ABSTRACT

HOLLAND, AMBER E. Exploring the Resilience Cultivation, Stress, and Coping Mechanisms of Mental Health Professionals During the COVID-19 Pandemic. (Under the direction of Dr. Elizabeth Craig, Committee Chair).

This study aims to identify and understand the communicative resilience processes enacted by mental healthcare professionals (MHPs) in the United States during the COVID-19 pandemic. Using Buzzanell's (2010) Communication Theory of Resilience (CTR) as a guiding framework for understanding resilience processes, a thematic analysis of interviews with twenty MHPs revealed insight into the triggers, stressors, and challenges faced as well as the resilience processes enacted by MHPs during the pandemic. In terms of the former, MHPs described (a) a lack of support from supervisors; (b) experienced and anticipated guilt; (c) challenges related to differing beliefs; (d) increased caseloads with decreased personnel; and (e) telehealth as a medium for connecting with clients. Regarding resilience processes, three from Buzzanell's (2010) CTR were particularly evident, including (a) crafting normalcy; (b) maintaining and using communication networks; and (c) foregrounding productive action while backgrounding negative feelings. This research extends the communicative resilience framework by identifying situated resilience processes enacted by mental health professionals in the context of the COVID-19 pandemic. Practical implications are explored and avenues for future research are considered.

Exploring the Resilience Cultivation, Stress, and Coping Mechanisms of Mental Health Professionals During the COVID-19 Pandemic

by
Amber E. Holland, MA, MPA

A dissertation submitted to the Graduate Faculty of
North Carolina State University
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

Communication, Rhetoric and Digital Media

Raleigh, North Carolina
2023

APPROVED BY:

_____	_____
Dr. Elizabeth Craig Committee Chair	Dr. Jessica Jameson
_____	_____
Dr. Andrew Binder	Dr. Stacey Pigg

DEDICATION

To all the mental health professionals who served clients during the COVID-19 pandemic, a time of exceptional uncertainty, whose dedication to their craft and demonstrated resilience continue to inspire me.

BIOGRAPHY

Amber Holland became interested in “the dark side of interpersonal communication” following the completion of an undergraduate course with the same title during her time as a student at Christopher Newport University. She found that in exploring the negative aspects and outcomes of interpersonal communication, there were opportunities to create strategies and solutions for navigating this type of communication. Over the years in her graduate programs, Amber worked with mentors and explored “dark side” research topics such as domestic violence, sexual harassment, and exploring the identities of fathers who did not live with their children. A commonality across her work was the idea that people face major, life altering challenges, adversities, and traumas, and despite this, many can recover from these and in some cases, even flourish. Thus began her interest in resilience literature, which was amplified by the events of the COVID-19 pandemic.

Originally from the tidewater area of Virginia, Amber moved to North Carolina with the goal of pursuing her graduate degrees in Communication. She completed her Master of Arts in Communication from the University of North Carolina at Greensboro in 2019 and received her doctoral degree from NC State’s Department of Communication, Rhetoric and Digital Media (CRDM) in December 2023. She began working at Duke University’s Samuel DuBois Cook Center for Social Equity as a Senior Research Associate and Communications Strategist in August 2023 and will continue teaching undergraduate courses part-time as a Lecturer for NC State’s Department of Communication.

ACKNOWLEDGMENTS

I am deeply grateful for the many people who served as pillars of support through my doctoral journey. First, I want to thank my mom, Laura Evans Holland, and my dad, William Thomas “Tom” Holland, for intentionally showing up for 30+ years as stellar parents, lifting my spirits daily, demonstrating healthy love, and always receiving me with open and welcoming arms. Recent years have proven to be challenging, and despite the physical distance, you were always there. I will forever remember your love and kindness. I want to thank my brother, Wesley Holland, and my sister-in-law, Kristen Childs Holland, for reminding me to have fun and enjoy life, whether through weekend gatherings to watch VT games or spending Sunday nights playing Mario Kart on the Switch. I want to thank my Grammy and Poppy, Judy and Wayne Evans, for always expressing your pride in me and for creating some of my most fond family memories filled with love and laughter overlooking the Rappahannock River. I want to thank Rebecca Downs who has known so many versions of me, from girlhood to womanhood, and who makes the world a brighter place just by being in it. Brittany, this is your necessary shoutout for always encouraging me to pursue the highest version of myself, to relentlessly follow my dreams, and to shamelessly live in a mindset of being #NeverNotExtra. Thank you for pushing me to get out of my comfort zone, for moving to North Carolina with me, and for reminding me that we are only here on this planet for a blip, so we might as well have fun while we’re at it. I want to thank David, my partner, for everything over the past couple of years. The care, effort, and intention to put into everything you do is deeply inspiring, and I look forward to living life with you by my side. Thank you to my incredible mentors – Drs. Liz Craig, Loreen Olson, and Linda Manning – for the pivotal roles you played in inspiring me to find awe in Communication Studies research. I want to thank my committee for their brilliance, time, and dedication to this

project. The Department of Communication and Dr. Jessica Jameson at NC State provided me with funding for my participants, and I am grateful that I was able to compensate mental health professionals for their time with this project. I want to thank everyone involved in the Doctoral Dissertation Completion Grant program at NC State, including Dr. Mike Carter, Dr. Michelle Bruno, Dr. Jenn Archer, Dr. David Shafer, Dr. Katie Homar, and my incredible cohort who supported me weekly in completing my dissertation. Finally, I want to acknowledge my appreciation for my Ph.D. cohort (2019-2023) in the Communication, Rhetoric, and Digital Media (CRDM) program at NC State, many of whom began referring to ourselves as Cohort-19 as our first year of the program coincided with the start of the pandemic. I could not have finished this dissertation without the incredible support of you all.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

As evidenced globally, the COVID-19 pandemic has impacted the mental health of the general population with its negative effects, including those of anxiety, fear, stress, isolation, and economic strain, among others (Amsalem et al., 2020). Diagnosed mental illnesses in the United States are at an all-time high, with the surge in need for mental health-related care further straining an already overburdened healthcare system (Auerbach & Miller, 2020). Some scholars are referring to the mental health spillover from COVID-19 as "a second pandemic" in itself (Choi et al., 2020). Healthcare workers have expressed feeling "stressed out and stretched too thin" while also indicating a lack of emotional support during the COVID-19 pandemic ("The Mental Health", 2020). Healthcare workers are serving those who need various types of care while also navigating the challenges of their own mental health, necessitating the role of mental healthcare professionals more than ever.

Given the demands and effects of COVID-19, the role of mental healthcare providers (MHPs) is critical in providing the care, relief and support for those who are struggling to cope with pandemic-related stressors *on top of* other life stressors. While the aim of MHPs is to improve the quality of life and wellbeing of their clients ("What Psychologists do", 2014), they are facing unprecedented challenges that can affect their ability to effectively and regularly provide care to those who need it. Since the start of the pandemic, MHPs are facing higher reported cases of marital conflict and domestic violence (Boserup et al., 2020), increased workloads with limited resources and support (Joshi & Sharma, 2020), additional COVID-19 trainings and duty in isolation wards (Kar & Singh, 2020), and the responsibility of adapting and learning new modalities of service delivery while managing their own pandemic-related stressors (Fish & Mittal, 2021), among other challenges. Mental health providers are not insusceptible to

stressors related to the pandemic, yet it is their responsibility to reserve a safe space for clients to process pandemic-related challenges. As such, mental healthcare providers are simultaneously facing their own adversities *and* their clients' stressors related to the pandemic. Preliminary research is already showing that the challenges faced by MHPs since the start of the pandemic have had adverse effects on their own mental health (Fish & Mittal, 2021), making the study of provider wellbeing a salient and timely research topic.

Researchers are just beginning to scratch the surface on understanding the challenges faced by MHPs during the COVID-19 pandemic. Existing articles advocating for the mental health of MHPs during COVID-19 have come in the forms of a call to action (Armitage & Nellums, 2020), letter to journal editors arguing the oft-ignored importance of MHP's mental health during the pandemic (Kar & Singh, 2020), considerations of MHP burnout (Joshi & Sharma, 2020) identifications of initial usability problems with technology (Feijt, 2020) and preliminary studies exploring the first few months of the pandemic for mental health professionals (Fish & Mittal, 2021). Although a multitude of calls have come forth advocating for the importance of addressing the mental health of MHPs, most research has focused on "first line" healthcare responders (i.e., those who can diagnose COVID-19) and few have explored the mental health of "second line" responders (i.e., counselors, social workers, and other MHPs) over the course of the pandemic. Further, to-date, there have been no studies exploring the process of cultivating MHPs' resilience during the pandemic. In this context, resilience involves the process of MHPs reintegrating and communicatively constructing new normalcies in an effort to secure a sense of stability from the various stressors of the pandemic.

To address this, the following qualitative study employs in-depth interviewing techniques to examine the challenges, opportunities, and practices of mental health professionals during the

COVID-19 pandemic while exploring resilience cultivation and the specific stress and coping strategies employed. In addition to learning about individual coping and resilience cultivation strategies, the goals of this research are to identify existing needs, assess the effectiveness of resources, and suggest interventions to better support mental health professionals through the remainder of the pandemic while preparing for anticipatory adversities.

Though this dissertation is grounded in Communication Studies theories and methods, there are larger implications of this project for interdisciplinary research. Based on the numerous calls for research on this topic across multiple academic disciplines, this project and related research studies involve collaborations with psychologists, therapists, and social workers, as well as organizations whose goals align with improving community mental health. The specific interventions from this dissertation project may have particular relevance to these scholars as they seek to understand the needs, challenges, and opportunities of mental health professionals who are practicing during (and after) this pandemic. This knowledge could be useful to a variety of stakeholders, including (a) those currently working in the mental health profession, (b) researchers seeking to better understand resilience cultivation, (c) mental health advocates seeking to improve public policy through legislation that affects the lives of people with mental health conditions, (d) organizations looking to best support their mental health professional employees, and (e) future mental health professionals learning what to expect and strategies for how to better manage and recover from large-scale adversities.

Current Situation: Mental Healthcare Professionals and COVID-19

While an abundance of literature has emerged exploring COVID-19 and mental health (see Rajkumar, 2020 for a literature review) and mental health among healthcare workers during the COVID-19 pandemic (e.g., Shaukat et al., 2020), most research has focused on frontline

healthcare workers such as doctors, nurses, physicians, physician's assistants, nurse practitioners, and other hospital and emergency department workers, where frontline workers are defined as those who are "directly engaged in clinical activities of diagnosing, treating, or providing nursing care to patients with elevated temperature or patients with confirmed COVID-19" (Lai et al, 2020, p. 4). Mental health professionals, or those labeled as second-line workers, have fallen into an "other patient care" category within research studies (Lai et al, 2020; Mental Health America, 2020).

Current Situation: Resilience and Mental Health

Resilience as a phenomenon has been studied across a multitude of academic disciplines, including (but not limited to): psychology, psychotherapy, sociology, biology, ecology, nursing, neuroscience, and communication. Because this project is centered around exploring the resilience, stress and coping mechanisms of MHPs as described in their own words, the field of Communication Studies offers an effective theoretical framework for understanding the resilience cultivation of MHPs. Communication scholarship frames resilience as a phenomenon that is created discursively following a single or series of adverse events (Wilson et al., 2021). In the context of the organizational communication workplace, the leading conceptualization of resilience cultivation lies with Buzzanell's (2010) Communication Theory of Resilience (CTR), which serves as the guiding theoretical framework for this study.

The Communication Theory of Resilience (CTR) defines resilience as "a constitutive process through which people reintegrate and actively construct their new normal through language, interaction, networks, and attention to their identities and identifications" (Buzzanell, 2019, p. 68). According to CTR, resilience is activated when a trigger event occurs and creates a disruption in people's lives. Following the trigger event, the cultivation of resilience can then

occur interactively between at least two individuals. This is a process theory (Poole, 2013) that is "based on the development of theoretical narratives that explain how [a] series of events unfold over time" (p.371). Buzzanell (2018) posits that resilience cultivation incorporates stories, memories, routines, and rituals about how people not only endured despite loss and suffering but also actively shaped and framed these experiences.

CTR conceptualizes the cultivation of resilience through five interrelated processes: (a) crafting normalcy; (b) affirming identity anchors; (c) maintaining/using communication networks; (d) constructing alternative logics; and (e) foregrounding productive action while backgrounding negative emotions (Buzzanell, 2010). The research suggests that those individuals who are able to enact these processes following a trigger event will experience greater well-being (Wilson et al, 2021). At the same time, those who struggle to enact these processes, due to a variety of reasons (i.e., multiple disruptive events, lack of relational or material resources), generally report lower well-being (Afifi et al, 2016; Buzzanell, 2019).

While CTR has yet to be explored among researchers examining the working lives of MHPs, there are several studies which have explored the communicative processes of resilience in the contexts of mental health. Applying the CTR framework, Craig et al. (2020) examined resilience in Equine Assisted Psychotherapy (EAP) among adolescent women with adverse childhood experiences (ACEs). In this context, adolescents worked with members of an EAP nonprofit (including mental health professionals, tutors, volunteers, equine specialists, and therapy horses) to foster and cultivate resilience (Craig et al., 2020). Whereas Craig et al. (2020) explored resilience cultivation among the patient/client or individuals receiving mental health-related services, Rush et al. (2022) examined "volunteer coping and resilience processes in emotionally taxing work" (p. 1) via client-facing volunteers who provided mental-health related

services. This study showed that processes related to CTR, including reframing and transforming struggle and invoking identity anchors, were evident among human services volunteers supporting survivors of human trafficking, refugee children, and people experiencing homelessness (Rush et al., 2022). Similarly, Brandhorst (2017) examined communicative resilience among employees and clients in a children's emergency shelter and considered the role of organizational culture in fostering resilience. Much like studies, this dissertation will utilize the CTR framework to explore how resilience is fostered and cultivated in a mental health context, but the focus will be on MHPs providing mental-health related services during the COVID-19 pandemic.

In sum, the Communication Theory of Resilience (Buzzanell, 2010) offers a robust framework for understanding how resilience is communicatively cultivated following an adverse event or series of events. The communicative dimensions of CTR applied in the context of mental health professionals during the COVID-19 pandemic enables a discursive exploration of resilience that has never been administered before. Utilizing CTR in this study provides insight as to how mental health professionals uniquely frame their experiences as well as the specific challenges, opportunities, solutions and resources providers encountered during the pandemic.

Overview of Dissertation Chapters

This first chapter has provided an introduction to the topic of mental healthcare provider wellbeing during the COVID-19 pandemic, as well as the overall scope, anticipated value, and contributions of this dissertation. In the second chapter, a review of the literature covers current research on the practices of mental health professionals during the pandemic, the evolution of resilience literature across disciplines, and a specific focus on how resilience has been investigated within the discipline of Communication Studies. Chapter three overviews the

methodology, including the research design, an evaluation of the method, and a statement of limitations. Following this, chapter four dives into the emergent themes and results uncovered as a result of conducting a thematic analysis of the qualitative interviews. Finally, chapter five concludes with a discussion of the results, a review of the research questions, reflections on the research process, implications for future work, and a consideration of the knowledge that this study contributes to the field.

CHAPTER 2: LITERATURE REVIEW

In a study exploring communicative resiliency among U.S. mental health professionals during the COVID-19 pandemic, conceptual clarity on trauma is required, as traumatic or adverse events serve as the precursor to resilience cultivation. The following review of literature begins with an overview of key literature within trauma work, as well as the common types of trauma seen in the mental healthcare profession. The second section transitions into definitions of resilience, summarizes influential works of resilience across disciplines, and explores how it has been textualized as a Communication Studies phenomenon. After reviewing trauma and resilience literature, the final section investigates emergent literature that examines the effects of COVID-19 pandemic of the general population, healthcare workers, and, specifically, mental health professionals. While this literature review does not capture every piece of literature across the topics of trauma, resilience, and the COVID-19 pandemic, it highlights seminal pieces that situate this project within relevant works and addresses the research gap that this study investigates.

Adverse Life Events & Trauma Work

Trauma: Conceptual Clarity and Theoretical Underpinnings

Since an adverse life event(s) must first occur for resilience cultivation to be enacted, and adverse events are linked to psychiatric disorders involving trauma (e.g., Dohrenwend et al., 1978; Selye, 1956), both concepts warrant clarity and distinction. An adverse life event (ALE) is defined as a, "...major [stressor] occurring at any time throughout the lifespan and pose a significant physical or psychological threat to safety and/or security" (Rhudy & Hellman, 2022, p. 359). ALEs can be a singular event, repetitive, or occur over a period of time and include instances that occur during childhood/prior to eighteen years of age (known in trauma literature

as adverse childhood events [ACEs] or early life adversities [ELAs]) or span into adulthood (Rhudy & Hellman, 2022). As Rhudy and Hellman (2022) point out, ALEs are not minor stressors or day-to-day hassles; instead, they are events such as neglect, abuse, or direct exposure to a serious threat such as an assault, accident, combat, or death. ALEs such as natural disasters, parental bereavement, and physical/sexual assault have been associated with detrimental effects on mental health and wellbeing (e.g., Edwards et al., 2003; Lucas, 2007).

Whereas an individual could experience an ALE without necessarily experiencing trauma, all individuals who have experienced trauma have also experienced an ALE or series of events. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), individual trauma is defined as an adverse life event resulting in physical, emotional, and/or life-threatening harm that leads to lasting detrimental effects on an individual's mental, physical, and/or emotional health ("Trauma and Violence", 2022). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR; American Psychiatric Association, 2022) defines a traumatic event as "exposure to actual or threatened death, serious injury, or sexual violence" (p. 301) either by:

> ...Directly experiencing the traumatic event (criterion A1), witnessing in person the event as it occurred to others (Criterion A2), learning that the event occurred to a family member or close friend (Criterion A3), or indirect exposure in the course of occupational duties, through being exposed to grotesque details of an event (Criterion A4) (p. 305).

As described in this quote, a traumatic event can be classified by the presence of any one of these or a combination of criteria at the individual level. In addition to conceptualizing trauma through direct or indirect exposure, there is the consideration of an individual's response to the traumatic event as immediate or delayed. Most modern theories conceptualize trauma as a

belated response to an event that is too emotionally shocking or upsetting to be processed when it occurs (Bond & Craps, 2020). A key facet of trauma is that it is not consciously experienced in-the-moment of the adverse event; rather, it is delayed and returns to "haunt" the individual later on. As such, a traumatic event is labeled as an adverse experience or circumstance that leads an individual to later experience trauma. Caruth (1995) identifies the paradox inherent within trauma and traumatic events, where one's initial response to an adverse event might be an immediate numbing effect, but this immediacy may manifest in the form of belatedness. Caruth (1995) further explains, "central to the very immediacy of [one's] experience… is a gap that carries the force of the event and does so precisely at the expense of simple knowledge and memory" (p. 7). The force of the event may not immediately be realized and is initially forgotten, later reemerging over time and outside an individual's psychological realm of control. The adverse experience is repeated after its forgetting, and it is only through forgetting first that trauma is even experienced (Caruth, 1995).

In their collaborative work *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History* (1992), Felman and Laub contributed significantly to trauma theory by conceptualizing trauma as an ongoing crisis of survival. They review several violent events of the twentieth century, including the Holocaust and World War II, and present the first "theory of testimony" that emphasizes the importance of the voices of the survivors, victims, and witnesses in relation to adverse events. Felman and Laub (1992) distinguish three levels of witnessing, including personal witness, secondary witnessing (where an individual talks to another individual about their experiences, such as through therapy), and the meta concept of tertiary witnessing, or observing the process of witnessing occuring, which seems to be an aim of this work. In

relevance to this study, Felman and Laub (1992) emphasize that it is through individual testimonies, speech, and narratives that a traumatic event can be better understood.

LaCapra (2004) greatly contributed to trauma theory through his critiques of foundational trauma scholarship, providing conceptual clarity to trauma studies. LaCapra examines Caruth's (1995) trauma framework, arguing that there is a distinction between the traumatic event and the experience, much like first order realities (the event occurrence itself) and second order realities (one's perception of the event). LaCapra (2004) notes that an individual may take part in an event without undergoing trauma, whereas others may undergo the same event and, in turn, experience trauma. This highlights the importance of trauma being a subjective experience that depends on an individual's existing mental schema. There are events that could be traumatic to one person but might not be to someone else. Further, another distinction LaCapra (2004) makes with Caruth's (1995) conceptualization of trauma is that trauma is not necessarily elusive or unknowable until it reemerges outside of the control of an individual; instead, it is a matter of connecting knowledge of a traumatic event with feeling. Trauma, to LaCapra, is less about uncontrollable and repetitive resurgences and more involving the intentional re-engagement with the past and present to have greater control of the future. Building off of the thoughts of Sigmund Freud (1917), LaCapra makes two oppositional distinctions to trauma responses: working-through and acting out. Working-through trauma involves a process of critically distancing traumatic experiences and redefining them in a way that allows reengagement with continuing concerns (LaCapra, 2004). As opposed to maintaining a distance to the trauma with working-through, acting out trauma involves dissolving the distinction between the past and present, enabling an individual to performatively relive the experience and re-engage with the traumatic event which may have been too much to process at the time of its initial occurrence.

Schick (2011) further expands upon LaCapra's (2004) distinctions between acting out and working through trauma, advocating for the working through approach. Schick (2011) argues that responding to trauma through acting out leads to the construction of meaning-making narratives (Yoder, 2005) where people search desperately for meaning in the midst of disasters in an attempt to understand what occurred and to bring forth comfort. Unfortunately, these meaning-making narratives alone are often over simplistic and extend current suffering, and when employed by governments, serve to shut down questioning and show strength and decisiveness following the occurrence of a traumatic event (Schick, 2011). Schick (2011) asserts the critical but difficult role of working through trauma as the preferable approach, which involves a slow process of painful questioning, expressing grief, sharing the story of what took place, reflecting on the various conditions that allowed the traumatic experience to take place, and communicating what happened with others, which can be an inherently political risk. It is inherently political, she argues, due to requiring a willingness to question current structures, go against settled norms, and potentially advocate for a different way of being and thinking, which is often challenged by those in power (Schick, 2011).

Well-being and Post Traumatic Stress Disorder

An important consideration while reviewing trauma work includes understanding the impact of trauma on an individual's wellbeing. Trauma can lead people to experience immediate and delayed emotional, physical, cognitive, and behavioral reactions (SAMHSA, 2014). According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014), "...initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, physical arousal, and blunted affect" (p. 61). Longer term reactions to trauma might involve intrusive memories or flashbacks, unforeseeable emotions,

emotional detachment, difficulty in relationships, and physical stress symptoms on the body such as elevated cortisol levels, persistent fatigue, lowered resistance to colds and infection, as well as heart, liver, autoimmune, and chronic obstructive pulmonary disease (SAMHSA, 2014; "Trauma", 2023). While the effects of trauma range in severity, longevity also serves as a principal factor in determining whether an individual has developed posttraumatic stress disorder, or PTSD.

Following a traumatic event or circumstance, most people experience some stress-related reactions. According to the U.S. Center for PTSD (2023), if an individual's stress reactions to a traumatic event continue for more than thirty days, that individual should get evaluated by a qualified mental healthcare practitioner for PTSD. Trauma that is not fully processed within the first thirty days following the traumatic event could be diagnosed as PTSD, which requires a specific mental health diagnosis by a professional. In addition to having flashbacks and re-experiencing a traumatic event for more than thirty days, to meet the criteria for PTSD, there must also be a high level of continual distress that is disruptive to an individual's life, an avoidance of stimuli related to the traumatic event(s), and intrusive symptoms associated with the traumatic event, among other diagnostic criteria (American Psychological Association, 2022). PTSD can develop following a traumatic event, but not everyone who experiences trauma develops PTSD. While trauma and PTSD are often intertwined, they are not synonymous, so it is important to distinguish the two.

Now that trauma and PTSD have been broadly but conceptually defined, it is worth noting that there are various trauma-related constructs that can manifest based on an individual's background, the timing of the event(s), and the context in which the trauma is experienced. As clients share their traumatic experiences in sessions with their clinicians, there are compounded

effects that professionals might encounter when engaging in active listening to these accounts day in and day out. In the next section, several types of trauma and trauma-related constructs that frequently occur among the experiences of mental health professionals are explored, including secondary traumatic stress, vicarious trauma, burnout, and collective trauma. These specific trauma-related constructs are frequently related to occupational stress literature surrounding professions affiliated with mental health.

Secondary Traumatic Stress Disorder, Burnout and Collective Trauma

Figley (1983) was the first scholar to introduce the concept of secondary trauma as the emotional duress that individuals experience when having close contact with another person who has survived trauma. People who have close contact with trauma survivors, often family members, naturally respond to a loved one's traumatic experience with empathy (Figley & Kleber, 1995). The symptoms of secondary trauma are highly similar to PTSD, with the main difference being that the person who experienced the trauma first-person could develop PTSD, whereas the individual hearing about the trauma may develop secondary traumatic stress disorder, or STSD (Jenkins & Baird, 2002). Figley later renamed STSD "compassion fatigue", viewing it as a regularly occurring hazard associated with the occupation of mental health professionals (Figley, 1995a). It is important to note that in the DSM-5-TR (American Psychiatric Association, 2022), indirect exposure to a traumatic event was added to the criteria for a PTSD diagnosis, meaning that therapists and others could be diagnosed with PTSD solely based on their indirect trauma exposure. STSD is thus considered as a diagnosis to PTSD symptoms that arise in response to indirect exposure (e.g., listening to client stories).

Whereas STSD, or compassion fatigue, involves the immediate adverse emotional reactions that individuals experience when listening to or trying to help trauma survivors,

vicarious traumatization occurs when an individual's worldview, frames of reference, identity, and/or spirituality shift after prolonged exposure to other trauma survivor's events (Pearlman & Saakvitne, 1995). Secondary trauma, then, is usually experienced simultaneously to hearing a trauma survivor's story, while vicarious trauma occurs over time, may be delayed, and is associated with having a sense of permanently altering the listener's perspectives. Vicarious trauma is particularly prevalent among therapists who help victims of violence, incest, and sexual assault (Jenkins & Baird, 2002).

Another construct frequently experienced by mental health professionals is burnout, which is defined as, "a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and provide inadequate support" (Jenkins & Baird, 2002, p. 424). Maslach (1982) provided a foundational conceptualization of burnout, used by most researchers studying the topic, as having three content realms: emotional exhaustion, depersonalization, and a decreased sense of personal achievement. Morse et al. (2012) provide a comprehensive literature review on burnout within mental health services and examine burnout from two perspectives: its prevalence and its connection with various unfavorable outcomes for mental health professionals, organizations, and their clients. In discussing the prevalence of burnout among several pieces of literature, Morse et al. (2012) report that anywhere from 21-67% of mental health professionals may be experiencing elevated amounts of burnout. Related to the second perspective, unfavorable outcomes, the researchers argue that the effects of burnout on mental health professionals can be serious and extensive (Morse et al., 2012). Notably, mental health professionals who experience high levels of burnout often develop health issues (such as flu-like symptoms and symptoms of gastroenteritis) (Acker, 2010), a diminished self of well-being (Stalker & Harvey, 2002), reduced commitment to the

organization (Burke & Richardsen, 1993), negative attitudes (Chemiss, 1980), has been connected with higher substance use among directors in mental health organizations (Rohland, 2000), and may lead to staff turnover (Stalker & Harvey, 2002). Farber (1985) found that mental health professionals who work in institutions and other variations of community care are far more at risk for burnout than those who work at private practice.

Finally, in considering the trauma faced by mental health professionals, particularly within the past few years, an overview of collective trauma is warranted. Collective trauma refers to the psychological effects of a catastrophic event that disrupt the established structure of a society, where a tragedy is embedded within the collective memory of a group of people that go through an active recollection of the trauma in an effort to make sense of it (Hirschberger, 2018). Collective trauma expands beyond the survivors of a tragedy and affects communities and generations beyond those that experienced or witnessed the traumatic event(s). Hirschberger (2018) argues that the memory of collective trauma is "a dynamic social psychological process that is primarily dedicated to the construction of meaning" (p. 2). One of the most prominent examples of a collective trauma is the Holocaust, which has received the most scholarly attention among other collective traumas (Mazur & Vollhardt, 2015). A more recent example of collective trauma involves the September 11, 2001 terrorist attacks in the United States, which has been explored empirically through works that have assessed the physical health impact of collective stress in the U.S. (Holman & Silver, 2011), explored perceived societal changes and well-being (Poulin et al., 2009), and examined the meaning in collective trauma following the events of 9/11 (Updegraff et al., 2008), among others. More recently, the collective trauma of the COVID-19 pandemic has been explored among various countries in (e.g., Stanley et al., 2021; Watson et al., 2020) and outside of the U.S. (e.g., Masiero et al., 2020). Some scholars argue that the events of

2020, including the COVID-19 pandemic, economic recession, natural disasters and racial social unrest have led to unprecedented cascading collective traumas (Silver et al., 2020).

As mentioned in the opening of this section, this study examines resilience among mental health professionals during the COVID-19 pandemic, which ultimately involves exploring the stressors, challenges, and various adverse events encountered by MHPs between February 2020 - April 2023 (the time of data collection) that led to resilience cultivation. This section has reviewed key definitions of trauma as well as types of trauma and stress that mental health professionals often encounter in their occupation. The following section transitions into a review of relevant COVID-19 literature, both broadly in its effects on the general population as well as situated within healthcare and mental health organizational settings.

COVID-19 Pandemic, Healthcare, and Mental Health Professionals

According to the World Health Organization (WHO) (2022), widespread evidence indicates that the COVID-19 pandemic has resulted in a worldwide increase in mental health issues, including depression and anxiety. Xiong et al. (2020) provide a systematic review of literature exploring the initial impact of the COVID-19 pandemic on the general population's mental health, reporting that there were high rates of anxiety, PTSD, anxiety and psychological distress among the general population. In fact, the mental health spillover from COVID-19 has been labeled by some scholars as "a second pandemic" in itself (Choi et al., 2020). This increase has affected both the people who have been directly affected by COVID-19 as well as those healthcare professionals who rose to address the surge in need. Frontline health professionals who have had close contact with patients diagnosed with COVID-19, especially those in Wuhan, China, frequently experienced an exorbitant workload and isolation, making them particularly vulnerable to physical and emotional exhaustion, fear, and sleep problems (Kang et al., 2020).

Healthcare providers have been faced with multiple challenges leading to emotional distress, including their risk of exposure to COVID-19, fear of potentially infecting their family and friends, long working hours, shortages of necessary medical equipment, and participation in challenging ethical decisions (Pfefferbaum & North, 2020). On top of the general population, healthcare providers, too, have faced mental health issues, necessitating the role of mental health professionals to provide support while simultaneously navigating the stressors of the pandemic.

The increase in need for mental health services because of the pandemic has over-burdened an already fragile mental health system in the United States (Auerback & Miller, 2020). Mental health professionals have been detrimentally affected by COVID-19; in a sample of 137 mental health providers across a variety of disciplines, Fish and Mittal (2021) found that a total of 112 (82%) indicated that the pandemic had negatively impacted their capacity to serve clients. Jow and colleagues (2022) found that among a sample of therapists during the first surge of COVID-19 hospitalizations, all reported experiencing increased levels of occupational stress, and those younger than 30 years old had remarkably higher scores on the General Anxiety Disorder 7-item (GAD-7) scale that therapists between 30-39 years old, making younger therapists at a higher risk for increased anxiety. Despite these increased levels of stress, unfortunately, many mental health professionals do not seek adequate help for their own mental health, likely out of the belief that as experts they should work through their mental health issues on their own (Kar, 2020).

While the need for mental health support among mental healthcare professionals during COVID-19 has been articulated (e.g., Armitage & Nellums, 2020; Joshi & Sharma, 2020; Kar & Singh, 2020), few studies have surveyed mental health professionals on their experiences during the pandemic (e.g., Feijt, 2020; Fish & Mittal, 2021) and none, to date, have qualitatively

interviewed MHPs directly to explore the challenges, opportunities, and communicative resilience cultivation practices experienced throughout the pandemic. Additionally, some literature has emerged on providing guidelines to clinicians for best servicing their clients and making mental healthcare more accessible during the pandemic (e.g., Fiorillo & Gorwood, 2020; Moreno et al., 2020), but no studies to the author's knowledge have emerged yet on how MHPs can best support themselves while supporting others in the midst of a global pandemic. In order to do this, it is important to understand the stress, coping, and resilience processes that MHPs employ to continue serving their clients while simultaneously navigating the stressors of the pandemic. Resilience, stress, and coping scholarship provides researchers with a framework to better understand how, despite a major adversity or series of adversities, individuals and communities are not only able to recover from challenges but in many cases, also thrive. Because this study involves understanding MHP experiences from a resilience framework, the following section overviews relevant literature which informs this study's research design process and interpretation of findings.

Resilience, Stress & Coping Mechanisms

Human resilience has been empirically explored across a multitude of academic disciplines, and is broadly conceptualized as the ability to recover and, in some cases, even thrive following an adversity or series of adversities. On their website, the American Psychological Association (APA) (2023) defines resilience as "…the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands." Given the decades of research and range of contexts in which human resilience has been examined (see Southwick et al. [2014] for an interdisciplinary literature review), the following section highlights seminal

pieces of the literature across three broad categories: resilience as a predictor/trait, an outcome, or a process. In each of these categories, various methods and approaches to defining and refining researchers' understanding of resilience are explored. While distinct in their approach, these categories are not necessarily mutually exclusive, as sometimes researchers will simultaneously conceptualize resilience as more than one of these categories. Following this overview, the discussion of resilience will be tapered and explored within the discipline of Communication Studies, highlighting critical pieces that have shaped resilience as a communicative phenomenon.

Resilience as a Predictor, Outcome, or Process

When thought of as a predictor, resilience is conceptualized as those relevant qualities evidenced *before* a major stressor is presented in an individual's life. It is a trait or characteristic that is often understood to be something that individuals either possess or do not possess. Across disciplines, resilience as a predictor is explored in several ways. Biologists, cognitive psychologists and neurologists (e.g., Curtis & Cicchetti, 2003) have examined genetic and immune factors that predispose some individuals to be more resilient than others. Psychology researchers have used the results of resilience scales as a predictor of depressive symptoms among young adolescents (Hjemdal et. al., 2007) and in the prediction of emotional response in breast cancer patients receiving a diagnosis (Markovitz et al., 2015). Some psychologists associate resilience with a certain personality type, which when a person has this, they have an enhanced ability to adapt individually to adversities and stress (Hu et al., 2015). Others examine internal resilience factors (e.g., personality traits or beliefs) and external resilience factors (e.g., material, social, or energy resources) and access to these resources as predictors of resilience cultivation, where those individuals who possess these resources are more likely to be resilient

(Chmitorz et al., 2018; Hobfoll et al., 2015). Communication scholars (e.g., Theiss, 2018) consider the necessary qualities, relationships, and communication strategies that must first be enacted in order for certain populations to be able to cultivate resilience. Across disciplines, scholars are searching for those traits, relationships and predispositions that set individuals up for having the qualities necessary to experience resilience before an adversity occurs. It is important to note that a critique of conceptualizing resilience as a predictor could be that this viewpoint is deterministic in nature, one which privileges resilience cultivation towards those that already possess designated traits.

When framed as an outcome, this research explores the resilient qualities as present *after* a stressor has occurred. In outcome-oriented approaches, the exposure to a major stressor is required before resilience can be cultivated, and the resilience of a person can only be determined if a person currently is or formerly was exposed to a stressor or traumatic event(s) (Chmitorz et al., 2018). Masten (2001) conceptualizes resilience as "a class of phenomena characterized by good outcomes in spite of serious threats to adaption or development" (p. 228). According to Masten (2001), resilience is contextual and requires two components, (a) the threat, or the risk, which may come in the form of a major adversity, number of life events, or massive community trauma, and (b) the quality of adaption or outcome is determined to be good or sufficient by someone/a group of people. In other words, resilience is not only an outcome that follows an adversity, but it is also something that is defined by a person or group by some designated or implied set of standards. Masten's (2001) thinking raises the important question: who gets to decide that a person or community is resilient, and by what standards is resilience being defined and/or measured? Whether scholars choose qualitative or quantitative methods for examining resilience as an outcome, in this capacity, they often explore how certain populations

reflect upon their experiences of adversity and "bouncing back" after-the-fact. This will involve having individuals recall past adversities while having them consider, in some capacity, how they can make sense of what happened and potentially even thrive from the experience.

Finally, as a process, resilience is explored as something occurring gradually, through intrapersonal and interpersonal communication, where individuals in a relational system provide feedback to one another while managing the stress together and ultimately ascribing meaning and understanding to the stress. Research in this realm, across disciplines, might have participants consider and examine a current adversity or former in their lives. Resilience as a process might look at how and why resilience is created, cultivated, and maintained, and how the effects of resilience can impact personal and relational health (Afifi, 2018). In viewing this phenomenon as a process, it is through enactment, negotiation, and dialogue that resilience is constituted.

Some scholars have argued that resilience exists on a continuum that may be more or less present to varying degrees and contexts throughout different stages of life (Pietrzak & Southwick, 2011). For example, an individual might cultivate resilience following a stressful work experience but not in their personal relationships (Southwick et al., 2014). A key distinction in resilience literature comes from Bonanno (2004), who argues that there is a difference between resilience and recovery. Resilience, according to Bonanno (2004), reflects one's ability to maintain stability following a traumatic event, whereas recovery involves a path where a person's ability to function normally temporarily dips beneath that threshold, usually for several months. In this capacity, adults who are exposed to a highly disruptive event are resilient when they are able to maintain relatively healthy and stable levels of regular functioning over an extended period of time (Bonanno, 2004).

Resilience in Communication Studies

In the discipline of Communication Studies, resilience has been explored at the micro, meso, and macro levels, including interpersonal relationships (e.g., Afifi, 2018), within families (e.g., Theiss, 2018), organizations (e.g., Buzzanell, 2010), communities (e.g., Houston, 2014) and at the national level (e.g., Bean, 2018). There has been consensus among Communication scholars in using Luthar and Zelazo's (2003) definition of resilience as a baseline conceptualization of the phenomenon, who describe the concept as the ability to adapt positively when confronted with a stressor or adversity. While Luthar and Zelazo's (2003) definition serves as a baseline for resilience scholarship in the Communication discipline, it has been further expanded upon based on the specific populations being examined.

Afifi (2018) argues that "the central question of interest [with resilience] is why some people and relationships adapt and even thrive when confronted with adversity and others do not" (p. 5). Afifi and colleagues (2016) developed the theory of resilience and relational load (TRRL) which explores how certain communication patterns and appraisals can positively or negatively influence one's relational health and adaptation during times of significant adversity. The TRRL argues that when people validate their relational partners and family members on a regular basis through positive relationship maintenance strategies, actions, and behaviors, they accumulate positive emotional reserves that help in managing and persevering through the stress. Much of Afifi's work explores resilience in romantic and close relationships and examines the processes in which resilience is cultivated.

Buzzanell's research looks at resilience within family and organizational systems. In Lucas & Buzzanell (2012), the authors explore how resilience is constructed in families, both in the short-term and long-term. Lucas & Buzzanell (2012) adapt Richardson's (2002) definition of

resilience as a "process of reintegrating from disruptions in life" (p. 309) by situating it in communication. In particular, the authors define resilience as "the process of meaning making through the everyday messages and stories that enable reintegration from life's disruptions" (p. 190). Lucas & Buzzanell (2012) situate the community as central in the resilience process, which supports Afifi and colleagues' (2016) concept of communal orientation.

While Afifi's and Buzzanell's overarching conceptualizations of communicative resilience (in the contexts of family and organizations) are more so in line with the research in this dissertation, it is Buzzanell's (2010) Communication Theory of Resilience (CTR) (2010) that ultimately serves as the foundation for this study. Buzzanell (2010) argues that human resilience is "constituted in and through communicative processes that enhance people's abilities to create new normalcies" (p. 9). Resilience, in this light, is not just about a person's ability to bounce back, but situates resilience in human interaction with others and with one's self (Buzzanell, 2018). Resilience is a process that draws upon one's connections using face-to-face and mediated communication with others, while leveraging the power of stories to make sense of adversities and our relationships with others (Buzzanell, 2018). CTR differentiates itself from other resilience theories by:

> …(a) focusing on ongoing communicative processes of adaptation and transformation, reactivity and proactivity, stability and change, description and reintegration, destabilization and restabilization; (b) situating resilience in interaction and relationships, integrating scholarship from interpersonal, family, organizational, health, and mediated communication contexts; (c) refocusing inability to "bounce back" from individual deficit approaches to politicized contexts in which material resources, policies, and ideological structures about the nature and characteristics of families are socially constructed and

> enacted; and (d) recognizing that there are both benefits and costs for the particular ways in which resilience is constituted (Buzzanell, 2018, p. 99).

As stated by Buzzanell (2018), CTR considers tensions in resilience processes, frames resilience as a constitutive occurrence among individuals, emphasizes the presence of resilience as influenced by one's context and access to resources, and acknowledges that resilience enactment could simultaneously be advantageous to some and disadvantageous to others.

According to Buzzanell's (2010) CTR, people are able to cultivate resilience through five communicative processes: (a) crafting normalcy; (b) affirming identity anchors; (c) maintaining/using communication networks; (d) constructing alternative logics; and (e) foregrounding productive action while backgrounding negative emotions (Buzzanell, 2010). Crafting normalcy involves the language and stories used to construct a new normal that acknowledges and integrates loss. Affirming identity anchors involves co-constructing identity in conversation by using language that explains who someone is in relation to others. Maintaining and using communication networks allows people to draw upon their relationships and connections with others to help make sense of what is happening, assess their circumstances, and stabilize their strong connections with those they are closest with. Constructing alternative logics occurs when the regular ways of sensemaking no longer work following a disruption, and people look into new/different ways of handling problems by challenging the status quo. Finally, when individuals foreground productive action while backgrounding negative emotions, they are intentionally and consciously acknowledging that one has a very legitimate reason to feel negative emotions (e.g., anger, sadness, loss) about the traumatic event, while then focusing on emotion work to move forward and reframe "the situation linguistically and metaphorically to one of constrained hopefulness" (Buzzanell, 2010, p. 9). CTR argues that the process of

resilience is activated and enacted following the occurrence of a trigger event(s); it is ongoing, dynamic, and cultivated through family rituals, messages, stories, visits to ancestral sites, and the retention of objects, sayings, and connections that have symbolic significance.

As stated previously, CTR is a process theory, and a goal of process theories is to generate new understandings about communication (Poole, 2013). As such, CTR provides a framework of five interconnected processes where patterns of resilience emerge in one's interactions, relationships, and understandings created with others. This theory is useful to utilize in research that seeks to understand how individuals communicatively enact resilience among their networks following a disruption or series of disruptions. Using this theory as a framework, this study explored the resilience processes as well as the stress and coping mechanisms employed by MHPs during the COVID-19 pandemic. From here, the following research questions are proposed:

RQ1: What triggers, stressors, and challenges did mental health professionals face throughout the COVID-19 pandemic?

RQ2: What, if any, resilience processes were enacted by mental health professionals during the COVID-19 pandemic?

CHAPTER 3: METHODS

Introduction and Research Questions

In this University IRB approved qualitative study, the resilience processes of twenty mental health professionals during the COVID-19 pandemic were explored via one-hour long, semi-structured interviews conducted over Zoom. As introduced in the first chapter, the following research questions were posed: First, what triggers, stressors, and challenges did mental health professionals face throughout the COVID-19 pandemic; and second, what, if any, resilience processes were enacted by mental health professionals during the COVID-19 pandemic? The methods and methodology utilized for this research were structured in an effort to best address the research questions. The following sections overview the qualitative framework and research design process selected, describe the consent and data security measures implemented, specify the targeted population, highlight relevant demographics, review the data collection and analysis processes, and consider potential risks and benefits as well as participant compensation.

Qualitative Framework and Research Design

Qualitative research within the Communication Studies discipline involves scholarship that explores human symbolic action within the context of *performances* and *practice*s (Lindlof & Taylor, 2019). Qualitative research methods are situated within certain paradigms, or frames of reference, that are used to justify choices made in designing and conducting studies. Lindlof and Taylor (2019) identify four qualitative paradigms: positivism, post-positivism, interpretivism and critique. Built upon the principles of the post-positivist paradigm, the approach to interviewing used in this study was within the interpretivism paradigm. Interpretivist communication researchers study how humans use actions and symbol systems in their unique

meaning-making experiences. Thus, it is the ethical responsibility of interpretivists to preserve the subjective experience of human subjects utilizing an empathetic lens (Lindlof & Taylor, 2019). Additionally, realities are unique, multiple, and concurrent in nature; instead of viewing communication reality as an objective and singular truth, interpretivists consider the social realities that are created as people collaborate with one another and make sense of the communication they encountered. It is from this paradigm that the following discussion of interviewing is situated.

While interviews are relatively common in our society, the qualitative research interview is seen as a social process that develops between (inter) two people (Brenner, 1985) and can be best understood as a conversation with a purpose (Bingham & Moore, 1959). Qualitative interviewing often involves a subject sharing personal matters, requiring the interviewer to utilize interpersonal skills where probing questions occur in a nonthreatening, conversational manner (Lindlof & Taylor, 2019). In terms of its purpose, the qualitative interview has a referential function (Briggs, 1986), where the interviewee refers to or provides information about people, events and processes occurring outside of the interview context itself. It is through these references that qualitative researchers are able to process the subject's meaning-making and understanding of their world.

Interviewing as a method takes researchers to a "live", present, participatory place of data collection. Effective interviewing involves real-time meaning-making occurring from the interviewee and also between the interviewer and interviewee in conversation and dialogue with one another. Qualitative interviews are well suited for understanding people's unique experiences and perspectives of the world, which serves as a primary strength of this method. If researchers have questions about phenomena occurring within or among certain populations,

they can design study criteria meant to capture participants within those specific populations. In doing so, researchers can analyze utterances by individuals who have "been there" or "are there" in terms of a certain experience(s) (Lindlof & Taylor, 2019). Qualitative interviews help researchers understand the symbol systems used by members of a particular culture, demographic, or common experience. Interviews can provide stories (Baumeister & Newman, 1994) and accounts (Scott & Lyman, 1968) of experiences and communities. They also serve as appropriate venues for acquiring people's unique explanations (Lindlof & Taylor, 2019). With this, qualitative researchers can explore how people understand, view, and express certain occurrences or phenomena. In the context of this study, interviews were utilized to explore the meaning-making, resilience-cultivating practices of mental health professionals who served clients throughout the entirety of the COVID-19 pandemic.

A challenge of interviewing is that the researcher must view each interview as a "speech event" (Mishler, 1986) where the researcher must remember that human recollection can be "flawed" and/or heavily influenced by the research context and questions. In terms of the latter, researchers must consider the notion of first and second order realities, where a first order reality is the event itself, and a second order reality is a person's perception of the event, which can be influenced, construed or altered by a variety of personal, physiological, or environmental factors. Additionally, specific details of events often fade from memory (Lindlof & Taylor, 2019), there is the possibility that "false recalls" of autobiographical events may occur (Burt, 2008), and people may withhold, exaggerate, or even lie about their experience. For these reasons, it is important for qualitative interviewers to be careful when presenting and framing facts in the context of lived experience. Furthermore, the interview context may influence the speech event itself. The types of questions asked, the order in which they are asked, and whether or not an

interviewee feels listened to can have a significant impact on the content produced during the interview (Tracy & Robles, 2010). Despite these potential challenges, qualitative interviewing was selected for this study given its capacity to explore and explain designated processes, behaviors, and experiences. Through collecting the stories of mental health professionals cultivating resilience during the pandemic, this study was able to effectively address the research questions and further explore the phenomenon of communicative resilience.

Sample Characteristics

The human subjects recruited for this study were twenty mental health professionals who had to meet several designated criteria. In order to participate in this study, participants needed to be eighteen years of age or older, reside in the United States, and self-identify as a mental health professional who had worked in this capacity since at least February 2020, and was still employed as a mental health professional at the time of participating in the study. For the purposes of this study, a Mental Health Professional (MHP) was broadly defined as a social and human services provider or a healthcare practitioner who offers services for the purpose of improving an individual's mental health or to treat mental disorders. This definition was based off of Mental Health America's (2023) definition of mental health professionals (which was provided to participants), that include but are not limited to: psychologists, counselors, clinicians, therapists, clinical social workers, psychiatrists, mental health nurse practitioners, primary care physicians, family nurse practitioners, psychiatric pharmacists, certified peer specialists, social workers, and pastoral counselors. The definition of mental health professionals used in this study was intentionally broad to capture larger themes across the profession while also exposing and delineating potentially diverse experiences (e.g., between private practice and community mental health professionals), thus serving as a starting point to define and guide future research.

Participants indicated their chosen pseudonym for the study, as well as their occupation title, pronouns, and gender identity, further depicted in Table 1 below. Out of the twenty participants, eighteen identified as women (cisgender) and two as men (cisgender).

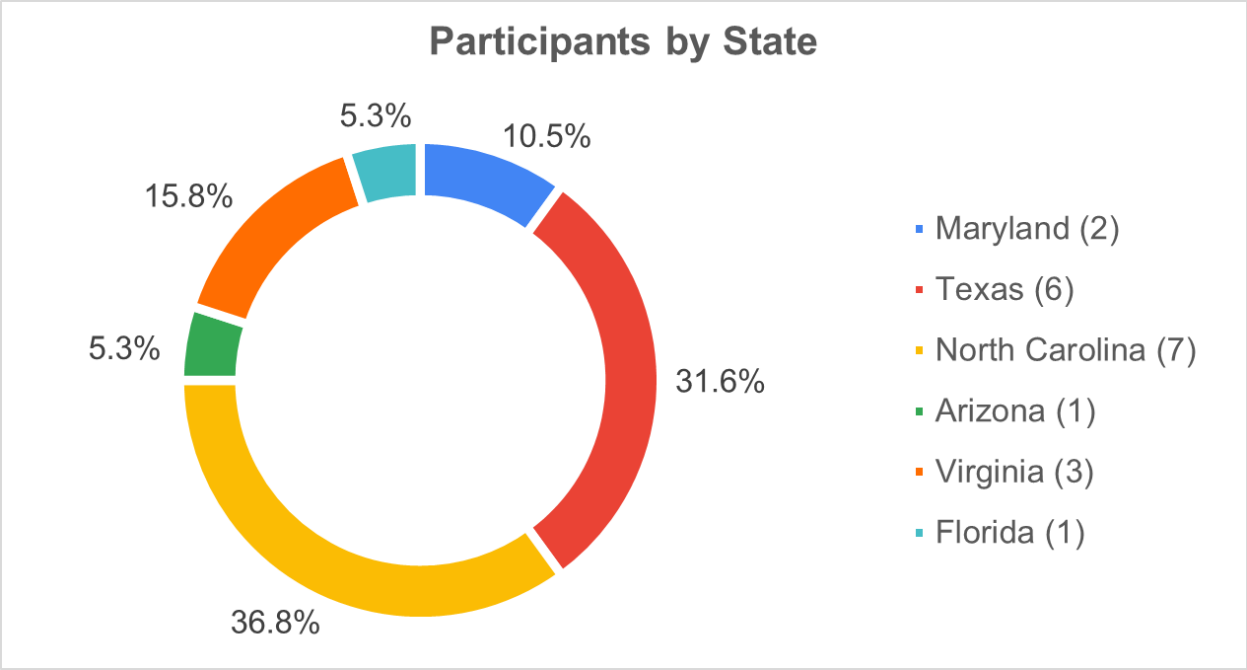
Table 1
Participant Pseudonyms, Occupation Titles, Pronouns and Gender Identity

Pseudonym	Occupation Title	Pronouns	Gender Identity
Laura	Licensed Therapist	She/Her/Hers	Woman (Cisgender)
Mollie	Outpatient Behavioral health Therapist	She/Her/Hers	Woman (Cisgender)
Texan	LPC	She/Her/Hers	Woman (Cisgender)
Nicole	Behavioral Health Manager	She/Her/Hers	Woman (Cisgender)
Alexis	Licensed Associate Counselor	She/Her/Hers	Woman (Cisgender)
Charlie	Licensed Clinical Faculty	He/Him/His	Man (Cisgender)
Cassie	Certified Alcohol and Drug Counselor	She/Her/Hers	Woman (Cisgender)
Cassie	Certified Alcohol and Drug Counselor	She/Her/Hers	Woman (Cisgender)
Dee	Mental Health Therapist	She/Her/Hers	Woman (Cisgender)
Ciara	School Counselor	She/Her/Hers	Woman (Cisgender)
Alice	Resident in Counseling (Mental Health Therapist)	She/Her/Hers	Woman (Cisgender)
Brooklyn	Therapist	She/Her/Hers	Woman (Cisgender)
Adam	Graduate Assistant, LCMHCA	He/Him/His	Man (Cisgender)
Teresa	Licensed Psychologist	She/Her/Hers	Woman (Cisgender)
Sarah	Licensed Psychologist	She/Her/Hers	Woman (Cisgender)
Bobbi	Employment Specialist	She/Her/Hers	Woman (Cisgender)
Paige	Behavioral Wellness Therapist, outpatient therapy	She/Her/Hers	Woman (Cisgender)
Azra	Lead Therapist	She/Her/Hers	Woman (Cisgender)
Marie	Clinician	She/Her/Hers	Woman (Cisgender)
Lillian	Licensed Psychologist	She/Her/Hers	Woman (Cisgender)
Pauli	Senior Counselor	She/Her/Hers	Woman (Cisgender)

Through convenience sampling, the call for participants was shared within the researcher's professional network. From here and through the online forums, snowball sampling was used as the call for participants was distributed to others' networks, yielding participants from several different states across the country. Figure 1 below breaks down the participants by state.

Figure 1

Donut Chart Showing Participants by State



In terms of race, two participants reported being Black, one Asian, one Middle Eastern, and sixteen reported being White. With regards to ethnicity, eighteen participants identified as non-Hispanic/Latino and two as Hispanic/Latino. Of the twenty participants, these professionals served an average of 7.1 years (*SD* = 4.6) as a mental health professional. Additionally, of those twenty, eighteen of them served an average of 5.7 (*SD* = 3.5) years as clinicians (two listed "NA", as they did not feel their occupational title classified them as clinicians). Finally, when

asked about the highest level of education completed, one participant had their bachelor's degree, fifteen had their master's degree, and four had completed their doctorate.

Procedures and Data Security

Participants were found through a combination of convenience and snowball sampling. The call for participants was distributed to faculty members in the Sociology, Social Work, and Counselor Educations departments at a large research institution in the southeastern United States. From here, faculty members distributed the call across their professional networks. Following this, the researcher emailed the call for participants to several personal connections who worked in the mental health profession and then asked those connections to share the email electronically with their professional network. The researcher also posted on her wall via Facebook and LinkedIn, asking connections to share the call for participants with members of their network. Finally, some participants were recruited through word of mouth; following completion of the interview, several participants recommended the study to colleagues who then also participated in the study.

Potential participants either received a recruitment email or saw an online forum/post containing the call for participants. Interested participants were asked to email the researcher for next steps. The researcher received over one hundred emails in response to the call for participants. When participants contacted the student researcher via email, within one week, the student researcher replied via email and sent the informed consent form and demographic form to confirm eligibility. The informed consent and demographic forms were completed by participants electronically via Google Docs, and a total of thirty-two individuals completed the paperwork. The participant's name, contact information, email, and a pseudonym of the participants' choosing (to protect the participant's identity) were collected within the informed

consent form. In the demographic questionnaire, participants were asked their name, state of residence, gender identity, ethnicity, race, pronouns, and the title best captures their role as a mental health professional. This information was used to support, or inform, any emergent themes and discussions of those themes. The data was, and remains, stored in the researcher's password-protected Google Drive. Additionally, on the informed consent form, participants were reminded that informed consent is freely and voluntarily given, and if it is given, consent can be withdrawn at any time. Participants were also reminded that there is no pressure or requirement to participate in the research, and that their identities and any identifying information will be protected and redacted from any studies produced from this research.

Within one week of completing the informed consent and demographic forms, the researcher verified that potential participants met the study requirements and then contacted interested participants to let them know if they have been selected for the study. Out of the thirty-two individuals that completed paperwork, twenty-five met eligibility requirements and were thus informed that they had been selected for the study. Those selected for the study were sent a link that directed them to a customized calendar created using Calendy, where they were then able to reserve a 60-minute interview time slot within the researcher's Google Calendar. Once scheduled using Calendy, a Google Calendar invitation containing a Zoom link was emailed to participants. At the start of their scheduled interview day and time, participants clicked on the Zoom link and were directed to a Zoom session with the researcher, who then interviewed them for 60 minutes. Zoom interviews were audio and visually recorded, and in addition to this being in the consent form, the researcher asked participants again during the call to receive verbal permission to record. Once all questions had been addressed and/or after the 60-minute time frame, the interview concluded. A total of twenty-two individuals responded to the calendar

invitation, and ultimately twenty participants completed the interview process, thus bringing the final sample size to twenty.

Because the researcher conducted and recorded all virtual interviews, this gave her knowledge of the dataset prior to starting the process of coding via thematic analysis. Zoom's transcription services were utilized to initially transcribe the interviews. While the interviews were being recorded via Zoom, the researcher took brief notes in order to mark dialogue she perceived to be significant. Following the completion of each interview, the researcher went through and replayed the interview, making any necessary edits and changes to the transcription to ensure accuracy. Once the interview transcriptions were corrected, they were uploaded to Atlas.ti for qualitative data analysis. Since the researcher conducted and recorded all virtual interviews, this gave her knowledge of the dataset.

Within one week of completing the interview, participants received an electronic $20 Amazon gift card sent to the email address that they provided the researcher. Participants could be contacted again if the research from this study is published, and if so, participants will be notified of this information via email and receive a copy of the published study. In terms of accessible information, participants were able to access their consent form, demographic form, their recorded interview, the transcription of their interview, and the final paper, all upon asking permission to access this information from the researcher. Once requested, the researcher would email participants a link to a Google Drive folder where they can view their study records. The folder they were given access to would only contain participants' own data files, as they will only be able to access their own records. Participants did not have access to the records of any other subjects in the study. Identifying information was collected in the demographic and consent forms; however, real/legal names, or any identifying information about participants or their

workplaces, were not used in the writing of this study. The recorded audio and Zoom transcripts were labeled based on the pseudonym, which was selected by participants and provided in the electronic consent form. Aside from sharing a specific link to a folder that only contains the participants' own data and information, data was not transferred from Google Drive. Participants had the option to request for their data to be deleted, which would be processed within forty five days of the request. Participants were informed that data will be retained for three years following completion of the research. After three years, data will be permanently erased from Google Drive.

Risks, Benefits, and Compensation

There was minimal risk associated with this research. In recalling experiences during the pandemic, participants were informed that they may experience stress. The interview questions, however, were not structured to cause any additional stress beyond what the mental health professionals had already experienced. **S**ome participants shared the names of specific programs, co-workers, or places of work; however, in the transcriptions, this information was redacted. The only instance in which the probability of reidentification could occur is if the situation was incredibly specific, and even without identifying information, someone might recognize the circumstances of the situation. The probability of this occurrence, though, is very low, and there would be no specific identifiers.

There were no direct benefits for participation, although the researcher anticipated that providing space to discuss their experiences during COVID-19 could be cathartic for mental health professionals. Prior to submitting any consequent manuscripts for journal publication, participants will receive a copy for their review to ensure voices are accurately represented via the pseudonym they selected. In having the chance to review this work, findings from this study

could help participants engage in retrospective assessments of the support networks, resources, self-care routines, and financial impacts of COVID-19 on their therapeutic work and practice.

Thematic Analysis

The method of thematic analysis (Braun & Clark, 2006) was utilized to analyze emergent themes from the interview transcriptions. While thematic analysis as a qualitative approach is nuanced and diverse in its application across disciplines (Holloway & Todres, 2003), it is commonly used in Communication Studies to code and interpret interview discourses (Lawless & Chen, 2019). This method was selected as it enabled the researcher to search for repeated patterns of meaning across the data while providing rich, detailed accounts of participant experiences, ultimately helping the researcher to achieve theoretical saturation. Braun and Clark's (2006) conceptual framework for thematic analysis was used given their clear and rigorous guidelines that challenge the "anything goes" criticism of qualitative research (Antaki et al., 2002). The process of data analysis with this method involved moving back and forth between the dataset. First, initial codes were generated in an effort to identify as many potential patterns and themes as possible. Codes were then organized into meaningful groups (Tuckett, 2005). Following this, the researcher considered the relationships and levels between codes, code groups, and themes. These were then reviewed and refined once more, themes were defined, sub themes were identified, and the stories within the themes were considered. Once these steps were completed, the researcher began writing the manuscript.

Since this method involved an interpretive analysis of the data, it is important to consider Creswell's (2013) note that researchers must "...bracket out, as much as possible, their own experiences" (p. 81). As such, an important acknowledgement is the researcher's bracketing of assumptions and experiences of the topic. Although the researcher is approaching this research

from a Communication Studies disciplinary perspective, she has also been meeting individually with a licensed clinical social worker for three years to receive mental health therapy services. From this lived experience, the researcher witnessed firsthand the difficulty of acquiring mental health services during the pandemic, and acquired familiarity with some of the challenges her counselor experienced. The researcher acknowledges these personal experiences and knowledge which informed her interest in this topic, but also made a conscious effort to consider any potential codes and themes only within the parameters of the dataset and against the backdrop of relevant literature.

CHAPTER 4: RESULTS

The first research question investigated the triggers, stressors, and challenges experienced by mental health professionals during the COVID-19 pandemic. The second research question explored what resilience processes were enacted by MHPs during this time. There were new triggers, stressors, and challenges that emerged as a result of the pandemic, as well as those which were exacerbated by the circumstances of the pandemic. Multiple processes from the Communication Theory of Resilience (CTR) (Buzzanell, 2010) were evident. Exemplars of these themes are shared next, followed by a discussion and exploration of thematic implications. All identifying information in the following section was redacted, and identifying names were changed to the participants' designated pseudonym of their choice.

Triggers, Stressors, and Challenges experienced by MHPs during the COVID-19 Pandemic

MHPs discussed a variety of new, unprecedented challenges that arose in their personal and professional lives as a result of the pandemic. They also detailed existing issues that were exasperated because of the COVID-19 pandemic. MHPs found themselves navigating changing workplace environments, personal circumstances, and community practices, all while continuing to serve and create a safe space for their clients. The following subthemes recurrently emerged as significant pandemic-related triggers, stressors, and challenges among the participant interviews: *Lack of Support from Supervisors, Guilt and Sympathy, Differing Beliefs, Increased Caseloads and Decreased Support,* and *Telehealth.*

Encountering a Lack of Support from Supervisors: "They Don't Value Me"

One of the most prevalent topics that emerged from the interviews involved workplace relationships and conditions that contributed to pandemic-related stressors, many of which, according to participants, led to resilience cultivation. When asked about the adversities that

affected their ability to continue serving clients during the pandemic, many participants directly referenced their supervisors and those in higher authoritative positions. Laura, a licensed therapist, stated:

> I didn't feel protected by the agency like at all during that, like full shut down, they did let us work from home for about [a] period of two weeks, and then they told us that that wasn't possible, and that it wasn't legal, and all sorts of things which ended up not being true. There was a lot of, like, fighting in the organization and just confusion, lack of answered questions ultimately culminating in me leaving the agency just because… it was clear that the employees were not being seen as [an] important part of the equation... So just not feeling valued, not feeling heard, that definitely impacted my mental health.

In addition to not feeling supported, Laura shared that her supervisors had lied to her and her colleagues about COVID-19-related workplace decisions. She stated:

> We are having a discussion with management about who made the decision to…not let us work from home, or to have [the office] open, that the client got to decide whether or not it was in-person or virtual…. There were two main, like, managers that were responsible for our department, and they had said that it was neither one of their decisions, that it was above their heads, and come to find out, about four or five months later, [we found out] that it was their specific decision… They had specifically…lied about it and that kind of broke trust for me. It's one thing if they said, “yes, we made the decision. It's hard, but we think that's what's best for the client and agency.” I would have asked about it, but it would have been okay. But to outright lie about it, that was kind of the straw that broke the camel’s back for me.

As demonstrated here, after making major pandemic-related organizational decisions which some employees questioned, Laura's managers avoided responsibility by lying and saying that the "higher ups" of the organization had made the call. When Laura found out about her managers' lies, she felt unsupported and betrayed, and eventually left the organization. Dee, a licensed mental health therapist, echoed these sentiments of feeling lied to by her supervisors; in discussing the move to telehealth, she said that her organization implied that telehealth was "bad" and that, while working remotely, her supervisors made her and her employees feel like they "weren't doing enough". To get her and her colleagues back in the office, Dee's managers told them that the overall organization was not allowing employees to work from home, which she later found out was a lie. Instead, it was the managers' decision to bring employees back into the office, but they did not personally take responsibility for it. Just like Laura's experience with her supervisor lying to her, this made Dee feel "basically invalidated at every step of the way." Another way in which Dee felt invalidated by her supervisors was that whenever she or her colleagues made suggestions for ways to feel better protected from COVID-19 or to potentially improve their processes, these were perceived to be criticisms or complaints. In response, her supervisors would say, in Dee's own words, "no, we should be just grateful that we're still coming to work. You know. Other people don't have a job anymore."

While lying from supervisors proved to be a source of stress for some MHPs, for others, they felt stressed due to seemingly continual changes in direction from leadership. Ciara, a school counselor, expressed feeling stressed due to changing decisions, both from her principal and her school board. Ciara felt that her principal would make an initial decision, hear from another school that their principal was doing something different, and would try to combine both tactics so as to not backtrack on her original decision. In response to this, Ciara said, "it's like,

that doesn't work… [my principal was] unnecessarily demanding with no results… She couldn't delegate. She couldn't trust someone to do it unless it was [done] her way." Not only did Ciara experience stress with shifting decisions from her supervisors, but also from her school board. She shared:

> There was a time where the local government, the school board changed their minds three different times, and I had to redo days, weeks of like within the span of three months, and it had to be then… So it started, let's say April. They had to be due by July, and they changed their minds three times, and it wasn't just, like, okay, add this. It was a complete reversal, and then revert[ed] back to the original. And so I was like, you're going to get what you're going to get. And so that was a very triggering event for me where it was like… That's, I think, when I decided I can't be in [redacted - county] anymore. Because, like, I had to stay for the next year, obviously because I didn't have a job…I was like, this is not a good county. I can't be here anymore. They don't value me, so… that's when I started looking for jobs, and that's when I started applying [for] the next, like… semester. And then here I am in [redacted - county].

As expressed in Ciara's account and from several other participants, given the uncertainty of the pandemic, their supervisors and those higher up in their organizations shifted the direction of organizational decisions multiple times, which led to significant stress. In some cases, interviewees felt that instead of an overabundance of shifting decisions being made, there was actually a lack of decision making coming from leadership. An example of this was from Cassie, whose title was "Clinician III with Emergency Services, Department of Behavioral Health" within her local city government. Cassie felt "totally neglected" by her supervisors and the higher governing board, despite giving a "white flag" and asking for help multiple times. Cassie

said that her clients were on hold on the phone for up to ten minutes to talk with a clinician, and "that's when things started spiraling as [clients] were like, 'I can't even get help', and we're like, 'right, because we're down to one person [today].'" It took Cassie's team getting down to below half capacity before the higher governing board stepped in to help.

Between experiencing a lack of support from direct supervisors and/or those higher up in the organization, many MHPs cited this as being a significant form of stress which impacted their ability to serve clients during the pandemic. Some MHPs felt lied to when their supervisors did not take personal accountability for decision making, while others experienced stress from a perceived sense of their supervisors over or under-making decisions. It is important to note that several other participants cited their supervisors as a source of support during the pandemic, which is further explored under the findings for RQ2.

Experienced and Anticipated Guilt: "People Have it So Way Worse than I Do"

Whether discussed explicitly or implicitly, many MHPs described experiencing a sense of guilt for their clients and their pandemic-related circumstances, or they anticipated situations that had yet to occur in which they could experience guilt. Some of this originated from being able to safely continue work at home via telehealth or from receiving the support that some of their clients were not able to receive. Laura, a licensed therapist, shared, "what got a lot harder is just watching people struggle with the isolation… I had friends and family stay in contact with me and give me a lot of support." While Laura felt supported, she said that many of her clients, "...had to stay home all day [by themselves], and they were afraid." Many MHPs observed people struggling while meeting with clients via telehealth, where they felt like their clients were experiencing more difficult circumstances than themselves. In discussing this, Charlie, a licensed clinical faculty worker at a research university, stated:

> [There is] the compassion trap of it all, or the trap of it all like, I'm not experiencing this… people have it so way worse than I do… maybe like a guilt. Or, I shouldn't feel this bad. Other people have it so much worse. Other people are having to make those [difficult] decisions in some way… so you know, I'm like so grateful.

In this case, Charlie expressed feeling pandemic-related stressors, but the guilt came when he perceived his clients to be in more challenging circumstances than his own. A significant reason for this guilt across participant experiences seemed to derive from the use of telehealth, where many were able to continue working from the safety of their homes or offices with clients who were struggling with issues the MHPs perceived to be worse than their own. Mollie, a licensed outpatient behavioral health therapist and former school counselor at the beginning of the pandemic, also experienced guilt associated with utilizing telehealth, but hers was because she felt like she finally felt a reprieve from her demanding, pre-pandemic in-person work schedule. She stated:

> When Covid hit it was so weird, but it was a little bit of, kind of like a breather. I was, like, feeling bad…. guilt, for getting a breather. There was more ease in terms of, I didn't have to adhere to that [pre-pandemic] schedule. For me, like I have to be at work between 8 and 5, I think, and that job specifically, our kids are so dysregulated, being cursed out, being punched, the yelling… I got to kind of take a breather that I had never experienced, and there was some guilt around that, because while everything… my people and my kids and my community was (sic) really struggling because it was a low-income community, it was kind of much better in terms of [my] mental health and emotional [wellbeing].

As articulated here, a significant portion of Mollie's guilt came from experiencing a sense of relief in being able to work from home. This sense of relief, though, came with a price. Because she was not struggling as much as some of her clients, she had the feeling of, in her own words, "I'm doing something wrong, or ill-prepared to handle telehealth… because I wasn't struggling as much as I was [before the pandemic]. It was a feeling of 'aw, man, I'm doing this wrong. I'm not giving it my all.'"

Not all MHPs were able to work via telehealth exclusively throughout the pandemic; some had to return to in-person meetings as early as two weeks after being initially sent home in March 2020. Working in-person during the pandemic came with some physical, virus-related concerns that led to many MHPs experiencing guilt. In talking about returning to work in-person early on in the pandemic, Paige, a licensed behavioral wellness therapist in outpatient therapy, shared:

> Okay, but specifically like the… just the emotional and mental stress of kind of fighting the feelings of guilt, right? Of like, okay, what if I'm the one, right, that is sick and unknowingly gets someone [else] sick. That, then creates the domino effect that we saw.

The domino effect that Paige discussed was in reference to clients and colleagues having the virus and unknowingly contaminating others via close physical proximity, particularly through in-person interactions. Alexis, a licensed associate counselor, also referenced this fear of contaminating others; in her situation, Alexis had a roommate who tested positive for COVID-19, and she wanted to wait to return to work to get tested, but her supervisors urged her to come in prior to finding out the results of her test due to staff shortages. As a result, Alexis felt like she could not stay home, went into the office, and worried about getting her clients and colleagues sick. The act of Alexis' supervisors requiring her to service clients in person after she had been

possibly contaminated served as an ethical violation for Alexis, and the potentiality of infecting others left her with feelings of worry and guilt. In the cases of both Alexis and Paige, their guilt was more anticipatory than experienced; the stress that they experienced came from hypothetical situations grounded in realities (i.e., being required by their supervisors to service clients in person) that they themselves did not choose.

Some of the guilt also manifested in MHPs personally struggling with pandemic stressors but feeling like they were not allowed or able to do so, given their profession. In considering this pressure, Mollie, the outpatient behavioral health therapist, shared, "we never think about [struggling], because being a professional means that you got to [have your] shit together all the time 24/7, and if you…don't, it means you're not a professional." Paige also felt like, as a mental health professional, she should be able to handle the stressors of the pandemic without any additional support such as medication. She stated that during the pandemic, "that was the first time I [had] ever taken medication, and even as a therapist I struggled with that, right? …I should be able to manage this."

As seen throughout this section, MHPs experienced guilt towards the perceived circumstances of their clients compared to their own situations. In other instances, MHPs had to face the guilt of potentially getting family and clients sick if they continued meeting clients in-person. Finally, another way in which guilt emerged was in the notion of struggling as a MHP; some participants felt that, given their profession, it was expected of them to not struggle or need additional resources to support their own mental health.

Navigating the Challenges of Differing Beliefs: "Is it Safe to Say How I Feel?"

Another challenge faced by MHPs involved navigating differing beliefs from family, supervisors, and coworkers while managing and refining their own beliefs. Differing beliefs were

evident by those in the personal and professional lives of MHPs, and topically involved whether or not to get the vaccine, the legitimacy of COVID-19 as a dangerous virus, and the risks related to contaminating others. Speaking about his experience with different beliefs among him and his family during the pandemic, Charlie, a Licensed Clinical Faculty member at a large research institution, said:

> It was so rough then, like our family, because of our differing opinions. Yeah, we felt very unsupported by them and kind of outcasted by [them]... So that was very difficult. The most area of stress that I experienced was… with family, differing, kind of, perspectives and beliefs about COVID-19. But the risk of COVID-19, about the precautions, and then about the vaccine... We [my wife and I] had a more, you know, risk averse kind of perspective with COVID-19 than my family did. They were very like "hey, you're… you're gonna get it. It's a matter of time. Just get it. It'll be fine… don't do the vaccine, like, it's fine." And we were like, well, we disagree, and that caused conflict. And then, you know, we didn't go back for the holidays because we didn't think they were taking enough precautions for us… and then we're worried about them just in general… So I think actually, that probably was the most stress."

In this situation, Charlie and his wife had moved far away from his family prior to the pandemic, but the physical distance was met with a feeling of an emotional distance as he encountered differing beliefs from his family. As detailed here and throughout the interview, Charlie described that he and his wife felt differently from his family regarding almost everything concerning COVID-19, including the importance of the vaccine, the severity of contracting COVID-19, and the value of taking precautions.

Many of the participants cited the vaccine as being a tumultuous topic within their families. Ciara, a school counselor, experienced a situation with her mother being unvaccinated; Ciara had decided to go to an event where everyone was wearing masks, and she thought that the masks would provide sufficient protection from the virus, but her mother disagreed with this. Ciara's mother had watched her dog while she went out to this event, and when she came back to pick up her dog, Ciara's mother would not allow her to come into the house or on the front porch. Instead, her mother told her to stay in the car and brought the dog to her. Ciara believed she was safe at the event with her masks on, but her mother did not, and because her mother did not let Ciara get physically close to her, this caused strain in their relationship. It was during this time that the stress of the pandemic, in Ciara's words, "became a little bit more real for me."

In addition to facing differing viewpoints and beliefs in their personal lives, MHPs navigated this topic in conversations with their clients. Some clients were uncertain as to whether or not they should get vaccinated, and many of them struggling with this decision turned to their mental health professionals to discuss it. Alice, a Resident in Counseling (Mental Health Therapist), shared her experience with this:

> But it was definitely challenging… when everyone was kind of deciding, "do I get the vaccine, do I not?" And there were a lot of clients coming in with like, decision fatigue, and just… really anxious about that whole process... And while, you know, as clinicians [we] are also kind of running through that whole process ourselves, and then we're also kind of supporting our clients through that process. And, you know, and we obviously are not medical providers. We're not allowed ethically to get that kind of advice, but it was definitely at the forefront for a lot of clients and deciding, "do I get it? Why not?"

In these conversations with clients, Alice was faced with questions that she felt she could not, and should not, answer. Similar to Alice's experience, Teresa, a licensed psychologist, also had clients talking with her about differing perspectives regarding the vaccine, which served as a source of stress for her. Teresa noticed two emerging schools of thought among her clients, including those who were "a strong believer of vaccines," and others who believed the vaccine "is just a poison." She noted that in her profession, MHPs already "deal with so many different types of people, and that you encounter… conflicting opinions, conflicting views, and sometimes it's contradictory to your own view as well." Teresa also shared that in an environment where clients were disclosing pandemic-related information, it was unavoidable to navigate the topic when they brought it up, which ultimately served as a source of stress. Brooklyn, a licensed therapist, also talked about helping clients navigate differing beliefs and considered whether or not she should disclose her personal beliefs. She stated:

> I would also just say more from a macro perspective, just how the pandemic… I don't know if I would say triggered, or at least brought to light how people have very different values in this country and… the division that was created from that. So I was navigating through that with clients who were navigating it in their lives and trying to figure out what was happening. And how do they respond to people that they would see post things on Facebook that they couldn't believe they posted… and I was doing that personally for myself as well. And, so, that was a big piece for a while… and just kind of the division that people felt… and, is it safe to say how I feel, or will I be shut out, or will [I] be outcast? And so my clients were going through this, and then I'm managing that with them, and then also trying to manage my own experience.

Brooklyn found herself navigating various beliefs with her clients and considered whether or not, and how much, information she could disclose regarding her personal beliefs. The theme of navigating different beliefs and disclosing personal thoughts while having these conversations with clients occurred multiple times throughout the participants' accounts. In several cases, MHPs also saw differing beliefs emerge within their organization. Dee, a mental health therapist, said that her supervisors (as well as her clients) did not take the risks of COVID-19 seriously. Dee felt invalidated when she and her coworkers would bring concerns up to their supervisors, and her supervisors responded by asking why they were "being so difficult." Dee stated, "I think that was the biggest [stressor], and then the second one was the clients who did not take it seriously, and not just that, but you know, they endangered others… including us." Whether between clients, supervisors, or their own family members, many MHPs had to navigate topics of differing beliefs during a time period already filled with many uncertainties and unknowns.

Increased Caseloads and Decreased Personnel: "I Was Begging for Someone to Cancel"

Another common stressor among all participants included increased caseloads during the pandemic, and in many cases, MHPs faced a high demand of mental health services with a low supply of peer support. The supply of MHPs was low for a number of reasons, including significantly increased caseloads without a corresponding increase in available providers, sickness striking MHPs or their families, resulting in them having to take leave, or MHPs leaving their organizations during the pandemic due to burnout and extreme exhaustion, among other reasons. Mollie, a school counselor during the first half of the pandemic, said that during this time, she was personally responsible for servicing one hundred and fifty kids which felt "really overwhelming", especially with her feeling accountable for "their mental health and emotional

health." Given the sheer number of students she served who needed support during the pandemic, Mollie asked, "where does our work stop, ever?" She also stated, "there were so… few of us compared to the needs of our clients that we couldn't [help all of them] ... it's non-stop day after day, and the weekend is not long enough." Texan, a licensed professional counselor, while considering how to serve all of those seeking mental health help during the pandemic while supporting her family, stated, "the need was [so] tremendous that I kept saying like, no, I can't… because I still have my family here dealing with our own stuff during the pandemic."

There were some MHPs who were tasked with wearing multiple hats during the pandemic; or, they were already balancing a great deal prior to the pandemic, and once the pandemic came, their workload became exacerbated and nearly unmanageable to do alone. Speaking on her experience with this, Texan, a licensed professional counselor and crisis intervention team leader within her school system, stated:

> I was in charge of [project name redacted], and this was a series of six videos that will prepare teachers, staff, principals, everybody about mental health [support during the pandemic]. And so who's gonna… [do] that? Well, the crisis intervention team leader. So I had to ensure that every staff member, teacher, [and] administrator for every campus in the district had access to this information… I had to like… I can't do this by myself.

Texan addressed this challenge by developing a task force of counselors from her school system to help develop the program. This project kept her so busy that Texan said, "I don't even think I even had a chance to feel stressed, quite honestly… [I was] going through the motions of everything that I now had to do." Mollie also felt the strain of wearing many hats during the pandemic, and as she noticed an uptick in her clients struggling with losing jobs, having to

arrange for childcare, and other issues, she wanted to help them find resources to better support them. On top of the regular responsibilities of her role as an MHP, Mollie stated:

> Yeah, we have to take care of people's mental health, but we also have to… see if we can find them… a place to live. And we also have to probably make sure that you… look for…health care, and childcare, and so there's all these things. If you're anxious, and you're coming to me because you're anxious [that is one reason]. But the reason why you're anxious is because you think that you can't pay your rent.

Mollie noticed that many of her clients were struggling with limited resources, but also personally struggled with the strain of trying to help her clients with challenges that arose during or were exacerbated because of the pandemic. In addition to helping individual clients with their own pandemic-related challenges, many MHPs found that the sheer volume of clients was stressful. Nicole, a behavioral health manager, compared the rise in demand for mental health services to the lines of "rides at Disneyland. It's like, we see the lines, and the demand is there, and… you can't serve it." Nicole said that clients were waiting three months to get an appointment, that the "challenge/barrier became how to schedule all these people in" and "we didn't have enough clinicians to meet the demand." In referencing her weekly calendar, Nicole stated:

> My calendar became nuts… I think I had thirty-four appointments available a week, and I was seeing thirty-three people and like… there were thirty three people…. showing up a week and, like, you don't get cancellation rates like that, ever. Yeah, so it was crazy. Honestly, it's the best way to describe it. But this scheduling just was nuts. It got to the point where I was begging for somebody to cancel just so I could have a breather.

In addition to her weeks being filled to the brim with nearly all of her clients attending their sessions, Nicole said that many of her days were back-to-back with appointments. On some days, Nicole shared, “I had five back-to-back patients. I'd get an hour for lunch, and I'd [have] five back-to-back again.” Echoing many other MHPs, Nicole shared that this allowed for little-to-no time during working hours for administrative activities such as taking notes, reviewing notes, and filing paperwork for insurance, among other job-related tasks. For many MHPs, this increased workload led to extreme exhaustion. Alexis, a licensed associate counselor, shared, “I kind of teeter on burnout/exhaustion just regularly, because I do have a high caseload, and I don't think they really talk enough or have enough resources giving information about burnout.” When asked further about why she thought she was experiencing burnout, Alexis shared:

> I think we were seeing a lot more clients like we were just busier. And so I think that took a toll on just, like, burnout and exhaustion because all of these people needed somebody. And so I kind of was early on in my career. So I was like, okay, I'll take them. And then I got really exhausted. And so you saw a spike in the number of people who were seeking [mental health] services… after the start of the pandemic. That was kind of a consensus among the whole private practice, like they realized that they were seeing more [clients] just in general.

Similar to Alexis, Cassie, a certified alcohol and drug counselor and a psychiatric hospital worker, also felt the exhaustion with the increased workload. She shared that at one point, her hospital was three hundred people above capacity, and “all of our clients had covid, too.” Describing the scene, she said “...it was, just, people was (sic) sitting in the hospital for days and days, and police were there, and they were like, this is such a mess, you know.” Cassie, similar to many other MHPs, were exposed to the virus and had physical concerns about

exposing others in their work environments. Despite the significant increase in patients requiring mental health care, many MHPs had to call out for sickness-related purposes, while others felt like they were unable to take the necessary time to recover from sickness and had to go to work sick to meet the demand. Cassie elaborated on this and said:

> Someone in my office had covid and, I'm really not exaggerating, we had a point when we got down to half capacity. Yeah, which is extremely scary, because we are a 24/7 program that is state mandated, like, they can get rid of case management, they can get rid of medication management, [as] those are not state mandated. Emergency services is state mandated because we have to send people to psych hospitals, and we are state mandated for the crisis hotline. We got to the point where we were like one or two people per shift. So it would be like, you got a case? Good luck. You got two or three others right behind… so people were working while sick, because we didn't have the manpower to call out, you know, we didn't have the ability to take ten days off… There is a shortage of workers, and there's a shortage of people that want to do my job. But then those of us who are in the trenches, what do we have?

As seen here, Cassie recognized that being short staffed not only affected clients but also the workers trying to service the overabundance of cases. Like Cassie, being properly staffed to meet the demand while following exposure protocol (which was often dependent on the rules established by each organization) was a stressor cited by many MHPs. Paige, a behavioral wellness therapist in outpatient therapy, said that the heavy restrictions around covid exposure meant that many staff members “weren’t coming back to work anytime soon.” With so many employees out of the office at once, Paige said that there “were no longer as many employees for that employee/patient ratio”, describing the increasing absence of employees as “it was like

people were dropping like flies all around me." As evidenced in Paige's and many other participants' experiences, the pandemic caused a significant spike in caseloads and a decrease in peer support, which led to overwhelming workloads and served as a consequential source of stress.

Telehealth: "We Never Had a Day Off"

All except two of the participants had their services/work moved online during the pandemic, ranging in duration from a couple of weeks to spanning throughout the entire pandemic. Telehealth was cited as a double-edged sword in terms of its role as a positive and negative influence in the experiences of MHPs. While telehealth existed prior to the pandemic, most participants had to shift from rarely using telehealth because, as Nicole phrased it, "nobody wanted to do it client-wise", to exclusively using telehealth to service their clients. In this particular section, telehealth is discussed in the context of being a source of stress for MHPs; however, within the section addressing RQ2, telehealth as a resource for crafting new normalcies and enacting resilience is further explored. Both aspects of telehealth appeared to exist simultaneously, and these implications are further examined in the discussion section.

At a basic operating level, some MHPs noticed challenges with telehealth due to technological issues. Mollie, a graduate student and an outpatient behavioral therapist, had internet issues at home where her Zoom sessions with clients would cut in and out, so she would often travel to her university's library which had a stronger internet connection. Sarah, a licensed psychologist, also struggled with internet and connectivity issues, but her struggles were "ironically at the office." It was here that she said the "internet was the worst " and that "it was so glitchy." Sarah wanted to work virtually from the office, but when she was doing telehealth sessions there, she said it was stressful because she kept, "having [to say], 'oh, you cut out,

repeat yourself', or they would freeze periodically." Another issue related to telehealth and technology came in the form of the digital divide, where some clients were not familiar with electronic means of meeting with people, and this led to stress for several MHPs. Paige, a behavioral wellness therapist and psychiatric hospital worker, said that for her patients who were diagnosed with COVID or experiencing COVID symptoms, they were having to use telehealth to meet with their treatment team. Paige said:

> I really did not like that because I had patients that some were, you know, psychotic or had difficulty understanding. I had patients that have never seen an iPad, right? So you have an iPad, and they don't grasp the fact that all of our Zoom… or, we were using Google Meet at the time, like all of our little bobble heads… they couldn't understand we were in our own offices, and we're all on a conference call about them… and so, I think there was kind of a breakdown there in patient care in some ways... Yes, we have to have health restrictions, and we have to do what's best as an organization. But I think sometimes the needs of our patient population... I don't think it was always realistic for what they understood.

In Paige's experience, she hinted at the presence of a digital divide among patients with telehealth which caused a breakdown in care. An additional aspect of telehealth that led to some stress among MHPs included witnessing clients who, in the words of Sarah, a licensed psychologist, "did not have a private place to meet." Alice, a resident in counseling and a mental health therapist, noticed that some of her clients would have their kids burst into the room during a session, or their spouse would walk in, and that the clients "couldn't get a break" to meet with their therapist during their scheduled telehealth meeting. Adam, a graduate assistant and student, noticed that when meeting with clients he, "would ask them, you know… 'are you alone in a

private, secure spacing?' [They would] say yes, and then I'm hearing someone, like, talking in the background." At one time, Adam also had a client who "was getting their hair done by their sister while they were [meeting with me via telehealth]. It's so, it's like, do you, like, say, 'hey, I'm sorry, I can't give services to you?'"

When using telehealth as a primary means of meeting with clients, several MHPs noted nonverbal differences from in-person meetings which served as an unprecedented challenge. Alexis, a licensed associate counselor, shared that during telehealth sessions, "body language is different, facial expressions are different… we weren't really taught how [to do this]." According to Alexis, these differences can lead to clients and MHPs not feeling connected with one other. Brooklyn, a licensed therapist, said that "you're getting cues nonverbally from people in therapy", and in telehealth sessions, counselors have to "figure out how to negotiate around that" because they can only observe their client's head and shoulders, provided their camera is on and working.

For many MHPs, they felt unprepared making the switch to telehealth during the pandemic because, as Alice said, "we didn't really have any control over it… we weren't taught this in grad school." This lack of training and exposure to telehealth proved to be challenging for many. Sarah, a licensed psychologist, said she had only ever met with one client over telehealth prior to the pandemic. In switching to telehealth because of the pandemic, Sarah said, "I was like, oh, how am I gonna do all these things, and there was some stress initially trying to figure out how to do, like, rapport building with telehealth and that kind of thing." In meeting with children through telehealth, Adam, a graduate assistant and student, said "How do I teach social emotional learning to a kid [through a screen]? … But, like, not having any formal teaching or

anything about that, and trying to figure it out on my own... my supervisor, too… we were, I was really just kind of, like, winging it."

Another challenging element of telehealth included safety concerns on behalf of the client. Texan, a licensed professional counselor, said that a client answered her telehealth call while he was in a moving vehicle, which was a cause for concern for her. Another example of this was from Adam, the graduate assistant and student, who had virtually met with a client, "who was actively expressing some suicidal ideation" and wondered "how do you… [handle] suicide in a virtual context?" He said:

> I know now… that it's important to ask the client for the address before you even start. You know, the intake, that sort of kind of thing. But I, I didn't know that at the moment. So they refused to give me their address, and so I'm on the office phone trying to dial the police, you know, jumping back and forth with this client. You know, he really struggles from the top challenge he gave me. He gave me an address, I called the police, and…nobody was home, and so, it turns out, he gave a fake address. Yeah, and so, you know, it's in those sort of kinda like settings and things... I wish I just received more guidance on how to actually provide care in a virtual space.

The implementation and regular use of telehealth identified unique safety issues such as what Adam and Texan have described.

Finally, the last common challenge that MHPs faced with telehealth involved the strain of the virtual nature of telehealth, which according to Dee, a mental health therapist, meant "we never had a day off. We never did, even when we worked from home." In other words, because telehealth was flexible in that MHPs could work from the office, their homes, or anywhere with a secure internet connection and privacy, they were not afforded a break in their day-to-day

schedules. Dee touched on this, saying "I was also at some point resentful of my friends, who were teachers, and got to stay home and work for a few hours, and then they got to garden, and they got to run all the miles." Working completely in a virtual setting meant that many MHPs had back-to-back telehealth appointments for most of their days. Commenting on this, Teresa, a licensed clinical psychologist, noted that after spending four hours straight talking with clients online, she felt like a "zoom-bie", a play on the word "zombie." As Teresa and other participants highlighted, telehealth came with its own set of challenges that, like many of the stressors described above, led to MHPs cultivating and enacting resilience processes.

Resilience Processes Enacted by MHPs During the Pandemic

The second research question (RQ2) asked: What, if any, resilience processes were enacted by mental health professionals during the COVID-19 pandemic? Three adaptive-transformative processes from the Communication Theory of Resilience (CTR) (Buzzanell, 2010) were particularly evident in the dataset, including: *Maintaining and Using Communication Networks*, *Foregrounding Productive Action while Backgrounding Negative Feelings*, and *Crafting New Normalcies*. Examples of how these processes were enacted by MHPs during the pandemic are provided below. Implications for these evident processes, as well as those CTR processes that were present but less exemplified in the dataset, are explored further in the discussion.

Maintaining and Using Communication Networks

The CTR process that was evident in every participant interview was "Maintaining and Using Communication Networks," which has also been called the "process of building and utilizing social capital" (Buzzanell, 2010, p.6). Mental health professionals leaned on their

families and friends, work peers, colleagues, and supervisors which provided much needed support during the pandemic. Each of these three subthemes is explored.

Families and Friends: "My Saving Grace was… My Relationship." When asked about how they managed the stressors of the pandemic, all participants referenced leaning on their family and friends to disclose stressors and process events, relate to one another, and bond with each other. The family discussed in this section that MHPs leaned on includes partners, siblings, and pets. Additionally, the friends mentioned in this section are those outside of the workplace. Many work colleagues were cited as friends and a source of support by MHPs, and these examples are explored further in the "coworker" section.

Partnership was a highly common source of support among MHPs. Laura, a licensed therapist, shared that she spent a lot of time with her partner and pets during the pandemic, and that "he was really supportive through the whole thing." Mollie, an outpatient behavioral health therapist, leaned on her partner and her partner's family, saying "my partner's family was really amazing." Texan, a licensed professional counselor, shared that "my husband was really like resilient." Texan's husband not only listened to her and supported her, but encouraged her to stay healthy and exercise with him. He also cooked her meals when she was too tired to cook her own, demonstrating his support both with his actions and words. Speaking on this, Texan shared, "I don't know where I would be, like, without my husband." Nicole, a behavioral health manager, was also appreciative of her husband, sharing "there are definitely days [where] I close my computer, and my husband comes home from work, and I'm like, I am so grateful to have you."

For some MHPs, circumstances of the pandemic strengthened their bond with their partners. Charlie, a licensed clinical faculty member, went to therapy with his wife during the

pandemic which he said strengthened their relationship and was “hugely meaningful.” Reflecting on this, Charlie shared that leaning on his partner was critical to coping with the stressors of the pandemic. Similar to Charlie, Brooklyn, a licensed therapist, felt her bond was strengthened with her husband because she was able to talk with him about creating a new future together.

While partners were a significant source of support, other family members served as a support system, including siblings. Speaking on this, Mollie said, “...my saving grace was definitely that I have a really close relationship with my sisters, and that we really… show up when things… we’re the firefighters of the family, and we work well together.” In other cases, the participants’ parents were strong supports. Cassie, a certified alcohol and drug counselor, shared that her “parents were super supportive”, that she talks with them a lot, and that “they’ve been a big support system for everything.” Some MHPs made intentional decisions in order to spend time with their parents. Sarah, a licensed psychologist, who said she had a close relationship with her parents, shared that “if I wanted to see my parents, I wouldn’t go anywhere but work for two weeks.”

Several MHPs discussed their pets, particularly their dogs, as helpful in coping with the stressors of the pandemic. As mentioned earlier in this section, Laura spent a lot of time with her pets in an effort to decompress after long days of meeting with clients. Nicole shared that she enjoyed taking her dogs for a walk, and for one in particular, said “I joke that I need to get her registered… [as a] therapy support dog.” Ciara, a school counselor, said that she found joy in the little things such as walking her dog and “trying to get outside, spending more time with him.”

Friends served as another significant support system for many MHPs. Laura shared that she stayed in contact with her friends during the pandemic which helped with feelings of isolation. Speaking on support during the pandemic, Ciara noted that her friends significantly

"helped me through it." Mollie said, "I have a group of friends that I've known since, like, middle school, and we're all over the place at this point, but we started doing Zoom groups together." Nicole echoed this, saying "I have an amazing friend group as well that, we're all over the place profession-wise, but we all make sure to stay in touch." Speaking of friends who live in the area near her, Nicole shared that "we were very strict about our circles, so we did feel comfortable seeing each other in person… because we took it seriously… it afforded us the luxury of being able to see each other in person." Having this strict circle of friends who limited their exposure to other people was, in Nicole's words, "so helpful for everyone as well." Like Nicole, Alexis limited the friends she saw in-person, saying "I had a lot of friends during COVID that I could still get together with, because we were kind of [all] being safe… so I felt like I had a good amount of support."

While many MHPs such as Brooklyn already had, in her words, "a good network of friends" established, some MHPs made friends during the pandemic and leaned on them for support. Charlie had moved away from family and friends to a different state with his wife and children, and found the first part of the pandemic to be incredibly isolating. He said:

> It wasn't until… Christmas of the first year… our first friends, we just, like, met them at the park. So we have a park in our backyard, like, our two sons, like, played together…. And I think they like played for an hour at the park, and I was like, I need to find his parents because we've just been stuck in this house. I cannot play with my kids anymore. You've maxed out, I'm maxed out … we started, like, connecting to a few neighbors through them, and having… a backyard fire pit, like, once or twice a month, you know. I remember, like the first time, like we met them without masks on, like year two. My,

> [their] faces don't look the way I thought they would! Yeah. So it was, that was incredible. And we've built some great friendships with them, with our neighbors.

As evidenced within this Charlie's account and the other examples within this subtheme, family and friends played an important supporting role in the lives of MHPs during the pandemic. Next, examples of coworker support will be reviewed.

Coworker Support: "We're All Going to Go Down." Many MHPs leaned on the support of their work colleagues, many of whom they called friends. Laura shared, "I think if I didn't have my friends that I worked with, or didn't have friends that I stayed in contact with, it would be a lot more isolated." Many coworkers made an intentional effort to look out for each other; Laura elaborated on this, saying, "I think we kind of all had that resilience, and we showed up together to make sure no one felt left behind or isolated." Dee has a group of colleagues she considers to be friends, and shared that she had, "[an] informal group of friends who are also in the same field that I can always, you know, send an email or a text message to, like… just checking in with them."

In addition to having specific work friends and colleagues, some MHPs felt like they could lean on their entire team/group of coworkers for support. Charlie shared that, during the height of the pandemic, there were, "...ten of us… they were very supportive [and] always wonderful to talk to." Dee found that being in-person with her coworkers was helpful. She said:

> It also helped to be… at our site. I think we were about to ten [staff members], including the front staff, and we were all on the same page, so we were all able to just vent to each other, and I think that has helped tremendously to know that we're all, you know… we all felt the same way about everything that was going on, and I think that helped.

Similar to Dee, Paige found that being in-person around her coworkers and being able to vent about pandemic-related stressors significantly helped in their coping. While reflecting on this, Paige shared:

> The other social workers within my department, we definitely had a bond that was very different than before [the pandemic]. I think there was a consistent general feeling of those in management or positions higher than us that… [they] do not understand how we feel, and do not… they have a different stress, right? Not saying they're not stressed, but it's a different stress. So, being able to kind of unite as a team and figure out like, you know... I could remember us huddling in the hallway before we would all spread to our units like, okay, we're going to do this, right? We're all going to go down. We would all be dressed out, you know, and we would all complain about how our goggles with the face shield [would] fog so much we couldn't see our patients, and you know, you just had to… There was sometimes a sense of, like, humor, even if it was self-deprecating at times, just something there to remind us of, like, it's okay. And we're going to go home later today, and then we'll come back tomorrow.

Paige found that talking with coworkers, using humor, and looking out for each other were all ways that she felt supported in her workplace. Similar to Paige's experience, Dee shared, "this support came from the peer level, you know, looking back, like, I'm so fortunate." Thinking about her small, tight-knit group of coworkers, Dee shared, "I don't know if I would have made it [without them]." It was also through small acts from her coworkers that she felt supported and a sense of camaraderie, whether it was because a coworker brought donuts in to share with the office, or through surprising each other by buying lunch. Brooklyn, who works in private practice, developed a friendship with the person she rents her space out from, who also

happens to be a psychologist. She eventually met her renter's wife, too, and they developed a friendship. Talking about this experience, Brooklyn said:

> We would meet, maybe like, every two weeks online, and we would just talk about, like, how the pandemic was impacting us. What was he noticing in his practice? What was happening in mine? And so it was kind of a combination of just mentorship, but also it was very specific to, how do we navigate through this? And, you know, what are you doing to deal with x, y, and z, and then I would share, and we would kind of help each other in that. So that was really valuable for me to feel like I had at least somebody I could call or just say, can we talk? And so he and his wife both were very influential from that perspective during that time.

Brooklyn looked forward to her biweekly meetings with her renter, who turned out to be a supportive colleague. Whether it was from one work colleague or the entire office, many MHPs relied on their coworkers and professional peers for support. They described feeling like their coworkers could relate to what they were going through, which helped to strengthen their bond and validate their experiences.

Supervisor Support: "[They Were] Very Validating." In RQ1, a primary theme of "triggers, stressors, and challenges" related to the relationship that MHPs had with their supervisors. Some of the participants who shared about their negative experiences with management switched jobs during the pandemic and worked for new bosses from whom they felt very supported. Other MHPs had the same supervisors throughout the pandemic and talked very highly of them. In this section, the accounts of participants who experienced supervisor support are cited as another major source of coping with and managing the stressors of the pandemic.

Strong communication skills, trust, and expressed validation were recurring themes among participants who felt supported by their supervisors. Dee shared, “I'm very fortunate to have had a very, very good clinical supervisor. So I feel like anything that did come up, I was able to process with her.” Having the ability to openly communicate with supervisors about any pandemic-related challenges without any judgment from them was significant in relieving stress. In addition to these qualities, Nicole shared that her boss was “amazing” because he was “a very transparent person” who always kept her and her coworkers “in the loop” about “what’s going on”, particularly with communication he received from higher up in the organization. Having this transparency, in Nicole’s words, “served to really help significantly reduce a lot of anxiety.”

For some MHPs, they appreciated being able to have open communication with their supervisors, whom they trusted. Speaking about her assistant principal, Ciara, a school counselor, shared:

> He was probably one of the best people I've ever met in education, and that's still true… like, he has a great personality… He's been very helpful. Like, he was just inspirational, and he and I got along so well, with like our beliefs and values, like at the core of education, and, like, it's what our roles were, even though he was admin, and I was a counselor, which are completely different roles, we worked really well together, and we would just... he would come to my office, and we would just talk and vent, and that was very, very helpful, because he was validating… he was very validating and encouraging for me that every day I got excited [to come to work].

Similar to Ciara, Brooklyn felt that she could openly share anything with her supervisor, including challenges that she encountered. An example of this was when Brooklyn lost internet from a winter snowstorm but had clients she had to meet with via telehealth. Brooklyn called her

supervisors and shared the situation, and her supervisors understood and made sure all of her clients were covered. Speaking on this, Brooklyn said, “I appreciate that the university and the supervisors… are sensitive to the… kind of changing nature of the job, and then these evolving dynamics. So… we still have a high level [of] autonomy in how we handle our job.”

Another way that supervisors showed support to MHPs was through sharing relevant and helpful information and resources. In addition to receiving “...a lot of affirmation for the work that we were doing, because the work was hard”, Adam, a graduate student, said that, “My supervisor was also… very, very supportive, providing a lot of information and feedback on just, you know, the sessions where I would be providing that asynchronous sort of kind of [meeting].” Paige, a behavioral wellness therapist, observed supportive communication with her most recent manager. Paige was able to compare the communication styles of her former and current employers, both of whom she worked for during the pandemic. With her former employer, Paige said the communication was more reactive, where she would receive an email that said, “we wish you the best… let us know if you need anything”, or “call us if you need to schedule a meeting.” This stressed her out, and she felt that she “did not have time for that” and that she “needed the extra hour in [my] schedule.” On the other hand, with her new employer, Paige expressed that she felt supported with the proactive communication they took, where they would share resources and podcasts, and more, in her words, “tangible, actionable things.” Overall, MHPs valued communication from their supervisors that they perceived to be transparent, relevant, intentional, all of which helped them to feel supported.

Foregrounding Productive Action While Legitimizing Negative Feelings

The second most prevalent resilience process apparent in the dataset involves acknowledging negative emotions about an adversity while taking thoughtful, deliberate action

in an effort to remedy the situation, possibly making it even better. According to Buzzanell (2010), backgrounding negative emotion does not mean repressing feelings or pretending that everything is alright; rather, it involves acknowledgement of difficult feelings while prioritizing actionable steps that can be taken. As explored in the previous section, all MHPs leaned on their relationships with people for support during the pandemic; while this section will cover interpersonal dynamics, the focus on this process is with ideas for how to problem solve and mitigate stress, as well as the professional actions taken to do so. Two of the most common actions taken by MHPs to alleviate stress included seeing their own therapist, as well as switching jobs in the middle of the pandemic to pursue better working conditions.

Meeting with their Own Therapist: "I Took it Upon Myself." While Buzzanell (2010) distinguishes five resilience processes in her Communication Theory of Resilience (CTR), she also argues that the five processes are "not mutually exclusive and are often entangled in complex ways" (Buzzanell, 2018, p.100). This entanglement became evident to the researcher when considering the recurring theme of MHPs seeking their own therapists for support; while MHPs may have a professional relationship with their own therapist, which could blur into Buzzanell's (2010) "Maintaining and Using Communication Networks" resilience process, this section was placed in "Foregrounding Productive Action" because scheduling an appointment with a therapist and regularly attending therapy sessions involves conscious decision making and taking actionable steps towards sensemaking and stress mitigation with the support of their therapist. Further, many MHPs talked about how their therapists validated their negative feelings related to pandemic-stressors and helped process them, while also practicing mindfulness and discussing practical ways to address challenges. This, in itself, is characteristic of mechanisms that reframe, and sometimes help the individual to reappraise the adverse event..

Across the dataset, more than half of participants cited seeing their own therapist as a contributing factor to cultivating resilience during the pandemic. In reflecting on her own mental health, Laura shared, “I see my own therapist which works pretty well, and I see a nurse practitioner for medication support.” Seeing her own therapist and meeting with a nurse practitioner to get on a medicine regime to support her own mental health are two actionable steps that Laura took to help manage the stressors she experienced. Based on her positive experience, Laura shared, “I also recommend that every therapist sees their own therapist just because it’s a stressful job.” Alice noticed that stressors from work were impacting her own mental health, which led her to pursue finding her own therapist. She shared:

> You know, I'm hearing what's going on with my clients and countertransference started happening. And they're, like, okay, we have to be able to process this in a healthy, safe space, and for me to just share what my own experiences were with quarantine, and going through it myself, like, I'm literally experiencing these symptoms while watching them unfold on national television. And right, okay, I need to be able to serve and support other clients going through something similar. I needed to process. So that was personally, how I coped with a lot of my stress and leaned on…. my own therapist to kind of help me through that, too. So that was helpful at the time.

While Alice pursued individual therapy to help mitigate occupational stressors, Charlie also pursued individual therapy for this reason as well as couples therapy with this wife to strengthen their relationship. A significant reason as to why Charlie did individual therapy was that he experienced “the compassion fatigue… the secondary trauma of, like, hearing everyone’s stories and seeing, you know, all of the things that we experienced. In considering how he got through that, he said, “I do think, like, going to counseling was very meaningful for me”, as it

allowed him to "not burden my wife or family" with the challenges he was facing. In addition to individual therapy, Charlie found couples therapy to be highly valuable towards his relationship with his wife. During the first part of the pandemic, Charlie shared that his stress and anxiety worsened, and "my wife and I's relationship started to suffer. I think [the pandemic] just kind of broke down a lot of things." It was at this point that they sought couple's counseling, and one of the most important topics they covered was developing healthy coping mechanisms.

In discussing the resources she sought to promote her own well-being during the pandemic, Alexis, a licensed professional counselor, shared, "I had my own therapist that I saw virtually, so I would kind of meet with her weekly or biweekly to talk about those things." In addition to pandemic related stressors, some MHPs faced their own personal challenges that happened within the timeframe of the pandemic. Following her divorce which happened during the pandemic, Cassie shared "I'm in my own therapy" and that "making therapy a priority" have been ways to cope and address her own mental health challenges. Cassie shared, "I took it upon myself to start my own therapy again to kind of process some things you know, especially with the divorce and things." Similar to many other participants in this study, Cassie made the intentional effort and action to find and meet with a therapist, acknowledging her stress while foregrounding productive action to better manage what she was experiencing.

Switching Jobs: "[They] Don't Value Me." D A common reason for switching organizations was due to staffing issues; Paige said that the lack of staffing in her department led to safety concerns, which proved to be a primary reason for leaving that position. In addition to safety concerns, some MHPs felt overwhelmed with the increased caseloads and corresponding paperwork and administrative tasks. This led Ciara to feel like her supervisors "don't value me, and I'm a data entry person, like I got [this] degree for nothing in this county" which is when "I

started looking for jobs." Mollie, reflecting on making the change that led to her life taking a "180" degree turn, said "paperwork is much less; support is much more. I [now] have a supervisor who is knowledgeable, who I can easily send a message to, and it's not usually for her to send me one back right away." Dee, like Mollie, made the switch because she was not happy in her role. She had doubts about going from community health care to private practice, but it ultimately worked out to be best for her circumstances. Speaking on this, Dee shared:

> I think the biggest shift was going from, "I could never work on my own. I don't have the money to open a private practice. I don't have the support. I don't have, I don't have anything" to within a few months, you know, really realizing that I was in a really bad place, while at the same time knowing that there are other [options]. You know… people are thriving, you know, opening private practices, and even…without having, you know, big reserves of cash, or, you know, other [resources] to fall back on.

Despite the uncertainties of leaving her old role, Dee recognized that her previous circumstances were not working and that something had to change. She observed her peers successfully making the transition from community healthcare to private practice, and this helped her to realize that the switch could be feasible for her. Leaving her old job to start her own private practice, to Dee, was the pinnacle of her experience with resilience during the pandemic. She elaborated on this, sharing:

> I think resilience for me was shifting, you know, recognizing that the work that I was doing… I think the pandemic just made everything, you know, exacerbated everything, and it made it clear faster that there [at my previous job] was not a good environment for me. Resilience was, you know, alright, let's step out of the box. You've never ever wanted to be anyone's boss, including your own. You never thought you could, you

> know, open a business. But this seems like a way to continue to do the work that you love, while not having some of these stresses that can be addressed… there's resistance when you try to really address them with the people who can do something about them. So I think it's just… shifting to something else… knowing that this is, I don't want to give this [career] up, but something needs to change in order to make this sustainable long term.

Just like Dee, Laura found that the challenges of the pandemic impacted her workplace to the point where it drove her to take action. She shared, "as far as coping, one of the best things that I did to cope [was] leave… sometimes you have to do what you have to do." For Laura, it had gotten "to the point where I would be fine with, like, doing another job for a while", and "it just wasn't worth it anymore to stay." Also similar to Dee, Laura noted that "a lot of my colleagues and my friends, too, a few of them were also leaving. Everyone else was [looking] for a different job, or they were moving, but that was kind of helpful knowing, like, I wasn't the only one." In each of these examples, the participants recognized that their situations were not working, so they took deliberate, productive action to change their circumstances for the better.

Crafting Normalcy

The third resilience process evident within the dataset was Buzzanell's (2010) "Crafting Normalcy" which, in this context, involves the discourse and performance utilized among MHPs to maintain and sustain the everyday activities and conversations. Despite the turmoil caused by the adversities of the pandemic, MHPs talked normalcy into being by establishing and maintaining new routines and rituals to keep consistency in their lives. Buzzanell (2010) notes that crafting normalcy is inherently a communicative process where people and organizations create new normalcies; ones that are "embedded in material realities and generated by talk-in-

interaction" (p. 4). Prior to the pandemic, MHPs had their own patterns and routines established in their personal and professional lives, but once COVID-19 became widespread, MHPs took action to create new normalcies. Two of the most common actions taken to establish normalcy in their day-to-day activities included utilizing telehealth to service clients and also turning to computer mediated communication to connect with loved ones that could not necessarily be seen in-person due to virus-related concerns.

Telehealth: "It was a Freedom… I Had Never Experienced." Following the initial shutdown of most services in March 2020, MHPs were able to continue rendering their services effectively via telehealth. Many practitioners adapted so well to telehealth and enjoyed using it that, when offered the choice to return to in-person meetings with clients, they opted to continue exclusively utilizing telehealth throughout the pandemic to the time that interviews were conducted (March-May 2023). An example of this was in Nicole's experience, who shared "I had such success with becoming telehealth permanently that I didn't want to return to the office." Laura chose to continue using telehealth as her primary form of meeting with clients because "it… improves compliance. It improves the amount of people that were showing up to their sessions, like, astronomically, because there was (sic) no barriers like having to drive their car, or having to get a ride." Telehealth provided a new way to connect with clients and, according to Laura, "has made it so much more accessible nowadays." The accessibility component, combined with the higher compliance rate of clients showing up to their scheduled appointments, led her to wanting to utilize Telehealth for her regular, everyday services.

As cited earlier within RQ1, Mollie shared that with telehealth, "I got to kind of take a breather" that led to some initial feelings of guilt towards her clients' circumstances, many of whom were unable to work remotely. Alongside this guilt, though, she shared that she was

"much better in terms of mental health and emotional [health]." After deciding that telehealth was her preferred method of delivery to clients, she implemented this in her everyday schedule, which ultimately allowed her to make the decision to move out of state with her girlfriend. It was telehealth that allowed Mollie the "...flexibility of being able to just say, like, hey… I can work remotely. It was a freedom… that I had never experienced, because work always felt… like a cage, and kind of, like, I didn't… have agency over my life." Another major reason why some MHPs preferred telehealth and chose to stick with it was because it eliminated any possibility of mutually contracting the virus in-person, should either the clinician or patient have it. Charlie shared that a major stressor for community mental health professionals was going into people's homes and physically transporting people, which led to the possibility of COVID exposure. Telehealth, though, allowed for MHPs to be, in Charlie's words, "very much in safer positions."

Texan, like several other MHPs, had initial reservations about telehealth, because in her words, she "kind of need[ed] to feel the person" through observing their full body language; however, she "was pleasantly surprised" in her ability to help her clients over telehealth, even if their cameras were not on or working. Laura was also surprised, as telehealth allowed her to observe more closely her clients' environments which were rich in information. Touching on this, she shared, "here [in telehealth] are these situations that are bringing up really clinically relevant information that we might never have touched on exactly with you just coming in my office." Laura noted that in her clients' homes, she could see their bedrooms and living conditions, which gave her "a lot of information about [their] mental health status." Another example of receiving more information came from one of her clients who answered a scheduled telehealth call from her car. When Laura asked her why she was in the car, her client shared that her boyfriend was home and she did not want him to overhear. Laura was then able to tap into a

topic they had not discussed while meeting in person, which allowed her to gain further insight into her client's wellbeing.

Online Community: "That Network… Helped a lot of Us Feel Less Alone." Once the pandemic became widespread, many MHPs found themselves at home, continuing to meet with clients via telehealth and adapting to electronic means as their new day-to-day reality. While they utilized telehealth in their capacity to meet with clients and many chose to continue doing so throughout the pandemic, MHPs also employed computer mediated communication (CMC) methods to connect and stay in touch with their personal and professional communication networks. Specifically, participants referenced using social media platforms, Zoom calls, emails, and other online means of communication to maintain important relationships and connect with their networks.

Some MHPs utilized Zoom for their telehealth platforms, but others used this software as a chance to regularly touch base, stay connected with their friend groups, and even play games together. Mollie shared that she had a group of friends that she had known since middle school who were geographically spread across many states; however, during the pandemic, they started doing Zoom calls to stay in touch. In her own words, "we [would] play games together, and that would create a sense of unity. It would create a sense of just connection that wasn't there before." Mollie noted that her friends have continued to meet this way since the pandemic began. Similar to Mollie, Nicole and her friends would do what they called "Zoom nights" where they would prepare dinner separately at their own homes but eat together via Zoom. Following this, Nicole and her friends would play "Jackbox Games", a series of quiz-based video games meant to be played with a group of people. Ciara, too, shared that "we did a lot of those apps with my friends where you could play games with each other, like Jackbox and stuff, so that was very

helpful." While Jackbox was mentioned by these two participants, Nicole also started playing online video games and "struck up a friendship" with players she met online while "playing an MMO", or a massively multiplayer online game. Outside of Zoom and Jackbox, Sarah found that "Facebook has, like, these little stupid games, where if you call somebody through Facebook like you do in video chat, there's always some games you can play." These platforms, used for entertainment, became a regular way for MHPs to connect with people.

Many MHPs turned to online social media networking groups to connect with other professionals or people going through similar life experiences. Cassie found a "MOPs" social networking group on Facebook, which stands for "mothers of preschoolers', and she credited this group with being the "biggest thing" that helped her cultivate resilience. Others found Facebook groups to support them in their work capacities. Dee did just this, saying, "moving on to private practice, I found support in these online communities. There's a couple Facebook groups that are, you know, national, you know, focusing on various things." Dee learned that after leaving her community mental health role for private practice, MHPs in Facebook communities shared their experiences with community mental health which proved to be commonplace. Reflecting on this, Dee shared:

> I remember feeling shocked when I read, you know, people basically sharing very similar things, and not just this, but… everything that I ended up disliking about that work, that environment. I thought it was specific to my agency, but it seems like it's been, it may just be the community mental health model.

Dee found solidarity in being able to connect with other MHPs online who shared very similar experiences, and after joining this group, checking in on the group activity and posts

became a new way of staying connected with like-minded colleagues across the globe. Like Dee, Alice joined a therapist Facebook group that was specific to her state. In this group, Alice said:

> There was a lot of positivity on there, just with empowering messages, as well as you know, referrals like for people, you know, like hey? I'm full, who can take this? …And so that network, I think, really helped a lot of us feel less alone. And as [a] therapist, we're not doing this alone, and that is also, I would say, one of the biggest takeaways that I've had, and working through this pandemic is that I'm not alone in this. And there are therapists you know, that have been working 25 years in this field that are experiencing compassion fatigue, and you know, and they're exhausted from it as well, too. So that was very validating… that we can lean on each other for support.

Alice's Facebook group that she joined helped her to see that new and experienced counselors alike were struggling during the pandemic. In addition to using Facebook, some MHPs used Snapchat, Instagram, and TikTok as ways to stay in contact daily with people. Ciara used a Snapchat group with her "close knit friends", and said, "you can just type whatever you're dealing with" and she felt like she had a valuable community who would listen. While Snapchat was around years before COVID, Ciara said that she thought, "we started using the group more during COVID because it was an outlet, like if someone else hated her job, or someone got laid off, it was just… I can truly talk to you, send videos, see your face." Adam, a graduate student, actually did not use social media prior to the pandemic. He shared, "my journey into social media didn't start…. probably wouldn't have started unless the pandemic happened." After the pandemic became widespread, he downloaded Snapchat, Instagram, and TikTok as a way to establish new modes of communication with his friends and stay in touch when in-person visits were not possible.

CHAPTER 5: DISCUSSION AND CONCLUSION

On May 9, 2023, the White House released an online statement from the Biden-Harris Administration officially declaring the end of the COVID-19 Public Health Emergency (PHE) within the United States, to take effect on May 11, 2023 (The White House, 2023b). The PHE had originally been declared by former President Trump on March 13, 2020 (The White House, 2023a). Interviews for this study took place between March and June of 2023, and more than half of the participants were interviewed following the official declaration of the end of the PHE. One of the unique perspectives that this study offers involves the timing of the interviews and the duration of participant experiences, where participants retroactively reflected upon their enactment of resilience, including the triggers they faced, from March 2020 through the time of their interviews. To the researcher's knowledge, compared to currently published research articles, this is one of the first studies to qualitatively interview mental health professionals on their pandemic-related triggers, stressors, and challenges within the context of communicative resilience.

This study provides greater insight as to how mental health professionals managing pandemic-related stressors were able to enact resilience via material-discursive processes. Buzzanell's (2010) Communication Theory of Resilience (CTR) is framed as a "springboard for theory development and communicative interventions to foster resilience" (p. 9); the results from this research illustrate pragmatic examples of CTR's processes in action and the stressors that led to resilience enactment. Further, this research reinforces considerations of temporality and agency later proposed by Buzzanell (2019). In the following sections, implications for the results are explored. The researcher then considers practical applications that can be derived from the findings, followed by study limitations and directions for future research.

Triggers, Stressors and Challenges That Led to Resilience Enactment

Most of the published articles exploring the adversities of mental health professionals during the COVID-19 pandemic are large-scale and quantitative in nature (e.g., Aafjes-van Doorn et al., 2020; Bekes et al., 2021) or provide insight into these aspects within the first few months of the pandemic (Fish & Mittal, 2021). While concentrated to twenty participants, this qualitative study provides a rich, retroactive reflection on the trigger events and adversities that led to resilience cultivation. In this section, trigger events are examined in interpersonal and organizational contexts, with a consideration of the participants' stress as eustress and distress. Following this, trauma, and more specifically, shared trauma, is identified as a type of trigger event that has not yet been named in communication resilience literature.

Trigger Events Considered in Interpersonal and Organizational Interactions

One of this study's strengths is revealing the specific adversities that mental health professionals faced at varying levels throughout the pandemic (RQ1). Mental health professionals described pandemic-related triggers which can be interpreted through interpersonal and organizational levels of interaction. At the interpersonal level, the communication that MHPs had with their supervisors, clients, and their families presented as a series of conversations with other people which served as a trigger event(s) or turning point, thus activating resilience processes. In the context of MHPs' experiences during the pandemic, examples of these came in the form of devaluing communication from a direct supervisor, expressing guilt when comparing their personal circumstances to clients who they perceived to be worse off, talking with clients or family members about beliefs different from their own, and articulating privacy or safety concerns with clients via telehealth. These themes highlight significant interpersonal disruptions that have implications for MHPs and the therapeutic relationship (TR), which has been called the

"foundation of mental health practice" (Khan et al., 2016, p. 223). There are three core aspects of TRs, including: a collaborative nature, a bond between client and counselor, and the mutual capacity to agree on goals (Martin et al., 2000); these core aspects can face interruption when "...patient related, therapist-related, and environmental factors… hinder the establishment of all three of these aspects" (Bolsinger et al., 2020, p. 2). As evidenced within participant experiences, the interpersonal disruptions they faced had the potential to be significant hindrances to the therapeutic relationship.

At the organizational level and from a hierarchical standpoint, communication took place in upward, downward, and horizontal capacities. Upward communication occurred when MHPs requested changes or raised complaints to their supervisors/executives, and the trigger event came in the form of MHPs feeling like their changes and complaints were explicitly or implicitly ignored or minimized from the organization or larger governing bodies. Downward communication flowed from the managerial or higher organizational levels down to MHPs, which manifested in the implementation of rules and regulations that frequently changed, which also caused stress. Horizontal communication occurred when MHPs met with their colleagues and peers to share information and resolve problems. Whereas upward and downward organizational communication served as points of trigger events *and* resilience processes (the latter discussed in the section on CTR processes), horizontal communication where MHPs connected with their peers *exclusively* served as positive, resilience cultivating events. In other words, adverse events happened at the upward and downward levels of organizational communication between MHPs and their supervisors/executives/higher governing bodies, but *not* at the horizontal level between coworkers; in this dataset, MHPs reported only positive interactions and outcomes in their communication with peers.

Some of the interactions that MHPs had with their supervisors, colleagues, clients, and family members were grounded in stressful circumstances but led to positive or negative perceptions of the conversations. This notion leads to a consideration of stress in both contexts; the stress-related concepts of "eustress" and "distress" may provide some insight as to how the trigger events and adversities played into resilience enactment. Originally introduced in the 1970s (Selye, 1974) and later refined (Le Fevre et al., 2003; Selye, 1987) and critiqued (Bienertova-Vasku et al, 2020), eustress and distress are characterized as distinct subsets of stress. Selye (1987) defined stress generally as "...the non-specific response of the body to any demand placed on it" (p. 17), and that stress comes in the forms of distress, eustress, or a combination of the two. When the stress placed on an individual (e.g., psychological and physiological) is greater than one is able to handle, this is considered "bad stress" or distress; the concept of eustress, on the other hand, is considered to be "good stress" or an optimal level of stress that stimulates an individual to feel motivated or happy (Selye, 1987). Selye (1987) went on to assert that eustress and distress are determined by an individual's perceptions of the demand and not necessarily the demand itself. Le Fevre and colleagues (2003) refined and expanded upon these notions by providing a series of tenets on stress, distress and eustress, where (a) stress is a response to stressors in an environment and is either eustress, distress, or both; (b) stressors can be identified by a set of characteristics, including: the source of the stressor, the timing of the stressor, the perceived control over the stressor, and the perceived desirability of the stress; and (c) the individual's interpretation determines whether stressors are perceived as eustress (positive) or distress (negative).

In the case of mental health professionals during the pandemic, participants identified their supervisors, organizations, and families as sources of eustress *and* distress; in some

accounts, stress with these populations resulted in both subsets simultaneously, and in others, it was one more so than the other. With regards to Le Fevre and colleagues' (2003) tenets of stress and eustress, the perceived control over the stressor seemed to play a significant role in determining whether the stress was perceived as "good" or "bad" by the MHPs, especially in expressed interactions with employers. When MHPs felt listened to and validated by their supervisors after raising concerns to them, they reported more positive, eustress-like perceptions of the interactions, perhaps partially due to feeling a sense of control and validation when listened to. Conversely, when MHPs raised concerns and were met with criticism, invalidation, and/or lies, they expressed more distress-like perceptions of the interactions with supervisors. As indicated in the results, for many who felt like their supervisors were not listening to them, they took action to leave the organization in pursuit of better working conditions, thus asserting an element of control. It can be gathered that MHPs experienced eustress, either from their initial perceptions of their interactions as positive or following distressful interactions where they consequently took positive action to enact control over their circumstances, aligning with Buzzanell's resilience process of foregrounding productive action while backgrounding negative thoughts. Communication resilience theories, then, might consider the relationship between stress, eustress, and distress as important distinctions related to the adversities and trigger events that activate resilience processes.

Finally, Le Fevre and colleagues (2003) assert that "...a study of stressor characteristics remains conspicuously missing in the literature" (p. 730); since then, stressors anchored in eustress and distress have been explored in specific contexts such as nursing home institutionalizations (Scocco et al., 2006), college life (Li et al., 2016), among athletes (Natsir et al., 2021) and the general public during a health quarantine (Merino et al., 2021). The current

study, then, adds to the growing literature on stressor characteristics by defining the specific stressors MHPs encountered during the pandemic and considering elements of distress (e.g., the expression of feeling invalidated by supervisors) and eustress (e.g., communicating with peers and coworkers coming together to support one another with positive messaging despite being short staffed). Future research related to resilience cultivation among MHPs during the pandemic could explore elements of eustress and distress by incorporating interview questions that center on their perceptions of the stress they experienced in their communication interactions, and whether it was positive, negative, or possibly both.

While more reactive rather than proactive in nature, a consideration to help mitigate the effects of trigger events and stressors would be to provide MHPs with free or reduced-cost mental and physical health care for themselves. Several participants mentioned that having help from their organizations with both of these types of healthcare would be beneficial in receiving personal and professional support. With the system as it is right now, Mollie shared that she, in her own words, "...couldn't really afford the copays which are fifty to sixty dollars [per session]". As articulated in the results, therapy for mental health professionals proved to be a beneficial, positive action they pursued during the pandemic, and also recommended for future mental health professionals to pursue. Brooklyn expressed that in an ideal world, she would "loved to have had, like, some type of grant or some other funding that gave mental health professionals access to therapy." Expanding upon this, she said "it would have been great if there was some kind of resource that said, hey, we're gonna offer, you know, mental health professionals six sessions during the pandemic with… a therapist." In addition to free counseling for MHPs, Charlie shared that he would want access to "more, like, fitness and outdoorsy things like that, like if it was funded; for example, my brother works for some government contracting company,

and they get like five hundred dollars a year to spend on health and wellness." Mollie supported Charlie's statements by saying "it should be embedded into the job where you should have access to wellness and mental health services, and something like a yoga class should be mandatory." Thus, an important way that organizations could help to support MHPs would be to partially or fully cover the costs of services that maintain and improve their employees' physical and mental health. Having this support at the organizational level would help employees receive the much-needed care that MHPs expressed they needed and wished they would have had.

Shared Trauma as a Type of Stressor Leading to Resilience Cultivation

As articulated by Buzzanell (2019) in her updated reflections on the Communication Theory of Resilience (CTR), the presence of an adverse event or series of adverse events is just as important to CTR as are the five core resilience processes; according to CTR, resilience is enacted when humans confront disruptive events that enable them to employ empowerment and control via the five resilience processes. These adversities can vary in occurrence (i.e., as a singular occurrence or a series of events), permanence (e.g., losing a job or dealing with a loved one's death) and in anticipated (e.g., one initiates a breakup with a romantic partner) or unanticipated (e.g., a natural disaster) capacities (Buzzanell, 2019). This study provides insight to the triggers, stressors, and challenges that mental health professionals faced in personal and professional capacities, many of which were already existing but exacerbated due to the pandemic, and others that arose as a result of the pandemic.

Many of the trigger events articulated by participants occurred as a result of working directly with clients while concurrently navigating similar personal pandemic-related traumatic experiences themselves. The trauma faced by MHPs has occurred at the intersection of their personal and professional lives, where they were providing safe, empathetic, caring spaces for

clients to process grief, loss, uncertainty, mental health issues, and other COVID-19-related challenges while simultaneously navigating these adversities on a personal level. As such, MHPs appeared to demonstrate aspects of primary and secondary trauma, a dual exposure phenomenon that has been conceptualized by Tosone et al (2016) as "shared trauma." The theoretical framework of shared trauma first emerged following the catastrophic events of 9/11 where mental health professionals strived to continue providing successful services to clients while also addressing the trauma in their own personal lives (Eidelson et al., 2003). Tosone and colleagues (2016) solidified the term shared trauma, or shared traumatic reality, as "the affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience as a result of dual exposure to the same collective trauma as their clients" (p. 233). Similar to vicarious traumatization and secondary trauma, the interactions that MHPs have with clients may lead to altering their world view; however, shared trauma adds the element of primary or first-person traumatization which, in tandem with secondary traumatization, can make therapists "...potentially more susceptible to posttraumatic stress, the blurring of professional and personal boundaries, and increased self-disclosure" (Tosone et al, 2016, p. 233). Shared trauma might also be a result of transference and countertransference occurring in counselor-client relationships. According to Stefana (2015), these concepts were initially introduced by Sigmund Freud in 1909 and have evolved to be recognized as essential components of the therapeutic relationship (Lorentzen et al., 2004). Transference occurs when clients redirect feelings, patterns, beliefs or assumptions about other people in their lives towards their therapist, and countertransference can occur when the clinician responds to a client's transference by redirecting feelings about their own beliefs or assumptions onto the client (Racker, 1982; Prasko et al., 2022). Transference and countertransference are important to be aware of in therapy and supervision, as identification of

these concepts can improve a patient's interpersonal functioning, remove roadblocks in therapy sessions, and enhance the therapeutic relationship (Prasko et al., 2022). When counselors are meeting with patients in the context of shared trauma, it is possible that they might inadvertently cast beliefs about this experience upon each other. Since shared trauma was evident in this dataset, future research might consider the role of transference and countertransference in the client-clinician relationship when they have experienced dual exposure to the same collective trauma.

Another important note concerning shared trauma is that the presence of this does not mean the client and the clinician have the exact same experience in relation to a collective trauma (Tosone & Figley, 2021). Kaplan (2020) highlights intersectional considerations of collective trauma, where race and class in the United States have informed the COVID-19 experiences of many patients of color. While these critical dimensions have not yet been explored in this dataset and should be taken into consideration in future research, shared trauma is applied to this research with the understanding that the clinicians' and clients' COVID-19 related trauma, as well as their response to this trauma, is not identical to one another but rather occurring concurrently within the broader context of the pandemic. At the same time, there are intersectional factors that inform individual experiences in unique, distinctive ways, despite clinicians and clients experiencing collective trauma stemming from the same overarching adversity or series of adversities.

The conceptualization of shared trauma as a trigger event leading to resilience enactment adds to literature existent across Social Work and Communication Studies disciplines. One of Tosone and Figley's (2021) recent edited volumes titled *Shared Trauma, Shared Resilience During a Pandemic: Social Work in the Time of COVID-19*, provides expert reflections on

working with specific populations as well as narrative, personal testimonies and case studies from chapter authors reflecting on their own experiences and interactions with clients. The findings from this study suggest that communication research and scholarship can add significantly to the growing conversation on shared trauma during the pandemic by offering retrospective, reflective narrative accounts that identify specific COVID-19 related clinician stressors. Additionally, this work centralizes communication in the context of mental health professionals working during the pandemic and asserts shared trauma as a type of trigger event or series of events that activates communicative resilience processes. As Buzzanell (2019) argues, an understanding of triggers and the five resilience processes not only form CTR as a theory but also demonstrate "*how* communication constitutes these processes" (p. 75); the accounts provided by the twenty MHPs in this study offer an understanding of triggers unique to this population and fruitful research collaborations among communication scholars and others in related disciplines.

Understanding how MHPs Enacted Resilience Utilizing CTR Processes

In response to identifying the triggers, challenges, and stressors evidenced by mental health professionals during the pandemic (RQ1), the researcher attempted to understand how, if at all, MHPs enacted resilience (RQ2).This was done by utilizing Buzzanell's (2010) Communication Theory of Resilience (CTR), which she later expanded upon as having three components: (a) trigger events, (b) a focus on anticipatory (proactive) and reactive resilience, and (c) five central processes that are inherently communicative in nature and are enacted by humans to better exert control or empowerment in their lives (Buzzanell, 2019). The following section explores implications related to the results of the second research question, further

exploring the dataset's evident CTR processes in the context of existent literature and then considering them as sites for contradictory tensions.

CTR Processes Enacted by Mental Health Professionals

Communication Networks and Person Centeredness. From the beginning of the pandemic and up through the time in which participants were interviewed, mental health professionals maintained and used their networks as a way to enact emotional and technical support. Mental health professionals drew upon their existing bonds with families, friends, coworkers and supervisors to help make sense of the pandemic, assess their situations, and stabilize their strong ties, all of which characterize the CTR process of maintaining and using communication networks. Furthermore, some MHPs went beyond their existing networks and sought new ties through connecting with neighbors, meeting new colleagues, and joining and participating in online communities.

One way in which the perceived support that MHPs received can be understood is by utilizing Burleson's (1985) concept of person centeredness (PC), a theoretical tool that helps to make sense of the kinds of supportive messages that individuals receive within their communication networks. Particularly, Burleson (1985) distinguished highly person-centered (HPC) comforting messages as those that acknowledge and recognize another's feelings, and low person-centered (LPC) comforting messages which deny, ignore, or criticize one's feelings. Later research confirmed that HPC messages are those messages which encourage the elaboration and exploration of one's feelings, leading recipients of HPC messages to feel legitimized; at the same time, LPC messages are most often viewed as unhelpful and can actually exacerbate stress (Bodie, 2012). As several MHPs received validating messages from their communication networks that activated resilience processes, these supportive messages can be

understood within the framework of highly-person centered messages. The results from this study suggest the possibility of a relationship between HPC/LPC messages and Buzzanell's (2010) resilience processes, particularly the messages exchanged as MHPs drew on existing bonds and created new bonds within their communication networks. Future research could expand upon this by framing HPC/LPC messages that MHPs received during the pandemic within the context of the dual-process theory of supportive message outcomes (Burleson, 2010). Dual-process theory helps to explain the variation in effects of HPC and LPC messages as they are perceived to be positive or negative; to test this theory's applicability to this study, questions with MHPs could not only identify the HPC/LPC messages received but also explore the variation in effects as positive or negative, a component that was not explored in this study but could help to illuminate and specify supportive messages and their relationship to resilience cultivation.

Along the lines of maintaining communication networks, most of the participants expressed a desire for, as Laura articulated, "having more opportunities for peer consultation." This could come in the form of allotted organizational time to connect with colleagues virtually or in-person. Alice thought that "a check-in type of thing… not necessarily supervision groups, but… a support group, like, [to see] how's everybody doing… because very often we're asking our clients how they're doing, but we're not always getting someone asking how we're doing." Alexis supported this when she said that support groups with other professionals would have been helpful during the pandemic, and that is something she would like to see implemented within her organization in the future. Peer support could come from the organization clients are a part of or from other organizations in their communities. Mollie expanded upon this idea of having a peer network, sharing that she wished she would have had "some kind of central

thing… like a collective resource for mental health professionals… professionals need help too… there should be a place where people who help people can go to for [their own] mental health." Mental health professionals could benefit from a centralized online hub for mental health professionals to access collective resources and receive their own support, both locally and nationally. Ultimately, having access to peer support could enhance other types of resilience processes by offering diverse perspectives for a repertoire of coping skills, opportunities to reappraise stressful events, and both weak and strong ties to foster environments where they receive high person-centered messages of support.

Foregrounding Productive Action through Goal Attainment. The second most prevalent CTR process that emerged among participant experiences involved foregrounding productive action while legitimizing negative feelings. The negative feelings most expressed by this participant group involved stress, and more specifically involved feeling overwhelmed and out of control due to pandemic-related stressors. Despite these negative feelings, participants expressed recognizing them and then taking positive action to change their circumstances, specifically, they sought out their own therapist and/or quit their job to pursue better working conditions at another organization. Buzzanell (2010) argues that this process involves "emotion work and the reframing of the situation" (p. 9), which participants did through acknowledging and recognizing negative feelings and then taking action in an effort to positively change their circumstances.

As MHPs continued their interactions with clients, supervisors, and other members of their communication networks, they actively practiced emotion work and reframing of their situations in an effort to background negative feelings and foreground positive action. While this study revealed how productive action was taken by MHPs during the pandemic, future research

with this population could explore the dynamic social interaction processes that evolved and led to goal attainment. For example, the ways in which mental health professionals took action to better their circumstances could broadly be understood through the planning theory of communication, which involves "goal attainment through communicative action" (Berger, 2015, p. 89). Planning theory suggests that communication with others is a tool that enables individuals to work towards and achieve their goals by enacting plans (Berger, 2015). According to Berger (2015), plans are "...hierarchical knowledge structures that represent goal-directed action sequences" (p. 91). Under this premise, individuals can create social interaction plans that can be altered as interactions unfold. While this could be done by asking MHPs to reflect on their previous interactions, as this is how planning theory has been previously explored, Berger (2015) argues that, ideally, there would be a way to measure the dynamic planning making process as it unfolds in real time. In the context of this study, one way to do this might be through ethnographic research that observes MHPs interactions as they occur, with an immediate follow up to assess how the discourse might have influenced their planning process.

Crafting Normalcy using Telehealth and Weak Ties through Social Networks.

Finally, the third resilience process most prevalent in this dataset involved crafting normalcy, which is done through talking and performing a system of meanings that allow people to "...maintain the mundane, the regularities in life that previously would have gone unnoticed" (Buzzanell, 2010, p. 3). This process is inherently communicative, where people bring normalcy to life in dialogue with other people. This discursive-material process is characterized by the practice of talk meeting action to create new normals, and in this study, this process was enacted through using telehealth as a new, regular, and day-to-day medium to connect with clients and utilizing computer mediated communication (CMC) as a tool to associate with new and existing

networks. In terms of telehealth, research confirms the jump of telehealth use articulated by participants; according to the U.S. Government Accountability Office (2022), after Medicare temporarily waived telehealth restrictions, the use of telehealth "rose tenfold: 53 million telehealth visits in Apr.-Dec. 2020 vs. 5 million during the same period in 2019". As of June 07, 2023, the U.S. Department of Health and Human Services has made some elements of telehealth adoption permanent via permanent Medicare changes (specific details can be found on their website, cited in the reference section). These changes, combined with the participants' expressed desire to continue using telehealth following the pandemic, indicate that future research could further explore how MHPs have enacted telehealth in their organizations and private practices as a way to establish new normals. Research could also explore the dialogue that occurred between supervisors and colleagues of MHPs as telehealth became a new day-to-day requirement for some and an option for others.

With regards to CMC, the results from this study support findings on the role of social networks in information diffusion (Bakshy et al., 2012), where it is through weak ties (rather than strong ties) on social networks that individuals, as a whole, receive novel information online. Mental health professionals sought various support groups on Facebook to help them navigate the pandemic in their personal (via "Mothers of Preschoolers" [MOPS] group) and professional (via local and national MHP groups) lives. It was through these groups with weak ties that MHPs found advice and insight on new, unprecedented scenarios grounded in the context of the pandemic. Bakshy and colleagues (2012) findings suggest that "...weak ties may play a more dominant role in the dissemination of information online than currently believed" (p. 519); the findings from this study posit the consideration of social media networks as support systems for MHPs and the role of strong and weak ties in providing social support. Additionally,

for the MHPs like Cassie who joined a "Mothers of Preschoolers" (MOPs) Facebook group, these online social networking sites act as a place for social identity construction and reinforcement. Social identity is derived from membership to social categories (Priante et al, 2017), and this was enacted by MHPs via the Facebook groups they joined for support. If identity is a dynamic process rather than a set of individual traits (Melucci, 1995), then social identity is enacted when an individual identifies as a part of a group and engages with that group. For MHPs, their identities as mental health professionals, mothers, or other markers were reinforced via specific Facebook groups through active engagement with weak ties and passive consumption of posts. Further, MHPs used these social networking sites in an effort to craft normalcy by adapting regular media habits and focusing on mundane accomplishments in their social media groups. Both of these have implications for Buzzanell's (2010) resilience processes of crafting normalcy and affirming identity anchors, the latter of which was not fully flushed out in this study but could certainly be explored in future research. This leads to the consideration of the role that online social networks play in the resilience cultivation of individuals, and more specifically, mental health professionals; future studies could explore these elements by investigating the role of social networking sites following a major life adversity or series of adversities.

Resilience Processes as Sites for Contradictory Tensions

While three of Buzzanell's (2010) five resilience processes emerged as salient in this dataset, competing tensions arose within the micro (individual) and meso (organizational) levels of resilience enactment. Resilience processes can be tensional; that is, they can be "facilitating and hindering" (Scharp et al, 2021, p. 4) at the same time. Resilience processes are not "all-or-nothing phenomena", as they are "formed, expressed, and contested differently in people's lives,

with tensions operated as sites of enraged contradictions, ambiguities, and possibilities" (Buzzanell, 2019, p. 79). Thus, the contradictory elements present at these sites function both as triggers and sources of support that exist concurrently. More specifically, in the dataset, tensions were evident in employee-supervisor interactions and in telehealth communications. In the following subsections, the contexts in which these tensions arose are considered alongside existent literature, and their implications for resilience are also explored.

Employee-Supervisor Interactions: Psychological Contracts and Upward Dissent Literature. From organizational and interpersonal perspectives, literature on psychological contracts (PC) and upward dissent (Schalk et al., 2018) could help to illuminate the nuances of how MHPs described their interactions with direct supervisors and those higher up in their organizations. A psychological contract refers to an employee's perception of the conditions implicit within the exchange agreement between themselves and their employers (Rousseau, 1989, 1995). When an organization or supervisor does not uphold their end of the perceived agreement (e.g., working conditions, promised obligations), employees might experience a psychological contract breach (Bordia et al., 2010). A perceived psychological contract breach could leave an employee with feelings of frustration and distress (Bankins, 2015). For some MHPs, the perceived psychological breach likely occurred when pandemic–related organizational changes were made by their supervisors, shifting the normal way that processes were regularly carried out pre-pandemic. It was then through problem-focused coping (Tomprou et al., 2015), which involves actions that strive to eliminate an issue, that MHPs approached their supervisors in conversation to raise organizational concerns. The action of speaking up, voicing concerns or disagreeing about negative workplace situations is known as employee upward dissent (Kassing, 2002). From here, after MHPs voiced their concerns to their supervisors, they

experienced either functional (positive) or dysfunctional (negative) outcomes (Tomprou et al., 2015). Tomprou and colleagues' (2015) four post-violation end states help to illuminate the functional or dysfunctional outcomes, describing: (a) psychological contract thriving (contract conditions are even better post-violation), (b) psychological contract reactivation (outcomes of the post-violation contract return to those of the pre-violation contract), (c) psychological contract impairment (outcomes are less favorable post-violation) and (d) psychological contract dissolution (the most dysfunctional state where employees remain in a continuous state of violation). For these MHPs, their actions of leaving the organization after feeling ignored or downplayed supports literature linking psychological contract breach and dysfunctional outcomes with employee turnover (e.g., Arshad, 2016; Salin & Notelaers, 2017). The act of leaving an organization following a psychological contract violation is labeled as a "deserted psychological contract" (Schalk et al., 2018) in PC literature. The results from this study suggest examples of upward dissent and psychological contract breach outcomes (functional or dysfunctional) among MHPs, which offers a specific context that, to the best of the researcher's knowledge, has not yet been explored. Further, as demonstrated in this study, upward dissent and PC literature could help to inform Buzzanell's (2010) resilience processes in organizational contexts, especially within employee-supervisor interactions following the occurrence of a disruptive adversity or series of adversities that breaches an established psychological contract.

Telehealth as a Contradictory but Material-Discursive Tool. Interestingly, telehealth served as a site for both individual and organizational constraints and freedoms. Some MHPs viewed telehealth as a tool for improving compliance (i.e., clients who attend their scheduled sessions), accessibility to clients, and promoting flexibility and "freedom" as a reprieve from their demanding in-person schedules. At the same time, several MHPs described technological

issues, safety concerns, and the "on" nature of the job where even though they had the flexibility of working from home, their schedules became even more crowded with appointments. Telehealth, then, proved to be a tool that both hindered and facilitated resilience processes; in some cases, telehealth served as the stressor that led to resilience activation, and in others, it helped in resilience cultivating processes and the effort towards establishing a new normal.

Another specific tension with telehealth appeared in its perceived richness and leanness, or the degree to which nonverbal cues clarify a message (Otondo et al., 2008). As a whole, MHPs described that on telehealth, the clinician is only seeing the client's face in an electronic rectangular box, thus they have to work harder to notice overall body language, congruence, and safety cues. In terms of physical cues, telehealth decreased nonverbal richness by eliminating body cues and limiting nonverbal gestures to the face. According to Otondo and colleagues' (2008) research, this would classify telehealth as having a lower level of nonverbal richness, also known as having a higher level of leanness (i.e., on a spectrum, leanness indicates lower nonverbal cues, whereas richness denotes higher levels of nonverbal cues, and thus, information). At the same time, several MHPs described telehealth as having increased nonverbal richness, where, as the clinician and in Cassie's words, "you're seeing an additional level of information that might not have been seen before… here are these situations that are bringing up really clinically relevant information." Using telehealth, some MHPs were able to get a glimpse into their clients' home environments, or in other cases, different environments because clients were unable to have private conversations in their homes. This demonstrates the complexity of media richness, where telehealth was simultaneously a site of nonverbal leanness and richness. It is through this contradiction that telehealth served as a critical material-

discursive tool for all participants in some capacity, acting as a site of stress and resilience enactment.

While most MHPs were aware of telehealth as a tool prior to the pandemic, none of the participants in this study received any kind of formal training in graduate school or through their employers on best practices for client-clinician communication via telehealth. Their first experiences using telehealth were with clients during the pandemic. As such, many had wished for, in Adam's words, "really having some paid training of how to provide clinical care in the virtual space." One of the participants interviewed, Charlie, talked about how his team pivoted during the pandemic to create virtual-based training sessions for clinicians that helped them "move online [and] become skilled with online work." Offering MHPs online tutorials for client-clinician communication could be one way to better prepare them for circumstances they may encounter when providing virtual care.

Limitations

This study provides several theoretical contributions and practical implications; however, it is not without its limitations. The parameters of this study captured mental health professionals who had worked continuously as mental health professionals from February 2020 to the time of the interviews in March of 2023; as such, this sample does not capture MHPs who may have changed professions during the pandemic, and also limited testimonies from any MHPs who had started working after February 2020 (e.g., one individual who expressed interest in participating did not meet the qualifications for the study, as she began her career in May 2020). It is possible that these populations would add varying perspectives on resilience processes based on their unique experiences. Second, this study asked MHPs to retroactively reflect on their experiences over the course of three years, offering a snapshot of participant experiences from a singular

point in time. Levels, degrees, and variations of resilience processes and stressors likely fluctuated over the course of the pandemic, and the interviews from this study occurred in one one-hour sitting where participants recalled all that they could.

Considerations for Future Directions

The Communication Theory of Resilience was used in this study given its ability to be applied using multileveled frames of analysis; while other communication resilience theories focus on dyadic relationships, families, organizations, and communities, this theory is "multilevel and multicontextual", meaning that it can be translated to all of these levels of analysis "as well as network structures of relational ties" (Buzzanell, 2019, p. 76). This study was broadly exploring the challenges and resilience processes of mental health professionals, and CTR was fitting as a theoretical framework because it allowed for analysis at multiple levels. Further, this study used a broad conceptualization of the term "mental health professional", which provided a snapshot of the stressors and resilience processes experienced by those in the profession. Some of the participant experiences, however, varied; for example, whereas private practice MHPs utilized telehealth exclusively for varying time periods throughout the pandemic, some community health MHPs only used telehealth for occasional check-ins while they still had to show up to work in-person, either at psychiatric hospitals or in the individual homes of participants. That being said, a future focus on a subset of professionals (e.g., psychiatric hospital mental health workers, private practice counselors, or on-call mental health crisis responders) could yield more distinct results on the unique adversities faced and resilience processes enacted within these populations.

Another consideration for future research would be to both expand but also refine the geographical reach of participants. This study was designed to broadly focus on practicing

mental health professionals within the United States, with the intention of interviewing professionals operating within the country's healthcare system, structural factors, and cultural conversations about mental health. Nevertheless, efforts should be made to consider the challenges and resilience processes among MHPs in countries beyond the U.S. At the same time, within the United States, each state has its own set of regulations that may have influenced MHP experiences at the structural/organizational level. For example, a couple of this study's participants from Texas shared that their state has very specific rules for their practices, which provided some limitations when serving clients, and undoubtedly, other states have their own sets of specific regulations, too. Future research could explore the resilience processes of MHPs within certain states.

An additional idea for extending this research involves exploring the "unknowns" as a source of stress or trigger event(s) related to the pandemic. The researcher noticed that many MHPs struggled with not definitively knowing how long the pandemic would last, what the next steps were, or how to continue supporting clients through a time period with significant uncertainties. These uncertainties served as trigger events that activated resilience processes, including conversations with communication networks and foregrounding productive action. Labeling a trigger event for MHPs during the pandemic as "the unknown" seemed inherently contradictory in nature to the researcher, but as explored in the discussion, Buzzanell (2019) reiterates tensions as sites of ambiguity and possibility, thus warranting potential future exploration.

An important element revealed in this study included the possibility of a sixth resilience process that Buzzanell (2010) mentioned in her original directions for future research, being "reframing life experiences through evocative, particularly metaphorical, language" (p.9). The

use of metaphors within this study's results was plentiful and utilized by nearly all participants in describing their pandemic-related stressors and employed coping mechanisms. Given the time constraints of completing the dissertation, the researcher focused on the evident existing processes of CTR; however, the data suggests that the employment of metaphors was a powerful tool in their meaning-making experiences. The researcher plans on combing through the dataset once more to focus on metaphorical language and to refine potential findings.

Finally, another potential topic that warrants further exploration involves considering dimensions of temporality and agency in the process of resilience cultivation. This aligns with Buzzanell's (2019) updated reflections on CTR published nearly a decade following her original theory, where she considers communicative resilience not only as a response to adversity, but also in anticipation of adversities that have yet to occur. She labels this concept as anticipatory resilience, which is resilience that "...presumes loss and is fostered prior to human engagement with events that are perceived as disruptive, [and] can be cultivated through stories, phrases, interactions with others during times of hardship, and memories that capture our imaginations and carry momentum" (Buzzanell, 2019, p. 68). While all of the participants in this study articulated the resilience processes they enacted following exposure to pandemic-related stressors, they also expressed anticipatory ideas that could potentially advance the mental health profession. When participants were asked about advice they would share with future mental health professionals to help mitigate potential upcoming stressors they may encounter, nearly all discussed the importance of going to therapy and developing time-related occupational boundaries to help protect their peace. Regarding therapy, Lauren expressed that she recommends, "...that every therapist sees their own therapist just because it's a stressful job, and you're going to experience vicarious trauma no matter what section of the field that you're in."

Lauren shared this advice anchored in her own experiences, and while it speaks to what she has been through, she also anticipates similar experiences to occur to others, though they have yet to happen. Another capacity in which counselors spoke of anticipatory resilience was in advising other mental health professionals to develop and maintain workplace boundaries. For some MHPs, this was in the form of protecting their time when working from home, suggesting having structured work-from-home hours and to turn work notifications off on personal devices. For others, they recommended that MHPs should develop and reinforce boundaries with their supervisors where they only respond to them "on the clock", and not on personal time in the evenings and weekends. This advice, along with the other suggestions, is derived from the personal experience of the MHPs who shared it; to them, the resilience they cultivated from these encounters was reactionary, or occurred after the boundaries had been violated and after they realized they needed therapy. From the perspective of future MHPs receiving this advice, it could be considered anticipatory resilience since these future MHPs have not yet encountered these adversities themselves; since receiving this advice, they may be able to anticipate some adversities, activating resilience processes prior to the adversities occurring. There is still much work conceptually to be explored with this, but the current dataset could be combed through again to explore this potential topic more thoroughly.

Conclusion

This preliminary study offers a more nuanced understanding of resilience processes and the triggers, stressors, challenges, and opportunities faced by mental health professionals during the pandemic. Through the employment of qualitative semi-structured interviews, the researcher examined the specific trigger events and resilience processes enacted by mental health professionals. Results indicated that a lack of support from supervisors, a sense of guilt towards

clients, differing beliefs, increased caseloads and decreased personnel, and telehealth served as sources of stress that led to resilience cultivation. Results also reiterated the prevalence of maintaining and using communication networks, foregrounding productive action while backgrounding negative thoughts, and crafting normalcy as resilience processes employed by mental health professionals. The findings supported a discussion of trigger events as occurring in interpersonal and organizational capacities, identified shared trauma as a type of trigger event specific to this context, highlighted CTR processes in the context of existent literature, and explored tensions evident in resilience processes. This study concurrently extends understanding of CTR and offers practical implications for mental health professionals and the organizations that employ them.

REFERENCES

Aafjes-van Doorn, K., Bekes, V., Prout, T. A. & Hoffman, L. (2020). Psychotherapists' vicarious traumatization during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12(*1), 148– S150. https://doi-org.prox.lib.ncsu.edu/10.1037/tra0000868

Acker, G. M. (2010). The challenges in providing services to clients with mental illness: Managed care, Burnout and somatic symptoms among social workers. *Community Mental Health Journal, 46*(6), 591–600. https://doi.org/10.1007/s10597-009-9269-5

Afifi, T. D., Merrill, A. F., & Davis, S. (2016). The theory of resilience and relational load. Personal Relationships, 23(4), 663-683.

Afifi, T. D. (2018). Individual/relational resilience. *Journal of Applied Communication Research, 46*(1), 5–9. https://doi.org/10.1080/00909882.2018.1426707

Agarwal, V., & Buzzanell, P. M. (2015). Communicative reconstruction of Resilience Labor: Identity/Identification in disaster-relief workers. *Journal of Applied Communication Research*, *43*(4), 408–428. https://doi.org/10.1080/00909882.2015.1083602

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders: Dsm-5-Tr*. American Psychiatric Association Publishing.

American Psychological Association. (2023). *Resilience.* https://www.apa.org/topics/resilience

Amsalem, D., Dixon, L. B., & Neria, Y. (2021). The coronavirus disease 2019 (covid-19) outbreak and Mental Health. *JAMA Psychiatry*, *78*(1), 9. https://doi.org/10.1001/jamapsychiatry.2020.1730

Antaki, C., Billig, M., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Athenea Digital. Revista de Pensamiento e Investigación Social, 1*(3), 14. https://doi.org/10.5565/rev/athenea.64

Armitage, R., & Nellums, L. B. (2020). Covid-19 and the consequences of isolating the elderly. *The Lancet Public Health, 5*(5). https://doi.org/10.1016/s2468-2667(20)30061-x

Arshad, R. (2016). Psychological contract violation and turnover intention: Do cultural values matter? *Journal of Managerial Psychology, 31*(1), 251–264. https://doi.org/10.1108/jmp-10-2013-0337

Ashforth, B. E., & Kreiner, G. E. (1999). "How can you do it?": Dirty work and the challenge of constructing a positive identity. Academy of Management Review, 24(3), 413–434. https://doi.org/10.5465/amr.1999.2202129

Auerbach, J. & Miller, B. F. (2020). COVID-19 exposes the cracks in our already fragile mental health system. *American Journal of Public Health, 110*(7), pp. 969-970.

Bakshy, E., Rosenn, I., Marlow, C., & Adamic, L. (2012). The role of social networks in information diffusion. *Proceedings of the 21st International Conference on World Wide Web*. https://doi.org/10.1145/2187836.2187907

Bankins, S. (2015). A process perspective on psychological contract change: Making sense of, and repairing, psychological contract breach and violation through employee coping actions. *Journal of Organizational Behavior, 36*(8), 1071–1095. https://doi.org/10.1002/job.2007

Baumeister, R. F., & Newman, L. S. (1994). How stories make sense of personal experiences: Motives that shape autobiographical narratives. *Personality and Social Psychology Bulletin, 20*(6), 676–690. https://doi.org/10.1177/0146167294206006

Bean, H. (2018). National Resilience. *Journal of Applied Communication Research. (46)*1. 23-25.

Békés, V., Aafjes-van Doorn, K., Luo, X., Prout, T. A., & Hoffman, L. (2021). Psychotherapists' challenges with online therapy during COVID-19: Concerns about connectedness predict therapists' negative view of online therapy and its perceived efficacy over time. *Frontiers in Psychology, 12*. https://doi.org/10.3389/fpsyg.2021.705699

Berger, C. R. (2015). Planning theory of communication: Goal attainment through communicative action. In L. A. Baxter & D. O. Braithewaite (Eds.), *Engaging theories in interpersonal communication: Multiple perspectives* (pp. 89–102). Sage Publications, Inc.

Betts, T., Hintz, E. A., & Buzzanell, P. M. (2021). Emplotting anticipatory resilience: An antenarrative extension of the Communication Theory of Resilience. *Communication Monographs, 89*(2), 211–234. https://doi.org/10.1080/03637751.2021.1971272

Bienertova-Vasku, J., Lenart, P., & Scheringer, M. (2020). Eustress and distress: Neither good nor bad, but rather the same? *BioEssays*, *42*(7), 1900238. https://doi.org/10.1002/bies.201900238

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research*, *10*(2), 141–163. https://doi.org/10.1177/004912418101000205

Bingham, W. V. D., & Moore, B. V. (1959). *How to interview* (4th ed.). New York: Harper & Row.

Bodie, G. D. (2012). Task stressfulness moderates the effects of verbal person centeredness on cardiovascular reactivity: A dual-process account of the reactivity hypothesis. *Health Communication*, *27*(6), 569–580. https://doi.org/10.1080/10410236.2011.618433

Bolsinger, J., Jaeger, M., Hoff, P., & Theodoridou, A. (2020). Challenges and opportunities in building and maintaining a good therapeutic relationship in acute psychiatric settings: A narrative review. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00965

Bond, L., & Craps, S. (2020). *Trauma*. Routledge.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, *59*(1), 20–28. https://doi.org/10.1037/0003-066x.59.1.20

Bordia, P., Restubog, S. L., Bordia, S., & Tang, R. L. (2010). Breach begets breach: Trickle-down effects of psychological contract breach on Customer Service. *Journal of Management*, *36*(6), 1578–1607. https://doi.org/10.1177/0149206310378366

Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *The American Journal of Emergency Medicine*, *38*(12), 2753–2755. https://doi.org/10.1016/j.ajem.2020.04.077

Brandhorst, J. K. (2017). Collectively cultivating resilience: The role of agency and community at a children's emergency shelter. *Southern Communication Journal*, *83*(2), 89–102. https://doi.org/10.1080/1041794x.2017.1404123

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brenner, M. (1985) Intensive interviewing. In Brenner, M., Brown, J. and Canter, D. (eds.) *The research interview: Uses and approaches.* London: Academic Press.

Briggs, C. L. (1986). *Learning how to ask: A sociolinguistic appraisal of the role of the interview in social science research*. Cambridge, UK: Cambridge University Press.

Burke, R. J. & Richardson, A. M. (1993). Psychological burnout in organizations. In R. T. Golembiewski (Ed.), *Handbook of organizational behavior.* (pp. 327-368). New York: Marcel Dekker.

Burleson, B. R. (1985). The production of comforting messages: Social-cognitive foundations. *Journal of Language and Social Psychology*, *4*(3–4), 253–273. https://doi.org/10.1177/0261927x8543006

Burleson, Brant R. (2010a). The nature of Interpersonal Communication: A message-centered approach. *The Handbook of Communication Science*, 145–164. https://doi.org/10.4135/9781412982818.n9

Burt, C. D. B. (2008). Time, language, and autobiographical memory. *Language Learning, 58,* 123-141.

Buzzanell, P. M. (2010). Resilience: Talking, resisting, and imagining new normalcies into being. *Journal of Communication, 60*(1), 1-14.

Buzzanell, P. M. (2018a). Communication theory of resilience: Enacting adaptive-transformative processes when families experience loss and disruption.In D. O. Braithwaite, E. A. Sutter, and K. Floyd (Eds.), Engaging theories in family communication: Multiple perspectives (2nd ed., pp. 97-109). Routledge.

Buzzanell, P. M. (2018b). Organizing resilience as adaptive-transformational tensions. *Journal of Applied Communication Research, 46*(1), 14–18. https://doi-org.prox.lib.ncsu.edu/10.1080/00909882.2018.1426711

Buzzanell, P. M. (2019). Communication theory of resilience in everyday talk, interactions, and network structures. In S. R. Wilson & S. W. Smith (Eds.), *Reflections on interpersonal communication research* (pp. 65–88). Cognella.

Caruth, C. (Ed.). (1995). *Trauma: Explorations in memory.* Johns Hopkins University Press.

Cherniss, C., & Cherniss, C. (1980). Staff burnout: Job stress in the human services. Sage.

Chmitorz, A., Kunzler, A., Helmreich, I., Tüscher, O., Kalisch, R., Kubiak, T., Wessa, M., & Lieb, K. (2018). Intervention studies to foster resilience – A systematic review and proposal for a resilience framework in future Intervention Studies. *Clinical Psychology Review, 59,* 78–100. https://doi.org/10.1016/j.cpr.2017.11.002

Choi, K. R., Heilemann, M. V., Fauer, A., Mead, M. (2020). A second pandemic: Mental health spillover from the novel coronavirus (COVID-19). *Journal Of The American Psychiatric Nurses Association, 26*(4), p. 340 - 343.

Craig, E. A., Nieforth, L., & Rosenfeld, C. (2020). Communicating resilience among adolescents with adverse childhood experiences (ACES) through Equine Assisted Psychotherapy (EAP). *Western Journal of Communication, 84*(4), 400–418. https://doi.org/10.1080/10570314.2020.1754451

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles: SAGE.

Curtis, W. J., & Cicchetti, D. (2003). Moving research on resilience into the 21st century: Theoretical and methodological considerations in examining the biological contributors to resilience. *Development and Psychopathology, 15,* 773– 810.

Dohrenwend, B. S., Askenasy, A. R., Krasnoff, L., & Dohrenwend, B. P. (1978). Exemplification of a method for scaling life events: The peri life events scale. *Journal of Health and Social Behavior, 19*(2), 205. https://doi.org/10.2307/2136536

Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: Results from the Adverse Childhood Experiences Study. *American Journal of Psychiatry, 160*(8), 1453–1460. https://doi.org/10.1176/appi.ajp.160.8.1453

Eidelson, R. J., D'Alessio, G. R., & Eidelson, J. I. (2003). The impact of September 11 on psychologists. *Professional Psychology: Research and Practice, 34*(2), 144–150. https://doi.org/10.1037/0735-7028.34.2.144

Farber, B. A. (1985). Clinical psychologists' perceptions of psychotherapeutic work. The Clinical Psychologist, 38, 10–13.

Feijt, M., de Kort, Y., Bongers, I., Bierbooms, J., Westerink, J., & IJsselsteijn, W. (2020). Mental health care goes online: Practitioners' experiences of providing mental health care during the COVID-19 pandemic. *Cyberpsychology, Behavior, and Social Networking, 23*(12), 860–864. https://doi.org/10.1089/cyber.2020.0370

Felman, S., & Laub, D. (1992). *Testimony: Crises of witnessing in literature, psychoanalysis, and history.* Taylor & Frances/Routledge.

Figley, C. R. (1983). Catastrophes: An overview of family reactions. In C. R. Figley & H. I. McCubbin (Eds.), Stress and the Family, Vol. II: Coping with catastrophe (pp. 3-20). New York: Brunner/Mazel.

Figley, C. R. (1995a). Compassion fatigue as secondary traumatic stress disorder: 'An overview. In C. R. Figley (Ed.), Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 1-20). New York: Brunnerhlazel.

Figley. C. R., & Kleber. R. J. (1995). Beyond the "victim": Secondary traumatic stress. In R. J. Kleber, C. R. Figley, & B. P. R. Gersons (Eds.), Beyond trauma: Cultural and society (pp. 75-98). New York: Plenum.

Fish, J. & Mittal, M. (2021). Mental health providers during COVID-19: Essential to the US public health workforce and in need of support. *Public Health Reports, 136*(1), 14-17.

Fiorillo, A., & Gorwood, P. (2020). The consequences of the COVID-19 pandemic on Mental Health and implications for clinical practice. *European Psychiatry, 63*(1). https://doi.org/10.1192/j.eurpsy.2020.35

Ford, J. S. (2018). (dis)identification as resilience in dirty volunteer work. *Corporate Communications: An International Journal, 23*(2), 242–256. https://doi.org/10.1108/ccij-04-2017-0035

Freud, S. (1909). Analysis of a phobia in a five-year-old boy. *Standard Edition, (10),* 3–152.

Freud, S. (1916–1917). Introductory lectures on psychoanalysis, Lecture 27. *Standard Edition, (16),* 431–447.

Glaser, B. G., & Strauss, A. L. (1964). Awareness contexts and social interaction. *American Sociological Review, 29*(5), 669-679. https://doi.org/10.2307/2091417

Grover, S., Dua, D., Sahoo, S., Mehra, A., Nehra, R., & Chakrabarti, S. (2020). Why all COVID-19 hospitals should have mental health professionals: The importance of mental health in a worldwide crisis! *Asian Journal of Psychiatry, 51,* 102147. https://doi.org/10.1016/j.ajp.2020.102147

Hammersley, M. & Gomm, R. (2008). Assessing the radical critique of interviews. In Hammersley, M. (Ed.) *Questioning Qualitative Inquiry*, London: Sage.

Hirschberger, G. (2018). Collective trauma and the social construction of meaning. *Frontiers in Psychology*, *9*. https://doi.org/10.3389/fpsyg.2018.01441

Hjemdal, O., Aune, T., Reinfjell, T., Stiles, T. C., & Friborg, O. (2007). Resilience as a predictor of depressive symptoms: A Correlational study with young adolescents. *Clinical Child Psychology and Psychiatry, 12*(1), 91–104. https://doi.org/10.1177/1359104507071062

Hobfoll, S. E., Stevens, N. R., & Zalta, A. K. (2015). Expanding the science of Resilience: Conserving resources in the aid of adaptation. *Psychological Inquiry, 26*(2), 174-180.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, *3*(3), 345–357. https://doi.org/10.1177/1468794103033004

Holman, E. A., & Silver, R. C. (2011). Health status and Health Care Utilization following collective trauma: A 3-year National Study of the 9/11 terrorist attacks in the United States. *Social Science & Medicine*, *73*(4), 483–490. https://doi.org/10.1016/j.socscimed.2011.06.018

Houston, J. B. (2014). Bouncing forward: Assessing advances in community resilience assessment, intervention, and theory to guide future work. *American Behavioral Scientist*, *59*(2), 175–180. https://doi.org/10.1177/0002764214550294

Hu, T., Zhang, D., & Wang, J. (2015). A meta-analysis of the trait resilience and mental health. *Personality and Individual Differences*, *76*, 18–27. https://doi.org/10.1016/j.paid.2014.11.039

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress, 15*(5), 423-432.

Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. *Asian Journal of Psychiatry, 54*, 102300. https://doi.org/10.1016/j.ajp.2020.102300

Jow, S., Doshi, S., Desale, S., & Malmut, L. (2022). Mental health impact of covid-19 pandemic on therapists at an inpatient rehabilitation facility. *PM&R, 15*(2), 168–175. https://doi.org/10.1002/pmrj.12860

Kang, L., Ma, S., Chen, M., Yang, J., Wang, Y., Li, R., Yao, L., Bai, H., Cai, Z., Xiang Yang, B., Hu, S., Zhang, K., Wang, G., Ma, C., & Liu, Z. (2020). Impact on mental health and perceptions of psychological care among medical and nursing staff in Wuhan during the 2019 novel Coronavirus Disease Outbreak: A cross-sectional study. *Brain, Behavior, and Immunity, 87*, 11–17. https://doi.org/10.1016/j.bbi.2020.03.028

Kaplan, R. (2020). Not all is shared trauma – The impact of COVID and anti-Black violence. *Psychoanalysis today*. Retrieved from https://psychoanalysis.today/en-GB/PT-Covid-19/NotAll-is-Shared-Trauma-The-Impact-of-COVID-and-A.asp

Kar, S. K., & Singh, A. (2020). Mental health of mental health professionals during COVID-19 pandemic: Who cares for it? *Asian Journal of Psychiatry, 53*, 102385. https://doi.org/10.1016/j.ajp.2020.102385

Kassing, J. W. (2002). Speaking up: Identifying employees' upward dissent strategies. *Management Communication Quarterly, 16*(2), 187–209. https://doi.org/10.1177/089331802237234

Khan, C.T., Collins, T.C., Weiss, & Roberts, L. (2016). Ethics and the therapeutic relationship in the care of people living with paraphilic disorders. In R. Balon

(Ed.), *Practical Guide to Paraphilia and Paraphilic Disorders*. (pp. 223–242). Springer.

LaCapra, D. (2004). *History in transit: Experience, identity, critical theory*. Cornell University Press.

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., Wu, J., Du, H., Chen, T., Li, R., Tan, H., Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Network Open*, *3*(3). https://doi.org/10.1001/jamanetworkopen.2020.3976

Lawless, B. & Chen, Y. W. (2019). Developing a method of critical thematic analysis for qualitative communication inquiry. *Howard Journal of Communications, 30*(1). 92-106.

Le Fevre, M., Matheny, J., & Kolt, G. S. (2003). Eustress, distress, and interpretation in Occupational stress. *Journal of Managerial Psychology*, *18*(7), 726–744. https://doi.org/10.1108/02683940310502412

Li, C.-T., Cao, J., & Li, T. M. (2016). Eustress or distress. *Proceedings of the 2016 ACM International Joint Conference on Pervasive and Ubiquitous Computing: Adjunct*. https://doi.org/10.1145/2968219.2968309

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (4th ed., pp. 1-19). Thousand Oaks, CA: Sage.

Lindlof, T. R., & Taylor, B. C. (2019). *Qualitative Communication Research Methods*. SAGE Publications, Inc.

Lorentzen, S., Sexton, H. C., & Høglend, P. (2004). Therapeutic alliance, cohesion and outcome in a long-term analytic group. A preliminary study. *Nordic Journal of Psychiatry, 58*(1), 33–40.

Lucas, R. E. (2007). Adaptation and the set-point model of subjective well-being. *Current Directions in Psychological Science*, *16*(2), 75–79. https://doi.org/10.1111/j.1467-8721.2007.00479.x

Lucas, K., & Buzzanell, P. (2012). Memorable messages of hard times: Constructing short- and long-term resiliencies through family communication. *Journal of Family Communication, 12*(3), 189–208. https://doi-org.prox.lib.ncsu.edu/10.1080/15267431.2012.687196

Luthar, S. S., & Zelazo, L. B. (2003). Research on resilience: An integrative review. In S. S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 510– 550). New York: Cambridge University Press.

Markovitz, S. E., Schrooten, W., Arntz, A., & Peters, M. L. (2015). Resilience as a predictor for emotional response to the diagnosis and surgery in breast cancer patients. *Psycho-Oncology*, *24*(12), 1639–1645. https://doi.org/10.1002/pon.3834

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438–450. https://doi.org/10.1037/0022-006x.68.3.438

Masiero, M., Mazzocco, K., Harnois, C., Cropley, M., & Pravettoni, G. (2020). From individual to Social Trauma: Sources of everyday trauma in Italy, the US and UK during the COVID-19 pandemic. *Journal of Trauma & Dissociation*, *21*(5), 513–519. https://doi.org/10.1080/15299732.2020.1787296

Maslach, C. (1982). Burnout: The Cost of Caring. Englewood Cliffs, NJ: Prentice-Hall.

Masten A. S. (2001). Ordinary magic: Resilience processes in development. *Annual Progress in Child Psychiatry and Child Development*, 56, 227-238.

Mazur, L. B., & Vollhardt, J. R. (2015). The prototypicality of genocide: Implications for international intervention. *Analyses of Social Issues and Public Policy*, *16*(1), 290–320. https://doi.org/10.1111/asap.12099

McLellan, E., MacQueen, K. M., & Neidig, J. L. (2003). Beyond the qualitative interview: Data Preparation and transcription. *Field Methods*, *15*(1), 63–84. https://doi.org/10.1177/1525822x02239573

Melucci, A. (1995). Individualization and globalization: New frontiers for collective action and personal identity. *Hitotsubashi Journal of Social Studies, 27,* 129-142.

Merino, M. D., Vallellano, M. D., Oliver, C., & Mateo, I. (2021). What makes one feel Eustress or distress in quarantine? an analysis from conservation of resources (COR) theory. *British Journal of Health Psychology*, *26*(2), 606–623. https://doi.org/10.1111/bjhp.12501

Mishler, E. G. (1996). *Research interviewing: Context and narrative*. Harvard University Press.

Moreno, C., Wykes, T., Galderisi, S., Nordentoft, M., Crossley, N., Jones, N., Cannon, M., Correll, C. U., Byrne, L., Carr, S., Chen, E. Y., Gorwood, P., Johnson, S., Kärkkäinen, H., Krystal, J. H., Lee, J., Lieberman, J., López-Jaramillo, C., Männikkö, M., Arango, C. (2020). How mental health care should change as a consequence of the COVID-19 pandemic. *The Lancet Psychiatry*, *7*(9), 813–824. https://doi.org/10.1016/s2215-0366(20)30307-2

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2011). Burnout in mental health services: A review of the problem and its remediation. Administration and Policy in Mental Health and Mental Health Services Research, 39(5), 341–352. https://doi.org/10.1007/s10488-011-0352-1

National Center for PTSD (U.S.), (2010). *Understanding PTSD*. Retrieved March 28, 2023, from https://permanent.fdlp.gov/gpo33188/booklet.pdf

Natsir, U. D., Dipoatmodjo, T. S., Arjang, A., Hidayat, M., & Mustafa, M. Y. (2021). Eight days a week: Eustress and distress among the athletes. *International Journal of Human Movement and Sports Sciences*, *9*(5), 912–920. https://doi.org/10.13189/saj.2021.090512

Otondo, R. F., Van Scotter, J. R., Allen, D. G., & Palvia, P. (2008). The complexity of richness: Media, message, and communication outcomes. *Information & Management*, *45*(1), 21–30. https://doi.org/10.1016/j.im.2007.09.003

Pearlman. L. A., & Saakvitne. K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W. W. Norton.

Pfefferbaum, B., & North, C. S. (2020). Mental health and the covid-19 pandemic. *The New England Journal of Medicine, 383:* 510-512.

Pietrzak, R. H., & Southwick, S. M. (2011). Psychological Resilience in OEF-OIF Veterans: Application of a novel classification approach and examination of demographic and psychosocial correlates. *Journal of Affect Disorders, 133,* 560-568.

Poole, S. M. (2013). On the study of process in Communication Research. *Annals of the International Communication Association*, *36*(1), 371–409. https://doi.org/10.1080/23808985.2013.11679140

Poulin, M. J., Silver, R. C., Gil-Rivas, V., Holman, E. A., & McIntosh, D. N. (2009). Finding social benefits after a collective trauma: Perceiving societal changes and well-being following 9/11. *Journal of Traumatic Stress*, *22*(2), 81–90. https://doi.org/10.1002/jts.20391

Prasko, J., Ociskova, M., Vanek, J., Burkauskas, J., Slepecky, M., Bite, I., Krone, I., Sollar, T., & Juskiene, A. (2022). Managing transference and countertransference in cognitive behavioral supervision: Theoretical framework and clinical application. *Psychology Research and Behavior Management*, *15*, 2129–2155. https://doi.org/10.2147/prbm.s369294

Priante, A., Ehrenhard, M. L., van den Broek, T., & Need, A. (2017). Identity and collective action via computer-mediated communication: A review and agenda for future research. *New Media & Society*, *20*(7), 2647–2669. https://doi.org/10.1177/1461444817744783

Racker, H. (1982). *Transference and counter-transference*. Maresfield Library.

Rahman, M. A., Yusoff, M. S., Roslan, N. S., Mohammad, J. A.-M., & Ahmad, A. (2021). Development and validation of the Medical Professionals Resilience Scale. *BMC Health Services Research*, *21*. https://doi.org/10.21203/rs.3.rs-154203/v1

Rajkumar, R. P. (2020). Covid-19 and mental health: A review of the existing literature. *Asian Journal of Psychiatry*, *52*. https://doi.org/10.1016/j.ajp.2020.102066

Rhudy, J. L., & Hellman, N. (2022). In R. Rajendram, V. R. Preedy, V. B. Patel, & C. R. Martin (Eds.), *The neurobiology, physiology, and psychology of pain* (pp. 359–373). Essay, Academic Press.

Richardson, G. E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology*, *58*(3), 307–321. https://doi.org/10.1002/jclp.10020

Rivera, K. D. (2014). Emotional taint: Making sense of emotional dirty work at the U.S. Border. *Management Communication Quarterly*, *29*(2), 198–228. https://doi.org/10.1177/0893318914554090

Rohland, B. M. (2000). A survey of burnout among mental health center directors in a rural state. *Administration and Policy in Mental Health and Mental Health Services Research*, *27*(4), 221-237.

Rousseau, D. M. (1989). Psychological and implied contracts in organizations. *Employee Responsibilities and Rights Journal*, *2*(2), 121–139. https://doi.org/10.1007/BF01384942

Rousseau, D. M. (1995). *Psychological contracts in organizations: Understanding written and unwritten agreements.* Sage Publications, Inc.

Rush, K. A., McNamee, L. G., & Garner, J. T. (2022). More than emotional coping: Cultivating resilience in human services volunteering. *Western Journal of Communication*, 1–23. https://doi.org/10.1080/10570314.2022.2139153

Salin, D., & Notelaers, G. (2017). The effect of exposure to bullying on turnover intentions: The role of perceived psychological contract violation and benevolent behaviour. *Work & Stress*, *31*(4), 355–374. https://doi.org/10.1080/02678373.2017.1330780

Sanders, C. R. (2010). Working Out Back: The veterinary technician and "Dirty work." *Journal of Contemporary Ethnography*, *39*(3), 243–272. https://doi.org/10.1177/0891241610366711

Schalk, R., De Ruiter, M., Van Loon, J., Kuijpers, E., & Van Regenmortel, T. (2018). Actively coping with violation: Exploring upward dissent patterns in functional, dysfunctional, and deserted psychological contract end states. *Frontiers in Psychology*, *9*. https://doi.org/10.3389/fpsyg.2018.00054

Scharp, K. M., Wang, T. R., & Wolfe, B. H. (2021). Communicative resilience of first-generation college students during the COVID-19 pandemic. *Human Communication Research*, *48*(1), 1–30. https://doi.org/10.1093/hcr/hqab018

Schick, K. (2011). Acting out and working through: Trauma and (in)security. *Review of International Studies*, *37*(4), 1837–1855. https://doi.org/10.1017/s0260210510001130

Scocco, P., Rapattoni, M., & Fantoni, G. (2006). Nursing home institutionalization: A source of eustress or distress for the elderly? *International Journal of Geriatric Psychiatry*, *21*(3), 281–287. https://doi.org/10.1002/gps.1453

Selye, H. (1956). *The stress of life.* McGraw-Hill.

Selye, H. (1974). *Stress without Distress* (1st edition). Philadelphia: Lippincott Williams & Wilkins.

Selye, H. (1987). Stress without distress. In L. Levi (Ed.), *Society, stress, and disease, Vol. 5. Old age* (257–262). Oxford University Press.

Shaukat, N., Ali, D. M., & Razzak, J. (2020). Physical and mental health impacts of covid-19 on Healthcare Workers: A scoping review. *International Journal of Emergency Medicine*, *13*(1). https://doi.org/10.1186/s12245-020-00299-5

Silver, R. C., Holman, E. A., & Garfin, D. R. (2020). Coping with cascading collective traumas in the United States. *Nature Human Behaviour*, *5*(1), 4–6. https://doi.org/10.1038/s41562-020-00981-x

Scott, M. B., & Lyman, S. M. (1968). Accounts. *American Sociological Review*, *33*(1), 46–62. https://doi.org/10.2307/2092239

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: Interdisciplinary perspectives. *European Journal of Psychotraumatology*, *5*(1). https://doi.org/10.3402/ejpt.v5.25338

Stalker, C., & Harvey, C. (2002). Professional burnout: A review of theory, research, and prevention partnerships for children and families project. *Brantford: Wilfrid Laurier University*.

Stanley, B. L., Zanin, A. C., Avalos, B. L., Tracy, S. J., & Town, S. (2021). Collective emotion during collective trauma: A metaphor analysis of the COVID-19 pandemic. *Qualitative Health Research, 31*(10), 1890–1903. https://doi.org/10.1177/10497323211011589

Stefana, A. (2015). The origins of the notion of countertransference. *The Psychoanalytic Review, 102*(4), 437–460. https://doi.org/10.1521/prev.2015.102.4.437

Strauss, A. L. (1987). Qualitative analysis for social scientists. Cambridge: Cambridge University Press.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273–285). Sage Publications, Inc.

Substance Abuse and Mental Health Services Administration (US). (2014). *Trauma-informed care in behavioral health services. A treatment improvement protocol*.

Suslovic, B., & Lett, E. (2023). Resilience is an adverse event: A critical discussion of resilience theory in Health Services Research and Public Health. *Community Health Equity Research & Policy*. https://doi.org/10.1177/2752535x231159721

The mental health of healthcare workers in COVID-19. Mental Health America. (2020). Retrieved January 4, 2023, from https://mhanational.org/mental-health-healthcare-workers-covid-19

The White House. (2023a, February 10). *Notice on the continuation of the national emergency concerning the Coronavirus Disease 2019 (covid-19) pandemic*. Notice on the

Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.whitehouse.gov/briefing-room/presidential-actions/2023/02/10/notice-on-the-continuation-of-the-national-emergency-concerning-the-coronavirus-disease-2019-covid-19-pandemic-3/

The White House. (2023b, May 10). *Fact sheet: Actions taken by the Biden-Harris Administration to ensure continued COVID-19 protections and surge preparedness after Public Health Emergency Transition*. FACT SHEET: Actions Taken by the Biden-Harris Administration to Ensure Continued COVID-19 Protections and Surge Preparedness After Public Health Emergency Transition. https://www.whitehouse.gov/briefing-room/statements-releases/2023/05/09/fact-sheet-actions-taken-by-the-biden-harris-administration-to-ensure-continued-covid-19-protections-and-surge-preparedness-after-public-health-emergency-transition/#:~:text=As%20the%20COVID%2D19%20Public,of%20COVID%2D19%20going%20forward.

Theiss, J. A. (2018) Family communication and resilience. *Journal of Applied Communication Research, 46*(1), 10-13.

Tomprou, M., Rousseau, D. M., & Hansen, S. D. (2015). The psychological contracts of violation victims: A post-violation model. *Journal of Organizational Behavior*, *36*(4), 561–581. https://doi.org/10.1002/job.1997

Tosone, C., & Figley, C. R. (2021). *Shared trauma, shared resilience during a pandemic: Social Work in the time of covid-19*. Springer Nature.

Tosone, C., Bauwens, J., & Glassman, M. (2016). The shared traumatic and professional posttraumatic growth inventory. *Research on Social Work Practice, 26*(3), 286–294. https://doi.org/10.1177/1049731514549814

Tracy, K., & Robles, J. S. (2010). Challenges of interviewers' institutional positionings: Taking account of interview content and the interaction. *Communication Methods and Measures, 4*(3), 177-200.

Trauma. (2023). American Psychological Association. Retrieved March 23, 2023, from https://www.apa.org/topics/trauma

Trauma and violence. (2022, September 27). SAMHSA. Retrieved March 20, 2023 from https://www.samhsa.gov/trauma-violence

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse*, *19*(1–2), 75–87. https://doi.org/10.5172/conu.19.1-2.75

Types of mental health professionals. Mental Health America. (2023). Retrieved January 4, 2023, from https://mhanational.org/types-mental-health-professionals

Updegraff, J. A., Silver, R. C., & Holman, E. A. (2008). Searching for and finding meaning in collective trauma: Results from a National Longitudinal Study of the 9/11 terrorist attacks. *Journal of Personality and Social Psychology*, *95*(3), 709–722. https://doi.org/10.1037/0022-3514.95.3.709

Watson, M. F., Bacigalupe, G., Daneshpour, M., Han, W., & Parra-Cardona, R. (2020). Covid-19 interconnectedness: Health Inequity, the Climate Crisis, and collective trauma. *Family Process*, *59*(3), 832–846. https://doi.org/10.1111/famp.12572

What psychologists do in Disaster Relief Operations. (2014). American Psychological Association. Retrieved January 4, 2023, from https://www.apa.org/topics/disasters-response/relief

Wilson, S. R., Kuang, K., Hintz, E. A., & Buzzanell, P. M. (2021). Developing and validating the communication resilience processes scale. *Journal of Communication*, *71*(3), 478–513. https://doi.org/10.1093/joc/jqab013

World Health Organization. (2022, March 2). Mental health and covid-19: Early evidence of the pandemic's impact. https://apps.who.int/iris/bitstream/handle/10665/352189/WHO-2019-nCoV-Sci-Brief-Mental-health-2022.1-eng.pdf

Xiong, J., Lipsitz, O., Nasri, F., Lui, L. M. W., Gill, H., Phan, L., Chen-Li, D., Iacobucci, M., Ho, R., Majeed, A., & McIntyre, R. S. (2020). Impact of covid-19 pandemic on Mental Health in the general population: A systematic review. *Journal of Affective Disorders*, *277*, 55–64. https://doi.org/10.1016/j.jad.2020.08.001

Yoder, C. (2005). *The little book of trauma healing when violence strikes and community security is threatened*. Good Books.

APPENDICES

Appendix A

Interview Questions:

1. To begin, what is your job title? From here, could you please describe an average day for you in your work? What are your duties and responsibilities?
2. The COVID-19 pandemic has affected job professions in many ways. How has the COVID-19 pandemic impacted your work and/or ability to serve clients?
    a. What challenges, barriers, or stressors have you encountered?
    b. Which of these had the most impact on your work?
3. How has the stress that you are experiencing in your life, outside of your practice but related to COVID-19, affected your ability to serve clients?
4. How have your experiences as a mental health provider during the COVID-19 pandemic affected your mental health?
    a. How have you coped with or managed the emotional/psychological aspects of COVID-19?
5. As a mental health professional, how would you define resilience?
    a. How would you describe your experience of resilience during the pandemic?
    b. What internal or external factors, mindsets, messages, and/or people helped you to overcome these challenges, barriers, and/or stressors?
6. Resilience has been defined as a phenomenon that occurs following an adverse event (or series of events) known as a "trigger event". In the context of the COVID-19 pandemic and your experience, what adversities would you say were"trigger event(s)" for you?
    a. In other words, what events led you to cultivating resilience?
7. What kind of social support from others did you receive [inside and outside of clinical practice] during the COVID-19 pandemic?
    a. What kind of support do you wish you would have had?
8. What resources or connections did you rely on to continue serving clients during the COVID-19 pandemic?
    a. Did you seek additional resources on your own to promote your own well-being? If so, what were those resources?
    b. What adaptations or changes did you have to make to maintain your own mental health as you continued performing your job?
9. The following is a two part question.
    a. What resources do you need right now for your own mental health to feel supported?
    b. What resources do you need right now to feel supported in your ability to provide therapy?
10. Given your experience, what recommendations would you provide to better prepare future generations of mental health professionals, should they ever have to experience an adversity like the pandemic?
11. Is there anything else you would like to share?