transformed into anger.

> You know it went from fear to anger. Just that idea that this is misinformation. You know, if there were this many deaths, yes, this would be a pandemic. But this is, it's bad, and we have a lot of deaths. However, if you compare them, and I saw research that did compare it to the regular flu, and some of those were like H1N1. I thought are we really facing a pandemic where there's going to be half of the country dies kind of thing? And then I realized it was just misinformation and it turned to anger.

George, too, experienced feelings of anger surrounding the communication and information provided about COVID:

> I began with and maybe what I would close with is just the complexity of the whole thing that was national, state, county, and churches response to it. It created anger and disappointment. I'm hearing people now, you know, there's talk about mask mandates being imposed again. There are some strong feelings against that. I don't think the anger has gone away and I would share in some of that. I feel like, you know, we were lied to in some regards. I think that if we weren't lied to, we were told to our best knowledge, to our best ability to guess what the future is or how we should respond and that was shared as absolute fact, you know, scientific fact. And now we look back and we go, you guys didn't know. I don't think a lot of it was intentionally being duped, but I think we were all duped. We were all and no one was courageous enough to say it. I think, especially in the midst of it all, because it was like, well, if you say no mask, thousands are going to die and you know, who wants that, so yeah, duped, duped but with certain qualifiers.

As Brenda has described previously, both of her parents passed away during the first year of COVID. So, while she did not experience a significant amount of anger in general during COVID, there was some expressed anger due to the restrictions at the time that prevented her

from seeing her mother in the hospital initially. When told initially that she could not visit her mother in the hospital, Brenda responded:

> Oh, we need to come see her. And they're like, well, you know, it COVID, we can't have this. I'm like, Oh no! We're coming to see her. So we had to get permission from his supervisor for my brother and I to go to see her.

Similar to the feelings of fear, each of these participants described their own personal experiences and reasons why they felt angry. On occasion it was for a very specific event; however, for others it was a more generalized response to how they themselves had been treated or how others had been treated.

Summary

This qualitative transcendental phenomenological study attempted to describe the experiences of Licensed Marriage and Family Therapists during the COVID-19 pandemic. The data were gathered through individual interviews of LMFTs. The participants described in their own words how they experienced the pandemic and the emotions they felt. From these interviews important data were collected that led to emergent themes related to the therapists' experiences including a newly discovered ability to slow down, to take a break, the need to reprioritize what was most important in one's life, the realization of significant differences in belief about the pandemic and a subsequent divisiveness, and a pressure to do what the therapist felt was right for the client even if it wasn't in accordance with the COVID restrictions/recommendations at that time. The emergent themes related to the feelings therapists described to be associated with stress during the pandemic included frustration due to the unknown nature of the virus, fear due to the uncertainty of circumstances, and anger due to how

they themselves were treated differently or how they witnessed people in general were treating others.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this qualitative transcendental phenomenological study was to describe the experiences of Licensed Marriage and Family Therapists during the COVID-19 pandemic. The purpose of this chapter is to summarize the research findings and provide interpretations of the findings. This section addresses the findings, implications of the current findings for therapists, counselors, and behavioral health providers, theoretical and methodological implications, limitations and delimitations of the study, and recommendations for future research.

Summary of Findings

All participants were licensed marriage and family therapists who were actively seeing clients at the time of the outbreak of COVID-19. Semistructured interviews with open-ended questions were used to collect the data and to obtain a deeper understanding the participants' lived experiences. Although the participants were of varied age and had a range of years of experience as therapists, each reported similar observations and common concerns in this shared experience.

When detailing the emotional impact on their personal and professional lives as essential healthcare workers during the pandemic, all the participants described the previously unrecognized ability to slow down. This was described by some as a welcome relatively short-term break of a month or two. Others described it as a permanent choice to see fewer clients and/or work less hours each day or fewer days in the week. Another similar observation was how they noticed differences in attitudes toward the virus and differences in beliefs on how to respond to it among others in their lives. Some viewed themselves as having a healthy respect for

the virus and others viewed the response as an overreaction, and there was a recognition of divisiveness and intolerance to others' opinions among people around them. While there has been research showing some "racial and ethnic tensions that sometimes lurk beneath the surface of public discourse" (McCauley et al., 2013, p. 12) as it related to the H1N1 pandemic, this current study revealed more diverse sources of division such as the severity of the threat of the virus and the response to it, as mentioned above. The third experience shared by the participants was that they felt it important to do what was right for their clients during the pandemic in spite of the sometimes stringent restrictions put in place by the county, state, and federal government.

Frustration was a feeling reported by all participants when describing the feelings associated with the stress experienced during the pandemic. This frustration was caused by a variety of factors, some of which were the unknown nature of the virus, concerns over the accuracy of the information that was given, and difficulties created by the response to the virus, including the stay-at-home order, mask requirements, and social distancing mandates. Participants also described a feeling of fear. This fear was due to the uncertain nature of the circumstances, including uncertainty of how long the pandemic and subsequent restrictions would last, uncertainty of what the future would look like, and wondering if life would go back to "normal." The third feeling experienced by the participants was anger. This anger was reportedly rooted in the observation of how people treated others differently, at times with judgment, condescension, intolerance, or impatience. These feelings were reported to occur in relationships with colleagues, peers, friends, and family members; however, it was observed that a mutual respect remained intact in the therapist-client relationships.

Discussion

The purpose of this study was to better understand the experiences of licensed marriage and family therapists during COVID-19 and the emotional impact the pandemic had on them. This section discusses the findings of the study and the relationship to the theoretical and empirical literature described previously in Chapter Two.

Theoretical Literature

Resilience has been described as an ability to adapt and overcome challenging circumstances (Garmezy et al., 1984; Rutter, 2013; Masten et al., 2009). Further, Doyle et al. (2021) posited that resiliency may play a mediating role and serve as a protective factor against occupational stress. Previous research has shown significantly higher levels of resilience in first responders such as police and fire and rescue workers as compared to healthcare workers and the general population (Pink et al., 2021). However, a study by Brillon et al. (2022) reported that mental health workers "were significantly more resilient than other workers" (p. 613). This understanding that resilience is an ability to adapt and overcome difficulties, and the notion of mental health workers exhibiting more resilience, provided the support for exploring this current study within the framework of resilience theory. Therefore, the study findings of Brillon et al. (2022) are corroborated based on the data obtained in this current study, which further reflected that mental health workers, in this case LMFTs, do indeed exhibit more resilience. Litam et al. (2021) stated that professional counselors were better able to reduce work stressors. This also was supported in the reports provided by the current study participants. Each described ways in which they actively pursued healthy ways to adapt to the circumstances presented by the pandemic and subsequent stay-at-home orders. This included engaging in self-care techniques such as participating in their own therapy, engaging in exercise, and/or reducing their workload. This is illustrated in the theme of the participants' realization that to best take care of themselves,

they needed to put into practice a slowing down of their busy schedules. Professionally, this also included adapting to new ways of continuing to see clients. This too was demonstrated by the participants' ability to adapt to new ways of seeing clients, and this emerged as a theme of the need to do best served the client. Examples of this include the need to be more creative in engaging clients when providing telehealth services and returning to the office even when discouraged to do so by the governing bodies of the county, state, or even federal government.

Empirical Literature

The COVID-19 pandemic has been widely researched in relation to its impact on essential healthcare workers. This qualitative study produced findings which corroborated those discovered in previous studies on similar topics. The data received revealed feelings of fear, frustration, and anger, which supported previous studies (Arcadi et al., 2021; Jun et al., 2020; Muz & Erdogan Yuce, 2021). For example, Miragall et al. (2021) found the stay-at-home orders caused negative emotions and distress. Chandiramani (2020) noted that many people experienced psychological problems, including fear and isolation due to the "lockdown" put into place because of the pandemic. Additionally, Arcadi et al. (2021) found that nurses caring for patients at the time of the pandemic specifically reported fear of the unknown and uncertainty. Uncertainty also raised existential concerns such as topics of death and dying, the unknown, and freedom (Bhattacharya & Prakash, 2021; Spiller, 2021). These concerns were also reported by licensed marriage and family therapists in this current study. The participants further corroborated feelings of confusion due to the unpredictable nature of the virus as well as separation from family, isolation, and fear as found in a study by Amorin-Woods et al. (2020; 2021) as well as uncertainty as found in studies by Bhattacharya & Prakash (2021) and Spiller (2021).

Previous findings related to challenges faced by mental healthcare providers transitioning from face-to-face therapy to remote therapy (Cronin et al., 2021; Hardy et al., 2021; Levy et al., 2021; Machluf et al., 2021; McBeath et al., 2020; Salcuni et al., 2020) were also supported by this current study. While their experiences varied, each participant did transition to providing online therapy for at least some portion of time and expressed, at least on some level, feelings of being unsure and/or disconnected from their clients, as found in a previous study by Cronin et al. (2021). The insights from the participants of the current study also support the finding of Agnello and Giubellini (2021) that telehealth therapy was better than the clients not receiving therapy at all. Most also reported greater convenience and flexibility in providing online therapy, which supports the findings of Hardy et al. (2021), and the ability to see clients at a greater distance within the state in which they were licensed, which also corroborates previous study findings (Cronin et al., 2021). Additionally, there were findings that extended the understanding of previous research in relation to the impact on licensed marriage and family therapists in their role as essential healthcare workers. Kotera et al. (2021) suggested areas of interest for further study, including changes in work/life balance. This current study extends the understanding of the changes that did occur in work/life balance for these licensed marriage and family therapists. The participant insights revealed that because of the lockdown, each of them recognized an ability to create a better work/life balance for themselves. This was accomplished in various ways, including seeing fewer clients or working less days, quitting a second job and focusing on private practice, spending more time on self-care. Not reported or reviewed in the previous literature, but incidentally discovered through interviews of this study's participants, was the finding that these therapists all made efforts to do what was best for their clients in spite of their own fears,

including fears of repercussions from seeing clients in-office, fear of judgment from others, and fears of the possibility of spreading the virus.

Implications

Theoretical

The findings of this study provide further support to the belief that resilience may serve as a protective factor against occupational stress (Doyle et al., 2021), as evidenced by the fact that all participants of this study self-reported an above average or high level of resilience and the capability to adapt to the challenging circumstances of the pandemic. Additionally, further this study supported the finding of Brillon et al. (2022) that mental health workers have higher resilience than those in other occupations, again based on the self-reported high level of resilience among participants. Cronin et al. (2023) found common characteristics in highly resilient therapists and these characteristics included: “a) drawn to interpersonal relationships, (b) desire to learn and grow, (c) possess a core values and beliefs framework, and (d) actively engage with self” (p. 76). The training that one receives while becoming a therapist may be one factor that contributes to a high level of resilience. Therapists learn coping strategies to teach to clients for use in stressful situations. While learning these strategies, therapists likely put them into practice themselves. The study findings also provide a better understanding of the ability for licensed marriage and family therapists to reduce work stress by engaging in self-care techniques.

Empirical

The resultant implications of this study include a better understanding of the impact of the COVID-19 pandemic on essential healthcare workers and feelings of fear, frustration, anger, and uncertainty, as the findings supported those of previous studies (Arcadi et al., 2021;

Chandiramani, 2020; Jun et al., 2020; Muz & Erdogan Yuce, 2021; Spiller, 2021). This current study allows for a more thorough comprehension of the underlying causes for the feelings of frustration, such as the question of how to move forward and the limitations that were placed on how to do so, anger because of how people were being treated, and fear due to the uncertainty during the pandemic that was experienced by licensed marriage and family therapists. Additionally, this study provides a better appreciation of how LMFTs experienced the differences in views, beliefs, and at times divisiveness related to the virus and responses to the pandemic. The study also sheds light on how they experienced reconciling themselves to doing what they believed was right for their clients, including returning to in-person sessions and whether or not to wear a mask regardless of the official recommendations at that time. From this study as well it was discovered that the participants experienced a shared theme of recognizing the need to reprioritize their own needs and the ability to slow down. This study provided deeper insights into the changes that occurred in the work/life balance of licensed marriage and family therapist participants at the time of COVID and that also remain in place three years post-pandemic.

Practical

From a practical standpoint, the current study reveals implications for practicing licensed marriage and family therapists, counselors, psychologists, other mental healthcare professionals, as well as other essential healthcare providers, by detailing further understanding of the pandemic's impact on those providing these services. Should there be another pandemic, such as the one the world experienced in early 2020, essential healthcare providers should keep in mind their own emotional and mental health, recognizing the vulnerability to feelings of fear, frustration, uncertainty, and anger and how this may impact them personally and professionally,

as articulated by the participants of this current study. It is equally important for these providers to recognize the significance of a healthy work/life balance, self-care, and the need to maintain a high level of resilience, as the participants of this study indicated, these measures helped them to cope with the pressures and stressors of the COVID-19 pandemic. As such, this study's findings has implications for educators of mental healthcare and other essential healthcare providers. Educators can help instill the understanding of these necessities in future generations of providers and help them learn ways in which to maintain healthy work/life balance, learn how to put self-care techniques into place, and learn ways to build emotional resilience.

Delimitations and Limitations

Delimitations of this study include restricting participants to licensed therapists who were in private practice at the time of the COVID pandemic. This delimitation was put into place in an effort to keep the focus on this specific population. Other groups not in private practice, such as those employed in mental health clinics, agencies, psychiatric hospitals, or residential treatment centers may have had varied experiences. An additional delimitation of this study is that all participants were located in San Diego County at the time of the pandemic. This was due to the use of convenience sampling and snowball sampling (Merriam & Tisdell, 2016).

Possible limitations of this study include the small sample size of eight participants. Additionally, there was just one man in this sample group. While efforts were made to recruit a sample of varying ages and people at varying stages in their careers as LMFTs, most of the participants were in the middle age range and/or well into their career and, therefore, the lived experiences of those just starting out in their professional life, those more financially dependent on their careers, and those with young children were not well-represented in this study.

Recommendations for Future Research

In view of this study's findings, there are recommendations for future research to be considered. One consideration would be to increase the sample size and make more efforts at obtaining a more diverse sample set with more men and more diverse ethnic groups. While there were varying ethnic groups represented in this study, it is a small sample size with the majority being Caucasian women. A survey distributed nationwide to LMFTs in a quantitative research model may yield results that are better able to be generalized to the research population. Furthermore, participants who were newer in their careers and who possibly had more financial stressors may have had different experiences due to the pandemic and subsequent lockdown, and parent therapists with young children at home were not well-represented in this current study. Therapists with young children at home during the pandemic may have experienced increased stressors due to the need to be sure their children were attending and focusing on virtual school, while also continuing to see and be present with their clients. In order to better understand the emotions experienced due to stress during the pandemic by this population, future research in the form of a qualitative study focusing on therapists who fall into this category could be beneficial. Lastly, in an effort at increasing transferability, a sample set more extensive than San Diego County that covers a larger geographic portion of the population would be recommended.

Summary

This qualitative study examined the lived experiences of licensed marriage and family therapists during the COVID-19 pandemic and explored LMFTs' perceptions of continuing to provide care for clients yet remaining unnoticed and/or unacknowledged as essential workers; this study also investigated how they described the feelings associated with stress they experienced both personally and professionally at that time. This study was performed by conducting individual interviews of licensed marriage and family therapists who were in private

practice at the outbreak of the COVID-19 virus. The study identified that the participants experienced feelings of frustration, fear, anger, uncertainty, and isolation (Arcadi et al., 2021; Chandiramani, 2020; Jun et al., 2020; Muz & Erdogan Yuce, 2021; Spiller, 2021), which corroborated results of studies previously performed. Also identified was that the participants of the study self-reported above average to high levels of resilience, which lends support to previous literature (Brillon et al., 2022) as well. Additionally, a better understanding of the recognition for creating a work/life balance and the steps LMFTs took to ensure this healthier balance was uncovered. The participants' reported efforts of maintaining a healthier work/life balance included recognizing the ability to slow down, both in professional and personal ways, as well as efforts at self-care, which included their own therapy and exercise. The study also uncovered the participants' commitment to their clients and their desire to do what was best for their clients even under uncertain and at times troubling circumstances such as a pandemic.

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Appendix A: Consent Form

This informed consent form is for Licensed Marriage and Family Therapists in San Diego County who I am inviting to participate in a qualitative study, titled "*A Transcendental Phenomenological Study Exploring How Licensed Marriage and Family Therapists Describe the Emotional Impact of the COVID-19 Pandemic*."

Name of Principle Investigator: Melissa Lund, a doctoral student in the School of Education, Liberty University

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

I am Melissa Lund, a doctoral student in the School of Education at Liberty University. I am doing research on the emotional impact of the COVID-19 pandemic on Licensed Marriage and Family Therapists (LMFTs). To participate you must be a Licensed Marriage and Family Therapist in private practice at the onset of the COVID-19 pandemic. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher.

Please take time to read this entire form and ask questions before deciding whether to take part in this research. Taking part in this research project is voluntary.

Purpose of the research

The COVID-19 pandemic had significant consequences both short and long term worldwide. The purpose of this study is to better understand how licensed marriage and family therapists describe the emotional impact of the virus had on their lives. A better understanding of the emotional impact of the pandemic will provide insights and "norms" that would benefit mental healthcare workers in the future should another similar event occur.

Type of Research Intervention

This research will involve your participation in an individual interview conducted via Zoom, Microsoft Teams, or other online platform. The interview will take approximately one hour.

Participant Selection

You are being invited to take part in this researcher because I feel that your experience as a licensed marriage and family therapist can contribute much to my understanding and knowledge of the emotional impact COVID-19 had on you as an LMFT.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may change your mind later and stop participating even if you agreed earlier.

Procedures

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

1. Be interviewed in your home or office or other setting that allows privacy for the interview. This will take place Zoom, Microsoft Teams, or other agreed upon online platform. Interviews will last approximately one hour and will be recorded.

2. Review the written transcript to verify the accuracy of the interview content, including your responses and clarify any discrepancies noted in interview content.

Prior to the interview, I will send a link via Zoom or other platform for the agreed upon appointment time. During the interview, no one else but the interviewer will be present. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. The information recorded is confidential, and no one else except myself, Melissa Lund, will access to the information documented during your interview. The entire interview will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept in a locked file cabinet behind two locked doors.

Duration

The research will consist in an interview that lasts for approximately one hour. In addition, the transcript of the interview will be forwarded to you for your review to verify accuracy. Review of transcription will take approximately 30 minutes.

Risks

The risks of this study are minimal. However, I will be asking you to share some information that may be very personal, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the interview if you do not wish to do so, and that is also fine. You do not have to give any reason for not responding to any question, or for refusing to take part in the interview.

Benefits

There will be no direct benefit to you, but your participation is likely to help provide a better understanding of the challenges faced by LMFTs in the midst of a pandemic and could help improve how mental healthcare providers approach client care and self-care should another natural disaster occur. This information will be beneficial to a wide spectrum of mental health providers, including but not limited to licensed professional counselors, licensed clinical social workers, licensed mental health counselors, and psychologists.

Reimbursements

There will no compensation for participation in this study.

Confidentiality

The information about you and information collected during the interview will be kept private. Any information about you will have a number on it instead of your name. Only the researcher will know what your number is and the information will be kept in a locked filing cabinet behind two locked doors. All data stored on a computer will be password protected.

Sharing the Results

The knowledge that is obtained from this research will be shared with you before it is made widely available to the public. Each participant will receive a summary of the results, following which the results will be published so that other interested people may learn from the research.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so. You may stop participating in the interview at any time that you wish. After the interview is transcribed I will give you an opportunity to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Who to Contact

If you have any questions or concerns regarding this study and would like to speak to someone other than the researcher, you are encouraged to contact:

Institutional Review Board
1971 University Blvd.
Lynchburg, VA 24515

Or email: irb@liberty.edu.

Part II: Certificate of Consent

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant__________________
Signature of Participant ___________________
Date ___________________________
Day/month/year

Statement by the researcher/person taking consent

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.
Print Name of Researcher/person taking the consent________________________

Signature of Researcher /person taking the consent__________________________

Date ___________________________
Day/month/year