“I Hear You”: Exploring the Lived Experience of Counselors’ Empathic Response to Clients when Conducting Telephonic Counseling during COVID-19

Michael Sickels

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“I HEAR YOU”: EXPLORING THE LIVED EXPERIENCE OF COUNSELORS’ EMPATHIC RESPONSE TO CLIENTS WHEN CONDUCTING TELEPHONIC COUNSELING DURING COVID-19

A Dissertation
Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

By
Michael B. Sickels, LPC, NCC

August 2022
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EMPATHIC RESPONSE TO CLIENTS WHEN CONDUCTING TELEPHONIC
COUNSELING DURING COVID-19

By
Michael Sickels, LPC, NCC

Approved June 29, 2022

Debra Hyatt-Burkhart, Ph.D., LPC, NCC, ACS
Department Chair, Counseling, Psychology, & Special Education
Associate Professor Counselor Education
(Committee Chair)

Yihhsing Liu, Ph.D., NCC
Clinical Assistant Professor of Counselor Education
Director of Program Practices & Clinical Facilitator
Department of Counseling, Psychology, and Special Education
(Committee Member)

Jered B. Kolbert, Ph.D., LPC, NCC
Professor of Counselor Education and Director of Program Practices
Department of Counseling, Psychology, and Special Education School of Education
Duquesne University
(Committee Member)
ABSTRACT

“I HEAR YOU”: EXPLORING THE LIVED EXPERIENCE OF COUNSELORS’ EMPATHIC RESPONSE TO CLIENTS WHEN CONDUCTING TELEPHONIC COUNSELING DURING COVID-19

By
Michael Sickels, LPC, NCC
August 2022

Dissertation supervised by Dr. Debra Hyatt-Burkhart

This study sought to unearth the lived experience of counselors empathically responding to clients via telephonic counseling during COVID-19. The term empathic response refers to as attending to the emotional and mental state of another person in a way that is attuned with the feelings and meanings of the individual’s experience. There are few studies that have assessed the merits of telephonic counseling, and even fewer that have examined counselors’ empathic response to clients through this medium.

To uncover the lived experience of the target population, the participants of the study were purposefully selected to include only those who had actively conducted telephonic counseling with clients in an outpatient setting during the pandemic. This hermeneutic phenomenological study was informed by Clark’s (2010) integral model of empathy and
Peoples’ (2020) general data analysis steps in phenomenological research. The study was conducted with a total of eleven participants who had conducted telephonic counseling during COVID-19. The results of the study identified the master theme of subjective empathy, under which fell the subthemes of identification, imagination, intuition, and felt-level experience. The study also identified the master theme of interpersonal empathy, under which fell the subthemes of understanding barrier to counseling, understanding clients’ SES situations, understanding the clients’ natural environment, environmental barriers to interpersonal empathy, and emotional barriers to interpersonal empathy. Finally, the study identified the master theme of objective empathy, under which fell the subtheme of information from supervision as a source for objective empathy and information from COVID-related media as a source for objective empathy. The limitations, implications of the study, suggestions for future research, and questions for future research were included.
DEDICATION

For Vivian, my best friend and support during the pandemic. Your soft purrs and snores kept me grounded during uncertain times. May you rest in peace, my friend.
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CHAPTER I: INTRODUCTION

This study involved a hermeneutic-phenomenological inquiry into the lived experience of counselors’ empathic response to clients when conducting telephonic counseling during the global outbreak of coronavirus disease 2019 (COVID-19). The term empathic response is defined as attending to the emotional and mental state of another person in a way that is attuned with the feelings and meanings of the individual’s experience (Clark, 2014; Zaki et al., 2009). In addition to the traditional notion of response, empathic response is qualified by the holistic process of the counselor’s empathic engagement with the client. That is, empathic response encapsulates the unobservable, internal processes of the counselor’s empathic experience (e.g., cognitive and affective state), in addition to observable, external processes (e.g., interpersonal transactions). This holistic process is packaged within the term empathic response, which will remain reduced to this term for ease of use. The term telephonic counseling is defined as the delivery of a standard counseling protocol via telephone (Coughtry & Pistrang, 2018). Due to the impetus for ongoing telehealth counseling services during the COVID-19 pandemic posited by the Center for Disease Control and Prevention (CDC, 2021), and the universal need for empathy across all modes of counseling (Feller & Cottone, 2003), developing a deeper understanding of the lived experience of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19 is of immediate importance to the field of clinical mental health counseling. The increased use of telephonic counseling (APA, 2020), which has been heretofore limited in use (Wilson et al., 2017), became ubiquitous during this time in which face-to-face work with clients was unsafe (CDC, 2021). Prior studies on telephonic counseling (Dilley et al., 1971; Reese et al., 2016) were conducted during a time in which the medium was conducted as a niche preference, rather than a widespread necessity. By contrast and following with the
pervasive changes precipitated by COVID-19, this study was conducted during a time in which amassing a greater understanding of telephonic counseling processes was of greater import than any other period to date in history. The aim of this study was to use the lived experience of counselors’ empathic response to clients via telephonic counseling during COVID-19 to inform future research and practice in the areas of empathy, telephonic counseling, and counselor navigation of the COVID-19 crisis.

**Statement of the Problem**

One need not look deeply into any given body of literature to ascertain the impact of the COVID-19 pandemic. According to the World Health Organization (WHO, 2022), the total number of COVID-19 cases stands at 532,887,351 as of June 13, 2022 with the total death count at 2,709,041. Specific to the United States, the CDC (2022) reported the total number of US cases at 85,402,874 and the total number of deaths at 1,006,592 as of June 13, 2022. The continued spread of COVID-19 has resulted in the proliferation of mental health concerns such as persistent fear, isolation, economic stress, and loss of loved ones (Rosen & Glassman, 2020). Similar consequences to mental health were reflected in the results of a survey administered to the Chinese population by Wang et al. (2020), finding that 75% of respondents reported significant levels of posttraumatic stress symptoms. In response to the COVID-19 global crisis, telehealth has become a common modality to encourage the practice of social distancing as a means of reducing potential infectious exposures (CDC, 2021), perpetuating a 4,347% national increase in telehealth claim lines from March 2019 to March 2020 (Gelburd, 2020). The CDC (2021) has cautioned practitioners that limited access to resources, such as computers, smartphones, and Wi-Fi may present a barrier to access for clients. Ninety-six percent of Americans own a cell phone of some kind (Pew Research Center, 2019), compared to only 74%
of US households having Internet access (US Department of Commerce, National Telecommunications and Information Administration, 2020). Moreover, lower income is associated with decreased Internet access, evidenced by 68% of US households having access to Internet with an annual income of $25,000-49,999, and only 57% of households having access to with an income of less than $25,000 (US Department of Commerce, National Telecommunications and Information Administration, 2020). Given this consideration, accessing mental health services via telephone may allow clients to receive such services with greater convenience and fewer financial barriers (Brenes et al., 2011; Reese et al., 2006). It is understandable that individuals residing in a mid- to high-range socio-economic status (SES) might broadly assume that remote counseling is synonymous with videoconferencing counseling. However, lack of internet access and other electronic sources presents a significant barrier to videoconferencing for lower SES clients, thereby precipitating an increase in telephonic counseling services demanded by this demographic. Remaining sensitive to this SES factor and taking into context the current dearth in the literature regarding telephonic counseling in comparison to videoconferencing counseling (Poletti et al., 2020; Rosen, 2020; Varker et al., 2019), I seek to study counseling that is delivered via telephone with no visual element accessed through mediums such as a computer screen.

An obvious discrepancy that arises in a transition from face-to-face to telephonic counseling is a lack of visual contact with the client. An immediate concern that may surface for counselors is how this shift may affect the counselor’s experience of interacting with and understanding the client, as several authors (Aviezer et al., 2012; Harris & Birnbaum, 2015; Russell, 2018) acknowledge, body cues and facial expressions present in face-to-face counseling as important sources of understanding and communicating with the client, and other authors
(Egan, 2014; Ekman, 1982; Hill & Stephany, 1990) regard such physical signals as important sources of information for identifying and understanding emotional presentation. Counselor empathic response may be an especially important factor to consider in this shift, as empathy has been shown to have an impact on treatment progress (Elliott et al., 2011), therapeutic intervention, (Zayas et al., 2002), therapeutic presence (Rogers, 1959), client growth (Schmid, 2001), prosocial behavior (Côté & Miners, 2006; Ickes et al., 1990; Stinson & Ickes, 1992), and ethical counseling (ACA, 2014). Potential shifts to the therapeutic alliance may also be important to consider in a transition from face-to-face to telephonic counseling, as therapeutic alliance has been noted as fostering trust, collaboration, and therapeutic bond between counselor and client (Bordin, 1979; Corso et al., 2012), thereby further enabling the process of empathy (Rogers, 1951). Furthermore, counselors may contend with burnout and compassion fatigue in their empathic response to clients during COVID-19, as counselors may be exposed to chronic emotional and interpersonal stress precipitated by COVID-19, factors that contribute to both burnout and compassion fatigue (Thompson et al., 2014). Due to existing empirical support for empathy in counseling (Côté & Miners, 2006; Elliott et al., 2011; Ickes et al., 1990; Rogers, 1959; Schmid, 2001; Stinson & Ickes, 1992; Zayas et al., 2002;) and the rapid, widespread transition from face-to-face counseling to telephonic counseling during COVID-19, the present researcher seeks to examine the lived experience of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19, an endeavor that could help to illuminate and better understand these lived experiences as they play out in the present day.
Purpose of the Study

The study involves a hermeneutic-phenomenological inquiry into the lived experience of counselors conducting telephonic counseling during COVID-19, and what their experience has been like when empathically responding to clients through this medium. In previous studies, empathic response via telephonic counseling has been quantitatively compared to empathic response through other mediums such as face-to-face and video conferencing counseling (Dilley et al., 1971; Reese et al., 2016), rather than conducting a more in-depth exploration into empathic response via telephonic counseling. The social psychology literature contains several studies that compare empathic response to audio, visual, and audio-visual content (Gesn & Ickes, 1999; Hall & Schmid Mast, 2007; Kraus, 2017; Zaki et al., 2009), but do so outside the context of psychotherapy. Moreover, none of these studies were conducted during COVID-19, a time in which empathic response to audio-only content has been more relevant than it has ever been in the counseling profession given the resultant mass proliferation of telephonic counseling services (Rosen, 2020). COVID-19 also presents a unique bearing on empathic response not observed in prior studies, as disaster events akin to COVID-19 may place counselors at risk of burnout (Maslach, 2003; Maslach et al., 2001), compassion fatigue (Thompson et al., 2014), and vicarious exposure (Collins & Collins, 2005; Hodgkinson & Shepherd, 1994; Wee & Myers, 2002), each of which may contribute to the lived experience of counselors’ empathic response to clients.

Due to the impactful nature of empathy in counseling (Côté & Miners, 2006; Elliott et al., 2011; Ickes et al., 1990; Rogers, 1959; Schmid, 2001; Stinson & Ickes, 1992; Zayas et al., 2002), and the sudden, mass increase in telephonic counseling precipitated by COVID-19, a major goal of this study was to ask counselors about their empathic response to clients via telephonic
counseling to gather a greater understanding of this lived experience. Another goal of this study was to inquire into how counselors’ transition from face-to-face counseling pre-COVID-19 to telephonic counseling post-COVID-19 has affected their empathic response to clients in a comparative manner regarding their lived experience. Given the multiple channels observed in Clark’s (2010) integral model of empathy and the ubiquitous nature of the COVID-19 crisis, a primary goal of this study was to inquire into how the pandemic affected counselor empathic response regarding the channels of subjective, interpersonal, and objective empathy.

**Research Questions**

The central question of this study is: What is the lived experience of counselors conducting telephonic counseling during COVID-19? The following subsidiary questions assisted the researcher in gathering the whole experience:

1. What has it been like for counselors to empathically respond to clients’ reported experiences through the medium of telephonic counseling during COVID-19?
2. What has it been like for counselors to transition from in-person to telephonic counseling regarding empathic response toward clients during COVID-19?
3. Is there a difference in counselors’ empathic response regarding face-to-face and telephonic counseling during COVID-19?
4. How have counselors’ own personal experiences regarding COVID-19 influenced their empathic response to clients in the delivery of telephonic counseling?

**Potential Significance**

Despite the financial barriers mentioned above, most telehealth articles in the literature exclusively concern the videoconferencing medium (Poletti et al., 2020; Rosen, 2020). As Varker et al. (2019) state, “there is generally very little research being conducted on telephone-
delivered interventions” (p. 633). A death in research on the modality of telephonic counseling could precipitate the effective marginalization of lower SES clients, as these clients likely have less access to computers, smartphones, and Wi-Fi (CDC, 2021). The increased attention in the research literature on videoconferencing counseling due to COVID-19 will likely create space in the literature for telephonic counseling that the present study could help to fill. Because several authors (Imel et al., 2017; Mallen & Vogel, 2005; Reese et al., 2016; Smucker Barnwell et al., 2012) in the literature have spoken to the greater financial accessibility of telephonic counseling, the completion of the present study aligns with Reese et al.’s (2016) call for further research regarding an exploration beyond the question of “does” telephonic counseling work, and into “how” telephonic counseling works best to more effectively reach and meet the needs of underserved populations. Furthermore, although many recent telehealth studies have explored the effectiveness of various telehealth treatment modalities (Poletti et al., 2020), few studies exist that explore the specific concern of empathic response in telephonic counseling (Reese et al., 2016).

Speaking further to the research of empathic response in the literature, Kraus (2017) found there to be an imbalance of scholarship focused on facial relative to vocal expressions of emotion, with facial expressions being studied with over twice the frequency of vocal expressions. Because several researchers (Gesn & Ickes, 1999; Hall & Schmid Mast, 2007) found that verbal cues dominated as a source of empathic accuracy, Kraus (2017) posits, “emotion research might benefit from added focus on the channel communication most active, [verbal], in emotion recognition processes” (p. 646). Being that the present study focuses on counselor empathic response to voice-only content via telephonic counseling, the study may help
to contribute to greater balance in the emotion research and help to compensate for the current
dearth in the voice-only emotional response literature.

In a survey administered by the American Psychological Association (APA, 2020) to
APA member clinicians, 76% of respondents reported providing solely telephonic or
videoconferencing services to clients. Due to this high volume of telehealth services precipitated
by COVID-19, this study on exploring the lived experience of counselors’ empathic response to
clients when conducting telephonic counseling during COVID-19 may prove to be timely given
current events, contributing to an expanding wave of research (MacMullin et al., 2020;
Weinberg, 2020) seeking to broaden the clinical and academic understanding of providing
counseling services remotely during COVID-19.

The National Board for Certified Counselors (NBCC, 2021) states on their website,
“…telemental health is a rapidly growing field spanning multiple mental health disciplines”
(para. 1). To facilitate training, knowledge, and credibility for counselors practicing telehealth,
the NBCC created the Board Certified-TeleMental Health Provider (BC-TMH) credential,
requiring counselors to complete a curriculum involving presentation skills, confidentiality, best
practices, crisis protocols, choice of technology, and telehealth care coordination in order to
receive the credential. The increased credentialing (NBCC, 2021) and greater normalization
(APA, 2020) of telehealth services suggests that the results of the present study will not be time-
limited to the context of COVID-19. The study’s implications may have the potential to help
inform telehealth practices in counselor empathic response long after the conclusion of the
pandemic, as empathic response has been reported as a significant predictor of psychotherapy
treatment outcomes (Elliott et al., 2011) and a crucial component in developing a working
alliance in the provision of telephonic counseling (Reese et al., 2016).
The Study

The study aimed to reveal the experiences of clinical mental health counselors in their empathic response to clients when conducting telephonic counseling during COVID-19. To uncover the narrative of the target population, the participants of the study were purposefully selected to include only those who possess a master’s degree or above and have provided telephonic counseling to clients for a cumulative period of at least six months. Participants were limited to individuals who had not been engaged in providing telephonic counseling services prior to COVID-19. Participants were also limited to those who are currently (or recently have been) providing telephonic counseling to at least ten clients per week. The participants were recruited by various mediums from clinical settings in which counselors provide telephonic counseling to clients.

Participant Selection

The study used purposeful and snowball sampling methods to recruit individuals whose experiences are related to the studied phenomenon, a necessary factor for a qualitative study (Creswell & Poth, 2016). Individuals who expressed willingness to participate in the study were first provided with a demographic screening instrument that was designed to assess a participant’s fit for the study (Appendix A). As mentioned above, participant inclusion was limited to individuals with a master’s degree or above who have provided telephonic counseling during COVID-19 for a cumulative period of at least six months to facilitate in-depth exploration of the phenomenon. After the participant’s fit was verified, the researcher contacted them to schedule a Zoom videoconferencing meeting for the interview. Conducting interviews via Zoom allowed the researcher to remain compliant with ACA’s (2014) Code of Ethics on taking precautions to avoid injury when conducting research (G.1.e.), and the Duquesne University...
Institutional Review Board’s (IRB) current policy for interviews to be conducted virtually due to COVID-19 (Delmonico, 2020). The researcher then reviewed informed consent (Appendix B) with participants to ensure that each participant was fully informed of the study’s intent and methods, institutional review board approval, their rights as a participant in the study, and the potential for distress or harm they might experience by participating in the study.

To gain a purposeful sample for the study, the researcher accessed interviewee participants through the Counselor Education and Supervision NETwork Listerv (CESNET-L, 2021), networked with supervisors and directors of various counseling agencies, and contacted counselors at a variety of private practices. In each of these recruitment efforts, the researcher advocated for the dissemination of the recruitment email (Appendix C) and informed prospective interviewees to contact the researcher if they would be interested and able to participate in the study.

To facilitate richness in cross-case comparison, the researcher was intentional about recruiting participants who had a diverse array of lived experience regarding empathic response to clients via telephonic counseling during COVID-19. Factors such as licensure, years of experience, amount of clinical supervision received, comfortability with telephone use, and experience implementing telephonic counseling prior to COVID-19 were assessed for in the demographic screening instrument (Appendix A). Not accounting for differing aspects in lived experience could have resulted in a diminished exploration of the lived experience, which may have limited hypotheses generated from the research.

Data Collection

As this is a qualitative study, the data is the narrative collected through interviews with the participants (Peoples, 2020), capturing the “essence” (Creswell & Poth, 2016, p. 106) of
participants’ lived experience. The researcher conducted interviews with each participant via Zoom videoconferencing to both obtain geographically diverse needs of the sample and remain compliant with current research precautions (ACA, 2014; Delmonico, 2020) stated above due to COVID-19. Participants had to be comfortable being recorded electronically to be deemed eligible for participation, a factor assessed for in the demographic screening instrument (Appendix A). The interviews were semi-structured in format. Participants were asked questions to provide understanding and background regarding their experience empathically responding to clients via telephonic counseling during COVID-19. The interview questions (Appendix D) were grounded in the primary and subsidiary questions of the study and will be discussed at length in Chapter 5. The server used to collect data obtained from Zoom videoconferencing interviews was protected and secure. The goal of these interviews was to gather the “data” of lived experiences regarding counselor empathic response to clients when conducting telephonic counseling during COVID-19.

Theoretical Foundation and Conceptual Frameworks

The researcher found in his review of the literature that there is generally little research being conducted on telephone-delivered interventions (Varker, 2019), and even less on the specific concern of empathic response in telephonic counseling (Reese et al., 2016). This finding was surprising due to the beneficial aspects of empathy stated above. To further the literature’s understanding of counselor empathic response via telephonic counseling, this study sought to unearth the lived experience of counselors during a time in which telephonic counseling has been more widely used than ever before in the history of counseling (Gelburd, 2020). These spoken reiterations of experience served as data to extrapolate larger themes and meanings to inform later work on the topic of counselor empathic response via telephonic counseling. The theoretical
framework of this study was oriented in hermeneutic phenomenology (Heidegger, 1971; Peoples, 2020) and Clark’s (2010) integral model of empathy.

Hermeneutic phenomenology is a research framework that allows the researcher to gather a progressively richer understanding of a given phenomenon by identifying themes across cumulative data that contribute to the overall findings of the study (Peoples, 2020). The researcher used this framework in tandem with People’s (2020) general data analysis steps in phenomenological research for analysis of the spoken reiterations of counselors’ experience empathically responding to clients via telephonic counseling. Although People’s (2020) data analysis steps should not be considered a totally comprehensive means of conducting qualitative research, they are nonetheless suggestions for conducting phenomenological analysis of qualitative research. People’s (2020) data analysis steps allowed the researcher to delineate meanings behind the themes to describe the common experiences and needs of the results.

Clark’s (2010) integral model of empathy is a theoretical model that integrates three channels of empathic response (subjective, interpersonal, and objective empathy) to attune with the feelings and meanings of the client’s experience from an immediate or extended perspective. In Clark’s (2010) words, “subjective empathy enables a counselor to momentarily experience what it is like to be a client, interpersonal empathy relates to understanding a client’s phenomenological experiencing, and objective empathy uses reputable knowledge sources outside of a client’s frame of reference” (p. 348). This model of empathy may be an especially useful framework when exploring counselor empathic response to clients through the medium of telephonic counseling, as counselors may be able to integrate multiple channels of empathy in order to compensate for factors such as not having visual contact with the client during sessions and not being physical present with the client. The fact that both counselor and client are
experiencing the same global pandemic may also have a bearing on these empathic channels, an aspect that further enriched the findings of this study.

**Explication of the Data**

After recording the individual semi-structured interviews in the study, the researcher transcribed the recorded audio and explicated the data using Peoples’ (2020) general data analysis steps in phenomenological research. According to Peoples (2020), “the goal of phenomenological data analysis is to present description from essential themes for an experience in a way that is comprehensible and identifiable to anyone who has had that particular experience” (p. 58). People’s (2020) data analysis steps are briefly described below, and will be described in greater detail in Chapter 3:

1) *Read the entire transcript and take out unnecessary language* is the initial step, in which the researcher reads the transcript in its entirety to discern the participant’s complete story, deleting any information that is irrelevant or unnecessary such as repetitive statements or filler linguistics (Peoples, 2020).

2) *Generate Preliminary Meaning Units* is the second step, in which the researcher creates preliminary meaning units while concentrating on the research topic. According to Peoples (2020), “A meaning unit is the allocation piece of data that reveals a feature or trait of the phenomenon being investigated (p. 60).

3) *Generate Final Meaning Units for each interview/survey question* is the third step, in which the researcher generates themes informed by a deepened understanding of each participant’s description (Peoples, 2020).
4) **Synthesize Final Meaning Units into Situation Narratives** under each interview/survey question is the fourth step, in which the researcher thematically organizes the specifics and experiences of each participant’s story under the specific interview questions. The meanings of each participant’s experience are highlighted thematically through direct quotes from the interviews (Peoples, 2020).

5) **Synthesize Situated Narratives into General Narratives**, integrating all major themes of participants is the fifth step, in which the researcher creates general narratives from the situated narratives, unifying participants’ accounts into a general description of all the participant’s narratives. The goal of this step is to organize the data from the situated narratives while highlighting all of the participants’ meanings of their experience (Peoples, 2020).

6) **Generate General Description** is the sixth and final step, in which the researcher discusses the themes that were implicit in all or most of the participants’ descriptions of their experiences, uniting the major phenomenological themes into a cohesive general description (Peoples, 2020).

**Definition of Key Terms**

**Disaster Event:** An event that involves threat of harm or death to large numbers of people, causing loss of resources and disruption of services and social networks (Rosen, 2020)

**Empathy:** “Attunement with the feelings and meanings of an individual’s experience from an immediate or extended perspective” (Clark, 2014, p. 162).

**Empathic Accuracy:** “The ability to perceive accurately how another person is feeling” (Levenson & Ruef, 1992, p. 234).
Empathic Response: Attending to the emotional and mental state of another person in a way that is attuned with the feelings and meanings of the individual’s experience (Clark, 2014; Zaki, et al., 2009).

Face-to-Face Counseling: Traditional counseling that occurs in an in-person setting (Day & Schneider, 2002).

Telehealth: The use of technology to provide health care when providers are geographically distant from patients (Field, 1996; Schopp et al., 2006).


Therapeutic Alliance: “The collaborative and affective bond between therapist and patient” (Martin et al., 2000, p. 438)

Videoconferencing Counseling: The delivery of counseling via secure video link (Norwood et al., 2017).

Overview of the Dissertation

Chapter 1 reviews the study’s background, statement of the problem, purpose, and significance. Chapter 2 reviews the current literature, organized by the following six categories: historical context of telephonic counseling, contemporary use of telehealth services, comparing telephonic counseling with other mediums of treatment delivery, the importance of empathy, empathic response in telephonic counseling, and theoretical foundations of the study. Chapter 3 describes the design and methodology that shaped the study. Chapter 4 provides the results that the study yielded. Finally, Chapter 5 discusses the data explication and analysis of the study’s data, in addition to implications for the field and potential areas for further research.
CHAPTER II: REVIEW OF THE LITERATURE

When considering an exploration of counselor empathic response to clients in the provision of telephonic counseling during COVID-19, it is important to acknowledge the origins of telephonic counseling, and how the effectiveness of telephonic counseling has historically compared to other delivery systems in counseling such as face-to-face and videoconferencing. This literature review will consider these factors to provide a contextual foundation on which to assess counselor empathic response through the medium of telephonic counseling. Other factors, such as the bearing of COVID-19 on telephonic counseling, the importance of empathy in counseling, prior research on empathic response to voice-only content, and theoretical foundations of the study will also be explored in this review.

Historical Context of Telephonic Counseling

Three years after Alexander Graham Bell’s invention of the telephone in 1876, the first report of telemedicine was published in a major medical journal, exploring the use of the telephone in the diagnosis of a child’s cough (“The Telephone as a Medium of Consultation and Medical Diagnosis,” 1879). Following this publication, the telephone quickly became a widely used tool in the practice of primary care medicine (Mohr et al., 2008). The incorporation of the telephone into psychotherapy was a comparatively slow process, evidenced by the first study on the topic being published in 1949 by Berger and Glueck, 70 years after the initial telemedicine report.

Suicide prevention was the first movement toward telephone use in mental health intervention, initiated by the opening of the first suicide prevention center in Los Angeles in the 1950s (Lester, 1977). This inception was followed by the instantiation of other telephone-delivered services, such as crisis intervention, teen hotlines, drug hotlines, and poison centers
(Lester, 1977). An example of such a service can be observed in the 24-hour telephone counseling and referral service at the University of Texas that began operations in July 1967 and received 62,000 telephone calls by July 1970 (Iscoe, 1971). Based on the nature of these services, one might observe that the use of telephone-administered psychotherapy was largely rooted in the treatment of depressive symptoms, which are commonly occurring and a significant cause of disability (Murray & Lopez, 1997). In 1959, videoconferencing was being practiced in its infancy at the Nebraska Psychiatric Institute to provide group therapy, long-term therapy, consultation-liaison psychiatry, and medical student training (Von Hafften, 2020). Ten years later, in 1969, Massachusetts General Hospital provided psychiatric consultations at a Logan International Airport clinic via videoconferencing, a practice that expanded into most diagnostic and therapeutic interactions in the 1970s and 1980s (Von Hafften, 2020). It was during this period, at the 1972 International Conference on Computers, when Stanford and the University of California, Los Angeles (UCLA) staff used linked computers to provide the first demonstration of text-based therapy (Rauch, 2017). The next development in text-based occurred in 1986, when Cornell University launched Dear Uncle Ezra, a question-and-answer forum in which individuals frequently discussed mental health concerns (Rauch, 2017).

In the 1990s, distance counseling became more commonly incorporated in outpatient psychotherapy with the rise of internet and videophone technology (Mozer et al., 2008). As technology continued to advance, therapists appropriated technological advancements into their offices such as cell phones and computers on an ongoing basis (Vincent et al., 2017). In 1995, telemedicine programs were active in at least 40 states (Perednia & Allen, 1995), and approximately 100 telehealth networks were in operation by 1999 (Winerman, 2006). Perednia and Allen (1995) note that the growth of telemedicine during this time was driven primarily by
the political and economic factors of a managed care approach to health services, in addition to
the national effort to develop the electronic information highway. Telemedicine also afforded
providers a reduction in economic and medical risks regarding caring for patients in rural areas
(Allen et al., 1992; Perednia & Allen, 1995).

Text-based therapy saw a departure from its history of public mental health advice
columns in the 1990s when Dr. David Sommers created the first text-based therapy service that
provided a one-on-one therapeutic relationship that resembled traditional outpatient therapy
(Rauch, 2017). Research on the practice of telehealth intervention also increased in the 1990s,
providing a platform for practice guidelines developed in the 2000s, such as those listed by the
American Telemedicine Association (2020) and the American Counseling Association (ACA;
2014). The 2000s also saw the proliferation of text-based therapy services, which became more
accessible to clients as smartphones became more sophisticated in the 2010s (Rauch, 2017). A
further exploration into more contemporary use of telehealth services will be explored below.

**Contemporary Use of Telehealth Services**

Prior to the widespread necessitation of telehealth services precipitated by COVID-19,
such distance-based services were conducted on a comparatively infrequent basis. The small
percentage of telehealth usage prior to COVID-19 can be observed in Wilson et al.’s (2017)
analysis of the largest private claims database in the United States, the Health Care Cost Institute
database. The authors looked at 3,986,159 claims from the years 2009-2013 and found that
13,480 of these claims were submitted for telehealth, constituting 3% of total claims. Of these
claims, 9,868 were submitted for psychiatry, 1,950 for clinical psychologists, 1,416 by mental
health professionals, and 246 by social workers. This small ratio of telehealth to face-to-face
services can be explained by a variety of barriers observed in the literature. For example,
although leaders of healthcare reform have judged telehealth as a viable option for curtailing the growth of healthcare costs (Simon, 2017; Wicklund, 2017), the economic cost of installing and operating telehealth systems, in addition to training staff on telehealth use, were considered a significant barrier to widespread adoption of telehealth services prior to its necessitation brought about by COVID-19 (Wilson et al., 2017).

In addition to systemic barriers to the incorporation of telehealth services, individual concerns regarding security and professional competence further presented a hindrance to the widespread use of telehealth services prior to COVID-19. A recent study conducted by Glueckauf et al. (2018) on clinicians’ (N = 164) use of telehealth technologies found that respondents reported concerns pertaining to confidentiality guidelines (79%), response to crisis situations (52%), and relevant professional association guidelines (55%). Another study conducted by Antoniotti et al. (2014) found that barriers to submitting telehealth claims such as coding issues, higher rates of denial for service, and lack of reimbursement from payers have been cited as reasons that clinicians have been historically hesitant to adopt telehealth practices. Another barrier that may have deterred the adoption of telehealth may have been hesitation regarding the general applicability of the medium, as 75% of respondents in Glueckauf et al.’s (2018) study were “slightly or not at all confident” they could provide telehealth services without an initial in-person assessment. The study also found that only 3% of respondents reported providing telehealth services to children, and 9% reported providing such services to elderly clients, suggesting that therapists may have historically seen the medium as applicable to only adult clients who were considered neither children nor elderly.

Although an increasing number of states steadily eased restrictions and clarified policies on reimbursements for telehealth services prior to COVID-19, Wilson et al. (2017) found that
telehealth policies nonetheless varied widely between states regarding types of services, types of providers, location of patients, and acceptable technologies. This variance in policy likely resonates with Glueckauf et al.’s (2018) finding that most clinicians in their study reported little or no awareness of laws regulating telehealth services. Wilson et al. (2017) also found that only seven states (Arkansas, Delaware, Hawaii, Minnesota, Mississippi, Tennessee, and Virginia) required telehealth services at the same billable rate as non-telehealth services as of January 2016. Data found by the authors indicate that telehealth-related services were reimbursed at lower rates on average than non-telehealth services for no clear reason, which likely acted as a further deterrent to counselors incorporating telehealth services.

Glueckauf et al. (2018) found that the lack of training and education in telehealth services likely acted as a yet another deterrent to counselors’ use of such services prior to COVID-19. In their study, the authors found that 96% of clinician respondents indicated that “mental health practitioners should undergo training about the clinical, legal, and/or ethical issues related to telehealth” (p. 210), and that 90% of respondents indicated that practitioners should receive training on technical issues surrounding the delivery of telehealth services. This finding aligns with those of other researchers in the literature (Callan et al., 2017; McMinn et al., 2011) who have advocated for telehealth services training in graduate programs and continuing education after completing terminal degrees.

Regarding telehealth services implemented by clinicians prior to COVID-19, Glueckauf et al. (2018) found that 63% of respondents reported using telephone, 26% reported using videoconferencing, and 6% reported using text-based intervention. The more frequent use of telephonic interventions than other methods of implementation may further warrant exploration into telephonic counseling, as most of the recent studies place emphasis on the medium of
videoconferencing (Poletti et al., 2020). Also, Glueckauf et al.’s (2018) findings regarding greater use of telephonic and videoconference than text-based interventions align with prior research (Mora et al., 2008; Perle et al., 2013) reporting that synchronous applications (e.g., telephone, videoconferencing) of telehealth intervention are used substantially more often than asynchronous interventions (e.g., text-based therapy).

**COVID-19**

*From Preference to Necessity*

An obvious discrepancy between the incorporation of telehealth prior to and during COVID-19 is that what was once available as a preference is now presented as a necessity. While having to follow *sheltering in place* (i.e., when large segments of the population are asked to stay at home) protocols precipitated by COVID-19, telehealth allows both counselors and clients to continue treatment despite having to quarantine in their respective homes (Rosen, 2020). This rapid necessitation of remote services brought about a widespread transition to telehealth in the provision of mental health services, effecting a 4,347% national increase in telehealth claim lines from March 2019 to March 2020 (Gelburd, 2020). Clinicians were forced to rapidly adapt despite the seldom prior incorporation of telehealth evidenced above. In a recent survey administered by the American Psychological Association (APA; 2020) to its member clinicians, 76% of respondents reported providing solely remote services to clients. Despite the necessitation of telehealth services by COVID-19, the literature suggests that clinicians should routinely ask their patients about their comfort level with receiving virtual care and address concerns about the modality (Rosen, 2020).
COVID-19 as a Disaster Event

In the words of Rosen (2020), “The COVID-19 pandemic is a modern disaster; it is a global event that involves threat of harm or death to large numbers of people, causing loss of resources and disruption of services and social networks” (p. 175). The disaster outcomes of COVID-19 bear similarity to the six common disaster event outcomes identified in Norris et al.’s (2002) review of 160 samples of disaster victims: (1) specific psychological problems, (2) nonspecific distress, (3) health problems and concerns, (4) chronic problems in living, (5) psychosocial resource loss, and (6) problems specific to youth. The disaster counseling literature finds that many individuals experience mental health symptoms such as anxiety, depression, stress, or insomnia within the first few months after a disaster, which resolve over time (Goldmann & Galea, 2014; Kessler et al., 1995; Norris et al., 2002). An example of this dynamic was observed in the wake of the severe acute respiratory syndrome (SARS) pandemic, as the prevalence of psychiatric disorders was found to be at only 11% four months after the final SARS case was reported (Peng et al., 2010). Regarding more acute reactions to disaster events, other authors (Adams et al., 2006; Kristensen et al., 2010) note that a small subset of the population will likely experience chronic mental health concerns such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, or complicated grief that may persist for years after the disaster event. A unique factor regarding COVID-19 that may further exacerbate acute stress reactions is the general population living with the risk of unknowingly transmitting the disease to their loved ones and having to physically distance from social supports, a coping avenue which has been considered one the most important protective factors against developing PTSD (Sayed et al., 2015). Returning to the SARS example, one hospital found that 48% of the patients who survived a SARS infection met diagnostic criteria for PTSD following the infection,
and that 26% of patients continued to meet criteria 30 months after the outbreak was resolved (Mak et al., 2010).

Factors such as asymptomatic transmission of the virus and the fact that coronaviruses can live on surfaces for up to 9 days (Kamp et al., 2020) may only further exacerbate the mental health symptoms stated above. Rosen (2020) encapsulates the pervasive sense of fear and danger precipitated by COVID-19 in the following quote:

…it is difficult for individuals to adequately determine whether situations or objects (e.g., delivered packages) are safe or dangerous. This leads to a pervasive sense of threat. Everyday events, like getting groceries, may now feel threatening and confusing. Further, in 2020, a significant portion of the population has unlimited access to a 24-hr news media cycle. This unprecedented exposure to real time information and insider access to the “front lines” (e.g., interviews with doctors, bereaved loved ones) may also serve to exacerbate anxiety, depression, and other mental health problems. (p. 176)

In addition to the factors stated above, other risk factors associated with COVID-19 may further exacerbate mental health concerns. For example, individuals who lose family members during the pandemic may experience traumatic grief or PTSD due to their loss (Vetter et al., 2016), especially if the person feels guilty for having unknowingly transmitted the disease to others. The risk of experiencing PTSD symptoms is only further exacerbated by resource loss, cumulative stress, and uncertainty brought about by COVID-19 (Rosen, 2020). Pre-existing risk factors may also impact a client’s symptomatic reaction to a disaster event such as COVID-19. For example, risk factors such as prior psychiatric disorders and lower socioeconomic status may place individuals at a greater risk of developing PTSD (Adams & Bocarino, 2006; Foa et al., 2006). Unique components of the individual’s personality may also affect how they behaviorally...
respond to environmental factors precipitated by a disaster event such as COVID-19 (Lewin, 1935). Following the conclusion of a disaster event, risk factors such as limit social support and concurrent stressors (e.g., financial stress) may further add to an individual’s risk of developing PTSD or other chronic mental health disorders (Goldmann & Galea, 2014; Sayed et al., 2015).

**Telehealth in a Time of Crisis**

In addition to remaining familiar with the resultant symptomology of a major disaster event such as COVID-19, it is likely important for counselors to glean an understanding of counseling strategies to implement in the wake of such a disaster event. The disaster counseling literature holds that there are generally two levels of response for counselors to engage in. Level 1 interventions involve preventative and supportive interventions aimed at reducing acute distress and helping people cope in the aftermath of disaster, whereas level 2 interventions involve formal treatment for individuals who are experiencing acute mental health concerns such as substantial stress disorder symptoms, PTSD, major depressive disorder (MDD), insomnia, or an anxiety disorder (Rosen, 2020). The following is a brief overview regarding these two levels of intervention.

**Level 1 interventions.** Level 1 interventions are strengths-based interventions that can be delivered by clinicians or by trained paraprofessionals. These crisis counseling approaches have been widely used in responding to federally declared disasters in the United States. Although level 1 interventions have traditionally been conducted in person, they can be adapted for delivery via telehealth (Rosen, 2020). A few examples that may approximate telephonic level 1 interventions prior to COVID-19 are crisis hotlines (Lester, 1977) and telephone-based employee assistance programs (Walsh, 1982). Psychological first aid (PFA) is a level 1 intervention that is designed for delivery during the first hours or first week after a disaster (Vernberg et al., 2008),
and includes principles of establishing safety, restoring calm, conveying individual and communal self-efficacy, promoting hope, and increasing connection to other people. Skills for psychological recovery (SPR) is designed to follow PFA to help trauma survivors cope during the weeks and months after a traumatic event (Berkowitz et al., 2010), and focuses on teaching clients to develop specific skills to help them improve functioning in the posttrauma period. Although once widely used after disasters (Rosen, 2020), the literature recommends that psychological debriefing strategies such as critical incident stress debriefing (Mitchell et al., 2003) should not be incorporated as a preventative intervention after trauma, as research has shown that debriefing implemented in this way does not benefit adults and may worsen symptoms in children (International Society for Traumatic Stress Studies, 2019). Furthermore, as a supplement to level 1 treatment interventions, counselors may also recommend online (Ennis et al., 2018; Torous et al., 2020) and app-based (Howells et al., 2016; Huberty et al., 2019; Kuhn et al., 2017; Owen et al., 2018) resources that promote the use of healthy coping skills.

**Level 2 interventions.** Level 2 interventions are implemented by a well-trained mental health care provider and involve evidence-based treatments such as trauma-focused cognitive behavioral therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR) (International Society for Traumatic Stress Studies, 2019). Several studies have reported statistically significant decreases in symptoms of anxiety and depression after the administration of an evidence-based practice via telephone (Coughtrey & Pistrang, 2018), and additional studies have demonstrated that psychotherapy delivered over the phone can be as effective, or more effective, at decreasing symptoms of depression compared with usual care (Castro et al., 2020). Overall, research on patient acceptability, comfort, and preferences regarding telephone-based
therapy is limited, but telephone care appears to be acceptable as other modalities (Cuijpers et al., 2019).

**Long-Term Implication to Telehealth**

Rosen (2020) observes in the literature that the greatest barrier to the adoption of telehealth practices prior to COVID-19 was clinician knowledge and comfort. The author writes, “Now that clinicians have been forced to adapt and change, and the greatest barrier to the expansion of telepsychotherapy has been eliminated, [telehealth] may become a permanent part of the mental health landscape” (p. 183). This claim by Rosen (2020) suggests that clients were comparatively more receptive to telehealth than counselors. This claim has empirical grounding, as many patients were highly receptive to receiving medical and psychiatric services via telehealth prior to COVID-19 (Grubaugh et al., 2008).

In addition to amassing greater acceptance from individual providers and recipients of care, telehealth appears to be gathering greater recognition and acceptance on an organizational level. A recent example can be observed in the creation of the Board Certified-TeleMental Health Provider (BC-TMH) credential by the National Board for Certified Counselors (NBCC; 2020), requiring counselors to complete a curriculum involving presentation skills, confidentiality, best practices, crisis protocols, choice of technology, and telehealth care coordination to receive the credential. The increased credentialing (NBCC, 2020) and greater normalization (APA, 2020) of telehealth services suggests that telephonic counseling may be a growing medium that is likely to remain in practice following the conclusion of the COVID-19 crisis.
Comparing the Effectiveness of Telephonic Counseling with other Mediums of Treatment Delivery: Validations and Cautions

Validations Regarding Effectiveness

When discussing the topic of telephonic counseling, an immediate concern may surface for the practitioner regarding the effectiveness of the telephonic counseling medium in comparison to the mediums of face-to-face and videoconferencing counseling. Several researchers, however, have found the effectiveness of telephonic counseling to be equally effective as its face-to-face and videoconferencing counterparts. Day and Schneider (2002), for example, found that treatment outcomes of face-to-face, video teleconference, and audio conference counseling yielded more similarities than differences, suggesting equal effectiveness across treatment modalities. Similarly, Phillips et al. (2001) found that video-based, telephone-based, and traditional follow-up care for patients receiving mental health treatment at a rehabilitation in Atlanta each correlated with decreased length of hospital stay. Moreover, Lovell et al. (2006) found comparable statistically and clinically significant changes in symptoms when assessing the effectiveness of face-to-face and telephone psychotherapy. Mohr et al. (2011) compared telephone-delivered cognitive-behavioral therapy (CBT) with treatment as usual for veterans diagnosed with depression and found that treatment outcomes did not differ significantly between groups. On a larger scale, Winerman (2006) conducted a 6-month pilot project during which over 9,000 patients received telehealth care in a rehabilitation hospital setting. This larger study revealed no difference in depression scores on the Mental Component Summary Scale across telehealth and face-to-face therapy groups.

Speaking even more broadly to the effectiveness of telephonic counseling, Verker et al. (2018) conducted a rapid evidence assessment of 11 studies on telephonic psychotherapy and
found that all studies except for one (Mohr et al., 2011) reported that telephone-delivered therapy was as effective as standard in-person or was better than treatment as usual on a range of outcomes. The authors rated the generalizability of these studies as moderate to high due to their range of disorders and samples and ranked the use of telephone-delivered therapy as “supported” (p. 632). Several other studies (Jenkins-Guarnieri et al., 2015; Norwood et al., 2018; Rintala & Willems, 1991; Tutty et al., 2005) in the literature also found the effectiveness of telephonic counseling to be comparable to that of video teleconferencing and in-person treatment. Furthermore, MacMullin et al. (2020) found in their study that counselors administering telephonic counseling reported no communication barriers to their work with clients, and several other researchers in the literature (Backhaus et al., 2012; Day & Schneider, 2002; Reese et al., 2016; Stiles-Shields et al., 2014) concluded that the delivery of telehealth services did not negatively impact the therapeutic alliance between counselor and client.

**Unique Benefits of Telephonic Counseling**

In addition to being argued as equally effective, some authors in the literature have posited that various aspects of telephonic counseling may provide advantages not seen in face-to-face and videoconferencing modalities. For example, several authors (Brenes et al., 2011; Day & Schneider, 2002; Mohr et al., 2008; Wierzbicki & Pekarik, 1993) found client participation rates to be higher in telephonic counseling than in traditional face-to-face counseling. Specifically, Mohr et al. (2008) found the mean attrition rate for randomized control trials (RCTs) of telephone-delivered psychotherapy for depression to be 8% lower than the mean attrition rate of an earlier meta-analysis of face-to-face psychotherapy conducted by Wierzbicki and Pekarik (1993). This finding aligns with the stipulation that telephonic counseling allows for easier access to care for clients (Imel et al., 2017; Lester, 1977; Mallen & Vogel, 2005; Perednia and
Allen, 1995; Reese et al., 2016; Smucker Barnwell et al., 2012), and Meadows et al.’s (2015) finding that increased location remoteness was consistently associated with lower service use regarding face-to-face psychotherapy. An example of increased access to care via telehealth can be observed in Morland et al.’s (2010) study on providing remote care to the demographic of veterans living in a rural area, in which the telehealth modality increased service accessibility. In addition to ease of access, Van Manen (2016) posits that people are generally able to be their most authentic selves in the home setting. Put simply, home is “where we can be what we are” (Van Manen, 2016, p. 102). Other authors (Bollnow, 1960; Heidegger, 1971) have described home as the secure inner sanctity in which we can feel protected and by ourselves. Wilson et al. (2017) speak further to this sense of sanctity, positing that receiving services from home may help to reduce the stigma associated with mental health services.

Additional therapeutic benefits to telephonic counseling include alleviation of disruptive transference (Lester, 1977; Robertiello, 1972), helping client to increase effective communication with social supports via telephone by means of parallel process (Beebe, 1968), and the client experiencing a greater sense of control and immediacy in session (Lester, 1977). Moreover, several authors (Lester, 1977; Reese et al., 2002) report that the lack of visual contact unique to telephonic counseling may grant a perceived anonymity to clients that accelerates disclosure in session. An example of this phenomenon was observed in a rap center in which callers statistically preferred telephone contact to face-to-face counseling four-to-one due to the rapid availability and anonymity of the medium (Tucker et al., 1970). Accelerated disclosure could entail higher expressivity from clients, a factor that has been found to positively correlate with higher empathic accuracy on the part of counselors (Zaki et al., 2008).
Regarding client satisfaction in telephonic counseling, Tutty et al. (2005) found in their study that 64% of respondents endorsed being “very satisfied” with telephone therapy at twelve months, compared to 36% endorsing this response in the care-as-usual condition. Speaking further to client satisfaction in the provision of telephonic counseling, Smucker Barnwell et al. (2012) reported in their study on proving telephone-based therapy services to veterans residing in a rural area that over 95% of participants reported satisfaction with service convenience and quality.

**Cautions Regarding Effectiveness**

Despite the above validations regarding the effectiveness of telephonic counseling, cautions regarding the effectiveness of telephonic counseling should also be noted. Although emergencies and dangerous incidents are reported to be rare in the provision of telehealth services (Gros et al., 2011), several authors in the literature (Benes et al., 2011; Gershkovich et al., 2016; Haas et al., 1996; Mozer et al., 2008) have noted that counselors may encounter increased difficulty providing for client safety in telehealth crisis situations. Brenes et al., (2011), Haas et al. (1996), and Mozer et al. (2008) also note an increased risk to privacy and confidentiality in telephonic counseling, in addition to decreased control over the appointment location by the counselor. Further speaking to appointment location in telephonic counseling, MacMullin et al. (2020) note in their writing, “traditional psychotherapy generally takes place in an intentional space” (p. 250). Authors have noted that a shared physical space helps to promote client safety (Pearson & Wilson, 2012), develop trust (Dales et al., 2018), and promote client organization and regulation (Dales & Jerry, 2008). The fact that clients can engage in telephonic counseling from whatever physical space they choose, however, could potentially affect the
therapeutic space observed in telephonic counseling (Russell, 2018; Mozer et al., 2008; Vincent et al., 2017).

Lustgarten and Elhai (2018) argue that technical difficulties experienced in the provision of telehealth services may be damaging to the therapeutic alliance. Bearing this stipulation in mind, other researchers (Cipolletta et al., 2018; Etzelmueller et al., 2018; MacMullin et al., 2020) posit that the most significant barrier to using technology such as telephones in counseling may be the technology itself. Further speaking to this matter, Gershkovich et al. (2016) comment on the potential for a decreased sense of personal connection between counselor and client in telephonic counseling sessions. The risk for technological barriers to negatively impact the therapeutic alliance may be problematic, as several authors in the literature (Horvath, 2001; Martin et al., 2000), find that the therapeutic alliance functions as a significant predictor of therapeutic outcome.

Mozer et al. (2008) consider the possibility of the appointment time being taken less seriously by the telephonic counseling client if the client views the process of telephonic counseling differently than the counselor. This aligns with Lester’s (1997) comment that it may be easy for sessions to slip into conversation, rather than retaining focus on therapeutic tasks. With such barriers in mind, Mozer et al. (2008) argue that counselors should meet with clients to assess whether the given client is an appropriate candidate for telephonic counseling, a step that may not be afforded by counselors during a time of crisis such as COVID-19.

Regarding cautions against the efficaciousness of telephonic counseling, the present author looked to six meta-analyses (Bee et al., 2008; Castro et al., 2020; Coughtrey & Pistrang, 2008; Cuijpers et al., 2019; Mohr et al., 2008; Osenbach et al., 2013) on the topic in order to assess as to whether telephonic counseling might be considered less efficacious than other
treatment mediums (e.g., face-to-face and videoconferencing counseling) or comparable to control conditions (in terms of effect size) in some studies. Across these meta-analyses, only one study (Mohr et al., 2011), an RCT of telephonic CBT for depression in veterans, was identified that reported no significant reduction in symptoms in the telephonic medium. Aside from this finding, all other studies assessed across the meta-analyses reported a significant effect size when comparing telephonic counseling to control conditions (Bee et al., 2008; Castro et al., 2020; Coughtry & Pistrang, 2008; Mohr et al., 2008), and similar effectiveness in comparing telephonic counseling to face-to-face (Cuijpers et al., 2019; Osenbach et al., 2013), and videoconferencing (Osenbach et al., 2013) counseling. However, in the spirit of cautious inquiry, the author observed limitations across these meta-analyses and found that three of the analyses (Bee et al., 2008; Castro et al., 2020; Osenbach et al., 2013) reported the limitation of having a small sample size for analysis. The number of studies observed in these meta-analyses were 13 (Bee et al., 2008), 11 (Castro et al., 2020), and 14 (Osenbach et al., 2013). Two meta-analyses (Castro, 2020; Cuijpers et al., 2019) reported high risk of measurement bias, as it is impossible to blind participants to the fact that they had received telephonic intervention. Four of the analyses (Castro et al., 2020; Coughtrey & Pistrang, 2008; Cuijpers et al., 2019; Mohr et al., 2008) reported heterogeneity of the examined studies in terms of intervention, time received, and client population. Lastly, three of the analyses (Castro et al., 2020; Coughtrey & Pistrang, 2008; Mohr et al., 2008) reported that possible moderators such as depression severity and medication were not accounted for in the analysis. Taken together, it is advisable that the reader observes the results of the above meta-analyses within the context of their limitations.
The Importance of Empathy

Empathy and Treatment Progress

Because this study aims to explore the lived experience of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19, it is important to delineate the importance of empathy in the counseling process. Classically, Rogers (1951) posited accurate empathic understanding as one of the core conditions necessary to achieve successful therapeutic outcomes. Across the literature, empathic response has been reported as a significant predictor of psychotherapy treatment outcomes (Elliott et al., 2011), a crucial component in developing a working alliance in the provision of telephonic counseling (Reese et al., 2016), and universally needed across all modes of counseling (Feller & Cottone, 2003). In a meta-analysis of 47 studies including over 3,000 clients, Greenberg et al. (2001) found that empathy accounted for almost 10% of outcome variance. The researchers identified four ways in which empathy contributes to positive treatment outcomes, stating that empathy (1) improves the therapeutic relationship, (2) contributes to a corrective emotional experience, (3) facilitates client cognitive-affective processing, and (4) promotes client self-healing.

Furthermore, Schmid (2001) describes empathy as “an ongoing joint checking” (p. 3) that fosters the process of client actualization. Other authors, such as Bohart and Greenberg (1997), have considered empathy to be a developmental process throughout the progression of therapy. The authors identify the stages of (1) empathic rapport (acceptance of the client’s feelings and internal frame of reference), (2) experience-near understanding of the client’s world (investigation of the client’s relationships and life history), and (3) communicative attunement (helps the client symbolize, organize, and make sense of life’s experiences).
Empathy as Informative to Therapeutic Intervention

Lewin (1935) classically posited that an individual’s behaviors are influenced by both personality and environment factors. Further adding to this proposition, Zayas et al. (2002) hold that a social encounter is influenced by both the personalities and presenting behaviors of either party. The authors argue that interpersonal encounters are not simply an interaction of two personalities, but the individuals’ perceptions of the other. Based on this information, it could be argued that the counselor must have an empathic understanding of the client’s behavioral presentation to understand how to effectively attend to the therapeutic encounter, and that the counselor cannot automatically become aware of therapeutic interventions that may be helpful for the client without first having had this empathic encounter. Speaking further to the dynamic interaction of disposition and situation, Zayas et al. (2002) state, “Some behaviors [e.g., those of the client] may not be meaningful or even observable without placing individuals within contexts, particularly those that involve interpersonal relations” (p. 852). In other words, empathy is the mode through which counselors may better understand the interpersonal context of the client’s presenting affect and behaviors. Holding with this same logic, empathy may also help to better inform case conceptualization, as intuitive prototypes of others are often characterized by the typical situations associated with them (Cantor et al., 1982).

Empathy and Therapeutic Presence

Several authors in the literature have commented on empathy as a means of attending to and valuing the client. For example, Hartley (1995) defines empathy simply as “being with the client” (p. 19), and Barnett and Mann (2013) define empathy as “an emotional response that is congruent with a view that others are worthy of compassion and respect and have intrinsic worth” (p. 230). Rogers’ (1959) person-centered therapy prioritizes the importance of therapeutic
presence as a means of encouraging the client to embark on a journey of self-discovery, whereas Kohut’s (1984) analytical self-psychology prioritizes behavioral interpretation over the notion of presence despite the theory’s emphasis on empathic response. A similar juxtaposition can be observed regarding the differing concepts of empathy and cognitive social perspective taking, as “empathy aims at contact, connection, and closeness”, and “cognitive social perspective taking aims at objective classification and evaluation” (Schmid, 2001, p. 4). A potential risk to cognitive social perspective taking can be observed in Stillars’ (1997) comment regarding closing oneself to new possibilities in developing the illusion of understanding another person: “Over time, frequently activated inferences may become increasingly entrenched and monitoring of the relationship for new information might decline as people listen more selectively and assume they ‘have heard it all before’ (p. 80). Maintaining a present, unassuming attitude allows the counselor to limit assumptions based on pre-existing relationship theories (Thomas & Fletcher, 1997), and to empathize with the client without new information being restricted by schematic presuppositions of the client (Gesn & Ickes, 1999).

Empathic, therapeutic presence may help to foster client growth. Horney’s (1950) classic acorn analogy can be used to illustrate this process:

You need not, and in fact cannot, teach an acorn to grow into an oak tree, but when given a chance, its intrinsic potentialities will develop. Similarly, the human individual, given a chance, tends to develop his particular human potentialities. He will develop then the unique alive forces of his real self: the clarity and depth of his feeling, thoughts, wishes, interests; the ability to tap his own resources, the strength of his will power; the special capacities or gifts he may have; the faculty to express himself, and to relate himself to others with his spontaneous feelings. All this in time enables him to find his set of values
and his aims in life. In short, he will grow, substantially undiverted toward self-realization. (p. 17)

**Empathy and Client Growth**

Beyond treatment progress, Schmid (2001) argues that empathy “facilitates growth and nourishes the development of the person” (p. 7) and encourages the client to become better acquainted with themselves. These observations align with Buber’s (1984) commentary that personality development in contingent upon relationships in which other people become aware of and confirm the essence of the given individual. Furthermore, research on infants (Dornes, 1993) and binding theory (Spangler & Zimmermann, 1997) suggest that individuals engage in an ongoing dialectical process striving to both understand and be understood, which likely benefits from empathic understanding. Speaking further to this process, Schmid (2001) states, “experiencing which is not empathically understood cannot be integrated into the self and remains alien” (p. 11), suggesting that empathy is required for the successful integration of life experiences. Furthermore, the understanding of emotional experience of oneself has been observed as an important factor in the cognitive and linguistic development, physical wellbeing, and educational readiness of children (Widen & Russel, 2010). Taken together, empathy is a condition that may help to facilitate client growth and understanding of self.

**Empathy as Modeling Prosocial Behavior**

Perhaps in its most fundamental sense, empathy can be seen as a survival-related social response that allows individuals to engage in basic connectivity with others and assess for survival threats (Bowlby, 1988). Such social sensitivity allows individuals to maintain an awareness of the emotions, thoughts, and feelings of others (Côté & Miners, 2006; Ickes, Stinson et al., 1990; Stinson & Ickes, 1992) and is a critical component to prosocial behavior (Eisenberg
& Miller, 1987). From a pragmatic perspective, empathy allows individuals to respond with greater appropriateness in conflict situations (Côté & Miners, 2006) and to maintain a well-functioning social life (Kraus, 2017). Moreover, Gesn and Ickes (1999) observe that ongoing contextualization of an individual’s emotional responses allows for greater empathic accuracy when interacting with the individual, suggesting that ongoing human connection (e.g., the therapeutic alliance) helps to build a greater basin for empathic understanding. Similarly, Newston et al. (1977) posit that framing ongoing interpretation of another person’s emotional experience via process of apperception helps to increase emotional accuracy. If counselors can model prosocial behavior via process of empathy, their clients may be encouraged to foster prosocial connections with others in their daily lives.

Empathy as an Ethical Calling

In its preamble, the ACA Code of Ethics (2014) defines autonomy as “fostering the right to control the direction in one’s life” (p. 3). This definition connects with Roger’s (1942) statement that what is non-directive for the counselor is self-directed by the client and can therefore be seen as promoting the autonomy of the client. Further speaking to the ethics of empathic response, Levinas (1959) classically considered the action of radically taking another person’s point of view to be the ‘ethical challenge’ and considers the phenomenological foundations of ethics to be rooted in the experience of relationships.

Empathic Response in Telephonic Counseling

Prior Studies

As the present study aims to explore counselor empathic response through the medium of telephonic counseling, it is important to observe prior studies that have assessed for empathic response to voice-only content. An early study on the topic of empathic response in telephonic
counseling was conducted by Dilley et al. in 1971 and was aptly titled, “Is Empathy Ear-to-Ear or Face-to-Face?”. The study involved 15 counselors who provided counseling sessions to 3 clients under the differing conditions of face-to-face, a confessional-style arrangement (separated by an eight-foot-high screen), and telephone. The researchers state, “after three sessions in the same type of counseling condition, the three counselees rotated to another type so that they spent an equal amount of time in each of the three situations. Each counselee saw each counselor once.” (p. 189). Upon the completion of counseling sessions, several teams of three raters assessed three-minute segment of tapes using a 3-point empathic understanding scale, and the average of the three ratings was used as the empathy score. The results of Dilley et al.’s (1971) study indicate no statistically significant difference between the three counseling conditions, suggesting that empathic understanding in the telephone condition was roughly equal to the other two conditions. The authors suggest that counselors in the study may have compensated for the lack of visual contact with clients by emphasizing verbal empathy, and that the training that counselors receive (e.g., tape review, etc.) may have facilitated greater exercise of voice communication than visual communication.

Another major study assessing empathic response to verbal content was conducted by Gesn and Ickes (1999), who researched the effects of information channels (video and audio, video and filtered audio, and audio only) and sequence (cumulative contextual cues) on participants’ empathic accuracy. After randomly assigning the 72 participants in the study to six experimental conditions involving pre-recorded tapes (video only, video and filtered audio, and audio only, each with and without original sequence), the researchers noted, “the perceivers' empathic accuracy depended more on the targets' verbal behavior than on their nonverbal behavior” (p. 757), suggesting verbal content to evoke greater emotional accuracy that nonverbal
content. The researchers also found that participants who displayed high empathic accuracy on one tape displayed similarly high empathic accuracy on the other two tapes, and that participants who displayed low empathic accuracy on one tape displayed comparably low empathic accuracy on the other two. In light of this finding, Gesn and Ickes (1999) state, “the empathic accuracy measure reflects a stable and reliably measured social skill” (p. 757), suggesting that counselors who accurately empathize with visual content are likely to do so with verbal and paraverbal content.

Hall and Schmid Mast (2007) conducted another major study regarding differing sources of empathic accuracy. In their study, 24 expressors (i.e., the person speaking) were videotaped in a competitive interaction with 24 peers. After engaging in the interaction, dyad members viewed their videotape individually and made two sets of judgements: (1) the thoughts and feelings they were experiencing during the interactions, and (2) the thoughts and feelings of their partner. The accuracy of this judgement was calculated by comparing each person’s inferences about what the partner was thinking and feeling to what the partner reported thinking and feeling. Perceivers (N = 197) of these videotaped interactions were then assigned to small groups, with each group being assigned to the presentation modality of full video, audio, silent video, or transcript. Upon examining the results of the study, the researchers found empathic understanding to be poor in the conditions of silent video and transcript, suggesting that visual-only and text-only conditions were not sufficient for accurate empathic understanding. Conversely, both the audio and full video conditions evoked high, statistically similar empathic understanding, suggesting the audio condition to be both sufficient for accurate empathic understanding, and comparable to full video in terms of accuracy. The researchers also noted that their results were consistent with those of Gesne and Ickes (1999), as verbal cues dominated as a source of accuracy.
In 2009, Zaki et al. conducted a similar study to those mentioned above. Their study was comprised of two phases. In the first phase, 14 participants (targets) completed the 16-item Berkley Expressivity Questionnaire and were then videotaped while discussing four negative emotional events in their lives. Targets then made summary judgements on a 9-point scale on how positive or negative and how aroused they felt while speaking. In the second phase, 95 participants (perceivers) completed the Balanced Emotional Empathy Scale and were randomized into one of three conditions (sound only and visual only, and both sound and visual), each of which involved watching a series of 20 target videos. According to the researchers, “perceivers used the same sliding Likert scale that targets had used to continuously rate how positive or negative they thought targets felt at each moment” (p. 480). Regarding the results of the study, Zaki et al. (2009) reported verbal information alone produced higher empathic accuracy than visual information alone. However, the researchers found that communication across all senses elicited higher accuracy than voice-only communication. This finding contrasted with prior observations (Gesn & Ickes, 1999; Hall & Schmid Mast, 2007) that no significant differences occurred between voice-only and combined communication modalities.

Reese et al. conducted a study in 2016 that measured the effects of telepsychology format on empathic accuracy and therapeutic alliance. In the study, 58 volunteer clients were randomly assigned to three conditions (videoconferencing, telephone, and in person) and were involved in a 30-minute simulated therapy session in the given format by one of six therapists participating in the study. Following the conclusion of the session, the clients completed the Empathic Accuracy Form while listening to the recorded session and were instructed to stop the recording a minimum of six times, noting the timestamp and thoughts/emotions they were experiencing at the time. The corresponding therapist then observed the recording at the given timestamps
indicated by the client and reported the perceived thoughts/emotions of the client. The researchers discovered four main findings when analyzing the results of the study: (1) therapists displayed similar levels of empathic accuracy regardless of service delivery format, (2) clients rated the therapeutic alliance similarly across all three formats, (3) client attitudes toward telepsychology predicted the therapeutic alliance, and (4) empathic accuracy predicted the therapeutic alliance in the phone and videoconferencing formats but no for participants seen in-person.

In 2017, Kraus conducted a study on the relationship between voice-only communication and empathic accuracy. The study consisted of 5 experiments (\(N = 1,227\)) that tested the hypothesis, “people often intentionally communicate their feelings and internal states through the voice, and as such, voice-only communication allows perceivers to focus their attention on the channel of communication most active and accurate in conveying emotions to others” (p. 644). Across the experiments, the authors found that voice-only communication elicited higher rates of empathic accuracy in comparison to vision-only and multi-sense communication among participants. Specific to the results of experiments 4 and 5, the researchers noted, “voice-only communication is particularly likely to enhance empathic accuracy through increasing focused attention on the linguistic and paralinguistic vocal cues that accompany speech” (p. 644).

Taken together, the above studies have yielded generally favorable results regarding empathic response to voice-only content. Several studies (Dilley et al., 1971; Hall & Schmid Mast, 2007; Reese et al., 2016) showed no significant difference in voice-only content other modalities, and two studies (Gesn & Ickes, 1999; Kraus, 2017) showed greater empathic response to voice-only content than other modalities. Two of the studies (Gesn & Ickes, 1999; Hall & Schmid Mast, 2007) found that verbal cues dominated as a source of empathic accuracy.
However, one study (Zaki et al., 2009) found that communication across all sense elicited higher empathic response from participants than voice-only content.

**Paralinguistics**

Because empathizing with clients via telephonic counseling solely entails auditory content, it is important to consider the depth that such content can offer. Ickes (1990), for example, delineated between content and valence regarding the accuracy one’s empathic response to verbal communication. The author describes content as the specific matching of reported thoughts and feelings from one person to another, and valence as inferences pertaining to the emotional tone of another person. The concept of valence lends itself to the idea of paralinguistics, another term referring to the general tone of a person’s speech. Paralinguistic vocal cues include factors such as pitch, cadence, speed, and volume, and provide a powerful channel for perceiving the emotions of others (Kraus, 2017). Paralinguistics also play a prominent role in accurate judgements (Hall et al., 2005). The informational presence of paralinguistics is strong enough that, even when content is reduced to vocal outbursts, the paralinguistic information contained in the outburst is sufficient to accurately communicate emotions (Simon-Thomas et al., 2009). Several authors (Ambady & Rosenthal, 1992; De-Paulo & Rosenthal, 1979) found that vocal cues are significantly more difficult to mask than vocal content, making leakage of internal states more likely. Paralinguistics also function as the differentiating variable between text-only content and vocal content, the latter of which has empirically been proven to warrant higher empathic accuracy (Archer & Akert, 1977; Hall & Schmid Mast, 2007). Taken together, it is reasonable to conclude that counselors have access to the layers of both content and valence when empathically responding to verbal content reported by clients. Gesne and Ickes (1999) suggest that interacting with the verbal content and valence of
the client is sufficient for empathically understanding the client, stating, “…the verbal content of the client-therapist discussion (the primary cue), along with the paralinguistic information contained therein (the secondary cue), may be the significant and sufficient clues for making relatively accurate thought-feeling inferences” (p. 757).

**Burnout and Compassion Fatigue**

Another important consideration regarding empathic response in telephonic counseling is that overuse of empathy may lead to chronic emotional and interpersonal stress, resulting in burnout (Maslach, 2003; Maslach et al., 2001). First recognized by social service professionals in the 1970s (Pines & Maslach, 1978), burnout is characterized by emotional exhaustion, depersonalization (a defense mechanism for caregivers and service providers to gain emotional distance from clients), and feelings of ineffectiveness or lack of personal accomplishment (Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001). Compassion fatigue is another term used to conceptualize a response to the stress of interpersonal reactions (Thompson et al., 2014), emerging from observations of psychological problems among caregivers in the human service sector (Figley, 1995, 2002). Unlike burnout, however, compassion fatigue is viewed as a response to working with traumatized clients (Thompson et al., 2014), often being used to describe post-traumatic stress (Bride et al., 2007). The core symptoms of compassion fatigue and secondary traumatic stress are similar and consist of flashbacks, nightmares, and intrusive thoughts (Galek et al., 2011). In the age of COVID-19, it may be possible that telephonic counselors must contend with their own distress regarding the pandemic, in addition to the distress of clients, potentially exacerbating this secondary traumatic stress. Moreover, although compassion fatigue has been historically considered a unique occupational hazard in counseling trauma victims (Devilly et al., 2009), the ubiquitous nature of COVID-19 may render trauma
work a more inevitable experience for counselors due to the potential trauma caused by disaster events (Goldmann & Galea, 2014; Sayed et al., 2015). Baron and Cohen (1982) also observe that burnout may be exacerbated when counselors are confined to telephone contact with clients, an experience that is highly applicable to counselors predominantly delivering the modality of telephonic counseling.

From a systemic perspective, the transactional model of stress posits a dynamic relationship between individuals and their work environment (Lazarus & Folkman, 1984). According to this model, “work stress and its potential results of compassion fatigue and burnout occur when individuals see the environment as taxing or exceeding their personal coping resources” (Thompson et al., 2014, p. 62). Individuals may appraise work demands as exceeding or not exceeding their own coping resources, this appraisal depending not only on the strength of the demands but also on the individual’s cognitive appraisal of the situation and of the coping resources available (Thompson et al., 2014). As compassion fatigue is associated with working with traumatized clients (Figley, 1995) and burnout with work environment (Lent & Schwartz, 2012), it is possible that trauma and work setting changes precipitated by COVID-19 may affect the wellness of telephonic counselors at a transactional, systemic level.

**Vicarious Exposure**

In addition to burnout and compassion fatigue, vicarious exposure is a concept that addresses the potentiality for counselors to become emotionally or cognitively disturbed when working with clients who have experienced traumatic events (Sommer, 2008). Pearlman (1999, p. 52) views vicarious exposure as a sort of “occupational hazard”, rather than attributing it to counselor inadequacy or client toxicity. Vicarious exposure may be especially applicable in the time of COVID-19, as disaster events have historically precipitated this phenomenon. For
example, Hodgkinson and Shepherd (1994) discovered that social workers responding to large-scale catastrophes experienced statistically significant levels of cognitive disturbance evidenced by intrusive, unpleasant thoughts and depressive symptoms. Moreover, Chrestman (1999) found that counselors involved with clients who are traumatized demonstrated increased levels of trauma symptomatology. Wee and Myers (2002) investigated the reactions of mental health workers who provided counseling to survivors of the 1995 Oklahoma City bombing and noted that most participants exhibited symptoms that fell in the midrange of PTSD diagnosis. It is possible that the COVID-19 pandemic has brought about an increased caseload demand for counselors due to the widespread trauma incurred by the event. Bearing this stipulation in mind, greater involvement with direct counseling services and higher numbers of clients with trauma-related difficulties has been shown to increase reports of trauma symptoms in counselors (Chrestman, 1999).

**Protective Factors to Burnout, Compassion Fatigue, and Vicarious Exposure**

Although burnout, compassion fatigue, and vicarious exposure pose an ongoing risk for counselors, protective factors may help counselors to mitigate this risk. For example, Thompson et al. (2014) posit that understanding how contextual factors may contribute to compassion fatigue and burnout, which may help counselors to take preventative measures to the accumulation of these effects. Moreover, Collins and Long (2003) note compassion satisfaction, workplace camaraderie, seeing clients recover, and receiving supervisor and staff support as protective factors. Counselors who work from home during COVID-19 may experience less staff support and workplace comradery, which may pose a hindrance to these protective factors. Stamm (2002) notes that sustaining relationships, practicing self-care, and using humor function as protective factors. Furthermore, Wallace et al. (2010) note that physical health activities such
as exercising and eating healthy foods, spiritually oriented activities such as meditation or being in nature, and leisure activities such as reading, gardening, and listening to music may all serve as protective factors to the experience of burnout, compassion fatigue, and vicarious exposure. Lastly, Sommer and Cox (2005) noted that collaborative supervision and a supportive work environment may help to improve counselors’ ability to cope with their work.

**The Telephonic Therapeutic Alliance and Empathy**

*Similarities to Empathy in the Face-to-Face Therapeutic Alliance*

In their systemic review of studies concerning the interactional differences between telephone and face-to-face psychological therapy, Irvine et al. (2020) found no evidence of mode-related difference in “a range of interactional features including therapeutic alliance, disclosure, empathy, attentiveness, or participation” (p. 127). Similarly, Stiles-Shields et al. (2014) found no significant differences in therapeutic alliance between the delivery of telephone and face-to-face CBT. The authors found that, in the absence of visual cues, participants looked to nonverbal cues such as prosody to inform conversation. However, Webb (2014) found that therapists in their study perceived both they and their patients as more treatment focused rather than relationship focused over the phone, focusing more narrowly on CBT tasks at hand. The above information suggests that empathy in the telephonic therapeutic alliance has the potential to bear similarity to the face-to-face modality but may also lend itself to a more task-oriented counselor-client paradigm in session.

*Empathy as Predictive to the Therapeutic Alliance*

Reese et al. (2016) found that empathic accuracy was an important variable for developing a therapeutic alliance in telepsychology formats, but not in the face-to-face format. A possible explanation for this occurrence is that empathic presence from the therapist was more
imperative in the telepsychology formats due to the lack of factors such as physical presence and body language. In spite of the absence of these factors, clients in the study rated the therapeutic alliance similarly regardless of the delivery format, suggesting that the therapists in the study demonstrated comparable empathic response across the three formats. The researchers also found that positive attitudes were an additional predictor to better therapeutic alliances, a finding that may be important to consider regarding the client’s attitude toward the telephonic counseling medium and their attitudinal navigation of the COVID-19 crisis.

**Interpersonal Engagement and Empathy**

Another factor to consider regarding the joining of counselor and client via telephonic counseling is the level of engagement they may have with each other. This is a factor worth considering, as the literature holds that empathic accuracy is significantly influenced by interaction processes occurring at the dyad level of analysis (Ickes, 1990; Stinson & Ickes, 1992). For example, Ickes (1990) found in his study on empathic accuracy in mixed-sex dyads that dyad member’s interest level positively correlated with content accuracy. In addition to interest, the level of familiarity a counselor has with the client likely improves empathic accuracy. Stinson and Ickes (1992) demonstrated this phenomenon in their study on the empathic accuracy in the interactions of male friends versus male strangers. Specifically, the researchers found that male friends demonstrated content accuracy scores that were about 50% higher than those of male strangers, and that friends shared a mutual understanding of one another, whereas strangers did not. Overall, the researchers found that empathy among friends depended upon (1) the quality of information received and (2) a cross-temporal understanding of the friend. The above information suggests that the empathic response of a therapist in the provision of telephonic counseling may be considerably influenced by the length and quality of the given
therapeutic alliance, and whether the counselor is personally interested in delivering counseling via telephone.

**Aligning with the Voice-Only Client**

A unique factor to consider regarding the telephonic therapeutic alliance during COVID-19 is whether the alliance was formed prior to the crisis in a face-to-face setting. If the alliance precedes COVID-19, the therapist may have physical factors to consider such as the client’s face and physical mannerisms when disposed to therapeutic engagement. However, if the therapist joined with the client following the inception of COVID-19, the therapist may have only the content and valence (as mentioned above) of verbal content to piece together a holistic conceptualization of the client. The stylistic use of language, however, is an identifying factor in its own sense. Looking to another person’s use of language as a means of deciphering the identity of the individual is a term that Pennebaker and King (1999) refer to as linguistic fingerprinting. Further speaking to this term, the authors posit, “the ways people talk and write have been recognized as stamps of individual identity” (p. 1296). This statement aligns with Allport’s (1961) classic delineation between adaptive behavior (what one is doing) and stylistic behavior (how one is doing it), and how each act has some degree of stylistic expression. One of the founding figures of personality psychology, Allport (1961) found that stylistic expressions such as speech are an important aspect to consider when assessing one’s personal identify. Thus, it is reasonable to state that, even when engaging with a voice-only client via telephonic counseling, counselors may successfully formulate a conceptualization of the person they are empathizing with.
Additive and Confounding Aspects of Nonverbal Content

As stated above, an obvious discrepancy between telephonic counseling and its face-to-face counterpart is the lack of visual content in the telephonic medium. The presence of visual stimuli, however, may not be an exclusively beneficial prospect in sessions. This section is designed to acknowledge both the potentially additive and confounding aspects that nonverbal content (e.g., body language, facial expressions, etc.) may add to the counseling session.

Additive Aspects

Contextualization via Body Language. Several authors (Aviezer et al., 2012; Harris & Birnbaum, 2015; Russell, 2018) note the potential for increased misunderstandings and miscommunications due to reduced face-to-face context present in telephonic counseling, such as body cues and facial expressions. Other researchers (Egan, 2014; Ekman, 1982; Hill & Stephany, 1990) regard such physical signals as important sources of information for identifying and understanding emotions. Lack of visual contact with the client, then, may limit the expressive pluralism (i.e., the different possibilities of how to express oneself and communicate authentically) presented by the client, a term coined by Max Pagès (1974). Rogers (1959) also spoke to the importance of body language as a source of empathic understanding, writing that such understanding is “to some degree expressed verbally” (p. 213), and that sensory awareness should be included in the wholeness of an empathic dialogue. Moreover, Reese et al. (2016) discuss how telephonic counseling does not afford counselors the “benefit of the doubt” (p. 262) regarding appearing as though they are empathically responding to the client through use of body language.
Greater Quantity of Informational Channels. Regarding the counselor’s empathic response to the client with visual, verbal, and paraverbal content, Hall and Schmid Mast (2007) state, “having more channels can increase redundancy and also increase the likelihood that relevant information will occur in at least one of the channels” (p. 444). As described above, this finding was previously discovered by Gesn and Ickes (1999) and was later replicated by Zaki et al. (2009). Archer and Akert (1980) found that visual and auditory cues produce roughly equal levels of empathic accuracy, suggesting the inclusion of both channels to be beneficial in the counselor’s efforts to empathize with the client. In addition to two other theories of social interaction that will be described below, Archer and Akert (1980) proposed what they termed the diffusion theory. This theory posits that all social cues are informative, even in isolation from one another. In this way, the researchers found each informational channel to be a unique and additive clue to empathic accuracy.

Confounding Aspects

Deception. Although nonverbal expressions offer an additional channel for empathic understanding, Kraus (2017) found that facial and nonverbal expressions are a less reliable source of accurate emotion expression than the voice, and that people use facial and nonverbal expressions to mask their internal states. In addition to the use of masking as means of replacing a genuine emotion with a falsified expression corresponding to a different emotion, Ekman and Friesen (1975) posit that individuals may also simulate an emotion when it is not genuinely felt and neutralize the expression of a true emotion so that the facial expression of a person remains neutral. In this sense, individuals have the capacity to use facial expressions as a means of dissembling their genuine emotional state from another person, a trait that is an evolutionary development of interpersonal deception (Porter & ten Brinke, 2008). In their study on identifying
concealed and falsified emotions in universal facial expressions, Porter and ten Brinke (2008) found that false neutralized facial expressions of participants ($N = 41$) did not differ from genuine neutral expressions. These findings suggest that clients may be able to succeed in concealing emotional states from counselors through process of neutralization, rendering the informational channel of facial expressions more confounding than additive to empathic accuracy.

**Cultural Factors.** Despite the recent push for cultural awareness in the counseling process, emotional display rules dictated by various cultural aspects may present a confounding factor to counselors regarding the use of body language (Sommers-Flanagan & Sommers-Flanagan, 2017). For example, outward expression of emotions (e.g., body language, facial expressions, etc.) is often discouraged in Japanese culture (Safdar et al., 2009), and men are typically less inclined than women to express emotions such as fear or sadness due to implied vulnerability (Labott et al., 1991) and lack of positive feedback in the expression of these emotions (Brody, 1999). Speaking further to the restriction of emotional expression, collectivistic cultures often place emphasis on group cohesion, thereby prioritizing control over emotional expression (Potter, 1988). Specifically, the expression of anger is often perceived as less acceptable in collectivistic cultures due to its potential threat to authority and harmony within relationships (Miyake & Yamazaki, 1995). Individualistic cultures have their own restrictive implications to emotional expression, often exerting pressure for individuals to present as happy as a means of signaling success, rather than signaling failure through sadness (Safdar et al., 2009). Referring to Porter and ten Brinke’s (2008) study, the researchers discovered that their Canadian participants were better able to create convincing displays of happiness than to create convincing displays of negative expressions. Commenting on this finding, the researchers
remarked, “This pattern may relate to people’s relatively high level of experience with creating false expressions of happiness in daily life” (p. 512). Referring back to Zaki et al.’s (2009) study, the authors had hypothesized that participants would be motivated to produce positive nonverbal cues and inhibit negative cues due to social display rules and confirmed their hypothesis in the results of the study.

**Empathic Multi-Tasking.** Another potentially confounding factor regarding the presence of nonverbal content in counseling sessions is the multi-tasking that counselors may have to implement in order to track the various channels of communication that are occurring simultaneously. Kraus (2017) suggests that the division of attention that multitasking necessitates may present a “potent barrier” (p. 644) to empathic accuracy. An example of this phenomenon can be observed in Diley et al.’s (1971) comment that eye contact may divert the counselor’s attention away from verbal content, resulting in the misinterpretation of verbal meanings.

Conversely, Reese et al. (2016) posit that a lack a visual communication channel with the client (as observed in telephonic counseling) may render empathy a more salient process due to the increased potency of the verbal channel. Similarly, Kraus (2017) contends that empathic accuracy relies less on the amount of information provided, and more on the extent to which the counselor can attend the information being vocalized. This observation aligns with decades of research finding that multitasking reduces the speed and accuracy of the given completion task in comparison to repeating the same task (Meyer & Kiersas, 1997; Rubinstein et al., 2001). Furthermore, Kraus (2017) notes that the voice is “already a complex cognitive perceptual process that becomes even more cognitively taxing when sense modalities are added. Thus, having more modalities for emotion recognition might paradoxically impede empathic accuracy” (p. 645).
In addition to reducing empathic potency through process of division, multi-tasking may involve attending to channels of information that do not contain significant meaning. In their significant clue theory, Archer and Akert (1980) explain empathic accuracy as primarily involving adherence to specific clues (i.e., accurate informational channels) that might increase empathic accuracy, whereas other clues may present as uninformative or even misleading. When explaining the results of their study finding that verbal cues were more potent than nonverbal cues in terms of warranting empathic accuracy from participants, Hall and Schmid Mast (2007) comment on the possibilities of (1) feelings not predictably being revealed though nonverbal cues, and (2) nonverbal cues presenting as ambiguous in meaning.

**Linguistic Understanding and Communication of Emotion**

Perhaps the most crucial factor regarding the topic of empathic response via telephone counseling is that fact that emotions can be conceptualized and communicated verbally. According to the core affect model of emotion, individuals experience low-level affective states (activation, deactivation, pleasure, and displeasure) that become more complex emotions when meaning is ascribed to them via language (Russel, 2003). In this way, clients understand their emotional states through language, rendering it a simultaneously affective and conceptual process (Lindquist & Barret, 2008). To communicate this conceptualized, affective experiencing to others, language functions as an effective method of delivery (Pennebaker & King, 1999). To understand the client’s communicated experiencing, the counselor attends to the information communicated through verbal content and is therefore strongly oriented toward the voice (Hill & Schmid Mast, 2007). Further speaking to the conceptualization piece of emotional experiencing, Widen and Russel (2010) posit that each emotion has its own script regarding eliciting event, conscious feeling, vocalization, label, temporality, and so forth. Such prepackaged scripts may
render verbal communication of emotions a quick and recognizable process for counselors, and may further explain Kraus’s (2017) comment, “voice-only communication enhances empathic accuracy relative to communication across senses” (p. 644-645).

**Theoretical Foundation**

The present study is a qualitative, exploratory study guided by an interpretive phenomenological approach while using Clark’s (2010) integral model of empathy to explore counselors’ empathic response to clients via telephonic counseling during COVID-19. Given that researchers are likely to benefit from having a sincere and honest interest in the phenomenon being researched (Van Manen, 2016), the present author felt compelled to study the topic of this dissertation due to his own experience providing telephonic counseling to clients in an outpatient setting. The author also noted a dearth in research on telephonic modalities in the literature, which further encouraged the prioritization of this topic.

**Phenomenology**

The present author aligns with People’s (2020) definition of phenomenology as “the essence of something as it is described and how the essence of something is described in terms of how it functions in the lived experience and how it shows itself in consciousness as an object of reflection” (p. 29). In a simpler sense, phenomenology is the study of an individual’s lifeworld (Van Manen, 2016). Founded by Edmund Husserl (1962), the initial framework of phenomenology sought to examine experience in a transcendental manner, placing emphasis on the need for the observer to bracket all presuppositions to glean a purer and less contaminated understanding of the observed phenomenon. However, Martin Heidegger (1971) posited that individuals cannot bracket themselves from the existence of another, seeing all individuals as
inseparably “being-in-the-world” together. This departure from transcendental phenomenology gave birth to the framework of hermeneutic phenomenology, which will be described below.

**Hermeneutic Phenomenology**

A central tenant in hermeneutic phenomenology is the idea of the hermeneutic circle. Rather than observing understanding as a linear phenomenon, the hermeneutic circle observes understanding as a spiraling process, in which the understanding of a given phenomenon “increases by moving from the understanding of the parts to the understanding of the whole and again back to the parts, continually changing as new data are introduced” (Peoples, 2020, p. 33). Instead of bracketing preconceived knowledge, or fore-sights, hermeneutic phenomenology considers such knowledge bases to be useful starting points from which the researcher may begin the hermeneutic circle. By engaging in the hermeneutic circle, the researcher can identify themes, which contribute to the overall findings of the given study. The present study incorporated hermeneutic phenomenology as a means of conducting a thematic analysis on the lived experience of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19. Specifically, the study looked to Peoples’ (2020) general data analysis steps in phenomenological research to ensure a thorough hermeneutic analysis of the data. These guidelines will be discussed at length in chapter III.

**Clark’s Integral Model of Empathy**

To better understand the lived experience of counselors’ empathic response to clients when providing telephonic counseling during COVID-19, it may be useful to ground inquiry in a theoretical model of empathy. Clark’s (2010) integral model of empathy will be used for this purpose. Clark’s (2010) conceptualization of empathy is composed of three parts: subjective empathy, interpersonal empathy, and objective empathy. Prior to Clark (2010), other authors
have conceptualized empathy as a multi-faceted process. Gladstein (1983), for example, separated empathy into two types: cognitive empathy ("I comprehend what you feel"), and affective empathy ("I feel what you feel"). What makes Clark’s (2010) model unique, however, is that he places emphasis on the integration of various components of empathy, rather than separation. As Clark (2010) states, “a comprehensive definition of empathy should include a counselor’s attunement to a client’s experiencing from both immediate and extended perspectives” (p. 351). The three components of the integral model will be described in detail below, followed by an explanation of how Clark (2010) considers each component as being used in an ongoing hermeneutic approach to empathizing with the client.

**Subjective Empathy**

Clark (2010) defines subjective empathy as “a counselor’s awareness of his or her sensibilities and internal reactions in response to the experiencing of a client” (p. 349), and divides the concept into the facets of identification, imagination, intuition, and felt-level experiencing. Buber (1978/1950) classically acknowledged the need for subjectivity in the empathic process, stating that it is not possible to acknowledge what is empathetically understood without bringing oneself into play as a person. Subjective empathy is divided into four parts described in greater detail below: identification, imagination, intuition, and felt-level experiencing.

**Identification.** Clark (2010) describes the process of identification as there being “sufficient commonality of experiencing to evoke a level of identification” (p. 349) in the therapeutic encounter. According to Stewart (1956), a counselor often experiences a sense of kinship with a client when engaged in the process of empathy. It is possible for this process of identification to last for only a moment (Katz, 1963), or for the counselor to experience a
merging of psychological boundaries with the client due to excessive emotional involvement (Teich, 1992). Identification also allows the counselor to acknowledge their unique and significant additions to the client’s experience in therapy (Zayas et al., 2002). Furthermore, it is possible that the empathic state of identification may be more easily assumed during a time of crisis such as COVID-19 due to the universality of the event. As stated above, a similar counselor-client solidarity in crisis to COVID-19 was observed during the severe acute respiratory syndrome (SARS) outbreak in Taiwan, during which both patients and hospital workers presented with posttraumatic symptoms (Wu et al., 2009). This overarching commonality in experience aligns with Clark’s (2010) comment on identification: “Emotional intensities and environmental conditions may vary qualitatively, but there is sufficient commonality of experiencing to evoke a level of identification” (p. 349). It should be cautioned though, that identification in excess may lead to the experience of countertransference (Peabody & Gelos, 1982), and that identification has the potential to “ignore the otherness of the Other” (Schmid, 2001, p. 3). The limitations of identification will be further discussed below.

**Imagination.** Clark (2010) describes the process of imagination as the counselor being able to recall times in which they experienced emotions and events reported by the client, which helps to facilitate “imaginary associations” (p. 349). If counselors can incorporate imagination into the process of empathizing with clients, they may be able to infer what it is like to walk in the shoes of the given client for a time (Watson et al., 1998). In this way, the counselor may be able to imagine the emotional experience of a client, which may allow the counselor to picture what the client wishes, feels, perceives, and thinks (Friedman, 1985). According to Clark (2010), “counselors are typically able to recall times when they felt rejected or overlooked, and these experiences facilitate imaginary associations.” (p. 349).
Imagination may play a unique role in telephonic counseling, as clients with whom counselors are empathizing with are able to access telephonic counseling services from the comfort of their own home or other familiar settings. This factor may afford the counselor a look into the daily lives of clients that is usually unavailable to the process of face-to-face psychotherapy (Cole et al., 1998). Providing telephonic counseling to clients in settings familiar to their daily routines may afford counselors a look into clients’ differing lifeworlds of home life, work life, and so forth (Schutz & Luckmann, 1973). This closer look into the client’s lifeworld aligns with Goethe’s (1827/2019) classical stipulation that one must travel to the land of the poet to gather a deeper understanding of the poet.

**Intuition.** As Clark (2010) states, “a counselor’s intuitive judgment relies on rapidly formulating hypotheses about a client and generating tentative means of apprehension” (p. 350). The notion of intuition in empathy is reminiscent of Nietzsche’s (1886/2002) philosophical commentary on the “third ear” (p. 76) attained from listening “for the ear” rather than “with the eyes” (p. 77). Some authors (Eisengart & Faiver, 1996; Petitmengin-Peugeot, 1999) have described therapeutic intuition as the counselor’s sensitivity to immediate responses and hunches that come to mind as the counselor interacts with the client. Intuition involves a series of therapeutic insights that help to discover overall patterns in the client’s experiencing (Bohart, 1999; Eisengart & Faiver, 1996; Rea, 2001). Although intuition may entail the experience of “gut reactions” (Clark, 2010, p. 350) and warrant the risk of practitioner bias, intuitive knowing has the potential to inform therapeutic interventions and facilitate strategic decisions (Hankammer et al., 2006).

Clark (2010) also discusses how the visual component to counseling may help to inform the counselor’s intuitive empathic process. This commentary aligns with research conducted in
the field of neuroscience (Decety & Jackson, 2006; Gallese, 2001) on the topic of mirror neurons, which activate when a person observes another individual perform an action, and experiences stimulation of neural circuits as though the observer were performing the action. Herein lies a potential missing piece of information when a counselor attempts to empathize with a client via telephonic counseling. The counselor cannot empathize with the client based on information intuited from the visual state of the client, an empathic process that Blair (2005) describes as motor empathy.

**Felt-Level Experience.** Clark (2010) describes felt-level experience well in stating, “drawing from the potential of a sensing body, the counselor vicariously experiences, for a momentary period of time, what it is like to be the client” (p. 350). This facet of empathy resonates with empathy’s etymological predecessor, *Einfühlung*, a German word referring to the process of feeling into another person’s experience (Duan & Hill, 1996). When engaging in felt-level experiencing, a counselor may experience corporeal reactions, such as a tightness in the throat or chest, which enables the counselor to build hypotheses relating to a similarity in the client’s realm of experiencing (Cooper, 2001). In this way, the counselor follows along with the series of somatic responses and emotional reactions experienced by the client (Gendlin, 1998), engaging in what Eliiot et al. (2011) would term “emotional simulation” (p. 20).

As described above in the empathic process of intuition, the counselor has no visual interface with the client to evoke felt-level experience when conducting telephonic counseling. Fernald (2000) and Vanaerschot (1997) discuss how the counselor may respond to evocative expressions made by the client in a bodily felt way, an experience that falls outside the realm of telephonic counseling. Given the lack of visual contact in telephonic counseling, it may be reasonable to suggest that felt-level experience may rely on auditory information in addition to
the counselor’s imagination regarding how the client may appear visually given the verbal and paraverbal content presented in session.

**Interpersonal Empathy**

Whereas subjective empathy involves empathic response using the counselor’s subjective experience, interpersonal empathy involves the counselor striving to “empathically understand the phenomenological experiencing of a client and demonstrate a sensitive attunement to the perceptual field of the individual” (Clark, 2010, p. 350). This state of empathy is reflective of the “as if” quality of empathy posited by Rogers (1959, p. 211):

The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition. Thus it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth. If this 'as if' quality is lost, then the state is one of identification.

Raskin (1947) commented on the nature of the need to deeply understand the client’s subjective world view, stating, “[the counselor] tries to get within and to live the attitudes expressed instead of observing them, to catch every nuance of [the client’s] changing nature; in a word, to absorb himself completely in the attitudes of the other” (p. 6-7). Raskin indicates that accurate empathic understanding does not simply call for a cognitive or affective appraisal of the client’s experience; it calls for the total phenomenological bracketing (Husserl 1962) of the counselor’s own internal frame of reference to accurately understand the client’s subjective appraisal of reality. Such bracketing may assist the counselor is better understanding both the
explicit and implicit messages expressed by clients in session (BarrettLennard, 2003; Redfern et al., 1993; Schmid, 2001).

Interpersonal empathy involves developing a general sense of how the client experiences life from an internal frame of reference (Bohart & Greenburg, 1997; Goldberg, 1999; Oliveria-Silva & Gonçalves, 2011; Schmid, 2001) and reflecting to the client the private meanings they might find to be important (Haugh & Merry, 2001; Rogers, 1975; Schmid, 2001). In this sense, interpersonal empathy encourages the counselor to regard the wholeness of the client’s experience without reduction or abstraction (Buber, 1978, 1984) and to withhold expectations regarding the client’s reported experiences (Pagès, 1974). Another way of phrasing this experience is respecting the incompatibility of the client’s experience, or the “Thou” (Welte, 1966, p. 19), and retaining the necessary distance to “distinguish between the Other’s and [the counselor’s] own experiences, feelings, and symbolizations” (Schmid, 2001, p. 7).

Due to the universality of the COVID-19 crisis, it is possible that counselors may find themselves more easily subjected to a state of identification with the client, which may disrupt the process of interpersonal empathy. Other phenomena such as countertransference may possibly present a concern that could disrupt interpersonal empathy due to the ubiquitous nature of the COVID-19 crisis. The hermeneutic aspect of Clark’s (2010) integral model will be explained below, which may help to describe how both ongoing use of subjective, interpersonal, and objective empathy may help the therapist to approach empathic response in way that incorporates various empathic processes.
**Objective Empathy**

According to Clark (2010), “objective empathy relies on a consensus of judgments from reputable reference groups composed of individuals external to a client’s frame of reference” (p. 351). Sommers-Flanagan and Sommers-Flanagan (2017) comment that objective empathy have the potential to expand counselors’ empathic responding beyond their own experience. Objective empathy may incorporate considerations such as cultural influence (Ivey et al., 2011; Sciarra, 1999), diagnostic criteria (APA, 2013) and theoretical conceptualization (Corsini & Wedding, 2011) of the client to inform a counselor’s empathic response to the client. Objective empathy may be especially relevant in the age of COVID-19, as media news media has generated an ongoing stream of information available to counselors about the unfolding pandemic (Rosen, 2020), commenting how it may affect people on both a systemic and individual level. Accessing literature on how social isolation, large-scale health crises, and other COVID-19-related concerns may affect people may provide counselors with an objective, referential base that may help them to further consider the unique experience that the client is navigating. Given the fact that the counselor does not have visual contact with the client in telephonic counseling, the base of information provided from objective empathy sources may allow the counselor to piece together a fuller picture of the client’s experience and accommodate the lack of visual contact.

**The Integral Model as a Hermeneutic Process**

As its name suggests, Clark’s (2010) Integral Model of Empathy integrates its various forms of empathic response in an ongoing, hermeneutic process. According to Edwards et al. (2004), hermeneutic activity provides a corrective procedure for deepening awareness of the client’s experience. Engaging in such a process allows the counselor to develop a hypothetical model of the client that is progressively more refined and accurate through ongoing attempts at
empathically understanding the client (Greenson, 1967; Pepinsky & Pepinsky, 1954). As this hermeneutic process continues, the counselor can ascertain a progressively more holistic and clear understanding of the client’s experience (Berger, 1987; Levy, 1985). Integrating multiple perspectives in empathy is consistent with Oliveria-Silva & Gonçalve’s (2011) definition of empathy, as the authors describe the process as “the capacities to resonate with another person’s emotions, understand his/her thoughts and feelings, separate our own thoughts and emotions from those of the observed and responding with the appropriate prosocial and helpful behavior” (p. 201). Although the counselor will invariably never reach an absolute comprehension of the client’s experiencing (Schmid, 2001), the hermeneutic process of empathy allows the counselor to steadily gain an increased empathic understanding of the client’s unique experiences.

Due to the specific nature of each component of the integral model mentioned above, each component entails the absence of important information when empathically responding to the client (Clark, 2010). For example, Rogers (1975) cautions that interpersonal empathy is subject to biases and distortions inherent in the perspective of the client and Duffy et al. (2002) posit that objective empathy may warrant the risk of arbitrarily categorizing or stereotyping clients. Moreover, although intuitive knowing has the potential to inform therapeutic interventions (Hankammer et al., 2006), Clark (2010) warns that counselor intuitive response is susceptible to practitioner distortion and biases. Regarding the empathic state of identification, Teich (1992) comments that the counselor risks excessive emotional involvement if they linger in the state of identification for too long. Due to these inherent limitations, Clark (2010) advises that counselors balance intuitive judgements and perceptions with more examined processes and combine referential sources with subjective and interpersonal knowledge avenues to enrich and deepen the empathic process. This consideration aligns with Eagle and Wolitzky’s (1997)
commentary on using multiple knowledge channels to reduce the possibility of biases and distortions, and Roger’s (1964) suggestion that counselors should interweave multiple ways of knowing as a means of forming evolving hypotheses regarding the client’s experience. Kohut (1977, 1982) also commented on integrating multiple ways of empathic engagement, speaking to the counselor’s capacity to blend experience-near and experience-distant perceptions of a client to glean a deeper level of empathy.

Several authors in the literature comment on the necessity to acknowledge both one’s subjective experience as a person and the unique experience of another person. Buber (1962/1963), for example, classically discussed the concept of ‘swinging into’ another person’s reality while experiencing one’s own concurrently. Similarly, Schmid (2001) describes empathy as a bridge that spans the gap between oneself and the other, which requires the recognition of both parties on either end of the bridge. Moreover, the author describes empathy as both touching and being touched existentially, and that there is no dialogue between counselor and client without both commonality and difference.

Assuming an integral, hermeneutic approach to empathy may be especially relevant in the delivery of telephonic counseling, as the lack of visual contact with the client may increase the need for a multiple-perspective approach. For example, if the counselor finds intuitive empathy to be reaching a limit due to a lack of visual contact with the client, the counselor may transition to a state of imagination to grasp the experience of the client more fully. Furthermore, due to the universality of the COVID-19 crisis, the counselor may find the empathic channel of identification to be implemented more frequently than in their counseling prior to COVID-19. The counselor may then balance empathic identification with interpersonal empathy, as both concepts of perspective taking and showing empathic concern from a state of identification
reflect desirable characteristics of therapeutic practitioners (Constantine, 2001). In this way, the empathetic process becomes a sort of dance described by Raskin and Rogers (1989), “the client leading, the therapist following: the smooth, spontaneous back-and-forth flow of energy” (p. 157).

Because both counselor and client are experiencing the same global crisis of COVID-19, it is possible that Clark’s (2010) empathic state of identification may surface more easily than in counseling prior to the pandemic. According to Peabody and Gelso (1982), countertransference stems from a state of identification with the client in an area that is unresolved in the experience of the therapist. Responses to this experience of unresolved identification may include under- or underemphasizing client material that is emotional threatening, and rigidly withdrawing from personal involvement in the given session (Cutler, 1958). The potentially unresolved emotional experience precipitated by COVID-19 may limit the counselor’s successful use of empathic identification, echoing Freud’s (1910/1957) comment on countertransference: “No psychoanalyst goes further than his own complexes and internal resistances permit” (p. 145). Furthermore, in their meta-analysis of 10 quantitative studies, Hayes et al. (2010) found countertransference to be associated with slightly poorer treatment outcomes, and that efforts to reduce countertransference were associated with reduced manifestations of countertransference and more positive treatment outcomes. Speaking further to efforts to reduce countertransference, Sommers-Flannigan and Sommers-Flannigan (2017) identify the following strategies as effective means of reducing the phenomenon: (1) recognizing that countertransference is inevitable, (2) increasing awareness of countertransference precipitants, (3) seeking out consultation/supervision, (4) seeking out additional countertransference reading, (5) engaging in meditation, and (6) seeking out therapy to address countertransference. Additionally, Peabody and Gelso (1982) suggest that counselors
who are more empathically inclined are better able to understand and modulate
countertransference responses due to their high sensitivity toward nuances of their own
emotional lives.

Although the above paragraph might suggest that countertransference is an exclusively
hindering phenomenon that should be moderated and avoided, a body of literature exists that
identifies countertransference as an inevitable occurrence that may be useful in the therapeutic
alliance. Apart from Freud’s (1910/1957) idea of classical countertransference based on
unresolved conflicts, other countertransference theories include totalistic (all reactions from
therapist to client are meaningful and should be studied, understood, and used), complementary
(specific client interactions “pull” therapist to respond in ways that others respond to the client),
and relational (constructed from unmet needs of both client and therapist; Sommers-Flannigan,
2017). Taken together, if counselors can recognize both the strengths and limitations of empathic
identification given the potential increased risk for countertransference during COVID-19, they
may be able to integrate this empathic channel effectively into Clark’s (2010) integral model of
empathy.

Chapter Summary

Although various iterations of telephonic counseling have existed since shortly after the
invention of the telephone itself (“The Telephone as a Medium of Consultation and Medical
Diagnosis,” 1879), counselors have been reluctant to work with clients through this medium
prior to COVID-19 for a variety of reasons. Lack of insurance reimbursement and training in the
medium, poor familiarity pertaining to relevant professional guidelines and laws regulating
telehealth services, and concerns regarding confidentiality and response to crisis situations have
all presented as barriers to the adoption of telehealth services (Glueckauf et al., 2018). The
economic cost of training employees in telehealth, in addition to the cost of installing and operating telehealth systems have further slowed wider use of telehealth at the systemic level (Wilson et al., 2017). In the wake of COVID-19, telephonic counseling moved from a niche preference to a widespread necessity, precipitating a mass proliferation in telehealth services to accommodate to the unfolding disaster event (Rosen, 2020). The increased credentialing (NBCC, 2020) and greater normalization (APA, 2020) of telehealth services suggests that telephonic counseling may not simply be a response to an anomalistic disaster event, but an evolutionary step in the field of counseling that may remain in place after the conclusion of the COVID-19 crisis.

Regarding effectiveness, studies comparing the effectiveness of telephonic counseling to other mediums have consistently yielded no significant differences in treatment outcomes (Day & Schneider, 2002; Lovell et al., 2006; Jenkins-Guarnieri et al., 2015; Norwood et al., 2018; Rintala & Willems, 1991; Tutty et al., 2005; Varker et al., 2018; Winerman, 2006). Several meta-analyses (Bee et al., 2008; Castro et al., 2020; Coughtry & Pistrang, 2008; Mohr et al., 2008) found telephonic counseling to have a significant effect size compared to control conditions, and other meta-analyses found telephonic counseling to have similar effectiveness compared to face-to-face (Cuijpers et al., 2019; Osenbach et al., 2013), and videoconferencing (Osenbach et al., 2013) counseling. However, one study (Mohr et al., 2011), was identified that reported no significant reduction in symptoms in the telephonic medium. Several other researchers in the literature (Backhaus et al., 2012; Day & Schneider, 2002; Reese et al., 2016; Stiles-Shields et al., 2014) concluded that the delivery of telehealth services did not negatively impact the therapeutic alliance between counselor and client. Unique benefits to telephonic counseling include increased ease of access to care (Imel et al., 2017; Lester, 1977; Mallen &
Vogel, 2005; Perednia and Allen, 1995; Reese et al., 2016; Smucker Barnwell et al., 2012), reduced stigmatization regarding accessing mental health services (Wilson et al., 2017), alleviation of disruptive transference (Lester, 1977; Robertiello, 1972), and perceived anonymity that may facilitate increased disclosure (Lester, 1977; Reese et al., 2002). Concerns regarding the effectiveness of telephonic counseling include difficulty providing for client safety in crisis situations (Brenes et al., 2011; Gershkovich et al., 2016; Haas et al., 1996; Mozer et al., 2008), difficulty ensuring client confidentiality (Brenes et al., 2011; Haas et al., 1996; Mozer et al., 2008), decreased control over the therapeutic space of the session (Russell, 2018; Mozer et al., 2008; Vincent et al., 2017), potential technological difficulties (Lustgarten & Elhai, 2018), decreased connectedness between counselor and client (Gershkovich et al., 2016), and the session time being taken less seriously by the client (Mozer et al., 2008).

Because empathy has been shown to have an impact on treatment progress (Elliott et al., 2011), therapeutic intervention, (Zayas et al., 2002), therapeutic presence (Rogers, 1959), client growth (Schmid, 2001), prosocial behavior (Côté & Miners, 2006; Ickes et al., 1990; Stinson & Ickes, 1992), and ethical counseling (ACA, 2014), counselor empathic response may be a critical factor regarding the incorporation of telephonic counseling. Prior research on empathic response to voice-only content has yielded generally favorable results. Several studies (Dilley et al., 1971; Hall & Schmid Mast, 2007; Reese et al., 2016) showed no significant difference in voice-only content versus other modalities, and two studies (Gesn & Ickes, 1999; Kraus, 2017) showed greater empathic response to voice-only content than other modalities. Some researchers (Gesn & Ickes, 1999; Hall & Schmid Mast, 2007) found that verbal cues dominated as a source of empathic accuracy. However, Zaki et al. (2009) found in their study that communication across all sense elicited higher empathic response from participants than voice-only content.
Factors such as paralinguistics (Kraus, 2017) and aligning with the voice-only client (e.g., linguistic fingerprinting; Pennebaker and King, 1999) render telephonic counseling a different yet comparatively effective medium to face-to-face counseling. Moreover, although nonverbal content is absent in the medium of telephonic counseling, such content may have both additive (Hall & Schmid Mast, 2007) and confounding aspects (Kraus, 2017) to the process of empathic response.

This study was a qualitative, exploratory inquiry guided by an interpretive phenomenological approach while utilizing hermeneutic phenomenology. The study incorporated Peoples’ (2020) general data analysis steps in phenomenological research and Clark’s (2010) integral model of empathy to stage a phenomenological inquiry into the lived experiences of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19.
CHAPTER III: METHODOLOGY

The review of the literature revealed only one prior article (Leffert, 2003) examining the lived experience of telephonic counseling. This article discussed the lived experience of a single psychoanalyst in his provision of therapy and psychoanalysis to clients via the telephone medium. No articles were found that explored the lived experience of multiple counselors in their provision of telephonic counseling. Only two articles (Dilley et al., 1971; Reese et al., 2016) were found that concerned empathy in the provision of telephonic counseling. These articles quantitatively compared counselor empathy via telephonic counseling to counselor empathy through other mediums such as face-to-face and video conferencing, rather than conducting a more in-depth exploration into empathic response via telephonic counseling. This chapter includes discussion on the present study’s theoretical framework, research methodology, sampling, participant recruitment, research design, and data collection and analysis processes.

Purpose of the Study

The purpose of this study was to highlight the lived experience of counselors conducting telephonic counseling during COVID-19, and what their experience has been like when empathically responding to clients through this medium. Few previous studies have investigated the provision of telephonic counseling in a qualitative manner (Leffert, 2003), much of the sparse literature on this topic consisting of quantitative comparisons to other treatment modalities (Day & Schneider, 2002; Jenkins-Guarnieri et al., 2015; Lovell et al., 2006; Norwood et al., 2018; Rintala & Willems, 1991; Tutty et al., 2005; Varker et al., 2018; Winerman, 2006). Due to decreased access to internet and other technological resources in lower socio-economic status (SES) clients (US Department of Commerce, National Telecommunications and Information Administration, 2020), it is vital to promote greater clinical and scholarly understanding of the
telephonic counseling medium, as clients within this demographic have reported increased ease of access and fewer financial barriers to treatment (Brenes et al., 2011; Reese et al., 2006). This study will also help to provide balance to the literature, as most recent telehealth studies concern the videoconferencing medium specifically (Poletti et al., 2020; Rosen, 2020). Lastly, this study will help to facilitate a greater understanding of counselors’ lived experience in the sudden, mass transition from face-to-face to distance counseling in the wake of COVID-19.

**Research Design**

The study used a hermeneutic phenomenological approach grounded in Clark’s (2010) integral model of empathy to understand the lived experience of counselors’ empathic response to clients via telephonic counseling during COVID-19. Clark’s (2010) integral model of empathy helped to ground the study in the three empathic response channels of subjective, interpersonal, and objective empathy to highlight the multiple channels through which counselors empathize with their clients. The absence of visual contact with clients may necessitate empathic response through multiple channels, further rationalizing the use of this theoretical model. Clark’s (2010) integrative model also observes empathy as occurring from both an immediate and extended perspective, an aspect that resonates with the ubiquitous, yet unique trials precipitated by COVID-19.

The researcher sought to explore this experience in all its richness and layers, aligning with Finlay’s (2011) description of the phenomenological researcher. This study sought to increase clinical and scholarly understanding of counselors’ lived experience of empathically responding to clients via telephonic counseling during COVID-19 due to the empirical relevance of empathy in counseling (Côté & Miners, 2006; Elliott et al., 2011; Ickes et al., 1990; Rogers, 1959; Schmid, 2001; Stinson & Ickes, 1992; Zayas et al., 2002) and sudden, mass necessitation
of telephonic counseling services precipitated by the pandemic (CDC, 2021). Peoples’ (2020) general data analysis steps in phenomenological research were used to analyze the research transcriptions. This chapter will explore rationales behind the study’s qualitative design, sample description and size, purposeful sampling, and the study’s recruitment and participant criteria.

**Qualitative Inquiry**

This study implemented a qualitative design to stage an inquiry into the essence of a lived experience, rather than testing a hypothesis that a quantitative method might explore (Creswell & Poth, 2016; Denzin et al., 2011). Exploring lived experience by process of interviews allows the researcher to gather and interpret specific meanings, themes, and concepts from explication of the interview data (Lune & Berg, 2017; Neuman, 2007; Peoples, 2020). As Van Manen (2016) states, it allows the researcher to “grasp the very nature of the phenomenon” (p. 10). Regarding interviews conducted with the telephonic counselor sample, the present researcher conducted analysis informed by the above practices to uncover themes that existed in each of the participant’s experiences.

Phenomenologically oriented qualitative research is meant to describe qualities and characteristics of a given phenomenon (Creswell & Poth, 2016). More specifically, qualitative research rooted in hermeneutic phenomenology can provide rich detail of human behavior and lived experience that quantitative research cannot, as the research is designed to explore both the holistic and specific aspects of a given phenomenon (Madrigal & McClain, 2012; Peoples, 2020). Given the new and sudden experience of both COVID-19 and the widespread use of telephonic counseling, the present researcher finds that exploring “what” and “how” (Moustakas, 1994) counselors have experienced this transition takes precedence over testing hypotheses via quantitate methodology. This study will use qualitative interviews of counselors providing
telephonic counseling to highlight their lived experience of empathically responding to clients through this medium during the global pandemic of COVID-19.

**Purposeful Sample**

Qualitative research rooted in hermeneutic phenomenology is not designed to make inferences and generalizations about a larger population through use of the research sample (Berg, 2009; Creswell & Poth, 2016). Rather, the purpose of this kind of research is to explore the essential aspects of a given phenomenon, describing the lived experience in a way that unearths what and how it is like (Moustakas, 1994; Van Manen, 2016). Due to this aspect of phenomenological research, the researcher chose to implement a purposeful sampling process. Purposeful sampling allows the researcher to “intentionally sample a group of people that can best inform the researcher about the research problem under examination” (Creswell & Poth, 2016, p. 148). This sampling process is non-probability based in nature, as it prioritizes phenomenological exploration over making statistical inferences to a larger population (Berg, 2009; Creswell & Poth, 2016; Merriam & Tisdell, 2016). The first task related to this non-probability sampling was defining a population of interest. For the present investigation, the population of interest was defined as counselors who have delivered the study’s definition of telephonic counseling (Coughtry & Pistrang, 2018). The next task was selecting a sample from those interested in participating who have experienced the phenomenon or incident under study to facilitate experiential commonalities (Peoples, 2020). For this reason, the researcher delineated selection criteria described below.
Selection Criteria

For this study’s purposes, appropriate participants were those who possess a master’s degree or above and have provided telephonic counseling to clients for a cumulative period of at least six months. In addition to these inclusion criteria, the researcher established a universal sample and exclusion criteria, as these steps facilitate commonality in participant experience (Peoples, 2020; Robinson, 2014). The universal sample or population for this study was defined as individuals delivering outpatient telephonic counseling to clients in a clinical setting during COVID-19 who had not been engaged in providing telephonic counseling services prior to COVID-19. Exclusion criteria used for this study pertained to those who (a) did not possess a master’s level degree or above, (b) did not provide telephonic counseling to clients at an outpatient level of care, (c) did not provide telephonic counseling during COVID-19, (d) provided telephonic counseling services prior to COVID-19, (e) had accumulated less than six months of total experience providing telephonic counseling, and (f) currently, or recently, saw less than ten telephonic counseling client per week.

Sample Size

As it is impossible to reach and interview all telephonic counselors in the population, it is vital to select a sample size range that offers a scope for developing cross-case generalities (Robinson, 2014). Sample ranges are different for all studies, as the goal of sample size is to gather an adequate amount of data so that adding another participant to the sample would not result in additional perspectives, leading to further saturation of existing data (Glaser & Strauss, 1967). For this reason, the research is considered to have reached a point of saturation when new themes stop emerging in the analysis of the interviews (Merriam & Tisdell, 2016). According to Polkinghome (1989), saturation is expected to be reached at 5-25 interviews.
Participant Recruitment

The participants in this study were recruited by networking with supervisors, directors, and counselors of various counseling agencies and private practices. The researcher reached out to each of these contacts, providing them with a recruitment flier (Appendix D) to either gauge their interest in participation in the study, or to disseminate the flier to staff who may be interested in taking part in the study.

Participants were recruited from various areas of the US to provide a geographically diverse sample. The geographic variance of the sample is intentional to include as wide a range of experiences as possible. It is self-evident that different areas of the country exhibit differing cultural, economic, and political characteristics. The setting in which an individual resides may present naturally occurring differences such as SES, population density, client and counselor demographics, and COVID-19 restrictions. Such differences could play a role in counselors’ lived experience of empathically responding to clients via telephonic counseling during COVID-19.

Data Collection

The data in this study was composed of the themes and reiterated messages of the participants’ lived experiences regarding counselor empathic response to clients in the provision of telephonic counseling during COVID-19. The procedure for gaining this information was through semi-structured individual interviews. This section discusses the procedures used for conducting these interviews, the guiding questions, and the methods for handling and interpreting the data.
Semi-Structured Interviews

The researcher used a semi-structured interview format to obtain information from participants in this study. Semi-structured interviews are well-suited to explore the perceptions and opinions of participants regarding complex and sensitive topics and offer the ability to probe for more information or to seek clarification of responses (Barriball & While, 1994). The semi-structured aspect allows the researcher to “standardize the stimulus” through use of identical prompts but allows the addition of clarifications and probing questions as differences among the respondents come to light (Barriball & While, 1994, p. 329).

Alternatively, structured analysis relies on the fact that all participants’ common vocabulary and the hope that each participant’s words carry the same meaning, which can present a major hindrance to the study (Barriball & While, 1994). Structured analysis also contradicts Brinkmann and Kvale’s (2015) definition of a qualitative interview as one that “attempts to understand the world from the subject’s point of view, to unfold the meaning of their experience, to uncover their lived world” (p. 3). Semi-structured interviews align closer to Brinkman and Kvale’s (2015) definition, as they allow the interviewer to change the wording and not the meaning, and respects individuals’ differences in vocabulary and understanding of the questions (Barriball & While, 1994). The flexible nature of semi-structured interviews does not entail the sacrifice of consistency in the interview process. Conversely, the trustworthiness and credibility of semi-structured interview depends on the researcher’s ability to keep the core meaning of the questions consistent (Barriball & While, 1994). Semi-structured interviews also offer the researcher the ability to use probing questions, which can assist in ensuring reliability due to their ability to clarify and prompt in the exploration of new topics, thereby getting more information than the question originally sought (Barriball & While, 1994).
Interview lengths ranged from 1 to 1.5 hours. The researcher conducted interviews with each participant via Zoom videoconferencing to both obtain geographically diverse needs of the sample and remain compliant with current research precautions (ACA, 2014; Delmonico, 2020) due to COVID-19. Prior to engaging in the interview process, participants completed a demographic questionnaire including information pertaining to education level, age, gender, race/ethnicity, licensure, total number of years accumulated as a practicing counselor, and whether the counselor provided telehealth counseling prior to COVID-19. The demographic questionnaire also assessed for number of cumulative months spent conducting telephonic counseling post-COVID-19, average number of telephonic counseling clients seen per week, comfort providing telephonic counseling, and hours of supervision currently received per week. The demographic questionnaire helped to inform participant inclusion and cross-case comparisons in the study. The interviews were audio recorded. The researcher also took field notes describing participants’ nonverbal communications, initial themes, and reactions to the content shared. The recordings were then transcribed for further analysis.

Following analysis of each interview, the researcher corresponded with the given participant via email to provide a summary of themes that emerged during the interview. Participants were given the opportunity to provide feedback to the researcher regarding whether the interview data had been interpreted accurately. The researcher made any necessary adjustments to the analysis in accordance with participants’ comments.

**Interview Questions**

Prior to conducting a semi-structured interview, the researcher sets the initial structure of the interview through use of interview questions (Merriam & Tisdell, 2016). The interview questions were based on the study’s research questions and were formatted for use in the
interview protocol. The interview questions consisted of both primary and subsidiary questions to gather a more in-depth exploration of the participant’s lived experience. The researcher administered each of the interview questions throughout the duration of the interview, which consisted of the following:

1. What has it been like for you to empathically respond to clients’ reported experiences through the medium of telephonic counseling during COVID-19? (RQ 1)
   a. What is the role of empathy in the process of counseling?
   b. What are your beliefs on the importance of empathy?
   c. Did you receive supervision during your provision of telephonic counseling? If yes, what was the medium through which supervision was delivered?
   d. Did you work primarily from home, or from an office? How did your work setting(s) influence your experience?
   e. How did media coverage of COVID-19 influence your empathic response toward clients?

2. What has it been like for you to transition from in-person to telephonic counseling regarding empathic response toward clients during COVID-19? (RQ 2)
   a. Did your empathic response to clients change after the transition? If yes, how so? If no, why not?
   b. Is there a particular SES group of clients that you primarily work with? How has this factor influenced you experience?

3. Is there a difference in your empathic response regarding face-to-face and telephonic counseling during COVID-19? (RQ 3)
   a. What is it like for you to empathize with clients in person?
b. What has it been like to empathize with clients over the telephone?

c. What has it been like for you to empathize with clients over videoconferencing?

4. How have your own personal experiences regarding COVID-19 influenced your empathic response to clients in the delivery of telephonic counseling? (RQ 4)

a. Did you ever test positive for COVID-19 or suspect that you had COVID? How did this factor influence your experience?

b. Were you ever exposed to COVID-19? How did this factor influence your experience?

c. Did you have to quarantine yourself from others? How did this factor influence your experience?

d. How much media coverage did you consume per day regarding COVID-19? How did this factor influence your experience?

Ethical Considerations

This study was submitted, reviewed, and accepted by Duquesne University’s Institutional Review Board. To prepare for this process, the researcher carefully constructed the informed consents and thoughtfully refined measures taken to ensure confidentiality, ethical treatment of participants, compliance with the time limits related to data gained from the study, and how to adequately report findings.

Informed Consents

Prior to participant engagement in the present study, the researcher reviewed with participants their rights, roles, and responsibilities as participants in this research project. This procedure took place both verbally and in writing. The researcher began the informed consent procedure by discussing the purpose of the study with prospective participants. Next, when
individuals reached out by email and conveyed interest in participating, the researcher requested that they fill out an initial demographic questionnaire. This initial questionnaire assessed for exclusion criteria to gauge as to whether the prospective participant fit the purposeful sample described above.

Individuals who did not fit the study’s purposeful sample were thanked for their interest and were informed they did not fit within the study’s parameters. Individuals who were interested and fit the parameters for participation were informed of the time and length of the study, intent and purpose of participation, confidentiality policies, and methodology. The researcher then verified that they wished to proceed with the study, reminding them that they could withdraw their participation at any time. After obtaining verbal consent from the participant, the researcher scheduled them for an interview via Zoom videoconferencing.

A written version of the informed consent document was also distributed to each participant prior to the given participant’s interview. This document included procedures of the study, confirmation that their participation is voluntary and can be revoked at any moment, a review of the risks and benefits of participants, and confidentiality efforts. These consents were reviewed with the participants and signed before the researcher conducted the semi-structured interviews. Copies of results and transcriptions were offered to participants to ensure transparency in the process. This was explained to the participants and was free of charge.

**Treatment of Participants**

Ethical treatment of participants was the researcher’s foremost priority in conducting the present study. To begin, the researcher discussed the small potential for risk that could be involved with their participation in the study. The researcher also discussed with participants that some individuals may experience negative feelings or reactions in talking about negative
experiences such as navigation of the COVID-19 pandemic. Participants were also informed that they are within their rights to revoke their participation status at any time during the process of the research project at no penalty to them if they are experience such a negative reaction, or for any other reason.

As a practicing counselor, the present researcher is well-versed in supportive factors, crisis intervention, and de-escalation techniques. The researcher evaluated the inception of the present study as low risk, especially given the participants’ foreknowledge that interviews could be stopped at any time for the needs of participants. The researcher also worked to identify follow-up options for affirming services to support the participants that they could access if needed.

Confidentiality

The researcher discussed the study’s confidentiality boundaries with participants and explained how the data would be reported at the end of the interview process. Participants’ identifying information was redacted from transcriptions and the results of the study were reported in aggregate. Knowledge pertaining to the actual identities of participants was limited to the primary researcher, entailing that committee members only knew each participant by their respective pseudonym. All names and identifying information of the participants were redacted from transcriptions, including those mentioned in participant recollections. All recordings and printed copies of transcriptions were kept in a locked storage device or under password protection to ensure that access to interviews was strictly limited to the researcher and committee members.

As interviews were conducted remotely due to COVID-19 restrictions (ACA, 2014; Delmonico, 2020), the researcher chose to use the Health Insurance Portability and
Accountability Act (HIPAA) compliant videoconferencing platform Zoom to protect participant confidentiality during interviews (Zoom, 2020). In the use of Zoom, privacy features remain in the control of the meeting host and approved participants at the discretion of the host. These features include entrance to the meeting, screen sharing, and recording abilities. Each meeting link is generated only for the purposes of each specific interview and the waiting room is enabled to allow for the meeting host to verify participants prior to entry. Following participant entrance to the meeting, the host can lock the room to prevent any further entry. Zoom also protects data at the application level using an advanced encryption system to further protect confidentiality (Zoom, 2020).

**Data Storage and Retention**

The researcher informed participants that interviews would be video- and audio recorded via Zoom videoconferencing and later transcribed. Any physical notes or documentation were kept in a locked storage device, the primary researcher being the sole individual who had access to these documents and files. Electronic media was password protected. Zoom recordings were destroyed upon the completion of the study. Documents related to the study were stored until the completion of the study and were then destroyed as well.

**Reported Findings**

Participants were informed that their interviews will be used to inform the study’s findings regarding the lived experience of counselors’ empathic response to clients via telephonic counseling during COVID-19. This information was later reported without the inclusion of their names or specific identifying information. Part of the process entailed sending the transcriptions to participants to provide them an opportunity to validate the transcriptions.
Participants were also offered the option to obtain a copy of the findings of the study if interested.

**Data Analysis**

As mentioned previously, this study implemented Peoples’ (2020) general data analysis steps in phenomenological research to mine for information. The progression of these steps can be observed in Figure 1 below. With each step, hermeneutic phenomenology and Clark’s (2010) integral model of empathy were used as the lens through which the researcher could interpret and find saturation of the themes mined from the narrative data. This section reviewed the guidelines that informed the practice of analysis of the transcribed interviews.

**Figure 1**

*People’s (2020) General Data Analysis Steps in Phenomenological Research*

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**Read the Entire Transcript and Take Out Unnecessary Language**

Once transcripts were typed, the researcher read through each transcript line-by-line to discern the participant’s complete story. The researcher also deleted any information that was
irrelevant or unnecessary such as repetitive statements or filler linguistics to further distill the essence of observed phenomena (Creswell & Poth, 2016; Peoples, 2020). Clark’s (2010) integral model of empathy helped the researcher to gather a more comprehensive view of the given counselor’s empathic response to clients, acknowledging the counselor’s “attunement with the feelings and meanings of an individual’s experience from an immediate or extended perspective” (p. 162).

**Generate Preliminary Meaning Units**

After the researcher gathered a comprehensive understanding of the participant’s complete story, the researcher generated preliminary meaning units while concentrating on the research topic of counselor empathic response via telephonic counseling during COVID-19. According to Peoples (2020), “the goal of phenomenological data analysis is to present a description from essential themes of an experience in a way that is comprehensible and identifiable to anyone who has had that particular experience” (p. 58). Bearing this stipulation in mind, the researcher used each transcription as a source of data to “reveal a feature or trait of the phenomenon being investigated (People, 2020, p. 60). When generating these preliminary meaning units, the researcher looked to Clark’s (2010) integral model of empathy to frame these preliminary meaning units in terms of subjective, interpersonal, and objective empathy. The researcher also looked to disaster counseling (Goldmann & Galea, 2014; Kessler et al., 1995; Norris et al., 2002; Rosen, 2020) and burnout (Collins & Collins, 2005; Hodgkinson & Shepherd, 1994; Maslach, 2003; Maslach et al., 2001; Thompson et al., 2014; Wee & Myers, 2002) literature to gather a fuller understanding of each counselor’s lived experience.
Generate Final Meaning Units for Each Interview/Survey Question

After preliminary meaning units were generated, the researcher generated final meaning units for each interview question. This step helped the researcher to generate themes informed by a deepened understanding of each participant’s description (Peoples, 2020). Themes that emerged that were not relevant to the original research questions were not included for further analysis. Units of meaning that were considered ambiguous or uncertain were included to err on the side of caution.

Synthesize Situated Narratives into General Narratives Under Each Interview/Survey Question

After final meaning units were generated for each interview question, the researcher thematically organized the specifics and experiences of each participant’s story under the appropriate interview questions. Clark’s (2010) integral model of empathy was used as a lens to facilitate thematization of the data. The meanings of each participant’s experience were highlighted thematically through direct quotes from the interviews (Peoples, 2020).

Synthesize Situated Narratives into General Narratives, Integrating All Major Themes of Participants

After thematically organizing the specifics and experiences of each participant’s story under the appropriate interview questions researcher created general narratives from the situated narratives, unifying participants’ accounts into a general description of all the participant’s narratives. The goal of this step was to organize the data from the situated narratives while highlighting all the participants’ meanings of their experience (Peoples, 2020). The researcher continued the use of Clark’s (2010) integral model of empathy to facilitate integration of all the major themes of participants.
Generate General Description

In the sixth and final step of data explication, the researcher discussed the themes that were implicit in all or most of the participants’ descriptions of their experiences, uniting the major phenomenological themes into a cohesive general description (Peoples, 2020). As in previous steps, Clark’s (2010) integral model of empathy was used to facilitate the general depiction of phenomena observed in the study.

Transcription

During the transcription procedure, the researcher reviewed each of the audio recordings himself. To begin the process, the researcher first only listened to the recorded interviews, taking in the narratives while paying close attention to the wording and intonation of the participants’ responses. The next stage of this process was to listen to the recordings a second time, this time typing verbatim the questions and probes spoken by the researcher as well as the responses given by the participant. During the facilitation of these interviews, the researcher took field notes to document observations or clarifications, which were later combined into the margins of the typed transcriptions as suggested by Hycner (1985). The transcripts were provided to each participant for feedback via email to determine their accuracy. The transcriptions were only reviewed by the primary researcher and his dissertation committee and were redacted of identifying information and kept locked when not in use by the researcher.

Dependability of the Data and Credibility

The researcher provided each participant with their respective interview transcript for feedback to determine its accuracy via email, as suggested by Hycner (1985). Field notes and observation notes were also used to aid triangulation of data. The transcriptions conducted were done by the researcher to attain an additional level of reliability to the text. Recordings were
transcribed verbatim to ensure open availability for critique and assessment. The use of supervision and consultation through committee interactions also ensured that the researcher considered potential biases and helped to limit the effect on data interpretation. The researcher used Peoples’ (2020) general data analysis steps in phenomenological research and Clark’s (2010) integral model of empathy to highlight the experiences of telephonic counselors in a manner as free from bias and ignorance as possible.

Instrument

In qualitative research, the researcher is considered the instrument of the study (Patton, 2002; Van Manen, 2016). Patton (2002) cautions that the researcher must be mindful of their own biases and emotional responses throughout the duration of the study. This section will provide an overview of the researcher’s qualifications, experiences, focus in the field, and initial impressions for potential biases that might arise during the study.

Researcher as the Instrument

As a Licensed Professional Counselor (LPC) in the state of Pennsylvania, I have worked in the field of mental health since 2017, accumulating approximately four years of experience to date. My first clinical experiences involved providing home- and school-based therapeutic support staff services. After this, I acquired my first graduate level counseling position providing mobile therapy and behavioral specialist consultation in home- and school-based settings. Following this experience, I began working in March 2019 as an outpatient therapist in an agency setting, where I work at the present time. Approximately one year into my outpatient work, in March of 2020, my agency shifted to telephonic counseling overnight due to COVID-19. My thirty-five-hour work week of seeing clients face-to-face rapidly transitioned to 100% of my clients being interfaced with via telephone or videoconferencing. Because my agency is
situated in a lower SES area in which clients have less access to videoconferencing technology and Wi-Fi, much of my caseload has been accessed via telephonic counseling. At the time of this writing (June 2021), I have been working full-time providing telephonic counseling to clients in an outpatient setting for approximately one year and three months.

In terms of counseling theory, I align primarily with cognitive-behavioral and existential approaches. On the topic of empathy specifically, I tend to incorporate Yalom’s (1980) four ultimate concerns of death, isolation, meaninglessness, and freedom as a means of aligning with the universal experience that the client is navigating. Once I have aligned with the client through process of empathy, I use a cognitive-behavioral framework to facilitate the client in acknowledging and working through cognitive distortions and maladaptive core beliefs pertaining to the given ultimate concern. This process allows me to help the client arrive at a place of greater clarity and self-empowerment regarding their personal values and directedness in their life. It should also be noted that I view empathy as an essential component of the counseling process much like Rogers (1951) does in his core conditions, which may present a potential source of bias. I think it is important to respect the client’s value system through process of empathy prior to advocating for change in session, and that the implementation of directedness in counseling without empathy and understanding may disempower the client and devalue their personal belief system. In this sense, I align with the prevailing wind (Côté & Miners, 2006; Elliott et al., 2011; Ickes et al., 1990; Rogers, 1959; Schmid, 2001; Stinson & Ickes, 1992; Zayas et al., 2002) that empathy is a beneficial component to the counseling process.

Another potential source of bias is my own comfort in the provision of telephonic counseling. Throughout most of my life, I have felt comfortable communicating with family and friends via telephone. I have comfortably spoken to others on the phone for several consecutive
hours on a variety of occasions. This comfortability transferred into my professional life when I began regularly incorporating the use of telephonic counseling. Although the initial transition to the medium precipitated a degree of anxiety, I presently experience little anxiety providing telephonic counseling to my clients. Due of this bias, I have benefited from consulting with my committee on alternative responses that other counselors might experience regarding the use of telephonic counseling with clients. My committee helped me to consider possible experiences such as burnout (Maslach, 2003; Maslach et al., 2001), compassion fatigue (Thompson et al., 2014), and vicarious exposure (Collins & Collins, 2005; Hodgkinson & Shepherd, 1994; Wee & Myers, 2002) that telephonic counselors might endure following prolonged use of the medium during COVID-19.

To avoid the opportunities for bias, I continued consultation with my committee to ensure that I avoided these biased ways of thinking and relied on what was being said in the participants’ narrative. The implementation of this procedure will hopefully reduce the implications of bias in my exploration of counselors’ lived experience empathically responding to clients via telephone during COVID-19.

**Chapter Summary**

The purpose of this study was to highlight the lived experience of counselors conducting telephonic counseling during COVID-19, and what their experience has been like when empathically responding to clients through this medium. No articles were found in the literature that explored the lived experience of multiple counselors in their provision of telephonic counseling, and only two articles (Dilley et al., 1971; Reese et al., 2016) were found that concerned empathy in the provision of telephonic counseling. This study was designed with a qualitative format informed by Clark’s (2010) integral model of empathy. Clark’s (2010) model
was used as a lens through which the researcher could explore the lived experience of counselor empathic response to clients via telephonic counseling during a global pandemic in which telephonic counseling rapidly accelerated from a niche preference to a widespread necessity.

Participants of the study were recruited using purposeful and snowball sampling methodologies. Once fit of participant was deemed appropriate, individuals participated in semi-structured interviews. Field notes were taken to capture observations and data that would not be apparent in the audio-recorded interviews. These field notes were included in the margins of the verbatim-typed transcriptions to offer different methods to data triangulation (Patton, 2002).

The narrative data of the interviews was explicated using Peoples’ (2020) general data analysis steps in phenomenological research. The process allowed for themes to surface from multiple interviews. Future considerations for research were also illuminated using this approach. Chapter four will detail these themes by each interview. The saturated themes and future considerations for research are included in Chapter four and five.
CHAPTER IV: RESEARCH FINDINGS

Introduction

The findings of this inquiry helped to illuminate the lived experiences of counselors’ empathic response to clients via telephonic counseling during the COVID-19 pandemic. The researcher used qualitative research to identify language that naturally emerges, and the meaning people assign to the language they use (Creswell, 2016). Qualitative research is a recursive and iterative process to find meaning behind participants’ spoken interactions of their experience (Creswell, 2016). The experiences portrayed in this study represent the variety of presentations and experiences that counselors may face when empathically responding to clients via telephonic counseling, and how this response may be further affected by a disaster event such as COVID-19.

The study was informed by the theoretical lens of hermeneutic phenomenology (Heidegger, 1971; Peoples, 2020) and Clark’s (2010) integral model of empathy. The premise of this approach and the semi-structured layout of the interviews was used to unearth participants’ subjective experiences and their individual perceptions of these experiences (Kafle, 2011). This chapter provides a narrative review of the data collected in a case-by-case analysis. Peoples’ (2020) general data analysis steps in phenomenological research served as a foundation to approach the interpretation of the participant interviews.

The data was first bracketed to find meaning from the transcripts, which facilitated in the generation of preliminary meaning units. Next, the researcher reviewed the narratives to delineate the central categories and clusters of meaning derived from the interview data. The categories were organized into tables that provide what the significant phrases were chunked into the analytical categories. From this point, the researcher reviewed the interview data again across
the cases for the relevant themes that emerge from across the different interviews. This chapter concludes with a discussion of the cross-case analysis to provide a deeper understanding of the lived experience of counselors’ empathic response to clients via telephonic counseling during the COVID-19 pandemic.

**Demographic Information**

There were eleven participants in this study. Each participant engaged in the semi-structured interview via Zoom Videoconferencing. All participants provided telephonic counseling to clients during the COVID-19 pandemic. The ages of participants ranged from 27 to 61. Not including the outlier age of 61, the mean age of this sample was 31.2. All participants held a master’s degree in the counseling field. Seven participants worked in an agency setting, two participants worked in a private practice setting, and two participants divided their counseling between both an agency and private practice setting. Of the two participants working solely in private practice, one participant (10) reported owning and operating her own practice. Regarding years of practice, Participant 10 was at outlier, reporting 30 years of counseling experience. Not including this outlier, the mean years of counseling experience in this study was 4.35. Participants were also asked about their locations of practice, which were reported by state. Seven participants identified that they practiced in Pennsylvania, two in Ohio, one in Florida, and one in Nevada. Table 1 provides a summary of the demographic information reported by the participants.
### Table 1
(summary of participant demographic information)

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**Individual Interviews**

All interviews were formatted as semi-structured and were audio and video recorded via Zoom Videoconferencing, the medium through which they were conducted. All interview recording were kept in a password-locked storage device. Interviews ranged from 1 to 1.5 hours in length.
Presuppositions

As the primary researcher behind this study, I acknowledge a certain degree of influence to its outcome (Creswell, 2016). To mitigate such influences when working with the interview data, I used reflexivity. As a means of enacting this reflexivity, I, as the researcher, had to have “an ongoing conversation with [myself]” (Berg, 2009, p. 198). This practice helped me identify presuppositions, assumptions, and potential biases that might affect the study.

The first presupposition I uncovered was my own comfort with the telephonic counseling medium. As mentioned in Chapter 3, I currently work in an agency setting in which telephonic counseling was considered normative treatment during the height of the COVID-19 pandemic. As such, I delivered telephonic counseling sessions to an average of 23 clients per week across a 1.5-year period. Because of this ongoing exposure, I gradually became more comfortable with the medium as time progressed, considering engagement in six or seven consecutive telephonic counseling sessions to be part of a normal workday. Additionally, I identified my comfort speaking to others on the phone in general. In my personal life, I regularly engage in phone conversations with friends and family that may easily last an hour or more. I recognize that many people may feel uncomfortable with phone conversations or may even dread such experiences.

A second presupposition that I identified was the history of my counseling work in an impoverished rural area. As mentioned in Chapter 3, I work primarily with lower SES clients who had limited access to videoconferencing hardware and Wi-Fi. Although I had several clients who voiced discomfort with talking on the phone, there were many clients who simply accepted their transition to telephonic counseling due to lack of access to videoconferencing resources. When my agency switched to remote counseling near the beginning of the pandemic, telephonic counseling was considered by administration to be a path of least resistance due to financial
barriers, whereas videoconferencing was considered an additional option if possible. I recognize that practices situated in more middle or upper SES areas might consider videoconferencing counseling to be immediately accessible to clients and might see telephonic counseling as a “last resort” option that might even be dreaded by counselors in such environments.

A third presupposition that I acknowledged was the fact that I primarily conducted telephonic counseling from my home setting in which I lived alone. I did not have to plan my work-from-home schedule around other family members and did not have to care for children in addition to the labors of the workday. I also had the option of working from the office as much as I wanted and chose to drive to the office to deliver telephonic sessions as a means of decreasing saturation regarding the isolation of working from home. It is also important to note that I exhibit introverted tendencies and enjoy spending time at home by myself, which may have presented a protective factor to feelings of isolation during the pandemic.

A fourth presupposition that I discovered was my exposure to literature that considered telephonic counseling to be equally as effective as other modes of counseling (Dilley et al., 1971; Hall & Schmid Mast, 2007; Reese et al., 2016), and empathy literature that considered empathizing with audio-only to be equally as effective as empathizing with other channels of communication (Gesn & Ickes, 1999; Hall & Schmid Mast, 2007; Kraus, 2017). It is also important to note that, in my own clinical experience delivering telephonic counseling, I found that empathizing with clients was relatively comparable to empathizing with clients in the face-to-face setting. I also perceived telephonic counseling as a growth opportunity, seeing the removal of visual contact as a chance to increase focus on verbal elements in session.

A fifth presupposition that I acknowledged was my view of empathy as important to the process of counseling. Although a multitude of authors in the literature (Côté & Miners, 2006;
Elliott et al., 201; Ickes et al.; 1990; Rogers, 1959; Schmid, 2001; Stinson & Ickes, 1992; Zayas et al., 2002) have spoken to the importance of empathy in the process of counseling, I acknowledge that perceiving this factor as foundational may present a degree presumption when asking into participants’ views on the importance of empathy.

A sixth presupposition that I unearthed was that I never tested positive for COVID-19, never had significant symptoms during the pandemic, and never had to quarantine during the pandemic. Additionally, none of my immediate family tested positive for COVID-19. It is also important to note that I am a relatively young and healthy person who did not have significant pre-existing conditions during the pandemic that exacerbated COVID-related fear.

A seventh and final presupposition that I found was that I did not perceive the COVID-19 pandemic as a politicized event, but rather a biological one. I identify as relatively moderate regarding political outlook and did not engage in politicized conversations with my clients regarding the pandemic. I took reasonable precautions during the pandemic, voluntarily received a vaccination, and abided by policies set forth by my agency.

Analysis of Interviews

As noted above, all interviews in this study were conducted via Zoom Videoconferencing. Interviews were conducted during a day and time that best accommodated participants’ work schedules. During these interviews, the informed consent documents were reviewed as well as the “next steps” of the research project. Participants were reminded that this meant recording their interviews, transcribing the recordings, and redacting any identifying information possible. The interviews would be summarized narratively, and an analysis of the interviews seeks words of significance between sessions.
All interviews followed the same general structure, as shown in Appendix D. Interviews began with a broad inquiry into the participant’s lived experience of empathically responding to clients via telephonic counseling during COVID-19. This allowed participants to openly speak to their experience with no imposed specificity from the researcher. Next, the researcher inquired into the participant’s view on the role of empathy in the process of counseling, and the importance of empathy. The researcher then asked the participant about whether they had received supervision during telephonic counseling, what setting(s) they primarily worked in during their delivery of this medium, and how consumption of COVID-related media influenced their empathic response toward clients. Next, the researcher asked into the participant’s lived experience of transitioning from in-person to telephonic counseling during COVID-19, asking the participant how this transition affected their empathic response toward clients, and what SES group(s) they primarily worked with during this transition. The researcher then asked the participant if they noted any difference in their empathic response regarding face-to-face versus telephonic counseling.

After this initial query, the researcher asked the participant what it was like for them to empathize with clients through the specific mediums of face-to-face, telephonic, and videoconferencing counseling. Lastly, the researcher asked the participant how their own personal experiences regarding the COVID-19 pandemic affected their empathic response toward client. Prior to engaging in this final series of questions, the researcher asked the participant if he could inquire into the personal nature of these experiences. Each participant reported offered their consent. The researcher asked whether the participant had tested positive for COVID-19, was ever exposed to COVID-19, ever had to quarantine themselves from others, and how much COVID-related media they consumed per day. Following each of these questions,
the researcher inquired into how the given factor affected the participant’s empathic response toward clients. The researcher concluded each interview by offering the participant the opportunity to share anything not discussed or anything that they were hoping the study was going to cover but was not addressed in the interview. Each interview lasted between 1 and 1.5 hours.

Interview data was explicated by use of Clark’s (2010) integral model of empathy and its central tenets to analyze interview data. Specifically, the researcher looked to the tenets of subjective, interpersonal, and objective empathy. Within the concept of subjective empathy, the researcher regarded the sub-concepts of identification, imagination, intuition, and felt-level experiencing to further enrich and thematize the explication process.

Most importantly, the present study aimed to highlight individuals’ lived experience regarding empathic response to clients via telephonic counseling during COVID-19 and used People’s (2020) steps to realize this objective. In the explication process using Peoples’ (2020) steps, the researcher explored the raw interview, delineated units of meaning in the interview data, and clustered units of meaning to identify themes that ran through the interviews. The goal here was to reduce the volume of information encapsulated within the eleven interviews into manageable pieces of information (Kruger & Stones, 1981). The themes and subthemes emerged from the research organically.

After saturation was reached in the eleventh and final interview, these themes were related back to the research questions. The study reached saturation by way of themes versus the unique details reported by each participant, as the ever-expanding nuance of participants would have rendered this an impossible task. Any information that was unrelated to the research questions was excluded from further analysis. These units of meaning were then combined into
chunks of data, while preserving the participant’s wording to address the actual perceptions of the participants’ experiences. The final stages of the process involved situating narratives into general narratives, integrating all major themes of participants, followed by the researcher generating a general description of the findings (Peoples, 2020). These significant themes could be divided into three general categories related to the research questions, with a total of eleven subcategories falling within the main categories. These themes and subthemes are discussed in greater detail in Chapter 5.

The three major categories and eleven major subcategories are as follows:

1. Subjective Empathy
   a. Identification
   b. Imagination
   c. Intuition
   d. Felt-Level Experience

2. Interpersonal Empathy
   a. Understanding the Client’s Lived Experience
   b. Understanding Barriers to Counseling
   c. Understanding Clients’ SES Situations
   d. Environmental Barriers to Interpersonal Empathy
   e. Emotional Barriers to Interpersonal Empathy

3. Objective Empathy
   a. Information from Supervision as a Source for Objective Empathy
   b. Information from COVID-Related Media as a Source for Objective Empathy
Case-by-Case Analysis

This section presents information in a case-by-case fashion using a narrative context with each participant. Each narrative discusses each participant’s relationship with the three themes and eleven subthemes discussed in the previous section.

Interview 01

Participant 01 is a 27-year-old white female master’s level clinician who works in an agency setting in Ohio, where she works primarily with clients experiencing intimate partner violence (IPV), providing individual outpatient counseling. Participant 01 has worked in the counseling field for 3 years, accumulating a total of 19 months of this time during the COVID-19 pandemic. On average, Participant 01 reported seeing 15 telephonic clients per week. When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 01 indicated 9.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 01 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 01 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 01’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“Over the phone, it's very interesting because it's so separated. When you're able to see things in person…mirror neurons are firing and you're able to truly be with them in that
moment, and there is that lens of separation with being able to have that experience and be able to read the nonverbal cues.”

Without further prompting, Participant 01 proceeded to comment on elements of the client’s natural environment that were additive to her empathy:

“There's also the interesting layer of having the clients in their natural environment, and so, in some ways that's able to increase my empathy, because my client might complain that their child is always crying or that the neighbors are always really loud, or they're living in a place with tons of noise pollution, and that stuff—contributes their mental health symptoms. And when you’re hearing with your clients, obviously you have some level of empathy for them and it's hard but it's so different when you're actually hearing these things happen during the session.”

After this initial exploration, the researcher asked Participant 01 about her perspective on the role of empathy in the process of counseling. The participant shared her perspective on the integral nature of empathy. She commented:

“…[empathy is] the number one driver. If we're not able to empathize with our clients, we're not able to do our job. If I don't have empathy for my clients, I probably wouldn't care about their outcomes. I wouldn't have that internal motivation to be able to watch them grow…”

The researcher then inquired into the participant’s thoughts were on the importance of empathy. Participant 01 discussed empathy as the factor that helps to establish a safe and welcoming therapeutic environment, stating:

“I just think [empathy is] what helps a client feel heard. I think it's what helps the client feel like they can trust you to be able to open up…you're not going to be sharing your
inner world with somebody who's not listening, who doesn't care, who doesn't really want to be there with you. And so I think that it's the most important for clients to be able to feel safe in an environment to open up and be able to heal.”

Following this inquiry into the participant’s broader thoughts on empathy, the researcher asked into whether Participant 01 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had. She spoke to supervision as a place to consult on differing scenarios that telephonic counseling precipitated. The participant said the following:

“…there was also ongoing supervision with my supervisor because weird situations, like, what happens when a client is driving their car, or you can hear them ordering fast food in the background? In the traditional office setting you never dealt with that, but now there's this extra layer of, what does safety look like? Now, how do we still be able to have a space where we can ensure confidentiality? Now I've had clients who have said, you know, we always have to ask the beginning, like, ‘Where are you?’ and, like, ‘Who's in the room, with you?’”

The researcher then inquired into the topic of setting. Participant 01 reported that she had primarily delivered telephonic sessions in her home. She commented on the loneliness that permeated the pseudo work environment of home:

“I think there's the level of burnout that you have from not being able to see your coworkers. The support that you would be able to have jumping into someone's office and between things and having that connection versus feeling very isolated doing very hard work…feeling cut off from the rest of the group, it was tough for sure.”
Further speaking to her experience working from home, Participant 01 discussed how the pandemic influenced how clients perceived her as a therapist, stating the following:

“I think [the pandemic] helped my clients also feel like it wasn't just them who felt like their world changed. Like, everyone's changed in some way. Even their therapist...”

Next, the researcher asked into Participant 01’s experience regarding COVID-related media. The participant reported that such media coverage acted as a precipitant of anxiety and excited worry for her clients. The participant also noted that COVID-related media brought to the fore social choices that clients are engaging in during the pandemic that may or may not align with her own value system. Participant 01 stated the following:

“I had a couple of clients who used this time to become social butterflies. They would tell me that it's fantastic. Everyone's home, so I’m having big family reunions. My kids are having birthday parties with everyone on the block. And I felt like my empathy was starting to lessen with some of those people, because I think I was getting frustrated because I saw it as more of a world problem and not just a client-centered issue...”

The researcher then moved to the next research question, inquiring into Participant 01’s experience of transitioning from in-person to telephonic counseling. The participant spoke the change therapeutic environment that she experienced, reporting the following:

“I think, for a lot of [telephonic counseling], it was harder. There were environmental distractions. I was able to, for the first time, do concurrent documentation, which was helpful in some ways, but hearing your client and typing it up is so different than seeing them.”

After some additional reflection on therapeutic environment, Participant 01 spoke to providing therapy to the client in their natural environment, noting the following:
“The gain was definitely being able to hear the client and their natural environment. I think a lot of times. It can be really, like, therapy offices, as nice as we try to make them warm and inviting, like, it's a therapy office it's not their home space, and so a lot of the time I was able to have clients feel a lot more relaxed…”

After some further commentary on her own distractions and restlessness providing telephonic counseling in her own home environment, Participant 01 spoke to the intersection of telephonic counseling and SES. The participant said the following regarding some of her lower SES clients finding telephonic appointments to be more accessible than videoconferencing:

“…I also think that so many of my lower SES clients do more of the phone calls because of the lack of a good environment. They have to go into their car and not have it running, but just sitting in their car, because they don't have their own space. I have people in a shelter, who have to go to a park bench on a non-busy street to be able to do those things. And I think all of those types of things contribute to the difference in the levels of what people are able to access.”

Participant 01 proceeded to discuss how telephonic counseling helped to mitigate barriers to counseling services such as transportation limitations and childcare considerations. However, the participant also commented on environmental distractions that her clients faced, which impeded their privacy. Participant 01 said the following:

“My clients with lower SES commonly had a lot of barriers to privacy… I had one client whose family members were camping in their living room…and I think that their level of external stressors that they were experiencing definitely impacted their ability to fully be present in the sessions and be able to get what they wanted out of it.”
Proceeding to the next interview question, the researcher inquired into differences that Participant 01 noted regarding empathizing with clients over the phone, versus other mediums. Regarding the difference between telephonic and in-person counseling, Participant 01 said the following:

“…[telephonic counseling] is definitely weird. What are you supposed to be focusing on? What are you supposed to be able to use to stay grounded, to stay present with the client? And also, I think there's that extra barrier of the lack of clarity. I think there's just so much more value to be able to see a person as they're speaking, versus hear.”

Speaking further to in-person counseling, Participant 01 spoke to a unique experience in which she delivered in-person counseling to a Spanish-speaking client who received interpretation services over the phone. She also commented on client facial expressions that are lost behind masked in-person sessions. The participant said the following:

“…we can't have interpreters in person…once I bring [my Spanish speaking client] to my office, I have to call an interpreting service, move the chair to sit between the two of us and interpret in that way. There are common errors made. They are asking us to repeat a lot. It's harder because of…the masks… she's one person I wish I could do video with, because I feel like being able to see her face would help so much, and it's just so unfortunate that the masks are really getting in the way.”

Further speaking to her work with clients in the midst of the pandemic, Participant 01 discussed the dynamic of navigating COVID-19 alongside her clients, and how this experienced precipitated a sense of both solidarity and division. She said the following:

“I think I was very much in the boat of, ‘We are all in this together. It’s up to everyone to make these changes.’…I think I had some human judgments [regarding clients’ choices
during the pandemic]…I’d have to kind of rain myself back and be like, ‘Okay, this isn't what it's about.’”

The researcher then briefly inquired into Participant 01’s experience with videoconferencing counseling during the pandemic. The participant discussed how being able to see the client’s natural environment offered new perspective on the client’s lived experience in their home environment. She stated:

“…I think you're able to see [the client] parent. You're able to see them do all of these things. I only see them as a client one hour a week, but in this way, I’m seeing so much more of them…I have clients who have described deplorable home conditions, but it's really different being able to see behind them…I have a client whose husband had punched holes and all of the walls. Most of the drywall is missing in her house.”

Participant 01 then spoke to the intersection of videoconferencing counseling and working with lower SES clients. She commented that being able to see into the environment of the client helped her to better understand clients’ financial struggles:

“…you just add this other level of just like, ‘I feel for you. Of course you're not doing your friggin’ homework that I gave you with the CBT worksheet. You're trying to handle these types of things.’…Maybe we need to do other things that I might not have known about prior to us being able to do video sessions.”

The researcher then moved to the final research question of the study, inquiring into how Participant 01’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant began by reflecting on how the saturation of her own own COVID-related concerns precipitated compassion fatigue and overwhelm. She shared the following:
“I lost a family member pretty early on to COVID…Prior to her death, I was just thinking about my concerns for her, and then after her death. And then experiencing these types of things as my clients are telling me it. I’m just like, ‘I don't want to hear any more of it.’”

Speaking further to the impact of her own personal experiences, Participant 01 discussed how the pandemic precipitated more self-disclosure and humanization in her role as therapist. She commented:

“…sometimes I’d have clients who had asked me, ‘I feel like I've been going through a lot with this. Is this impacting you? Have you lost anybody?’ And I would say my level of disclosure with clients has been a lot more during COVID just because it's just relevant, and it kind of comes with the territory.”

On a sobering note, Participant 01 discussed her fear regarding the pandemic and how her death or coworkers’ deaths would impact clients at her agency. She reported that she and her coworkers discussed this prospect, stating the following:

“…there was this level of concern that, if I'm sick, where are my clients going? And you know, we had talked in my therapy group about what we would do in those types of situations–if one of us got COVID; if one of us dies from COVID. My boss was trying to get us all to get our wills straightened out. It was very concerning at the beginning, and I think that was a major concern that I had, this extra pressure.”

After Participant 01 reported that she had not tested positive for COVID-19, the researcher inquired into the participant’s empathic response to clients who had tested positive. The participant said the following:

“…I truly don't know what it's like to experience having to go tell your family and having to figure out the isolation piece of it. I had a client, today actually, who tested positive
last week. And she was telling me about the body soreness and what it meant for her. Her
daughter has been vomiting a lot and she's like, ‘I don't even know that was something
that was part of COVID’…So I didn't know what that was like. But at the same time, I
think that I know so many people personally and around me that I’m still able to kind of
get an idea.”

Despite not testing positive, Participant 01 spoke to the fear around being tested for
COVID-19, and how this experience impacted her ability to be present with clients. She
reported:

“I think it was really scary…I didn't know what the long term [of having COVID-19]
would look like, and luckily my work has a testing site and we only had to wait 24 hours.
But during those 24 hour it was hard to stay fully present with clients, because I was
nervous in the back of my head, like, ‘What if I'm sick?’”

The researcher then inquired into whether Participant 01 had quarantined herself during
the pandemic. The participant reported that she had quarantined out of precaution due to her
husband working closely with patients as a physical therapist. She commented:

“My husband is a physical therapist…so he was redeployed for a long-term rehab where
he essentially did temperature checks and other inpatient type physical therapy, so
working hands-on with patients. So, because of that I was really nervous about
interacting with others. So that Easter, my parents came to my patio and brought me an
Easter meal and they waved to me, but I was very strict about not wanting to see them. I
didn't see them for my birthday. Traditional things that we would normally do, I said no
to…I did take it very seriously.”
As a result of this quarantining, Participant 01 shared that her investment in her cases increased. She stated:

“…some of [my clients] were the only people I was talking to… and sometimes I felt like I got more invested than I ever had because I was very isolated… I felt like there's a strange need in me that ended up getting met in addition to what they were getting from therapy just because it was some sort of connection.”

The researcher then inquired once more into Participant 01’s consumption of COVID-related media, this time querying into how this experience has impacted the participant’s empathic response toward clients. The participant shared that the majority of COVID-related media was consumed via Reddit, where she read information about how the pandemic had impacted restaurant workers. She made the following reflection:

“…hearing clients’ dilemmas about, ‘It's either I don't have a job or I risk my safety and my kids’ safety to make some sort of money this week’, because a lot of them, they couldn't get unemployment if they quit the restaurant job or those types of things, and so you really felt for them hearing those types of things…”

Participant 01’s reflection on restaurant workers’ challenges during the pandemic spurred further conversation on client SES and how this variable has impacted their progression through telephonic counseling. She shared the following:

“…the clients of the higher SES, you have a really nice home office and are safe. We were still able to talk about the presenting issues and their goals and treatment plans were the exact same, versus my other clients with lower SES, who didn't have quite those same privileges. A lot of the therapy was focused on just the day-to-day. We weren't able to
focus on those long-term goals, because we were just trying to focus on how to make it through today.”

As a final question of the interview, the researcher invited Participant 01 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant commented on the increased access to treatment that telephonic counseling provides. She stated:

“…[clients’] attendance was low, to the point where they had to be discharged, because they were breaking the attendance policy. But now we're having a lot less of that because we're able to reach them in different ways. And sometimes it's not ideal, but sometimes it's still meeting them where they're at and they're still able to get therapy, when they otherwise might not have been able to.”

At the end of the interview, the researcher thanked Participant 01 for her participation in the study. The participant shared that she had no further information about her lived experience to add to the interview. The interview with Participant 01 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 2 provides a visual representation and review of these phrases of significance from the narrative above.
### Table 2

*Participant 01 Phrases of Significance*

<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective empathy a</td>
<td>“If I don't have empathy for my clients, I probably wouldn't care about their outcomes. I wouldn't have that internal motivation to be able to watch them grow…”</td>
</tr>
<tr>
<td>Identification</td>
<td>“…you're just trying to help them through something that you don't understand yourself…”</td>
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<td></td>
<td>“…because of the sudden shift, [clients] felt [being stuck at home] with me as well…”</td>
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<td></td>
<td>“I think I was very much in the boat of, ‘We are all in this together. It’s up to everyone to make these changes.’”</td>
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<td></td>
<td>“I think [navigating the pandemic] was one of those things that I was able to have a genuine connection with a lot of the clients.”</td>
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<tr>
<td></td>
<td>“I think [the pandemic] helped my clients also feel like it wasn't just them who felt like their world changed. Like, everyone's changed in some way. Even their therapist…”</td>
</tr>
</tbody>
</table>
“I would say my level of disclosure with clients has been a lot more during COVID just because it's just relevant, and it kind of comes with the territory.”

Imagination

“At certain times, I would try to close my eyes and visualize the client in front of me.”

“…[the client and I] would constantly have to do, like, check-in questions and things like that, because on the telephone it's so much harder to see those things…”

“Imagine being able to save [a long] drive and being able to still get the kind of quality of care.”

Intuition

“…without the visuals you have to really focus on the tone of [the client’s] voice and what it is that they're saying, and so you have to be a lot more intentional…”

“Over the phone, it's very interesting because it's so separated. When you're able to see things in person…mirror neurons are firing and you're able to truly be with them in that moment, and there is that lens of separation with being able to have that experience and be able to read the nonverbal cues.”

“I had a client who had even told me—she's like, ‘There's only so far I can go with this, because I don't know what you look like.’”
“I think there's that extra barrier of the lack of clarity. I think there's just so much more value to be able to see a person as they're speaking, versus hear.”

Felt-level experience “…feeling cut off from the rest of the group, it was tough for sure.”

“But I also think that the alternative of being in the office and being with people probably wouldn't have helped my COVID anxiety at the time either…”

“…there was this level of concern that, if I'm sick, where are my clients going?”

“…I was really nervous about interacting with others.”

“I know there was obviously a lot of fear and a lot of sadness that we experienced through all of this…”

“…some of [my clients] were the only people I was talking to… and sometimes I felt like I got more invested than I ever had because I was very isolated…”

“…I might have been having more dreams or thinking more about my clients outside of work hours than I had prior to [telephonic counseling].”
“I lost a family member pretty early on to COVID…And then experiencing these types of things as my clients are telling me it. I’m just like, ‘I don't want to hear any more of it.’”

“…it was sometimes really difficult and hard to hear more and more about how is impacting other clients and their lives and things like that.”

“I picked up this habit of fidgeting [during COVID-19]…usually that was something that helped me stay a little more grounded…”

“What are you supposed to be focusing on?
What are you supposed to be able to use to stay grounded, to stay present with the client?”

“I think [media consumption] increased my anxiety…I was worried for my clients…”

Interpersonal empathy

“I just think [empathy is] what helps a client feel heard. I think it's what helps the client feel like they can trust you to be able to open up…you're not going to be sharing your inner world with somebody who's not listening, who doesn't care, who doesn't really want to be there with you. And so I think that it's the most important for clients to be able to feel safe in an environment to open up and be able to heal.”
“I feel like presence and empathy, for me, go really hand in hand…”

Understanding the client’s lived experience “…this was kind of like a specific problem to just my client, rather than something I was also feeling.”

“…I truly don't know what it's like to experience having to go tell your family [that you have COVID-19] and having to figure out the isolation piece of it.”

“There's also the interesting layer of having the clients in their natural environment, and so, in some ways that's able to increase my empathy…”

“…I work with domestic violence survivors, so sometimes I can hear abuse happening in the background…”

Understanding barriers to counseling “I had people's attendance rates skyrocket because of COVID and their ability to attend therapy.

Because all of those other barriers were reduced”

“…[telephonic counseling] is still meeting them where they're at and they're still able to get therapy, when they otherwise might not have been able to.”
“I've had clients who had to leave an hour early from work because they have such bad driving phobias that they were so afraid of the traffic to get to my office. Like, ‘it's so great that I don't have to do that.’”

Understanding clients’ SES situations “…I also think that so many of my lower SES clients do more of the phone calls because of the lack of a good environment. They have to go into their car and not have it running, but just sitting in their car, because they don't have their own space.”

“…the clients of the higher SES, you have a really nice home office and are safe. We were still able to talk about the presenting issues and their goals and treatment plans were the exact same, versus my other clients with lower SES, who didn't have quite those same privileges. A lot of the therapy was focused on just the day-to-day. We weren't able to focus on those long-term goals, because we were just trying to focus on how to make it through today.”

“My clients with lower SES commonly had a lot of barriers to privacy… I had one client whose family members were camping in their living room…”

Environmental barriers to interpersonal empathy

“There were environmental distractions. I was able to, for the first time, do concurrent documentation, which was helpful in some ways, but hearing your client and typing it up is so different than seeing them.”

“I will also admit that there were times worrying on the phone I wasn't able to fully feel as present because I'm in my house and I am trying really hard…”

“If they can't see what I'm doing, I can try to fix my hair or do something small that's not going to be impacting my ability to hear them. But it definitely took away some of the focus…”

Emotional barriers to interpersonal empathy

“…it was sometimes really difficult and hard to hear more and more about how [the pandemic] is impacting other clients and their lives and things like that.”

“…you could feel [empathy for clients’ experiences] on a deeper level, but at certain times I wasn't in a position where I wanted to feel it anymore.”

“…it's harder for me to stay fully present if I'm focusing more on COVID risk and my feelings of not being as comfortable with the client.”

“…it was really scary, the first time that I got
tested [for COVID-19]…during those 24 hour it was hard
to stay fully present with clients, because I was nervous in
the back of my head, like, ‘What if I'm sick?’”

“I had a couple of clients who used this time
to become social butterflies…I felt like my empathy was
starting to lessen with some of those people, because I
think I was getting frustrated because I saw it as more of a
world problem and not just a client-centered issue…”

Objective empathy

“…[empathy is] the number one driver. If
we're not able to empathize with our clients, we're not
able to do our job.”

Information from supervision as a source for objective empathy

“…there was also ongoing supervision with
my supervisor because weird situations, like, what
happens when a client is driving their car, or you can hear
them ordering fast food in the background? In the
traditional office setting you never dealt with that, but
now there's this extra layer of, what does safety look
like?”

“I've had people who have been on city buses
or people who you can hear shushing others in the
background, because they want to have their session but
don't have space to do that when in homeless shelters.
Don't have the space, and so there's a lot of problem
solving. So, there was a lot of ongoing consultation and supervision with that…”

“…[supervision] really broke it down because there wasn't a lot of direction when telephonic therapy started in terms of what works and what doesn't work.”

Information from COVID-related media as a source for objective empathy “…you feel so terribly, but [consuming COVID-related media] also brings up that stuck feeling of being a therapist and just recognizing the larger community and things that are outside of your control…”

“…a lot came out on Reddit about health care about restaurant workers, and what their experiences were like…I have a lot of clients in the restaurant industry, and I was thinking about how it must be like for them and how they were treated…”

^Master theme.

**Interview 02**

Participant 02 is a 27-year-old white female master’s level clinician who works in an agency setting in Pennsylvania, where she primarily provides individual outpatient counseling to adult clients. Participant 02 has worked in the counseling field for 3 years, accumulating a total of 18 months of this time during the COVID-19 pandemic. On average, Participant 02 reported seeing 15 telephonic clients per week. When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 02 indicated 8.
The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 02 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 02 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 02’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“[Telephonic counseling] has been a challenge…I'm very conscientious when it comes to observing people when we are in person or doing Zoom—any kind of visual. I cater—obviously my body language and my words; just how I interact with the individual that gives so much data…essentially having a blindfold on has been difficult in the way of understanding how [clients] are feeling and having to use more specific language to say, ‘What are you feeling?’, ‘What are you doing right now?’, ‘What does your face look like?’…making them have to say that and explain it has been helpful for me to be able to empathize…”

Despite the difficulties reported above, Participant 02 added that empathy made her a “better counselor” due to the visual buffer that telephonic counseling provided. She elaborated with the following:

“…not having to see the client’s reaction, it's made challenging them easier. Which in some ways, I think, is what can be needed, and has probably been better in terms of giving them better quality of care in that regard, where it doesn't stop me. Their
expression to what I'm saying doesn't stop me from challenge them if that makes sense. Where in person, it can be more challenging to do that because of that empathy factor.”

After this initial exploration, the researcher asked Participant 02 about her perspective on the role of empathy in the process of counseling. The participant reported, “I don't know that it's possible to do this job unless you have the ability to empathize.” She then followed with a caution regarding empathic response:

“…some people would say you have to have had the exact same experience to empathize. I disagree. I think that it has to be similar, being able to see an emotion, or hear an experience—something that you can identify with. Doesn't have to be exact, or similar, but like human emotion you can understand. Puzzle through it in that way…”

Participant then reiterated the importance of empathy by discussing its bearing on the therapeutic alliance. She said the following:

“…bottom line, I mean, counseling is a relationship, so I think if you can build that relationship with the client, you build their trust. You spend time with them and get them to a place where they feel as though they are safe. I don't think that process can happen without empathy.”

Participant 02 then spoke to her use of verbal narration as a means of compensating for no visual contact with the client and the initial discomfort of this transition. She stated:

“I'll call it out and say, ‘We're over the phone; you can't see me. I'm smiling right now…’ I'll specifically say what I’m doing instead of showing it, which is was initially very uncomfortable to have to say, ‘I'm smiling.’”
Further speaking to the growing pains precipitated by telephonic counseling, Participant 02 commented on greater emphasis on vocal tonality due to speech being the only tool available to the counselor:

“…your only sense that we have available is speech, so that tightened…I think I’m much more animated through words, and I am visually when someone's sitting with me, I like to use in-person calming behaviors. I think, on the phone if I don't answer up higher, where I’m like, ‘Hey! How's it going? Tell me what's going on.’ If you don't have energy going into that and humor and your personality, it makes it harder to establish and maintain the relationship.”

Following this extended query, the researcher asked Participant 02 about her thoughts on the importance of empathy. The participant spoke to the double-edged nature of empathy regarding sensitivity to clients’ experiences. She said the following:

…I think sometimes having a lot of empathy can make life harder. And so having gone through that experience of growing up or be a person who has seen the world through that lens is a beautiful thing, but also…you see the flip side of that, the shadow side which can be very painful…”

Leaning back into the benefits of empathy in session, Participant 02 reported the following:

…I think it would be very difficult for a person to be in this field without having empathy and maintaining a therapeutic relationship. So I feel like—I don't feel like—I know that that's how people make the most progress—is if they have that relationship established…I think people who have more empathy—it's easier for them to give themselves in that therapeutic dynamic.”
Following this inquiry into the participant’s broader thoughts on empathy, the researcher asked into whether Participant 02 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had. She discussed how supervision had given her clinical support that was otherwise absent due to workplace isolation during the pandemic. She stated:

“…during [the pandemic], not having coworkers to bounce things off of and losing that support system physically…that supervision was a lifeline…I think it helped me stay grounded.”

Participant 02 then further elaborated on her supervisory experience during the pandemic, reporting that supervision helped to facilitate self-confidence and diminished self-doubt. She said:

“I was going through a period with my clinical development where I was having a lot of self-doubt because of that transition of having to use your voice more and rely less on visual cues. I had gotten very reliant on watching my clients and changing myself and accommodating my language to those visuals, that it was just very jarring to only have to use speech. So yeah, supervision with that aspect of gaining confidence was very crucial…I think it was one of the biggest reasons why I was able to stay balanced during that time.”

As the semi-structured interview progressed, the researcher heard Participant 02 speak to increased self-disclosure in session with clients and inquired further into this experience. The participant shared that commonality in experience regarding the pandemic likely precipitated increased self-disclosure. She reported:
“…I don't know why I was able to feel more comfortable sharing more details about what was going on…we had all gone through the same experience, too, which I think is probably the biggest piece. We were all coping with the same thing.”

Continuing to inquire into the participant’s self-disclosure and navigation of the pandemic, the researcher asked the participant about her use of identification as a tool for empathizing with clients. Participant 02 shared that identification helped as a substitute of sorts for the lack of visual client with the client. She said the following:

“…you'd have to see the person's expression and be like, ‘Oh, they're upset.’ You don't have that. You have to connect with something inside yourself and a previous experience. Or be like, ‘Oh, she's probably sad because of this, or that probably created this reaction, am I right?’…You could repeatedly be wrong. It puts…your empathy to the test in that way.”

The researcher then inquired into the topic of setting. Participant 02 reported that she had primarily delivered telephonic sessions in her home for the first year-and-a-half of the pandemic. She commented on the suddenness of the transition to conducting telephonic sessions in her home:

“We received an email…‘everything’s shutting down, and we're going to transition immediately to work from home.’…it was a complete overhaul that day. And then it was just, “Call all of your clients, let them know that they're no longer coming in person.’”

The researcher asked the client what her experience had been like in the early months of the pandemic when she had worked exclusively from home. The researcher began with, “I think I learned how much social support I was receiving from the people that I work with. And [being isolated from them] was the biggest challenge.” The participant followed this narrative with
commentary on her adaption to preferring the process of telephonic counseling in the home environment. She said the following:

“I think probably six months, about, went on…and then it switched—something clicked in my brain and flip-flopped to being, ‘I want to keep doing this.’ Like, ‘I’m good at this. I feel confident in this, more so than I do giving counseling in person. I don't want to go back.’ (laughs)...I was able to adapt. I didn't want to change, again, I just wanted to keep it as is.”

The researcher then asked into the client’s experience providing telephonic counseling while located in an office setting. Participant 02 spoke to the isolating environment that an empty office space held:

“I very much steered clear of the office during [quarantine]. I would maybe go in once every two or three months. And when I was...It was very lifeless. There was nobody around. Yeah, it was quite lonely. It was just, ‘Shut your door, call your client on the office phone,’ and just kind of sit in your chair and I thought, ‘Why would I do this if I could just be at home? So why am I sitting in this place?’ And then that kind of shifted my thinking of maybe I don't want to be back here.”

The researcher then asked Participant 02 how providing telephonic counseling in this desolate office setting impacted her empathy toward clients. The participant spoke to the increased sensitivity it precipitated regarding client experiencing a similar sense of isolation:

“...it was those moments of being in the office and missing that environment of the warmth and then realizing like, ‘Oh, I’ll just have to go out and find this elsewhere,’ and I was able to do that and enjoy a nice support system, and then the reality setting in that a
lot of my clients just don't have that. And what that impact and the magnitude of that feeling must be.”

Next, the researcher asked into Participant 02’s experience regarding COVID-related media. The participant shared that she did not find such media worthwhile to consume, as it began to precipitate increased anxiety. She said the following:

“I think [media consumption] was much heavier in the beginning [of the pandemic]…I didn't really get anything from it in terms of comfort or information, and so I learned very quickly that that was not a helpful thing to consume.”

The researcher followed up by asking Participant 02 how COVID-related media consumption affected her empathy toward clients. The participant shared that she used the “common ground” illustrated in media to empathize with her clients. However, she reported that oversaturating in the content of the pandemic with clients led to political conversations that the participant did not find to be therapeutic. She stated:

“…there were just so many political things involved with [COVID-related] content, it very quickly would lead to places that I didn't think it would be useful to go to.”

The researcher then moved to the next research question, inquiring into Participant 02’s experience of transitioning from in-person to telephonic counseling. The participant discussed her own initial hesitance about delivering telephonic counseling. She reported:

“I just had a lot of concerns with being able to maintain rapport, and whether my client was gonna get as much out of it, because I didn't really know if a client could get as much out of it, having not done it before. I didn’t know how to do telephone therapy, so my biggest concerns were just making sure that it was going to be worth their time and that I
could make it…worth their time, so it was…a challenge with trying to get out of my own way…”

The researcher followed up by inquiring into how transitioning from in-person to telephonic counseling affected Participant 02’s empathic response toward clients. The participant shared that she felt a stronger inclination to promote comfort and structure in her telephonic sessions. She said:

…I wanted my clients to feel comfortable, so I made sure there was a structure; a new structure that they could latch on to…they could feel like they're doing [telephonic counseling] right…”

Next, the researcher asked into the topic of SES. Participant 02 shared her thoughts on lower SES client being hit harder by crisis events such as the pandemic. She commented:

…people not having phones, or their phones malfunctioning, or their phone was turned off because they can’t pay for it….I think anytime you have a crisis in general, people in poverty get hit harder, so it was very difficult. It would have been very difficult to ignore that that was a factor…it was easier to do that in person.”

Without further prompting, Participant 02 went on to share her perceptive on lower SES clients living with environmental distractions, such as living in crowded situations and lacking privacy in the home setting. She shared:

…if you're living with grandparents, parents, siblings, maybe a cousin; an aunt, that's going to be a very different telephone experience than a person who can shut their door, or even just go outside and have space to talk.”

Further elaborating on the topic of therapeutic environment, the researcher inquired into
what it was like for Participant 02 to conduct telephonic sessions in the office after other 
clinicians had returned to work in the office setting. The participant shared that she felt a greater 
sense of warmth and connectivity in the company of other counselors:

“[workplace isolation] definitely improved from the scenario I was describing earlier. It's 
so weird to think about. Significantly improved, a lot more warmth. I think it's just, again, 
opening your door and knowing that somebody could be walking by once you're done 
with the session, versus opening your door and having no one else being there 
(laughs). So yeah, the client isn’t responsible for holding all that weight of being the only 
other human building.”

After some further discussion on the topic of working in the office, Participant 02 shared 
that she appreciated the consultation piece of having other practitioners in the office. She 
reported:

“…I think that brings some of that anxiety down with the uncertainty of, “Am I doing 
good work?” when you can process with another person and get more ideas and different 
approaches; run something by them. It's important and I didn't realize how important it 
was until it was taken away.”

Proceeding to the next interview question, the researcher inquired into differences that 
Participant 02 noted regarding empathizing with clients over the phone, versus other mediums. 
Regarding the difference between telephonic and in-person counseling, Participant 02 observed 
obeneficial aspects of the client having the barrier of no visual contact with the therapist, stating 
the following:

“…if you have someone with social phobia, why not incorporate [telephonic counseling] 
into the process of therapy? Have that be a gradual exposure process…if you push that
person too far out of their comfort zone, that’s just going to create paralysis…they don't
feel safe…I think you can get to the core of some of some issues more easily if you're not
staring at someone—the self-conscious factor. I do think people feel safer being more
honest.”

Further inquiring into perceived differences regarding empathizing with clients over the
phone versus face-to-face, the researcher asked Participant 02 how it has been difference
empathizing with clients while masked in person versus over the phone. The participant spoke to
the differing degrees of separation that these mediums involved:

“I just think [counseling in-person with a mask on] is like having your eyes closed on the
phone, versus holding a sign in front of your face, standing in front of a person. You still
get so much more data, but it's almost a tease. Clients with a mask on in person would be
my least favorite medium thus far.”

The researcher then briefly inquired into Participant 02’s experience with
videoconferencing counseling during the pandemic. The participant shared her personal dislike
of videoconferencing. She indicated that this factor may have been influenced by a lack of
exposure to the medium, offering a “realistic” figure of 85% of tele-health being conducted via
telephone, and the rest via videoconferencing. She shared, “…I do not like video chatting. I
don’t like it…Video is its own beast, but I probably had the least experience with it, because I
favored phone calls over that.” She spoke to her personal grievances regarding the
videoconferencing medium:

“…the eye contact is not in line with the eyes of the person—the eye contact is in line
with the camera. And the other person knows, logically, that the other person is not
looking them in the eye; they're looking at the camera. But it still feels like they're
looking you in the eye. But then they do the same performance of looking at the camera to *pretend* like we're looking at each other in the eyes and then, if they're not looking in the eyes, it gives this illusion of not paying attention, even though you're more intensely paying attention than pretending to. I think it's the eye contact. And then the fact that the visual of myself or whoever is closer to the camera where the eye contact is, I feel like I’m just staring at myself the entire time. It’s much more of my own stuff than it being a bad medium. To get over that, I just minimize myself.”

Participant 02 further discussed her disinterest in the videoconferencing medium, commenting on how her use of communication modalities in her personal life may have been brought to bear on her professional incorporation of these modalities. She stated:

“[Videoconferencing is the] most difficult modality for me to empathize with a client…I tend to call my family members on the phone, my friends. I prefer that. I usually don't do video chatting. it's probably a comfort level…I just feel I can facilitate a lot more empathetic understanding in person and through the phone.”

The researcher then moved to the final research question of the study, inquiring into how Participant 02’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant began by reflecting on how her COVID-related anxiety was more emotional than physical due to her family’s good physical health:

“[The pandemic] affected me more emotionally than I was ever concerned about it physically. But that's also just the privilege of knowing that I have a healthy family…so I had a very mild experience emotionally and physically.”

The participant then commented on how separate many of her lower SES clients’
COVID-related fears were more physical and extreme than her own. She reported that recognizing these differences has afforded her a greater understanding of her clients’ experiences. She said:

“Most of my friends are pretty healthy, and so I think that was a very, very different experience for my clients where, for them, they had experiences of life and death. And that, again, put it in perspective of poverty versus different life experiences, different access to care, different genetics, different nutrition…different education…So many things, this has pointed out.”

When asked if she had quarantined herself from others during the pandemic, Participant 02 shared that she had done so out of caution for her grandmother’s health. She stated:

“[Quarantine] was self-inflicted. I would do that before holidays…just out of being extra cautious. I didn't want to get my grandmother sick, so I only self-quarantined at least two weeks before.”

The researcher then asked Participant 02 how quarantining had affected her empathy toward clients who had also quarantined. The participant shared that she felt greater empathy for clients whose families were undergoing illness and hardship during the pandemic. She commented:

“[I felt] more empathy for the clients, whose family members were ill. Or in some way their support system was filled with unhealthy people, not necessarily just because of circumstances, because of preexisting conditions. It was hard to hear that, because you realize, even in that situation-, I'm lucky enough to have a healthy support system who could handle worst case scenario If I were to get exposed to something.”
Despite identifying as privileged when providing counseling client from a lower SES group during the pandemic, Participant 02 shared that she felt as though she could empathize with these clients in spite of the dissimilarities of their experience. If she could use her imagination to find some point of commonality, she could find the ground on which she could provide empathy to her clients. She shared:

“…if you can somehow relate, you don't have to directly experience it. I didn't directly experience it, but I do know I can imagine how painful that would be to not have had my sibling there to support me. That's the same feeling…everyone has, if you have a sibling and they're supportive and you don't have them anymore, that's a universal it's going to be painful. So I could imagine how awful that would be.”

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected her empathy toward clients. The participant spoke to the fear that consuming this type of media brought about, stating:

“…I’m already experiencing anxiety in general from [the pandemic], and so I think it was just an additional layer of; ‘Also our body of government is telling us to be really scared’…all I could control where my actions; my small bubble, and I didn't need the added layer of, ‘Oh, you don't know what to do.’ So yeah, I think steering clear of that brought down, individually, my anxiety for some [clients].”

As a final question of the interview, the researcher invited Participant 02 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant shared that she had nothing further to add. The researcher thanked Participant 02 for her participation in the study. The interview with Participant 02 provided many phrases of significance that related to
the analytical categories noted earlier in the chapter. Table 3 provides a visual representation and review of these phrases of significance from the narrative above.

Table 3

*Participant 02 Phrases of Significance*

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</tbody>
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|                       | “…some people would say you have to have had the exact same experience to empathize. I disagree. I think that it has to be similar, being able to see an
emotion, or hear an experience—something that you can identify with. Doesn't have to be exact, or similar, but like human emotion you can understand. Puzzle through it in that way…”

Identification “…if you can somehow relate, you don't have to directly experience [a client’s reported experience].”

“You have to connect with something inside yourself and a previous experience.”

 “…that launchpad of, ‘What was March 15th like for you? What was going on?’”

 “…it was those moments of being in the office and missing that environment of the warmth and then realizing like, ‘Oh, I’ll just have to go out and find this elsewhere,’ and I was able to do that and enjoy a nice support system, and then the reality setting in that a lot of my clients just don't have that. And what that impact and the magnitude of that feeling must be.”

 “…I was able to feel more comfortable sharing more details about what was going on…we had all gone through the same experience, too, which I think is probably the biggest piece. We were all coping with the same thing.”
“I think if we didn't give something
[regarding navigation of the pandemic], that could’ve
really damaged the relationship.”

“…[the pandemic] definitely changed my
perspective on self-disclosure. I was very anti-self-
disclosure…But then, after this experience, it's like it can
do a ton for validation and to normalize what we all
experience as people. We all have emotions; we all deal
with stress. We all go through global pandemics.”

“I would make it clear [to my clients]. I'd say,
‘I’m in the office This is my experience.’ I’d make a joke
out of it and be like, ‘this is super weird.’…it was an easy
icebreaker.”

“…[lack of visual contact] gives us more
freedom of building whatever visual we want to…”

“…having to use more specific language to
say, ‘what are you feeling?’, ‘what are you doing right
now?’, ‘what is your face look like?’ And I think—
making them have to say that and explain it has been
helpful for me to be able to empathize…”

“…there's still rapport there…you have to
build it in a different way that might be less
about…connection, physically, and more about having to
use your words to build that connection.”

“I’ll call it out and say, ‘We're over the
phone; you can't see me. I'm smiling right now…’ I’ll
specifically say what I’m doing instead of showing it,
which is was initially very uncomfortable to have to say,
‘I'm smiling.’

“…throughout each session I’ll say, ‘Hey,
again I can't see you, so how did you—what's happening
with you after I've said this thing?’ to give me some
information.”

“You had to…check in and see, ‘does that
emotion that I’m experiencing as you're telling the story—
is that matching what they're actually showing on their
face?’ Because you can't see it.”

Intuition

“…your only sense that we have available [in
telephonic counseling] is speech, so that tightened…”

“You have to show them your emotion and
what you're emoting through…the ups and downs of the
voice.”
“I had to do a lot more listening to the details
of stories…I would say, ‘Okay, from what I’m getting,
I’m sensing with your change in tone or with your change
in language there, I’m sensing a lot of sadness from that
experience.’”

“…being in person…I had sort of a script that
I would say, and I would tailor it to whatever information
I was getting from the person, visually. And so that's had
to change, where I think, over the phone, I've had to alter
that script, and make it much more transparent so,
whereas if they could see me, I could just communicate
that through my body, or visually.”

“I think I still use some of the same skills
being back in person. Like, ‘This data that I’m
experiencing, is that accurate?’”

“…I think, empathizing-wise and emotion-
wise, I don't think I feel quite as much for them. [lack of
visual contact] creates more of a barrier…”

“…I think if you don't verbally check in you
could have a whole session where it's like this (gestures
hands missing each other in passing).”
“…you'd have to see the person's expression
and be like, ‘Oh, they're upset.’ You don't have that [in
telephonic counseling].”

Felt-level experience

“I think I learned how much social support I
was receiving from the people that I work with. And
[being isolated from them] was the biggest challenge.”

“I very much steered clear of the office during
[quarantine]…It was very lifeless. There was nobody
around. “

“[Being alone is the workplace is] just a
strange feeling. It’s just very disconnected.”

“[workplace isolation] definitely improved
from the scenario I was describing earlier. It's so weird to
think about. Significantly improved, a lot more warmth.”

“…at this point it's exactly the same doing
telephone therapy in the office as it is at home. Feels the
same.”

“I really wasn't worried about myself getting
[COVID-19]. I just didn't want to pass it indirectly to
someone close to me. That was more of my concern.”

“[The pandemic] affected me more
emotionally than I was ever concerned about it
physically.”
“…[telephonic counseling] made me a better
counselor, being confident and not using my empathy to
stop me from challenging a client…”

“I really liked my supervision, and I think
it helped me stay grounded.”

“…supervision with that aspect of gaining
confidence was very crucial…I think it was one of the
biggest reasons why I was able to stay balanced during
that time.”

“I think probably six months, about, went
on…and then it switched—something clicked in my brain
and flip-flopped to being, ‘I want to keep doing this.’
Like, ‘I’m good at this. I feel confident in this, more so
than I do giving counseling in person. I don't want to go
back.’ (laughs)...I was able to adapt. I didn't want to
change, again, I just wanted to keep it as is.”

“Once the comfort level was established [with
telephonic counseling] and I felt pretty good at it, I had a
new way of approaching clients. Yes. I'm on board. It
could be forever.”
“…not having to see the client’s reaction—it's made challenging them easier. Which in some ways, I think, is what can be needed, and has probably been better in terms of giving them better quality of care in that regard, where it doesn't stop me—their expression to what I'm saying doesn't stop me from challenge…where in person, it can be more challenging to do that because of that empathy factor.”

“…[lack of visual contact with the client] protects me more from feeling what they're feeling.”

“…having a blindfold on has been difficult in the way of understanding how [clients] are feeling…”

“…quite frankly, it was nice to have the stability of continuing to talk to clients for myself to be like I still have a purpose, I still have a job. I'm still needed in some capacity.”

“I think [media consumption] was much heavier in the beginning [of the pandemic]…I didn't really get anything from it in terms of comfort or information, and so I learned very quickly that that was not a helpful thing to consume.”

“[COVID-related media] just was a lot of fear
and sensationalizing.”

“…the first two weeks [of the pandemic] I watched a lot of it, but that was still the mentality of like, ‘Oh, things are gonna get back to normal.’ So I wanted to watch it and be like, ‘This is an important blip on the radar of history.’ And then, once the reality set in of It was gonna be much longer, I backed off because I thought…if I keep it up at this level, I’m gonna really spiral. So I just stopped.”

“…I’m already experiencing anxiety in general from [the pandemic], and so I think it was just an additional layer of, ‘Also our body of government is telling us to be really scared’…all I could control where my actions; my small bubble, and I didn't need the added layer of, ‘Oh, you don't know what to do.’ So yeah, I think steering clear of that brought down, individually, my anxiety for some [clients].”

Interpersonal empathy a …“I think sometimes having a lot of empathy can make life harder. And so having gone through that experience of growing up or be a person who has seen the world through that lens is a beautiful thing, but also…you see the flip side of that, the shadow side which can be very painful…”
Understanding the client’s lived experience “…if I had a client who felt very strongly and intensely about [COVID-19], I knew it helped me understand the severity of it and how it can affect other people.”

“…[telephonic counseling] was a wakeup call, in terms of people's experiences. You…see more and, without seeing, you hear more than you would being in person. You get access to their world, being in their home…it definitely gives more information.”

Understanding barriers to counseling “…if you have someone with social phobia, why not incorporate [telephonic counseling] into the process of therapy? Have that be a gradual exposure process…”

Understanding clients’ SES situations “[I felt] more empathy for the clients, whose family members were ill. Or in some way their support system was filled with unhealthy people, not necessarily just because of circumstances, because of preexisting conditions.”

“I felt for the people who, either their support system died from COVID, or they physically couldn't be around them, or if they did, then they got them sick and then they had to deal with the guilt of that. That's a mental health nightmare to not have your support system,
physically. I just knew they were going to be a lot more vulnerable. I knew…those calls were going to be a lifeline.”

“I do have a lot of empathy for people during this whole period, who have not had a support system…”

“…people not having phones, or their phones malfunctioning, or their phone was turned off because they can’t pay for it….I think anytime you have a crisis in general, people in poverty get hit harder, so it was very difficult. It would have been very difficult to ignore that that was a factor…it was easier to do that in person.”

“[Support during COVID-19] is a privilege thing. It really is, and I think if people don't look at it that way…it really puts it into perspective—who gets care and who doesn't, and who has had access to health. And it's not equal.”

“…if you were doing this job, it would be very difficult to have a viewpoint that didn't see different disparities and how that affects people. So yeah, it was a challenge with empathy, with trying to be patient with my clients who had…just based on their lived experience, a more self-focused survivalist me-before-you mentality.
That was a challenge to be patient with that and to try to understand where that was coming from.”

“Most of my friends are pretty healthy, and so I think that was a very, very different experience for my clients where, for them, they had experiences of life and death. And that, again, put it in perspective of poverty versus different life experiences, different access to care, different genetics, different nutrition…different education…So many things, this has pointed out.”

“…I can't imagine how my clients feel if they don't have financial stability, if they don't have a social support, if their mental health is unstable. All these things. And I’m upset because my supervisor is changing. So, yeah. It gave me, certainly, empathy but also perspective.”

Environmental barriers to interpersonal empathy

“…if you're living with grandparents, parents, siblings, maybe a cousin; an aunt, that's going to be a very different telephone experience than a person who can shut their door, or even just go outside and have space to talk.”

Emotional barriers to interpersonal empathy

“…there were just so many political things involved with [COVID-related] content, it very quickly would lead to places that I didn't think it would be useful to go to.”
“…as soon as …the [political] polarization came out, I would redirect.”

Objective empathy

“I don't know that it's possible to do this job unless you have the ability to empathize.”

“I know that that's how people make the most progress—is if they have that relationship established…”

Information from supervision as a source for objective empathy

“…during [the pandemic], not having coworkers to bounce things off of and losing that support system physically…that supervision was a lifeline.”

Information from COVID-related media as a source for objective empathy

“…using [media] as a common ground, and like, ‘We have to be doing this because of the news and what's happening and now doing telehealth. Isn't this crazy?’ From that perspective, yes, I would use it.”

^Master theme.

**Interview 03**

Participant 03 is a 27-year-old white female master’s level clinician who works in an agency setting in Pennsylvania, where she primarily provides individual outpatient counseling to adult clients experiencing substance abuse or co-occurring disorders. Participant 03 has worked in the counseling field for 4 years, accumulating a total of 12 months of this time during the COVID-19 pandemic. On average, Participant 03 reported seeing 12 telephonic clients per week.
When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 03 indicated 8.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 03 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 03 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 03’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“Honestly, at times, [telephonic counseling] has been really difficult. I feel that at the beginning of the pandemic when we went to telephonic it was a little bit easier, and easier to empathize. But then, as time went on, and I kept happening. It was very easy to kind of get distracted by other things, and that sometimes took me out of like being able to kind of attune, pay attention, respond. So, it was a little bit more challenging because it was very impersonal, not even seeing somebody—seeing their face.”

Further reflecting on her experience, Participant 03 shared that her empathic response varied in accordance with the client’s level of engagement in the telephonic session. She reported:

“…if [a client] was really engaged processing, it was a little bit easier for me to be empathetic and really connected and listen at attune, but if somebody was just kind of
calling, checking in, wasn't very engaged, was just doing it because it was required, it was a bit of a struggle for me to really be present with them.”

Further commenting on clients’ various levels of engagement in telephonic counseling, Participant 03 shared that some mandated clients preferred the telephonic method due to its convenient access, even after in-person sessions were once again permitted. She shared:

“…eventually we were able to get in person again, so some people came in person. Other people still chose to stay telephonic and those were usually the mandated clients who wanted to keep it, you know, ‘I don't want to come in. It's easier for me to just not.’

After this initial exploration, the researcher asked Participant 03 about her perspective on the role of empathy in the process of counseling. The participant discussed that she sees empathy as a vital tool in counseling, but not an absolute necessity in the process. She also issued some caution regarding overinvestment via empathy. She commented:

“I don't necessarily think empathy is required for counseling. I think that it can be helpful, and it can be an asset…[empathy] can also be a hindrance if you're too empathetic and getting too invested, sometimes it can take you actually out of doing something that could be therapeutic.”

Participant 03 then further discussed her perspective on empathy. She shared that she views empathy as “holding a space”, rather than taking on the perspective of another person. She stated:

“…especially novice counselors, the idea of, ‘I’ve really got to be able to put myself in someone else's shoes.’ That's not always required to have empathy. Just holding a space and being there and really seeing what the client wants when they're sharing something.”
The participant further spoke to the ideal of “walking in the client’s shoes”, drawing attention to the potential inauthenticity of claiming to fully understand the perspective of another person. She said:

“…when working with [substance use] clientele, this idea of being able to walk in their shoes is almost dishonest and not genuine and inauthentic so the empathy has to come…from more of a mutual understanding of what it means to be human and means to be someone who experiences pain.”

Following this extended query, the researcher asked Participant 03 about her thoughts on the importance of empathy. The participant reiterated the notion of “sitting with the client”, rather than assuming an understanding of their experience. The participant then shared that she views empathy as a good “starting point” to the process of counseling, and that “it’s not enough to just have empathy.”

Following this further questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 03 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had. She discussed that she had received supervision both from her agency and a private LPC supervisor, stating that supervision through her agency was comparatively pragmatic and “surface level”, and that her LPC supervision was “a little more in depth and meaningful and helpful.” She shared the following regarding agency supervision:

“I felt like [agency supervision] was very surface-level, like focusing on client presenting problems and concerns and, ‘Oh, let's check your chart. Let's audit it, et cetera.’ It wasn't very deep or meaningful, necessarily.”

Participant 03 shared that the more in-depth nature of her LPC supervision helped her to
navigate uncertainties that surfaced in her provision of telephonic counseling. She shared the following:

“…[telephonic counseling] was a struggle, not knowing where someone's at physically. It's telephonic, so they could be like, ‘Yeah no one's with me’. How am I to know? (laughs)...That was important for me to process in supervision.”

The researcher then inquired into the topic of setting. Participant 03 reported that she had primarily delivered telephonic sessions in an office setting, being in the office “90% of the time”. The participant shared that being in an office setting helped to feel more focused in her telephonic counseling, stating, “I felt like being in the office was important for me to feel like I was in the counselor zone…” Participant 03 further spoke to this improved focus:

“So, even though the client couldn't be [in the office], I was still there. So for me, having that routine was helpful. So even in the world's a big question mark I’m still going into work ‘as usual’ (air quotes). Now, the daily operations are not as usual, so it helped me keep my routines. But it also helped me keep my attention and focus, because if I would have been at home, I would have been even more distracted.”

Continuing the topic of focus and mindset, Participant 03 shared that she felt more compelled to concurrently take notes while delivering telephonic counseling than in-person sessions. She said the following:

“…when I meet with a client in person, I may have paper or something nearby, and maybe like 20% of the time I write something down if I think it's important. But I usually don't keep a paper in front of me and keep notes. I'm very attentive to eye contact, et cetera. When I was doing the telephonic sessions, I kept a notepad, and I would be really keeping track of what was going on. I was writing more notes; I was way more detailed,
which was helpful when I went to go then do the notes. So, that was a big difference, though, that I actually think the telephonic was super helpful with, because I could leave a session and forget, but if I had the notes I’d be like, ‘Oh yeah, that's right. That's what we talked about.’”

Further speaking to the topic of concurrent notation, Participant 03 discussed that the act of note taking during telephonic sessions helped her to stay grounded and attentive to the client. She also felt more at liberty to take notes due to the lack of visual contact with the client in session. She shared:

“…when I was keeping the [progress] notes, it really did keep me grounded and focused in the session, and trying to stay attuned to the client. It was almost my version of direct eye contact and not taking notes in an in-person session…with telephonic, if I’m intently looking at my notes and kind of tracking things, I'm not looking at them because we're already not looking at each other (laughs).”

Next, the researcher asked into Participant 03’s experience regarding COVID-related media. The participant shared that she would discuss with clients about the overwhelming nature of COVID-related media, but that the media itself did not significantly impact her empathy toward clients. When asked what it was like to empathize with clients who had been deeply impacted by COVID-related media, Participant 03 shared that she found it easier to empathize with these clients, in comparison to clients who had not been affected by such media coverage. She commented:

“…[it was] maybe a little bit easier to empathize with [clients emotionally affected by the pandemic], because they were almost kind of struggling and in a place of…urgency…So that was more apparent for me to be like, ‘All right, let me get there with you. Let's figure
this out, et cetera. For the people who were not like that, there was almost a limited need to empathize in that way with them, because they were just kind of like, ‘All right, I’m cool.’ If someone's just kind of like, ‘I'm cool, no problem’, is there a need to empathize at that point?”

The researcher then moved to the next research question, inquiring into Participant 03’s experience of transitioning from in-person to telephonic counseling. The participant discussed that the universality of the COVID-19 pandemic allowed her to empathize with clients more easily. She said the following:

“Honestly, because the pandemic was something that pretty much everyone experienced, I felt like it was really easy to empathize with what clients were going through, because I was going through it too (laughs)...all of a sudden, there's a lot of question marks, and clients, some of them, had questions about what those question marks would mean for them, and I could empathize and relate to that, so I would say the transition, it was it was pretty easy to empathize with clients.”

The participant then further spoke to her transition from in-person to telephonic counseling, sharing that the “fresh and new” nature of the transition caused her to be more attentive and empathic toward ger clients. Participant 03 shared the following:

“I think, at the beginning [of the pandemic] it was almost easier to empathize. It was kind of fresh and new, and it was still easy to kind of be in there. And then, as time went on and we all get kind of complacent with telephonic and COVID, et cetera, it kind of became a little bit more challenging. But that transition period didn't feel too difficult to empathize with. It was a difficult time, but in terms of empathy, not too difficult.”

Further inquiring into the topic of transition, the researcher asked Participant 03 what it
was like to empathize with clients she had seen in person prior to switching to telephonic counseling, versus clients she had never seen at all. The participant shared that she found it easier to empathize with clients she had previous seen, but that this factor intersected with the client’s presenting level of severity. She said:

“I would say, overall, it was probably easier for me to empathize with people that I could visualize. But…If there was someone I met in person, and they weren't having a difficult time, I would probably have less empathetic ability with them than someone who I never knew but was really struggling.”

Next, the researcher asked into the topic of SES. Participant 03 shared that she worked primarily with lower SES clients, commenting, “…some [clients] at times struggled with, ‘Am I going to keep my house? Am I going to be able to pay my bills?’, et cetera.” When asked what it was like to empathize with lower SES clients via telephonic counseling, Participant 03 reiterated her beliefs on holding a space for her clients, rather than assuming understanding. She reported:

“[It was] hard to fully feel like I could understand [lower SES client concerns] because I knew that my job was going to be secure, right? So, again, keeping that in mind that I can't fully relate to their situation, that doesn't mean that I can't hold the space and be there for them and let them talk about what that means for them.”

The researcher then inquired into what it was like for Participant 03 to transition from telephonic counseling back to in-person sessions. The participant shared that she was relieved to return to in-person sessions and mentioned some differences in empathic response. She shared:

“…I would say that my empathy levels were maybe slightly diminished in telephonic services, but I wouldn't say by a lot. I would just say that it was different, the way that I had to engage with empathy with clients was just different. But if I had to quantify it, I
would say it's easier and I'm more readily able to empathize with in-person, compared to telephonic.”

The researcher then inquired into Participant 03’s experience empathizing with clients via differing mediums. The participant shared the following about her differing levels of empathic response:

“[Regarding the difference between empathizing over the phone versus in person], I do think that the lack of body language and just sharing a room made a difference, but just not being able to see…I feel like Zoom and telephonic are almost very similar, too. Still same levels of empathy, but I'd have to pay more attention. *But* it's still not the same as holding a room. So I think not sharing the same space is important.”

The researcher then moved to the final research question of the study, inquiring into how Participant 03’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant began by discussing how the universality of the COVID-19 pandemic facilitated greater empathic response from the participant. She stated:

“I think that universal experience of, ‘Oh, we're all in this pandemic’, really allowed me to be empathetic with my clients, particularly about COVID-related issues and concerns… I was able to really identify with my own confusion, concern, overwhelming feelings.”

The researcher then asked further into the participant’s experience regarding her navigation of the pandemic. Participant 03 shared that she experienced fear regarding whether she might inadvertently exposure other people to COVID-19 via transmission. She reported:
“…when I was with my sister [prior to her testing positive for COVID-19], we were in close proximity…I guess my biggest thing was like, ‘Oh my gosh, can I have this and have given it to other people?’ And then I got worried about how I may have affected other people, but not knowing.”

Next, the researcher asked Participant 03 what it was like for her to empathize with clients who had tested positive for COVID-19. The participant shared that these clients excited feelings of worry and concern. She commented:

“…[when a client tested positive for COVID-19], it was less empathy and more concern and worry, because the one time, I called…I remember hearing the coughing, and I remember being like, “oh my gosh, you sound awful. Please, we are not meeting. You need to go lay down.’ (laughs) ‘Please take care of yourself.’”

Shifting from the topic of legitimate excuses for missing telephonic counseling sessions, the researcher inquired into what it was like to provide this mode of counseling to mandated clients, as the participant had shared that a portion of her caseload was composed of such clients. Participant 03 began by commenting on mandated clients’ receptivity to telephonic counseling:

“…[clients] who were being drug tested weekly and having to go to counseling, all of a sudden were told [at the beginning of the pandemic], ‘…you can stay at home and your meetings with POs, your meetings with the counters, are all going to be telephonic’.

They were stoked.”

The researcher the asked Participant 03 how this “stoked” reaction from clients influenced her empathy in session. The participant shared that she found happiness in the dynamic of clients have easier access to sessions in which they presented as more comfortable, stating:
“So having this opportunity to do telephonic counseling with [substance use clients], I was very happy to be able to provide that to the people who, counseling would normally be a stressor; it no longer had to be a stressor…I felt very good about [telephonic counseling] in terms of understanding [clients’] situations and being able to empathize with, ‘Oh wow, these people genuinely have transportation barriers that are very, very real, and we have a way to overcome them.’ That was pretty exciting.”

When asked if she had quarantined herself from others during the pandemic, Participant 03 shared that she had done so while awaiting the results of a COVID test. The researcher then asked the participant how this experience affected her empathy toward clients. The participant stated once again that commonality of experience spurred her empathic response:

“…I felt I could relate to that experience [of quarantining]…it's hard to feel disconnected from other people and not also know what the results are going to be. So yeah, I felt like I was able to empathize with [clients].”

The researcher then asked Participant 03 what her experience was like empathizing with clients who had chosen not to quarantine, as she had chosen to adhere to quarantine procedures. The participant shared that she approached from a position of understanding, rather than judgement:

“…during COVID, I tried to be smart and considerate for other people, as I could be. I understood that not everybody felt that way [regarding COVID-19 precautions], so their decision to not quarantine and to kind of gather and things like that. I could understand why they would want that.”

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected her empathy toward clients. The participant shared, “I
wouldn't watch news coverage, but then also I would see things on social media, so that's why I’d say maybe a half hour to an hour of looking up specific information about it” The researcher followed up by asking how this consumption of COVID-related social media affected her empathy toward clients. Participant 03 shared that she found a sense of comradery in the consumption of this information, sharing:

“…I did feel a sense of kind of camaraderie in that—being bombarded by all this [COVID-related] information and not knowing what to make of it…I could really empathize with [regarding COVID-19], this confusion of, ‘What are we supposed to do now?’”

Next, the researcher asked Participant 03 how tapering COVID-related media consumption influenced her empathy toward clients. She shared that, as she decreased immediate attentiveness to COVID-related concerns, she and her clients were able to move toward counseling topics outside of the pandemic:

“…COVID kind of really went like (gestures an encapsulating dome) and kind of created the space for us all to relate. But it almost became a dependent thing for us to talk about or relate to. And as I got away from getting caught up in the media, it became more of focusing on things outside of that.”

As a final question of the interview, the researcher invited Participant 03 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant commented that she found telephonic counseling to require greater focus, and that the medium did not come as naturally for her as in-person counseling. She shared:

“…I do think empathy [in telephonic counseling] was affected. I just had to almost work harder to be more focused and intentional with how I engaged with empathizing with
clients. So I almost had to be more deliberate about it, because it didn't come as natural...What I would say would be the biggest thing is that it just required more focus and more emphasis than if I would just sit in a room with somebody where it feels more natural.”

At the end of the interview, the researcher thanked Participant 03 for her participation in the study. The participant shared that she had no further information about her lived experience to add to the interview. The interview with Participant 03 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 4 provides a visual representation and review of these phrases of significance from the narrative above.

Table 4

Participant 03 Phrases of Significance

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<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
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<tr>
<td>Subjective empathy a</td>
<td>“…[empathy] can also be a hindrance if you're too empathetic and getting too invested, sometimes it can take you actually out of doing something that could be therapeutic.”</td>
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<tr>
<td></td>
<td>“…[empathy] is something that you should use with kind of purpose and intention and awareness…there's plenty of people who feel empathetic but that doesn't mean that you're necessarily a qualified counselor…”</td>
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“…when working with [substance use] clientele, this idea of being able to walk in their shoes is almost dishonest and not genuine and inauthentic so the empathy has to come…from more of a mutual understanding of what it means to be human and means to be someone who experiences pain.”

Identification

“Honestly, because the pandemic was something that pretty much everyone experienced, I felt like it was really easy to empathize with what clients were going through, because I was going through it too (laughs)…all of a sudden, there's a lot of question marks, and clients, some of them, had questions about what those question marks would mean for them, and I could empathize and relate to that, so I would say the transition, it was it was pretty easy to empathize with clients.”

“I think that universal experience of, ‘Oh, we're all in this pandemic’, really allowed me to be empathetic with my clients, particularly about COVID-related issues and concerns… I was able to really identify with my own confusion, concern, overwhelming feelings.”
“…it's hard to feel disconnected from other people and not also know what the results [to a COVID-19 test] are going to be. So yeah, I felt like I was able to empathize with [clients].”

“…I did feel a sense of kind of camaraderie in that—being bombarded by all this [COVID-related] information and not knowing what to make of it…I could really empathize with [regarding COVID-19], this confusion of, ‘What are we supposed to do now?’”

“…COVID kind of really went like (gestures an encapsulating dome) and kind of created the space for us all to relate. But it almost became a dependent thing for us to talk about or relate to. And as I got away from getting caught up in the media, it became more of focusing on things outside of that.”

“I would speak to my own experience, and I would attempt to normalize as much as you can normalize a pandemic.”

Imagination “I would say, overall, it was probably easier for me to empathize with people that I could visualize…overall, if I had met them, it was a little bit easier.”
“When I was doing the telephonic sessions, I kept a notepad, and I would be really keeping track of what was going on.”

“…I do think empathy [in telephonic counseling] was affected. I just had to almost work harder to be more focused and intentional with how I engaged with empathizing with clients. So I almost had to be more deliberate about it, because it didn't come as natural.”

“What I would say would be the biggest thing is that it just required more focus and more emphasis than if I would just sit in a room with somebody where it feels more natural.”

“…if [a client] was really engaged processing, it was a little bit easier for me to be empathetic and really connected and listen at attune, but if somebody was just kind of calling, checking in, wasn't very engaged, was just doing it because it was required, it was a bit of a struggle for me to really be present with them.”

“…[telephonic counseling] was a struggle, I mean, not knowing where someone's at physically, right? It's telephonic, so they could be like, ‘Yeah, no one's with me.’ How am I to know?”
“…I would say that my empathy levels were
maybe slightly diminished in telephonic services, but I
wouldn't say by a lot. I would just say that it was
different, the way that I had to engage with empathy with
clients was just different. But if I had to quantify it, I
would say it's easier and I’m more readily able to
empathize with in-person, compared to telephonic.”

“[Regarding the difference between
empathizing over the phone versus in person], I do think
that the lack of body language and just sharing a room
made a difference…”

“…[telephonic counseling] was a little bit
more challenging because it was very impersonal, not
even seeing somebody—seeing their face.”

Felt-level experience

“We were all kind of going a little bit crazy
with not being able to socialize, so when [clients] started
coming back in, I was relieved in that way.”

“…financially, I knew it was going to work
out. I was going to still have a job because counseling was
still going to be important for people.”

“I got worried about how I may have
affected other people, but not knowing.”

“…when I was keeping the [progress] notes,
it really did keep me grounded and focused in the session, and trying to stay attuned to the client.”

“I think, at the beginning [of the pandemic] it was almost easier to empathize. It was kind of fresh and new, and it was still easy to kind of be in there. And then, as time went on and we all get kind of complacent with telephonic and COVID…”

“I think, at the beginning [of the pandemic] it was almost easier to empathize. It was kind of fresh and new, and it was still easy to kind of be in there. And then, as time went on and we all get kind of complacent with telephonic and COVID…”

“So, even though the client couldn't be [in the office], I was still there. So for me, having that routine was helpful. So even in the world's a big question mark I’m still going into work ‘as usual’ (air quotes). Now, the daily operations are not as usual, so it helped me keep my routines. But it also helped me keep my attention and focus, because if I would have been at home, I would have been even more distracted.”

“…I think the paper and keeping diligent notes, as I was talking, was really my way of creating intentional space and tracking…”
“I feel like, at the beginning [of the pandemic], there was almost like an over-concern about, “Will [one of my clients] get COVID? What's going to happen to them?”

“[COVID-related media consumption] just got to a point where it was like, ‘What are these numbers even meaning anymore? And “what is looking at them going to do? Help provide clarity or a sense of safety or security?’”

Interpersonal empathy a “…especially novice counselors, the idea of, ‘I’ve really got to be able to put myself in someone else's shoes.’ That's not always required to have empathy. Just holding a space and being there and really seeing what the client wants when they're sharing something.”

“…even if we can't fully understand what someone's experience is, just to be able to sit with it is very important. I think if people aren't empathetic and creating that space, I think a lot of people wouldn't make connections.”

Understanding the client’s lived experience “…during COVID, I tried to be smart and considerate for other people, as I could be. I understood that not everybody felt that way [regarding COVID-19 precautions], so their decision to not quarantine and to
kind of gather and things like that. I could understand why they would want that.”

Understanding barriers to counseling “A lot of [clients] were very happy to not have to travel or leave their house or whatever it might be.”

“I felt very good about [telephonic counseling] in terms of understanding [clients’] situations and being able to empathize with, ‘Oh wow, these people genuinely have transportation barriers that are very, very real, and we have a way to overcome them.’ That was pretty exciting.”

“So having this opportunity to do telephonic counseling with [substance use clients], I was very happy to be able to provide that to the people who, counseling would normally be a stressor; it no longer had to be a stressor.”

Understanding clients’ SES situations “…some [clients] at times struggled with, ‘Am I going to keep my house? Am I going to be able to pay my bills?’, et cetera.”

“[It was] hard to fully feel like I could understand [lower SES client concerns] because I knew that my job was going to be secure, right? So, again, keeping that in mind that I can't fully relate to their
situation, that doesn't mean that I can't hold the space and be there for them and let them talk about what that means for them.”

Environmental barriers to interpersonal empathy “…there were [clients] who were able to be sneaky and would engage in substance use behaviors, and it was easier because it was all on telephone.”

“…as [telephonic counseling] went on, it was easier and easier to get distracted. To like, “Oh, I'm on the phone, let me organize this quick”…was susceptible to do that, which isn't very good (laughs), but it's truthful. But at work, when I went into the office, I was way more attuned.”

“I feel that, at the beginning of the pandemic when we went to telephonic, it was a little bit easier, and easier to empathize. But then, as time went on and I kept happening, it was very easy to kind of get distracted by other things.

“I felt like being in the office was important for me to feel like I was in the counselor zone…”

Emotional barriers to interpersonal empathy “…[it was] maybe a little bit easier to empathize with [clients emotionally affected by the pandemic], because they were almost kind of struggling and in a place of…urgency…So that was more apparent
for me to be like, ‘All right, let me get there with you. Let's figure this out, et cetera. For the people who were not like that, there was almost a limited need to empathize in that way with them, because they were just kind of like, ‘All right, I’m cool.’ If someone's just kind of like, ‘I'm cool, no problem’, is there a need to empathize at that point?”

**Objective empathy**

“I don't necessarily think empathy is required for counseling. I think that it can be helpful, and it can be an asset.”

“I think it's not enough to just have empathy. It's a good starting point.”

**Information from supervision as a source for objective empathy**

“…instead of focusing on the pragmatic aspect, [LPC supervision] was a little bit more about what I was experiencing with having telephonic clients who struggle with substance use disorders, so it was a little bit more meaningful to me and helpful.”

“…[lack of visual contact with clients] would cause a lot of uncertainty with me. That was important for me to process in supervision.”
“...I don’t know much [consumption of COVID-related media] really impacted empathy for me in particular. But I will say that, sometimes when I was talking to clients, I’d be like, ‘All right, let me look at the stats quick’ (laughs). But in empathy, I don't know. I don't think the news coverage itself was a big thing, except for the fact that it was overwhelming, and we would talk about how it was overwhelming.”

^Master theme.

**Interview 04**

Participant 04 is a 28-year-old white male/non-binary master’s level clinician who works in an agency setting in Florida, where he primarily provides individual outpatient counseling to elderly adult clients. Participant 04 has worked in the counseling field for 4 years, accumulating a total of 14 months of this time during the COVID-19 pandemic. On average, Participant 04 reported seeing 10-15 telephonic clients per week. When asked how comfortable he was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 04 indicated 9. Following completion of the interview, the researcher emailed Participant 04 to inquire into what gender pronouns would be preferred for use in the following narrative. The participant reported that he uses he/they pronouns with a variable preference for either. Therefore, he shared that he is comfortable with the use of he/him pronouns when illustrating his experience in this study.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 04 electronically signed and emailed to the researcher a consent form (Appendix B)
detailing the process, his rights as a participant, and that she could withdraw from participation at any time. Participant 04 indicated her awareness of these policies and that he wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 04’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“I think [empathizing with clients via telephonic counseling during COVID-19] is something that has continued to evolve with time. What I'm finding, at least in my practice, is, when I got started, we were a few months into it, so it was a lot like COVID was kind of dominating the conversation, but, for the most part, it was like, ‘I don't want this to happen to me’, and ‘I want this to happen to my family. I'm staying in. I'm staying safe.’ So really a lot about empathizing with those fears, validating those fears, and then also doing what I can to establish rapport and safety for that client.”

After Participant 04 shared that “things really started to pick up” following the emergence of the Delta variant of COVID-19, the researcher further inquired into this increased intensity. The participant commented on the greater “headspace” that clients were beginning to occupy, stating:

“…clients, right now, are requiring so much more headspace than they were previously, for me…it just feels like they're sticking with me for a lot longer after we end the call.

While I'm with them, it feels like I’m using more cognitive resources to try to stay with them, because it feels like there's a lot of this like up and down, going really deep, trying
to share about some deep emotion, but then also trying to pull themselves back up out of it before they can go too deep; experience that emotion too fully.”

After this initial exploration, the researcher asked Participant 04 about his perspective on the role of empathy in the process of counseling. The participant discussed that he sees empathy as an integral part of both the process of counseling and the therapeutic alliance. He shared:

“…I think [empathy] is foundational. That central piece that kind of, regardless of orientation, should be at the core of who you are as a counselor…I have to have that relationship and that empathy really, really solid, so I can go in and confront. Go in and help clients take responsibility…empathy can speed or spur on that therapeutic rapport, that alliance and allow for that disclosure and allow for that healing to take place. So, it's one of the vehicles of healing, in my opinion.”

Following this extended query, the researcher asked Participant 04 about his thoughts on the importance of empathy. The participant further elaborated on empathy as an essential underpinning of the therapeutic process that helps clients to feel heard, and commented on how this process translates in telephonic counseling. He shared the following:

“…[empathy] is that thing that should underpin everything. Everything that happens in that relationship has to be grounded in empathy…You build the [therapeutic] alliance through empathy and you can maintain it through empathy.…“When we [are]…getting distracted with telephonic counseling…I think that clients notice and they can hear it, even in just with your voice. So I think that they recognize that, as almost like you pulling away, which can maybe even be potentially misjudged as rejecting of that client over the phone. Especially when all you have is that voice.”
Following this further questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 04 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that he had. He discussed that she had received supervision from multiple supervisors at his agency, which he found to be helpful in navigating the newness of telephonic counseling. He commented:

“…I have received supervision. It's been really helpful for getting me through those stuck points with regards to reaching a particular client with empathy…I have to really do a great job in that first session of connecting with them, of establishing empathy, because it's so much easier to just not pick up a phone call, versus not drive to a place. And we're like, ‘All it takes is one slide of a button, and that client is no longer answering phone calls.’ So, I feel some pressure to really do the best job that I can, to establish as much relationship and demonstrate as much empathy as possible.’”

Further discussing the newness of telephonic counseling. Participant 04 commented on the initial vagueness of what this mode of counseling is supposed to “look like”. He shared:

“…we've been doing telephonic counseling as a profession a couple decades ago, and then everyone started switching to video and it's like we all forgot this was an option. And so that's kind of trickled down among the among our clientele to this point of like, ‘What is this supposed to look like? What am I supposed to do?’”

The researcher then inquired into the topic of setting. Participant 04 reported that he had primarily delivered telephonic sessions from home. He shared that working from home required mindful transition between his roles as counselor, doctoral student, instructor, and romantic partner. He stated:
“…I feel like I am living from work at this point, so I have to be really mindful of how I transition from the rest of my day-to-day life and all my other roles…and move just into the counselor role, which is a little bit harder when I’m in the space where I live…I think the hardest thing for me is not showing up, not getting that into mode, but it's moving out of it when I'm done. How do I leave my desk and go back to being all of these other sides of myself that I probably wouldn't share with a client? How do I move from role to role in a way that doesn't feel like emotional whiplash?”

Next, the researcher asked into Participant 04’s experience regarding COVID-related media. The participant discussed how the politization of the pandemic impacted his work with clients. He said the following:

“…the way in which COVID has been politicized has really complicated clinical work, in my opinion, because…clients…want to know your stance on vaccines, on masks, on COVID, on all of these different safety precautions. And so that's been really—I wouldn't say challenging for me to deny them that information—but doing it in a way that feels congruent to me in who I am and also does not impact our therapeutic alliance. At times, [that] has been kind of challenging.”

The researcher then inquired into what it was like for Participant 04 to empathize with clients who shared opposing political beliefs to the participant regarding the pandemic. The participant commented that he chose to approach from a place of understanding, rather than judgement. He shared:

“…my big thing for working with clients who are kind of opposed to where I'm coming from [politically] is to really focus on being empathetic in terms of just acknowledging where they're at. ‘I hear you, this doesn't seem fair. This really is frustrating you that
you're being forced to get the vaccine to stay employed. I understand that it feels so unjust.’ It doesn't take anything away from my story to say that. It doesn't take anything away from me at all to listen and apply those foundational counseling skills of reflecting that emotion and just validating them where they are. Because it's not my job; it's not my position to want to change that.”

When asked what is was like to empathize with clients who shared similar political beliefs regarding the pandemic, Participant 04 shared that it was more difficulty to remain objective with these clients. He said the following:

“…when folks share with me they got the vaccine or they're staying masked, I'm finding it actually a little bit more challenging to provide empathy in the most professional way, because it's like I’m relieved for them. I’m relieved that, ‘Oh good, you're going out in public, and you are eighty-five years old, and you've been vaccinated, and you're wearing a mask. I'm so glad that you're doing what you need to do to protect yourself.’ That feels very different to me, than, ‘I hear you. You're so frustrated about this mask mandate or this vaccine mandate.’ So, in some ways, I’m having to pull back a little bit and try to avoid that interest convergence merging with my clients when they share things like that with me.”

The researcher then asked Participant 04 how his empathy toward clients had been near the beginning of the pandemic when media was broadcasting the sudden changes that had been occurring. The participant shared that he reached out for support from “anyone who would listen” and reported some frustration he felt toward other who did not adhere to COVID-related precautions. He shared:
“I did have a period where I had to work through my own frustration of, ‘Why is it so hard for people to inconvenience themselves temporarily, so that we can get back to…something that is less restrictive later on?’

The researcher then moved to the next research question, inquiring into Participant 04’s experience of transitioning from in-person to telephonic counseling. The participant discussed that he felt a need to be more attentive to the delivery of his voice in telephonic sessions. He reported:

“I really had to become more conscious of my tone, my delivery, all of these things. Not that I wasn't before, but when that's all you have to go on, you really have to lean into it.”

The participant further elaborated on his experience transitioning to telephonic counseling, commenting on the universal distress that both he and his clients faced during this transition:

“I was feeling so disorganized and dysregulated, and all of my clients are feeling disorganized and dysregulated, having to speak with…clarity as I’m explaining whatever we're talking about. Distress tolerance, different coping skills, whatever we're working on…it felt like for a while, at the beginning that it was like, ‘We already only have this many cognitive resources’, but then at the beginning of COVID it was only like, that many (brings hands together).”

The researcher then further inquired into what it was like for Participant 04 to empathize with clients with no visual contact. The participant shared that he found this lack of visual contact to potentially allow for other distractions to occur, and tried his best to put “blinders” on to prevent such distractions from occurring. He commented:
“…when I'm focusing on the empathy piece [in telephonic counseling]…I find that I’m looking down on my phone, not like we're on video chat or anything, but I’m looking down as I’m speaking, and I’m really trying to direct my energy through my voice. I'm still emoting like I probably would if we were face-to-face, but I have to close out the rest of the world…I’m having to completely put blinders on for a second, especially in those moments where they're needing a lot of empathy, and just sit with just them. Almost close my eyes. It's my voice, it's your voice. That's all that I’m taking in right now to try to be present with them through it.”

Next, the researcher asked into the topic of SES. Participant 04 shared that she worked primarily with lower SES clients, with some middle SES clients as well. The participant reported that working with lower SES clients demanded greater emphasis on immediate need, such as access to basic resources. He shared:

“I’ve gotten into some work with some [lower SES] clients who, it's literally like, ‘Wow, you just shared with me this long history of trauma and I want to work on that because that's important and every night you're having flashbacks. But your power shut off; your water's turned off. We can't do any of that work together until we figure out those basic needs.’”

As the researcher continued to inquire into the intersection of client SES and Participant 04’s empathic response, the participant shared that he “showed up better” for lower SES clients due to their comparatively greater struggles. He shared that he did not have this same level of empathic response in a previous counseling position in which he provided therapy to wealthy clients. He shared the following:
“I think that I’m able to show up better for lower SES clients…. [Empathizing with wealthy clients] was a lot harder for me versus, ‘You don't have water, you don't have electricity, you're not sure where your next meal is going to come from.’ Because I can work with that. I can be like, ‘Let's get you connected with resources, let's figure that out. Of course, starting with that empathy of like, ‘How are you feeling? How are you making it? How are you taking care of yourself?’ But I know where to move with that from there.’

Next, the researcher asked Participant 04 if SES affected the fact that he primarily delivered telephonic sessions to clients, as opposed to videoconferencing sessions. The participant commented that he might have had a “few more” videoconferencing sessions with clients, but that the primary deciders for his delivery of telephonic sessions were his older client demographic and administrative choices made by his agency. He commented further, sharing that several of his clients appreciated the “buffer” and “distance” that telephonic counseling entailed. He stated:

“…[clients] almost appreciated having a little bit of a buffer, a little bit of an emotional or psychological distance by not showing their face; that it made it a little bit more doable for them, especially for folks who had never been in therapy before. That it felt safer.”

Due to Participant 04’s experience of providing only one videoconferencing counseling session, the researcher asked the participant to briefly compare his experience empathizing with clients via this medium, versus telephonic counseling. The participant commented on his discomfort with the videoconferencing medium, stating the following:

“…it had been so long since I had done [videoconferencing] in a counseling capacity, that I felt a little bit uncomfortable. I noticed an emotional reaction to engaging in the
video sessions. I had to work through that pretty quickly, because all of a sudden, the clients in my face were talking and I can't let my stuff influence their stuff and our time together….I noticed that I was having a little reaction [during video conferencing counseling], and my little video screen that I had in my lower right hand corner, so I was having to monitor and kind of self-correct as I was going.”

Further inquiring into comparing Participant 04’s experience providing empathy to clients through different mediums, the researcher asked the participant what it is like to provide support and structure to clients via telephonic versus face-to-face counseling. The participant commented on the greater challenge he experienced providing structure in telephonic counseling. He commented:

“…when we're face to face, even video chat, I can open my mouth to start to speak and the client processes that as like, ‘Let me slow down. Let me stop talking so that the therapist can speak as well.’…So clients are able to pick up on nonverbals in face-to-face or video that kind of allow there to be a little bit more structure, know that I'm trying to speak. That does not exist in telephonic counseling. I can open my mouth to start to speak, I can even get half a sentence out and sometimes clients will still steamroll over. And I'll say, ‘Oh, hold on a second. I had a thought. I'm wondering.’ So I sometimes have to lean into more assertiveness skills…”

The researcher then further asked into the participant’s empathic response to clients via telephonic versus face-to-face counseling. Participant 04 shared that he paid greater attention to his vocal response toward clients in telephonic counseling due to the absence of visual contact with the client. He commented:
“I'm going to use my voice to convey empathy, both through my tone and also through the words that I'm using regardless of where I’m at. And regardless of the modality. When my voice is all that I have, I'm going to focus on that. I'm going to be much more intentional and shut out other things…When I'm face to face with someone, of course the voice matters, but it can also be paired with body language…”

Without further prompting, Participant 04 discussed that he found a greater need to “check” in verbally with clients via telephonic counseling to compensate for no visual contact. He shared the following:

“There are times on the phone where I'm like, “I think we're together. I think we're in the same place right now, but I'm not 100% sure…I do think that I lean a little bit more into—not even evaluations—but just to check in with clients over the phone. “How is this going for you? Are you feeling supported? Are you getting what you need?” Which I think is an important piece of the counseling process, regardless…”

The researcher then moved to the final research question of the study, inquiring into how Participant 04’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant shared that he had not been exposed to COVID-19 and had not tested positive. When asked how these factors influenced his empathy toward clients, Participant 04 commented that he found it harder to empathize with clients who were “diametrically opposed” to the precautions he took in the interest of the health of his loved ones. He stated:

“My partner is at a little bit of a higher risk category. Some of my family's at higher risk categories, so I would be concerned for them. If I were to expose them, how would I feel? And then also, the idea of, ‘Who am I exposing that I don't know? Am I exposing
someone who is immunocompromised, or someone who is in an extremely high-risk category?’ So that was hard for me…That was hard for me to empathize with people who were, it felt like, diametrically opposed to my philosophy at that point in time, which was like, ‘Let me stay safe so everyone else can stay safe. And the sooner we all do this together, the sooner we can ease some of these restrictions.’”

The researcher then further inquired into the participant’s experience of empathizing with clients who chose not to take safety precautions during the pandemic. Participant 04 shared that he tried to “meet them where they are”, stating:

“Sometimes it's a little bit of motivational interviewing, like, ‘I hear you. You’re telling you that you shouldn't have to wear a mask; you shouldn't have to get vaccinated. Also, we're looking at your file; you've got this health condition and that health condition, and you're also telling me that you know that you're high risk for COVID, and for having a negative reaction to COVID. What do we do about that?’ Trying to meet them where they are, empathize with them, and then, ultimately, ‘What do we do to move forward?’”

When asked if he had quarantined himself from others during the pandemic, Participant 04 shared that he had engaged in “self-imposed” quarantine procedures after he had experienced potential exposure to COVID-19 in public. He stated:

“…I would kind of self-impose quarantining myself. Like, ‘Oh, I've been in public and I didn't really feel comfortable with how close this person was to me’, or, ‘I took my mask down to eat something, and someone else was unmasked came by. I'm going to spend a lot less time outside of my house for a while, just to make sure that…everything's okay.’”

Further inquiring into this time spent alone, the researcher asked the participant how his comfortability with telephonic counseling played into his lived experience. Participant 04 shared
that, although he was initially uncomfortable with the medium, he gradually developed greater comfortability with telephonic counseling as he became more familiar with the medium. He shared the following:

“...I actually had to get comfortable using the phone pretty quickly because of COVID...I did have a lot of phone anxiety prior to starting this telephonic counseling job. So [telephonic counseling] has been really helpful for me to move past that, personally. ‘Cause now it’s like, ‘Man, I’ve talked to people about everything on the phone. This is nothing. So I can call and order a pizza, that's no problem.’ So in terms of grading, I went in the deep end.”

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected his empathy toward clients. The participant shared that his consumption had originally been “too much” due to his partner having the news on “24/7”, and that this amount of media consumption was eventually decreased, stating:

“...too much [consumption of COVID-related media], because my partner had a news site or a news channel on all all day, every day. And that was really hard, for me personally, because I don't consume any media that way, especially news about a global pandemic. So that, I think, fed into a lot of the fear that I had at the beginning. And then, over time, we both decided, ‘We probably should not have the news on 24/7 anymore. It's probably not a good decision for either of us.’ So then it became, my partner would have the TV on for a set period of time, just to check and see how things are going.”

Next, the researcher asked Participant 04 how his initial saturation in COVID-related media consumption influenced his empathy toward clients. The participant reported that this
media increased his frustration toward clients who were not adhering to COVID-19 precautions, sharing:

“…it increased my frustration to consume that much media and to see all of these things that people were doing that were not going to help us ease these restrictions. So that, I think, could have been a little bit detrimental to my empathy at the time.”

Without further prompting, Participant 04 further explained the impact of COVID-related media on his empathy for clients, stating:

“[Consuming COVID-related media] helped me be more empathetic when working with my older adults, because…I had more exposure to where they're coming from. I could understand it a little bit better, just because they were covering it as a special topic of like, ‘Wow, you must be feeling really isolated right now. Let's talk about that. How can we get you connected in a way, in your community that feels right for you?’”

As a final question of the interview, the researcher invited Participant 04 to speak to any lived experiences that he had not yet had the opportunity to discuss. The participant shared that he had nothing further to add. The researcher thanked Participant 04 for his participation in the study. The interview with Participant 04 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 5 provides a visual representation and review of these phrases of significance from the narrative above.
### Table 5

*Participant 04 Phrases of Significance*

<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
</tr>
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</table>
| Subjective empathy a  | “You build the [therapeutic] alliance through empathy and you can maintain it through empathy.”  
“…we don't just get stuck in the emotion of [the client’s experience], in the weeds of all of it…” |
| Identification         | “…COVID was kind of dominating the conversation, but, for the most part, it was like, ‘I don't want this to happen to me’, and ‘I want this to happen to my family. I'm staying in. I'm staying safe.’ So really a lot about empathizing with those fears, validating those fears, and then also doing what I can to establish rapport and safety for that client.” |
| Imagination           | “What is it that you're sending? How is that being received? And also, knowing that that's going to look different for different folks depending on their experiences, their background, and what they want to hear from you.” |
| Intuition             | “When we [are]…getting distracted with telephonic counseling…I think that clients notice and they can hear it, even in just with your voice. So I think that they recognize that, as almost like you pulling away,” |
which can maybe even be potentially misjudged as rejecting of that client over the phone. Especially when all you have is that voice.”

“I really had to become more conscious of my tone, my delivery, all of these things. Not that I wasn't before, but when that's all you have to go on, you really have to lean into it.”

“I'm going to use my voice to convey empathy, both through my tone and also through the words that I'm using regardless of where I'm at. And regardless of the modality. When my voice is all that I have, I'm going to focus on that. I'm going to be much more intentional and shut out other things…”

“I do think that I lean a little bit more into—not even evaluations—but just to check in with clients over the phone. “How is this going for you? Are you feeling supported? Are you getting what you need?”

“There are times on the phone where I'm like, “I think we're together. I think we're in the same place right now, but I'm not 100% sure.”

“When I'm face to face with someone, of course the voice matters, but it can also be paired with body language…”

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“You can read the subtext so much more clearly face-to-face versus over the phone.”

“…when we're face to face, even video chat, I can open my mouth to start to speak and the client processes that as like, ‘Let me slow down. Let me stop talking so that the therapist can speak as well.’ …So clients are able to pick up on nonverbals in face-to-face or video that kind of allow there to be a little bit more structure, know that I’m trying to speak. That does not exist in telephonic counseling. I can open my mouth to start to speak, I can even get half a sentence out and sometimes clients will still steamroll over.”

Felt-level experience “Some of my family's at higher risk categories, so I would be concerned for them. If I were to expose them, how would I feel? And then also, the idea of, ‘Who am I exposing that I don't know? Am I exposing someone who is immunocompromised, or someone who is in an extremely high-risk category?’ So that was hard for me.”

“…at first, like a lot of people, [navigating the pandemic] felt like a constant fear.”

“…every time I touch anything when I’m in
public, it's like, “Oh, hand sanitizer. Can’t do it, not doing it.’ Wear my mask constantly, because there is still a little bit of a concern there, a little bit of a fear there…”

“…I would kind of self-impose quarantining myself. Like, ‘Oh, I've been in public and I didn't really feel comfortable with how close this person was to me…””

“…I had to figure it out pretty quick, how to be comfortable. How to continue to protect myself even though I was ‘re-entering the world’ (air quotes) with people who are choosing not to be vaccinated, who are choosing not to wear masks…”

“I remember supervision…it felt like there was a period where I was like, ‘Anyone who would listen’, whether that be my clinical supervisor, for licensure. Whether that be a case supervisor, a supervisor faculty member at my institution. It was like, ‘I am so frustrated. I don't understand why my clients are [disregarding COVID precautions]. I want them to be safe. I don't want them to be in the hospital with a ventilator.’”
“…I actually had to get comfortable using the phone pretty quickly because of COVID…I did have a lot of phone anxiety prior to starting this telephonic counseling job. So [telephonic counseling] has been really helpful for me to move past that, personally. ‘Cause now it’s like, ‘Man, I’ve talked to people about everything on the phone. This is nothing. So I can call and order a pizza, that's no problem.’ So in terms of grading, I went in the deep end.”

“I think the hardest thing for me is not showing up, not getting that into mode, but it's moving out of it when I'm done. How do I leave my desk and go back to being all of these other sides of myself that I probably wouldn't share with a client? How do I move from role to role in a way that doesn't feel like emotional whiplash?”

“…clients, right now, are requiring so much more headspace than they were previously, for me…it just feels like they're sticking with me for a lot longer after we end the call.”

“I was feeling so disorganized and dysregulated, and all of my clients are feeling disorganized and dysregulated.”
“…it felt like for a while, at the beginning
that it was like, ‘We already only have this many
cognitive resources’, but then at the beginning of COVID
it was only like, *that* many (brings hands together).”

“…too much [consumption of COVID-related
media], because my partner had a news site or a news
channel on all all day, every day. And that was really
hard, for me personally…And then, over time, we both
decided, ‘We probably should not have the news on 24/7
anymore. It's probably not a good decision for either of
us.’”

“There was…some doom scrolling going on,
looking at different news articles [regarding the
pandemic…”

Interpersonal empathy

“I have to have that relationship and that
empathy really, really solid, so I can go in and confront.
Go in and help clients take responsibility.”

“…empathy can speed or spur on that
therapeutic rapport, that alliance and allow for that
disclosure and allow for that healing to take place. So, it's
one of the vehicles of healing, in my opinion.”
“…something that I have to be more intentional about is, while I’m providing empathy, still providing structure. It's always, especially as a Gestalt counselor, it's always support and challenge.”

Understanding the client’s lived experience “…I’m getting more of a handle on what it means for me to show up as a counselor in this time where everything's up in the air and just be present and just validate folks where they are.”

“For a lot of clients, kind of regardless of their presenting concern, I really see the ability to sit with tough emotions as being a fundamental thing that a lot of folks are struggling with right now.”

“Sometimes it's a little bit of motivational interviewing, like, ‘I hear you. You’re telling you that you shouldn't have to wear a mask; you shouldn't have to get vaccinated. Also, we're looking at your file; you've got this health condition and that health condition, and you're also telling me that you know that you're high risk for COVID, and for having a negative reaction to COVID. What do we do about that?’ Trying to meet them where they are, empathize with them, and then, ultimately, ‘What do we do to move forward?’”
“…my big thing for working with clients who are kind of opposed to where I'm coming from [politically] is to really focus on being empathetic in terms of just acknowledging where they're at.”

Understanding barriers to counseling: “[clients] almost appreciated having a little bit of a buffer, a little bit of an emotional or psychological distance by not showing their face; that it made it a little bit more doable for them, especially for folks who had never been in therapy before. That it felt safer.”

Understanding clients’ SES situations: “I think that I’m able to show up better for lower SES clients.”

“[Empathizing with wealthy clients] was a lot harder for me versus, ‘You don't have water, you don't have electricity, you're not sure where your next meal is going to come from.’ Because I can work with that. I can be like, “Let's get you connected with resources, let's figure that out. Of course, starting with that empathy of like, ‘How are you feeling? How are you making it? How are you taking care of yourself?’ But I know where to move with that from there.”

“I’ve gotten into some work with some [lower SES] clients who, it's literally like, ‘Wow, you just shared with me this long history of trauma and I want to work on
that because that's important and every night you're
having flashbacks. But your power shut off; your water's
turned off. We can't do any of that work together until we
figure out those basic needs.”

“…sometimes there's a lot of validation of,
one or both partners [regarding the client’s family system]
lost their jobs during COVID, and now their *entire* world
is upside down in *multiple* ways because of that.”

<table>
<thead>
<tr>
<th>Environmental barriers to interpersonal empathy</th>
<th>“…I feel like I am living from work at this point, so I have to be really mindful of how I transition from the rest of my day-to-day life and all my other roles…and move just into the counselor role, which is a little bit harder when I’m in the space where I live…”</th>
</tr>
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</table>

“…when I'm focusing on the empathy piece
[in telephonic counseling]…I find that I’m looking down on my phone, not like we're on video chat or anything, but I’m looking down as I’m speaking, and I’m really trying to direct my energy through my voice. I'm still emoting like I probably would if we were face-to-face, but I have to close out the rest of the world…I’m having to completely put blinders on for a second, especially in those moments where they're needing a lot of empathy, and just sit with just them. Almost close my eyes. It's my
voice, it's your voice. That's all that I’m taking in right now to try to be present with them through it.”

Emotional barriers to interpersonal empathy

“…when folks share with me they got the vaccine or they’re staying masked, I'm finding it actually a little bit more challenging to provide empathy in the most professional way, because it's like I’m relieved for them.”

“I did have a period where I had to work through my own frustration of, ‘Why is it so hard for people to inconvenience themselves temporarily, so that we can get back to…something that is less restrictive later on?’”

“I have some high-risk folks in my family as well, so that was another piece…like, ‘You're the reason why my family member has to live in fear’… it was definitely frustrating for me.”

“That was hard for me to empathize with people who were, it felt like, diametrically opposed to my philosophy at that point in time, which was like, ‘Let me stay safe so everyone else can stay safe. And the sooner we all do this together, the sooner we can ease some of these restrictions.’”
“...the way in which COVID has been politicized has really complicated clinical work, in my opinion...”

“...it increased my frustration to consume that much media and to see all of these things that people were doing that were not going to help us ease these restrictions. So that, I think, could have been a little bit detrimental to my empathy at the time.”

Objective empathy

“I think [empathy] is foundational. That central piece that kind of, regardless of orientation, should be at the core of who you are as a counselor.”

“...[empathy] is that thing that should underpin everything. Everything that happens in that relationship has to be grounded in empathy...”

“...you look at common factors research, that empathy, being able to express that and have that felt by our clients. I think that's where a lot of the healing work takes place...”

Information from supervision as a source for objective empathy

“I have received supervision. It's been really helpful for getting me through those stuck points with regards to reaching a particular client with empathy.”
Information from COVID-related media as a source for objective empathy

“[Consuming COVID-related media] helped me be more empathetic when working with my older adults, because… I had more exposure to where they're coming from. I could understand it a little bit better, just because they were covering it as a special topic of like, ‘Wow, you must be feeling really isolated right now. Let's talk about that. How can we get you connected in a way, in your community that feels right for you?’”

*Master theme.*

**Interview 05**

Participant 05 is a 29-year-old African American female master’s level clinician who works in both an agency and a private practice setting, both located in Pennsylvania. In both settings, the participant provides individual outpatient counseling to adults and children. Participant 05 has worked in the counseling field for 5 years, accumulating a total of 20 months of this time during the COVID-19 pandemic. On average, Participant 05 reported seeing 8 telephonic clients per week. When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 05 indicated 8.5.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 05 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 05 indicated her awareness of these policies and that she wished to
continue participation in the study. The participant also completed and submitted the
demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 05’s experience
empathizing with clients over the phone during COVID-19. The participant’s response was the
following:

“…I have learned how to try to be present, engaging kinda like if they were just [in the
same room as the client], trying to create a space to mimic like them being there. But I
will say it. I will be honest, that I have had to work a lot harder to create that space and
presence to be there present with clients, especially because the world keeps moving
around…things are moving. It's easy to disconnect and not be 100% present.”

Further reporting her lived experience, Participant 05 discussed how having no visual
contact with the client lost her the ability to visually convey her empathic attentiveness. She
stated:

“…staying completely engaged and connected [with the client], that responsibility
becomes a thing that’s solely on me, and not just me looking like I'm present anymore.”

After this initial exploration, the researcher asked Participant 05 about her perspective on
the role of empathy in the process of counseling. The participant discussed that she sees empathy
as “…the baseline of what any therapeutic relationship…should be”. The participant then added
that empathy is “not something that everyone has”.

The researcher then asked Participant 05 about her thoughts on the importance of
empathy. The participant stated her belief in the crucial importance of empathy. She shared:

“I think that empathy is counseling. I think that if you cannot have empathy, all you're
doing is harming your client.”
Following this questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 05 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had. Because she works as a program manager at her agency, Participant 05 shared that the majority of her supervision sessions were delegated to administrative concerns. She stated:

“I absolutely was not supported [by supervision] during that time. More so because I’m a program manager and things like that. It was with the director, and our use of supervision wasn't about the clients I was thinking about. More so, like running the program.”

The researcher then inquired into the topic of setting. Participant 05 reported that she had primarily delivered telephonic sessions from home, with “some office work”. When asked how working primarily from home affected her empathy toward clients, Participant 05 shared that it was more difficult for her to remain present when conducting telephonic sessions from home. She shared the following:

“…[telephonic counseling from home] was a lot harder to navigate and manage because there was so much going on, and it's your responsibility when you're not physically looking at someone to be wholly present with them. And it's hard when you're not in a space where you feel like that’s not what you’re supposed to be doing.”

Further discussing home as a setting in which “you’re not supposed to” be conducting telephonic counseling, Participant 05 discussed how other roles in her lived experience conflicted with her role as counselor. She commented:

“…my brain was kind of everywhere. I’m a mother, so my kids were sometimes there. If he got TV on or music, it's easy to get distracted…[at home], I wear a completely different hat. As a counselor and as a parent, I'm not the same at all. Or even as a
counselor and a wife. I wear a different hat and I play a different role…Supervisor, student, all of those hats. There was no take-off place.”

Next, the researcher asked into Participant 05’s experience regarding COVID-related media. The participant shared that COVID-related media precipitated a sense of overwhelm that caused her to “slow down a lot”. The participant also spoke to her lived experience during pandemic times, in which racial tensions were high. She stated:

“[Consuming COVID-related media] was really hard. Not even just the COVID stuff. The racial piece that was going on in the world significantly impacted my empathy; my ability to engage as a clinician, to the point where, for me, I had to slow down a lot.”

The researcher then moved to the next research question, inquiring into Participant 05’s experience of transitioning from in-person to telephonic counseling. The participant shared the irreplicable factor of being with a client “in their space”. However, the participant also spoke to greater comfort and anonymity that clients might feel in engaging in telephonic counseling in their own home. She shared:

“There's nothing like engaging with a person in their space. There's just not…being face-to-face, sometimes it's comfortable for me, because I feel safe. But it's not so necessarily comfortable for clients, and I found that having…that invisible barrier of not being in person or face-to-face, it allowed people to feel completely safe to be completely authentic and transparent.”

Further inquiring into the topic of transition, the researcher asked Participant 05 what it was like to transition with a client from face-to-face counseling to telephonic counseling. The participant shared that this transition bolstered rapport with her clients, as client could be
“authentic” and the participant had to “take their word” regarding what was happening in their home environment. She said the following:

“…[the transition to telephonic counseling] impacted rapport with some clients. Some clients struggled really hard, ‘cause they’re used to what they’re used to. And other ones, like I said, it made them do even better in counseling, and I felt like I was the most connected with them that I had ever been because they felt like they could just be authentic, just themselves, and I couldn't judge them…I had to take their word, and that created a different trust and different bond for us. And I think that that transition for a lot of people was very helpful.”

Next, the researcher asked into the topic of SES. Participant 05 shared that she worked primarily with “low to middle” SES clients. When asked how working primarily with this SES demographic impacted her empathic response, Participant 05 commented that seeing her lower SES clients navigate the trials of COVID brought about “a new level of empathy” for these clients. She stated:

“For some instances, [working with lower SES clients] made me garner a completely new level of empathy that I didn't even know I could reach, because I felt like I was very empathetic…the way that the media was presenting the world and being someone from originally kind of low SES and knowing the trials and tribulations that people don't necessarily understand, it gave me a new level of empathy for those in a lower SES, just because of life being out of their control and seeing a lot of people succumb to COVID and life and the chaos that was—is our world.”
Adding further to the above reflection, Participant 05 shared that her increased empathy for client grew to a critical degree, which precipitated compassion fatigue. That compassion fatigue prompted her to take a four-month hiatus from counseling. She shared the following:

“…my empathy definitely grew, but at the same time…with the media and all of those things, my empathy kind of started to kind of seize up. So it was definitely a double-edged sword…My empathy grew so much that I just couldn't do [counseling] anymore.”

The researcher then inquired into Participant 05’s experience empathizing with clients via differing mediums, first asking what it is like for the participant to empathize with clients in a face-to-face setting. The participant discussed how she feels greater pressure to exhibit empathic response in person due to having physical presence with the client. She commented:

“I think it's fairly easy to empathize in-person, because you have to, right? As a clinician, you have to engage. Just reading [the client’s] body language, their expressions. They could do the same thing for us. So, it's kind of like an act. You have to click that act up. Whether you want to be empathetic or not, you have to. Because they physically see all responses from your body. So it's more of a controlled empathy.”

The researcher then asked Participant 05 what it is like for her to empathize with clients over the telephone. The participant commented on a greater sense of emphasis on verbal expression of empathy. She said the following:

“I think that [telephonic counseling] is a different type of exposure…[in telephonic counseling], you have to be super engaged. You have to really be present…[clients] can't see a head nod, right? They can't see your body language, so you have to verbally express that. So, making sure that I'm processing out, verbally, first my body language.”

Next, the researcher asked Participant 05 what it is like for her to empathize with clients
via videoconferencing. The participant shared that she has greater influence over her body’s natural response in videoconferencing, preventing herself from “tensing up” as a natural somatic response. She shared:

“[videoconferencing counseling] been different, but I feel like I have more control of how I present…if someone’s saying something that I think is stupid or I don't agree with, instead of my body tensing up or them maybe seeing it, I’m able to be present, acknowledge myself, but still be present with a client and engage with them on what they need, and not just my body's natural response.”

The researcher then moved to the final research question of the study, inquiring into how Participant 05’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant began by discussing the loss of three loved ones during the pandemic, and how this experience precipitated overwhelm and influenced a change in her career trajectory, stating:

“I lost three loved ones during COVID, and they all died tragically and quickly. Not from COVID, but during COVID, so that has been very traumatic for me, as a person. Super shook up about it. I still haven't recovered, and I don't know if I will anytime soon to be quite honest…COVID also alerted me on a lot of things. Well, I was living a life that I choose to not move in that direction anymore, which has been rewarding and fulfilling.”

With the participant having sustained such deep loss, the researcher asked how this experience affected her empathy toward clients. Participant 05 reiterated that she had to take a four-month period of time away from the profession to focus on her own healing. She commented that it would have likely been unethical for her to continue counseling during this time, as she may have committed involuntary harm to both herself and her clients. She shared:
“...I had to quit counseling for a while...‘I can't carry anything else.’ And now you think, because we’re not supposed to carry anything into counseling, but the reality of it is, you do, especially being empathetic. I couldn’t carry anything else, because I had nothing else to carry at all...It's hard as clinicians, especially when you’re empathetic, because you're like, “I need to be there for these people, and I want to help them through. But the reality of it is, the whole saying of, ‘You can't pour from an empty cup.’ It hit me over the head really hard. At a certain point, if you're really not in the space to do what you need to do, there's nothing you can do, ‘cause you're not helping anybody...’cause then you do self-harm, and then you harm people. And they're already living through a pandemic and then adding additional harm, it's just not useful...[Taking a break from counseling] didn't come down to me wanting to...ethics are super important to me...”

The researcher then asked Participant 05 about her experience regarding possible COVID-19 exposures, and how they might have influenced her experience. The participant shared that she lives in an urban environment in which others did not take much precautions, stating, “...honestly, I’m probably one only people in the hood that hasn't had COVID.” When asked how lack of precautions from others impacted her empathy toward clients, the participant shared the following:

“I think sometimes people make stupid decisions, and you gotta live with it. So maybe [COVID-related negligence] did impact my empathy (chuckles)... and, obviously, we know those basic protocols. Doesn't guarantee you won't get it, but there are certain things that we can do. Just like in counseling, these are things we can do to help avoid some of the problems we run in to, and we don't.”
Further inquiring into the participant’s lived experience, the researcher asked Participant 05 what it was like for her to return to telephonic counseling after her four-month hiatus. The participant shared that she felt “overwhelmed” upon her return, She clarified that this feeling of overwhelm was primarily felt before and after her sessions, stating:

“…I was able to do the work with the clients, but [visible compassion fatigue] was before and after. It was the overwhelming, getting ready to meet with them, getting ready for session. And then organizing it after the session and all of that stuff. I was able to be present and them not know how I was feeling, but I definitely feel overwhelmed with just the experience of having to do [telephonic counseling].”

When asked if she had quarantined herself from others during the pandemic, Participant 05 shared that she had done so on three occasions while awaiting the results of a COVID test. The researcher then asked the participant how this experience affected her empathy toward clients. The participant shared that she found greater difficulty in being present with clients while she was in quarantine. She commented:

“…I was still able to be present, but I just found myself being less patient working for people that like, ‘Hey, I’m in quarantine. I feel like I shouldn’t be working right now’ (chuckles). But you still have to work. You still have to be present.”

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected her empathy toward clients. When asked how much COVID-related media she had consumed at the beginning of the pandemic, Participant 05 simply stated, “it was too much”, and that consuming this type of media “definitely negatively impacted me”. The researcher followed up by asking how her consumption of COVID-related media affected her empathy toward clients. Participant 05 commented on the intersection of various
factors such as racial identity and politics, and how these factors coalesced with COVID-related media to negatively impact her empathy toward clients. The participant shared the following:

“…it's hard to answer that question [regarding [COVID-related media coverage and empathy]. I wasn't isolated. It wasn't just COVID. It was the COVID, the racial identity, me caring for a dying loved one. It was—the empathy—the fact that our president was toxic and disrespectful, and lacked empathy. It became harder and harder to have empathy because of the lack of role modeling and modeling empathy in the public eye. It was toxic.”

Participant 05 then further commented on the intersection of her African American racial identity and her the sense of overwhelm she felt during the pandemic. She stated:

“…during the racial war, people telling me that my existence wasn’t true. The things I experienced were not true. That race didn't exist, or the whole pull-yourself-up-by-your-bootstraps, which, as someone that's a first-generation college student, is in a doctorate school, I know is not true at all. So it was probably the biggest caveat for me to be done with counseling and everybody…I don't have the privilege or luxury to be able to disconnect from [my race]. I can't take my skin off. I can’t change the reality of what God created me to be. This is who I am. But I have to constantly fight for my existence to be acknowledged or my experiences to be validated; not even validated, to just be acknowledged. It's very taxing. And it was too much. It was too much…It's not something that you cannot see, the whole idea of, “I don't see color.” You do. I’m brown (chuckles). I am a color. You see it. So, yeah. And that's why we had said, “Too much”, when you asked how much [media] consumed. It’s too much, because it was every aspect of my life, it was consumed in. Whether I took a social media hiatus of not, there are
conversations around me about it. ‘We need to do diversity work’, but you're not really making any changes about it. Or family. I have to talk about this, because I have family. We have to discuss it. ‘How do you move through this?’ So it was too much.”

After further questioning and discussion about hardships during the pandemic, Participant 05 shared her concerns about counselors navigating the pandemic, and the toll that they may have to undergo if they are cast in a narrative with the role of saving others. She said the following:

“[Therapists are] living through global pandemic, like everybody else. That's why you see the rate of us committing suicide is so high for those who have depression and anxiety and don't get help. Because there’s this ‘fake narrative’ (air quotes) that we have to be superheroes. We have to carry everything and that's okay. It's not (chuckles). We’re people.”

As a final question of the interview, the researcher invited Participant 05 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant shared that she had nothing further to add. The researcher thanked Participant 05 for her participation in the study. The interview with Participant 05 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 6 provides a visual representation and review of these phrases of significance from the narrative above.
### Table 6

**Participant 05 Phrases of Significance**

<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective empathy a</td>
<td>“I think that empathy <em>is</em> counseling. I think that if you cannot have empathy, all you're doing is harming your client.”</td>
</tr>
<tr>
<td>Identification</td>
<td>“…most of the people who were dying were people that looked like me. We look at impoverished areas. My communities, communities I live and work in. So those were people that looked directly like me. So that could have easily been me.”</td>
</tr>
<tr>
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</tr>
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<td>Imagination</td>
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Felt-level experience

“I lost three loved ones during COVID, and they all died tragically and quickly. Not from COVID, but during COVID, so that has been very traumatic for me, as a person. Super shook up about it. I still haven't recovered, and I don't know if I will anytime soon to be quite honest.”

“…during the racial war, people telling me that my existence wasn’t true. The things I experienced were not true. That race didn't exist…it was probably the biggest caveat for me to be done with counseling and everybody.”

“I don't have the privilege or luxury to be able to disconnect from [my race]. I can't take my skin off. I can’t change the reality of what God created me to be. This is who I am. But I have to constantly fight for my
existence to be acknowledged or my experiences to be validated; not even validated, to just be *acknowledged*. It's very taxing. And it was too much. It was too much.”

“It's not something that you cannot see, the whole idea of, “I don't see color.” You do. I’m brown (chuckles). I am a color. You see it. So, yeah. And that's why we had said, “Too much”, when you asked how much [media] consumed. It’s too much, because it was every aspect of my life, it was consumed in. Whether I took a social media hiatus of not, there are conversations around me about it. ‘We need to do diversity work’, but you're not really making any changes about it. Or family. I have to talk about this, because I have family. We have to discuss it. ‘How do you move through this?’ So it was too much.”

“I think that [telephonic counseling] is a different type of exposure…”

“…being face-to-face, sometimes it's comfortable for me, because *I* feel safe. But it's not so necessarily comfortable for *clients*, and I found that having…that invisible barrier of not being in person or face-to-face, it allowed people to feel *completely* safe to be completely authentic and transparent.”
“The racial piece that was going on in the world significantly impacted my empathy; my ability to engage as a clinician, to the point where, for me, I had to slow down a lot.”

“My empathy grew so much that I just couldn't do [counseling] anymore.”

“…I had to quit counseling for a while.”

“‘I can't carry anything else.’ And now you think, because we’re not supposed to carry anything into counseling, but the reality of it is, you do, especially being empathetic. I couldn’t carry anything else, because I had nothing else to carry at all.”

“It's hard as clinicians, especially when you're empathetic, because you're like, ‘I need to be there for these people, and I want to help them through. But the reality of it is, the whole saying of, ‘You can't pour from an empty cup.’ It hit me over the head really hard. At a certain point, if you're really not in the space to do what you need to do, there's nothing you can do, ‘cause you're not helping anybody…’cause then you do self-harm, and then you harm people. And they're already living through a pandemic and then adding additional harm, it's just not useful.”
“[Taking a break from counseling] didn't come down to me wanting to...ethics are super important to me...”

“If you need me to quantify [COVID-related media intake], it was too much. That’s a number, that’s a number... Definitely negatively impacted me...”

Interpersonal empathy a “...[empathy] is not something that everyone has.”

Understanding the client’s lived experience “...staying completely engaged and connected [with the client], that responsibility becomes a thing that’s solely on me, and not just me looking like I'm present anymore.”

Understanding barriers to counseling n/a

Understanding clients’ SES situations “For some instances, [working with lower SES clients] made me garner a completely new level of empathy that I didn't even know I could reach, because I felt like I was very empathetic.”

Environmental barriers to interpersonal empathy “…I think that professionals lacked empathy for each other, which then bled in, draining my empathy for professionals, and for wanting to do the work.”

“...[telephonic counseling from home] was a
lot harder to navigate and manage because there was so much going on, and it's your responsibility when you're not physically looking at someone to be wholly present with them. And it's hard when you're not in a space where you feel like that’s not what you’re supposed to be doing.”

“…my brain was kind of everywhere. I’m a mother, so my kids were sometimes there. If he got TV on or music, it's easy to get distracted…”

“…[at home], I wear a completely different hat. As a counselor and as a parent, I'm not the same at all. Or even as a counselor and a wife. I wear a different hat and I play a different role…Supervisor, student, all of those hats. There was no take-off place.”

“…I was still able to be present, but I just found myself being less patient working for people that like, ‘Hey, I’m in quarantine. I feel like I shouldn’t be working right now’ (chuckles). But you still have to work. You still have to be present.”

**Emotional barriers to interpersonal empathy**

“…[the transition to telephonic counseling] impacted rapport with some clients. Some clients struggled really hard, ‘cause they’re used to what they’re used to. And other ones, like I said, it made them do even
better in counseling, and I felt like I was the most connected with them that I had ever been because they felt like they could just be authentic, just themselves, and I couldn't judge them… I had to take their word, and that created a different trust and different bond for us. And I think that that transition for a lot of people was very helpful.”

“I have learned how to try to be present,

engaging kinda like if they were just [in the same room as the client], trying to create a space to mimic like them being there. But I will say it. I will be honest, that I have had to work a lot harder to create that space and presence to be there present with clients, especially because the world keeps moving around… things are moving. It's easy to disconnect and not be 100% present.”

“I think sometimes people make stupid decisions, and you gotta live with it. So maybe [COVID-related negligence] did impact my empathy (chuckles)…”

Objective empathy a “[Empathy] is the baseline of what any therapeutic relationship…should be.”

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Information from supervision as a source for objective empathy

“I absolutely was not supported [by supervision] during that time. More so because I’m a program manager and things like that. It was with the director, and our use of supervision wasn't about the clients I was thinking about. More so, like running the program.”

Information from COVID-related media as a source for objective empathy

“…my empathy definitely grew, but at the same time...with the media and all of those things, my empathy kind of started to kind of seize up. So it was definitely a double-edged sword.”

“…the way that the media was presenting the world and being someone from originally kind of low SES and knowing the trials and tribulations that people don't necessarily understand, it gave me a new level of empathy for those in a lower SES, just because of life being out of their control and seeing a lot of people succumb to COVID and life and the chaos that was—is our world.”

“…it's hard to answer that question [regarding [COVID-related media coverage and empathy]. I wasn't isolated. It wasn't just COVID. It was the COVID, the racial identity, me caring for a dying loved one. It was—the empathy—the fact that our president was toxic and
disrespectful, and lacked empathy. It became harder and harder to have empathy because of the lack of role modeling and modeling empathy in the public eye. It was toxic.”

a Master theme.

Interview 06

Participant 06 is a 27-year-old white female master’s level clinician who works in a private practice setting in Ohio, where she provides individual outpatient counseling to adult and adolescents. Participant 06 has worked in the counseling field for 2.5 years, accumulating a total of 12 months of this time during the COVID-19 pandemic. On average, Participant 06 reported seeing 2 telephonic clients per week. Although this number does not meet the present study’s inclusion criteria of 10 clients per week, the researcher chose to include this participant in the study to enrich the data regarding what it is like for counselors who are less normalized to telephonic counseling to empathically respond to clients through this medium. When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 06 indicated 5.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 06 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 06 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.
The researcher began the interview by broadly inquiring into Participant 06’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“[Empathizing via telephonic counseling] has been a lot harder. I think as we have gone through this pandemic, we've separated ourselves. There's multiple degrees of separation through telehealth, and seeing someone on Zoom, but not being in the physical space with them, that's one less degree. And then when you do it on the phone, that is even one less degree than something through Zoom or Doxy, because you can't see their face at all. And so it's not impossible; you can definitely do it…I had trouble doing that, though. Because you couldn't really see [the client’s] face, it was so hard to sometimes read their emotions accurately when you couldn't see anything with them. All you had was their voice. And as you probably know, sometimes clients will have a tone of voice that doesn't really reflect their facial expression or their body language or anything like that, so it was a lot. It was definitely a challenge.”

Participant 06 further spoke to the challenges of telephonic counseling, discussing how counselors are typically trained to work with the whole client, and not just their voice. She stated:

“As counselors, I think we're taught to look at the entire client when we're talking to them. We weren't really prepared for this [telephonic] way of doing counseling. In our training programs, we were taught to like, ‘Yeah, the client may say this one thing, but listen to their vocal expression, see what their body language is doing, look at the what their face is doing.’ And when we can't do the vast majority of those things, then it makes our jobs, I think, a lot harder…we're used to doing all of this stuff, observing all of these
different things, and that suddenly goes down to this one little piece of maybe just what they're saying, and maybe just what their voice sounds like. And that tells us so little.”

After this initial exploration, the researcher asked Participant 06 about her perspective on the role of empathy in the process of counseling. The participant discussed that she sees empathy as “absolutely foundational” to counseling. She shared the following about the importance of empathy:

“I think [empathy] is absolutely foundational. I'm a very big Carl Rogers fan. And I do a lot of motivational interviewing, which motivational interviewing is like person-centered, but with the direction, a little bit more. So, it's necessary. I've seen clients who, I just use the most basic form of empathy with them. And when talking to them about their situation and why they're coming into counseling, and I've seen that do wonders, because…people tend not to get a lot of empathy from other people in their life, and so when their counselors can provide that I think that…can be completely life changing. Some person just having empathy for you and your situation and maybe your mental illness. Yeah, it's not going to fix someone's bipolar disorder, but it can really be so beneficial to clients, because think about how we often respond to people's mental illness in society: it's like, ‘Oh, just use some coping skills and you'll be fine.’ And in reality it's quite a bit more than that.”

The researcher then asked Participant 06 about her thoughts on the importance of empathy. The participant stated her belief that empathy is a necessary factor in strengthening the therapeutic alliance. She shared:
“…when you don't have empathy for someone in their situation, whether that person’s a client, whether person's family or friends or whoever, it makes the relationship kind of weak in a lot of ways. And so, to strengthen that relationship, empathy is needed.”

Following this questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 06 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had received group supervision at her private practice setting, and that the newness of the pandemic prevent discussion on the intricacies of telephonic counseling. She stated:

“…I was getting supervision. I would not say it was quality supervision…our supervision at my practice is group supervision. I think, because everyone was losing their shit about the pandemic, the supervision that I just got was also, like, everyone losing their shit (laughs) in just a group supervision setting. But now that I'm thinking about it, though, I never brought up phone sessions in supervision. I don't think that was something that I talked about. I mean, I may have mentioned it if I had to see them on the phone because their Internet sucked, or something like that. But at no point did I talk about the complexities of seeing someone over the phone, compared to seeing them in person, or seeing them through Zoom. Yeah, I don't think that was ever really brought up. But I don't think I brought up many things in that supervision situation either, if that makes sense…[Supervision] was just like, “Oh my God. How do we see clients like this? This is horrible. We're miserable. Yeah, it was not getting to that next level of like, ‘…what would you recommend to see clients over the phone?’ (laughs)”
Further adding to the above comment on supervision, Participant 06 discussed how having basic needs such as safety compromised detracted from greater focus on nuanced aspects of counseling. She shared the following:

“…[supervisees] weren't having a lot of our safety needs met, and then we definitely weren’t having our social needs met. So yeah, we weren't getting to the more philosophical pieces…the peak end of counseling of…Maslow's Hierarchy of Needs. You have the bottom needs met so you can focus on the top. We didn't have all of those bottom needs met, so we were not focusing on some specific details…in the beginning of the pandemic, when I was doing much more phone sessions, it was rough (laughs).”

The researcher then inquired into the topic of setting. Participant 06 reported that she had primarily delivered telephonic sessions from home at the beginning of the pandemic, and that she works primarily works in an office setting in the present day. When asked how working primarily from home affected her empathy toward clients, Participant 06 shared that the combination of working from home, having no visual contact with the client, and navigating her own COVID-related struggles had a negative impact on her empathy. She stated:

“I think I was, in a lot of ways, not comfortable working from home. And so that made my job that much harder…I was not in a good place mentally during [the beginning of the pandemic]. And so it was hard to empathize with clients to begin with. Part of me just wanted to be like, ‘Your problem is not that big of a deal.’ And that's terrible to say. And normally before that, if you would have told me a year before the pandemic that that's what my thought would have been as a counselor, I would have not believed you at all….I'm sure most people can empathize with it like, ‘We're going through so much. And then I can't even see your face?’…It was so much harder to empathize with people
when you had all of those layers of like, ‘I'm working from home and I don't like it, and I’m not doing well mentally. And then it's really hard to see clients through telehealth, and then it's even harder to see clients over the phone and I can't see your face, so I don't know what's going on…”

Further speaking to her experience providing telephonic counseling from her home, Participant 06 shared the greater amount of distractibility and irritability she experienced when providing telephonic counseling from her home near the beginning of the pandemic, stating:

“…with phone sessions, it would be really easy to get distracted. It would be so much easier to just write up a case note while I'm in the session with the phone session with the client, which is not something I pride myself on (laughs). That was not something that I did before COVID. That's not really something I do so much anymore, because I'm in a better space, and I'm not at my house anymore doing it. I remember there were times when I was in a phone session and…I was honestly annoyed with this client, like, ‘Everyone is struggling right now. Why are you bringing this to me?’ Which is, like I said, that's a terrible attitude to have and it sucks. But…it would be really easy for me to be like, ‘Okay, I'm not going to have the energy to do their case note after the session is done. Why don't I just write it as we're talking?’ kind of deal. And so, all of those things, all of those layers contributed to a lot less empathy for my clients. It was really hard.”

Upon further inquiry into her experience, Participant 06 further shared her experience of compassion fatigue and distractibility regarding the intersection of COVID-related struggles and providing telephonic counseling:

“…when you're already not that empathetic for a client because you're not in a good space mentally, it does become so much easier to neglect them, in a way. Which is what I
kind of perceive as me doing case notes while I was in a session with them...for the first time I kind of understood like, ‘I'm not really with my client right now’ when I was in those kinds of sessions. When I was in phone sessions, specifically. Because you can't really, even in a Zoom, you can maybe get away with typing up a sentence here or there, and that's one thing. But they can still see you. And so that wasn't something that I had so much of a problem with. It was really the phone sessions, because I think there was a point where, ‘Oh well, if...I can't see them, they can't see me. I have less empathy for them already and for their situation”. And so yeah, it was just easy to type up a note.”

Next, the researcher asked into Participant 06’s experience regarding COVID-related media. The participant shared that COVID-related media was “horrible” to consume, and that she eventually chose to distance herself from it in the interest of her mental health. She said the following:

“[COVID-related media] was horrible. Oh my God. I had to just stop listening to the media after a while and stop watching the news...I think the media, especially the first few months of the pandemic before I kind of tried to turn it off and distance myself from it, it just added to my own fatigue and poor mental health...I was having a hard time being empathetic with clients because of my mental health, and the media just contributing to that of like, ‘Every day is a panic and every day we're going to die’ (laughs). Like, we haven't seen another human in months. All of this very chaotic catastrophizing kind of stuff that you saw, you still see that, to a degree. But back at the beginning of the pandemic was really bad. I think that just made my own mental health that much worse, and then that made empathizing with anyone, let alone clients, that much worse.”
The researcher then moved to the next research question, inquiring into Participant 06’s experience of transitioning from in-person to telephonic counseling. The participant shared that she saw almost “no clients” during the first few weeks of the pandemic due to her higher SES clients viewing counseling as a “privileged” activity. She stated:

“The vast majority of my clients were canceling. (1) Because they didn't want to be in person, and (2) they just couldn't handle counseling at that moment. We think that, in moments of crisis, you need to go to your counselor, but that's sometimes not what people end up doing. They're kinda in survivor mode, and counseling is often a very privileged activity, in a lot of ways, especially when you're at a private practice and the majority of your clients are privileged themselves. And typically not having severe, severe safety issues. Sometimes I see that, but not as often. And so, we tend to just neglect our mental health when our physical safety needs are not being met, and they weren't. And so, for the first two weeks, I think I had almost zero clients.”

Participant 06 then shared that, after her practice closed its doors to in-person sessions and transitioned to telehealth, she “defaulted” to videoconferencing counseling and used telephonic counseling as a secondary option. She shared:

“I ultimately switched some clients over to using the phone, it was when I tried using Doxy, and I tried using zoom…phone was the next best thing…[telephonic counseling was] literally the last resort. It's either this or we just don't have counseling. You just don't have the counseling.”

Next, the researcher asked into the topic of SES. Participant 06 shared that she worked primarily with “upper-middle” SES clients. The participant contrasted her current work with
upper-middle SES clients with previous work she had done with lower SES clients. She said the following:

“…the clients that I saw in the office that was in the upper-middle class area, I was working with them on self-awareness and, like…’Let's talk about your relationships and how your relationships are impacting your mental health’, whereas at the other office that was in a pretty bad part of town, it was like, ‘Do you have food on the table? Are you able to afford your electricity this month?’ And it's the middle of winter. I would have to give you the people who are coming to me at that one office so many more resources. Not just to other counseling resources, like a psychiatrist or groups or something like that. But also like, ‘Let me refer you this to this social worker who's going to help you get your bills and make sure that your kids are being fed.’ Just vastly different populations.”

When asked how her empathic response compared regarding working with upper-middle SES clients who has basic needs met, versus lower SES clients who did not have basic needs met, Participant 06 shared that she found it easier to empathize with upper-middle SES clients. She commented:

“I do sometimes think it's easier [to empathize with clients who have their basic needs met] because it's sometimes, and this sounds terrible, sometimes it's easier to work with them. They're already meeting some of those basic needs on the Maslow’s hierarchy. And so we can immediately just go in and be like, ‘Let's work on self-actualization.’…I don't have to go through all these boxes of like, ‘Okay, are you safe? Do you have adequate housing? Are your kids safe? Do I have to refer you to somebody to make sure that you're safe? And then, if you tell me that you've got kids and, for whatever reason, maybe to no fault of your own, your kids are not being safe or your kids are not safe where they're
living with you now.’ I have to make a call to Children’s Services, because I'm a mandated reporter. And, like, there's a lot more layers to that, you know? And I don't mean to disparage those individuals at all. Their issues are real, their issues are legitimate, and they absolutely deserve any kind of help that can be provided to them. And, at the same time, I also know I have to work a lot harder when I'm with them. And sometimes, just with my own bandwidth, it can be kind of exhausting.”

Asking into the intersection of upper-middle SES and telephonic counseling, the researcher inquired into what it was like empathizing with this SES group over the phone. Participant 06 reported that she found this experience frustrating, as she found that poor Wi-Fi was a willful limitation in this SES group, rather than a forced limitation. She shared:

“I think [higher SES clients having poor Wi-Fi] was something that also frustrated me, like, ‘I know your financial situation’ (laughs). ‘You literally pay me $135 every session. I know you can, and is not an issue for you whatsoever. You just hand me a credit card and tell me to charge whatever’ (laughs). ‘I know you can afford good Wi-Fi.’...it wasn't a good priority. It just wasn't a priority period. You know, ‘You had Wi-Fi at your house, and, if it was shitty Wi-Fi, well, you don't spend that much time at your house. Maybe you watch Netflix on your phone, but if you have unlimited data on your cell phone plan, who cares if your Wi-Fi sucks? Just switch over to data and it's fine...maybe you'll send a few emails here and there, from your house, but everything else takes place at work.’”

The participant then further spoke to this willful limitation of Wi-Fi, discussing that some upper-middle SES clients chose to prioritize Wi-Fi in the work setting over the home setting. She reported:
“…with COVID, and home suddenly became your place of work, now it's like, ‘Okay, now we actually have to care about our Internet speed’ (laughs) ‘while we're home.’ And some people, I think, there was a really long delay with that, partially because a lot of people just assumed or hoped that the pandemic was going to be a quick month or two thing of like, ‘Oh, why do I need new Wi-Fi? This is going to be over soon.’ And then it wasn't. And even then people were like, ‘Okay, it can't last that much longer. I'll just keep dealing with this for a little while’ (laughs). And then a year and a half later (laughs). And they still don't always have great Wi-Fi. And now, at this point, people have kind of neglected that, because a lot of people are going back to work in person. So it's like, ‘All right, well…it still doesn't matter if I have good Wi-Fi at home. I can just go back to work…It's more of the option to have good or bad Wi-Fi [for higher SES clients], because the option might not be there with people in lower SES brackets, whereas the option is definitely there, and people in higher SES brackets. They just might not care. It's just not as much of a priority to them.”

The researcher then inquired into what differences Participant 06 noted regarding empathic response through various counseling mediums during the pandemic. The researcher began by asking about the difference between the participant’s empathic response via face-to-face versus telephonic counseling. Participant 06 shared that empathizing via telephone is “a little bit harder”, reporting her personal dislike for the medium in comparison to face-to-face counseling. She stated:

“…I, just personally, don't like having a session over phone…I'm almost kind of forced to have one because it's…the last resort. I feel annoyed about that. I can feel myself becoming physiologically annoyed. Having those bodily responses to that… it's still
different to this day. And it's still a lot less empathy. And in this time, I’ve worked on myself a lot, and it's still not great.”

In order to further gauge a contract between the participant’s experience empathizing with clients via telephone versus in person, the researcher asked Participant 06 what it is like for her to empathize with clients in a face-to-face setting. The participant shared the joy she experienced upon her return to empathizing with clients in this setting, stating:

“…it was wonderful returning to in-person clinical work after being virtual, because I think I had forgotten what it's like to be in person, and to empathize with a person face-to-face and to really sit in this space with them and be empathetic and use all of those person-centered aspects. And I got to, and it was amazing after returning and it just made me so happy. I felt good. I felt like a counselor again, instead of just like a life coach, honestly (laughs). And it's so much easier to empathize with the client, because so can see their whole self, their whole body…I can hear [clients] better [in person], because sometimes you get that tinge-y sound when you work with clients over the phone, or virtually. And so I could hear them better I could hear their voice and their inflections. So it's just easier. I see empathy in a lot of ways of just being able to be with a client. It's a lot it's a lot easier for me to be with a client in person than to really be with a client in that way over the phone or virtually…the tinge-y-ness isn’t there, and I forgot what people sounded like without it, because there were some clients that I started seeing into COVID. And so I hadn't heard their voice without that tinge-y-ness until I saw them in person. So for months and months and months. And I'm like, ‘Oh my God, this is amazing.’ (laughs)”

Next, the researcher asked Participant 06 what it is like for her to empathize with clients
via videoconferencing. The participant shared that she perceives videoconferencing as being one degree of separation from face-to-face counseling, whereas telephonic counseling is two degrees of separation. She commented:

“Doxy and Zoom are degrees of separation, but I can at least see the client’s face. I can at least see if they're about to cry. It's harder to see if they're about to cry, because maybe the coloring is off on the screen, or the resolution is kind of weird. Or maybe they're just in a really dark room. That happened a few times. You can't see them super well, but you can at least see a little bit, and you can hear them...taking away that visual of [the client’s] face made it a lot harder. And I felt kind of at least a little bit more on my game if I was seeing them through Doxy or Zoom, because I knew that they could see me, I can see them. We were together in that space, a little bit more. I was with them a little bit more. Whereas over the phone...I didn't always feel with them at all.”

The researcher then moved to the final research question of the study, inquiring into how Participant 06’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant began by discussing that, although she personally has no interest in telephonic counseling, she has chosen to “meet clients where they’re at” when they prefer the telephonic medium. She shared:

“I've had to adjust to become more empathetic [in telephonic counseling], and it's still really hard...even just the other day it was really hard. And I don't think I'm done with that yet. Part of me is even hoping that maybe I just will never have another phone session again, and I won’t have to work on that part of myself (laughs). Maybe it'll just go away. And I don't think that's the reality, though. I think now that people have experienced phone sessions, maybe that's just going to be their preference, even though
it's not mine. And that's a piece of meeting the client where they're at. A sacrifice that I have to make as a counselor. And so I've had to become better at that in accepting like, ‘This is where the client’s at right now’, and that's a part of empathy too. I need to be with them… in the way that's most convenient for them, and no matter that it kinda sucks for me. There's things that I can do outside of counseling that make this a little bit better. And that’s like self-care and stuff like that.”

When the researcher further asked into the self-care piece of Participant 06’s experience, the participant shared that she had to get “really creative” with self-care strategies for her mental health. She commented:

“…a big piece of my self-care is exercise. And, at the being a pandemic, you couldn’t go to a gym, or you couldn’t go to work-out classes or anything like that. And so I got to see what that part of my life was like without any kind of exercise, ‘cause that's such a key piece of my self-care. And it sucked. I definitely had much worse mental health because of that. And so I had to get pretty creative in order to tolerate it, and thankfully I can go back to a gym again and it's okay. But I think I had to get really creative with my mental health in order to still be empathetic with clients.”

The researcher then asked Participant 06 if she had ever tested positive for COVID-19. The participant shared that she had. The researcher followed up by asking the participant how testing positive had impacted her empathy toward clients. She shared that this experience reiterated the seriousness of the COVID-19 pandemic and that, in some ways, in diminished empathy toward clients who wished to be seen in spite of their physical symptoms. She shared:

“…I knew it was important to maintain social distancing. And I knew we couldn't go back to the office, even at that point. I knew that. And I knew COVID was very serious. I
know people that have died from it, before I got it...before COVID, if a client told me they weren't feeling very well, and they just had a cold or something, I'd be like, ‘Okay’, you know? I'd still give them the option to come in, and I’d still maybe Lysol their chair in my office. I’ve definitely taken it a lot more seriously, and I think in some ways, maybe I have less empathy for when people tell me that they're not feeling well. After having gotten COVID, I’ll sometimes be like, ‘Okay, well don’t come in.’...I think if a client did tell me in the middle of a session and we're in person that they're not feeling well, I'd be like, ‘Okay, session’s over. You're going to go home, you're going to rest, I'm going to, like, shower’ (laughs). I think I've taken it more seriously for myself, and then I kind of model that for my clients, of like, ‘This is very serious. You need to take care of yourself, and also, I need to take care of myself, quite frankly. And I'm not going to let you tell me, like, ‘Oh no it's not that big of a deal, I can still come in’, or whatever. I'm very much like, ‘No...we can have a virtual session, but you're not coming in again until (1) you're feeling better, and (2) you've tested negative for COVID.”

When asked if she had quarantined herself from others during the pandemic, Participant 06 shared that she had quarantined for two weeks after testing positive for COVID-19. Because her symptoms were mild and her counseling work during the heart of the pandemic was conducted in the home setting, the participant shared that her experience quarantining at home did not significantly affect her empathy toward clients.

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected her empathy toward clients. When asked how much COVID-related media she had consumed at the beginning of the pandemic, Participant 06
commented that she had consumed “way too much” media. She illustrated her overwhelm with the following commentary:

“…in the very beginning [my COVID-related media consumption] was a lot; way too much, because I just didn't know what was going on, and I wanted to know what was happening, when this was going to be over, what else was closing down…I was just like trying to keep up with like, ‘Where can’t I go now?’ And then, after that, it was, ‘When is this going to be over? How bad is it? How many people are dying every day? How many people are getting sick?’ All this stuff, and I want to say I did that for like a few weeks, and then it was just bad. So I slowly started to cut back, and then after like a month or so, I was like, ‘I really can't keep doing this.’…[COVID-related media] was oversaturating, it was exhausting, it was stressful, it was anxiety-inducing, because…anyone in the media with having a full blown panic. And so they didn't know what's going on, really, any more than I did. And so watching other people who didn't know what was going on, well, and they were anxious and they were in a crisis while I was also anxious and in a crisis and didn't know what's going on. It just created this weird feedback loop of chaos (laughs).”

As a final question of the interview, the researcher invited Participant 06 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant shared that she had nothing further to add. The researcher thanked Participant 06 for her participation in the study.. The interview with Participant 06 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 7 provides a visual representation and review of these phrases of significance from the narrative above.
<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
</tr>
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<tbody>
<tr>
<td>Subjective empathy a</td>
<td>“…when you don't have empathy for someone in their situation, whether that person’s a client, whether person's family or friends or whoever, it makes the relationship kind of weak in a lot of ways. And so, to strengthen that relationship, empathy is <em>needed.</em>”</td>
</tr>
<tr>
<td>Identification</td>
<td>n/a</td>
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<tr>
<td>Imagination</td>
<td>n/a</td>
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<tr>
<td>Intuition</td>
<td>“[Empathizing via telephonic counseling] has been a lot harder.”</td>
</tr>
<tr>
<td></td>
<td>“…in the beginning of the pandemic, when I was doing much more phone sessions, it was <em>rough</em> (laughs).”</td>
</tr>
<tr>
<td></td>
<td>“I think as we have gone through this pandemic, we've separated ourselves. There's multiple degrees of separation through telehealth, and seeing someone on Zoom, but not being in the physical space with them, that's one less degree. And then when you do it on the phone, that is even one less degree than something through Zoom or Doxy, because you can't see their face at...”</td>
</tr>
</tbody>
</table>
all. And so it's not impossible; you can definitely do it… I
had trouble doing that, though.”

“…it's even *harder* to see clients over the

phone and I can't see your face, so I don't know what's

going on…”

“I see empathy in a lot of ways of just being able to be with a

client. It's a lot it's a lot

easier for me to be with a client in person than to really be

with a client in that way over the phone…”

“Because you couldn't really see [the client’s]

face, it was so hard to sometimes read their emotions

accurately when you couldn't see *anything* with them. All

you had was their voice. And as you probably know,

sometimes clients will have a tone of voice that doesn't

really reflect their facial expression or their body

language or anything like that, so it was a lot. It was
definitely a challenge.”

“As counselors, I think we're taught to look at

the entire client when we're talking to them. We weren't

really prepared for this [telephonic] way of doing
counseling.”
“…we're used to doing all of this stuff, observing all of these different things, and that suddenly goes down to this one little piece of maybe just what they're saying, and maybe just what their voice sounds like. And that tells us so little.”

“…it was wonderful returning to in-person clinical work after being virtual, because I think I had forgotten what it's like to be in person, and to empathize with a person face-to-face and to really sit in this space with them and be empathetic and use all of those person-centered aspects.”

“…taking away that visual of [the client’s] face made it a lot harder. And I felt kind of at least a little bit more on my game if I was seeing them through Doxy or Zoom, because I knew that they could see me, I can see them. We were together in that space, a little bit more. I was with them a little bit more. Whereas over the phone…I didn't always feel with them at all.”

Felt-level experience “…[the pandemic] was really hard. It was hard on myself; it was hard on my clients. It was just hard across the board and very mentally taxing and draining.”
“…I was not in a good place mentally. I was focusing on like, ‘Oh my God, I haven't seen a human being other than my husband in like a week. What am I doing?’, because I'm a very extroverted person. And so, listening to [my client] sob about [the pandemic] was honestly really emotionally draining to me to have so much empathy for that client in that moment…”

“…I don't like giving my phone number out to clients to begin with. That just makes me very uncomfortable. Thankfully, none of my clients have ever abused it. But that was like that was another level of exhaustion and anxiety. Because I'm just like, ‘Shit. I don't give out my phone number to clients. That's not something I do.’”

“…before COVID, if a client told me they weren't feeling very well, and they just had a cold or something, I’d be like, ‘Okay’, you know? I'd still give them the option to come in, and I’d still maybe Lysol their chair in my office. I’ve definitely taken it a lot more seriously, and I think in some ways, maybe I have less empathy for when people tell me that they're not feeling well. After having gotten COVID, I’ll sometimes be like, ‘Okay, well don't come in.’”
“[COVID-related media] was horrible. Oh my God. I had to just stop listening to the media after a while and stop watching the news.”

“…we have over-exhaustion with the media, I think, even before COVID. It was just rough to begin with, and then it just got amped up by 100. So it just made, I think, everyone very mentally unwell.”

“[COVID-related media] was oversaturating, it was exhausting, it was stressful, it was anxiety-inducing, because anyone in the media with having a full blown panic. And so they didn't know what's going on, really, any more than I did. And so watching other people who didn't know what was going on, well, and they were anxious and they were in a crisis while I was also anxious and in a crisis and didn't know what's going on. It just created this weird feedback loop of chaos (laughs).”

Interpersonal empathy

“…people tend not to get a lot of empathy from other people in their life, and so when their counselors can provide that I think that…can be completely life changing.”

Understanding the client’s lived experience

n/a
“I ultimately switched some clients over to using the phone, it was when I tried using Doxy, and I tried using zoom…phone was the next best thing.”

“…[telephonic counseling was] literally the last resort. It's either this or we just don't have counseling. You just don't have the counseling.”

“Some clients had the worst Internet ever. It was awful…we would have future sessions over the phone.”

“…[my client’s] kids were home, and she wanted to go on a walk and talk. And she thought she could just join in a Doxy or on Zoom as she's walking around her neighborhood, which that did not work (laughs)….So she ended up having a phone session.”

“I think [higher SES clients having poor Wi-Fi] was something that also frustrated me, like, ‘I know your financial situation’ (laughs).”

“It's more of the option to have good or bad Wi-Fi [for higher SES clients], because the option might not be there with people in lower SES brackets, whereas the option is definitely there, and people in higher SES brackets. They just might not care. It's just not as much of a priority to them.”
Understanding clients’ SES situations “…the clients that I saw in the office that was in the upper-middle class area, I was working with them on self-awareness and, like…” Let's talk about your relationships and how your relationships are impacting your mental health’, whereas at the other office that was in a pretty bad part of town, it was like, ‘Do you have food on the table? Are you able to afford your electricity this month?’ And it's the middle of winter. I would have to give you the people who are coming to me at that one office so many more resources. Not just to other counseling resources…”

Environmental barriers to interpersonal empathy “I do sometimes think it's easier [to empathize with clients who have their basic needs met] because it's sometimes, and this sounds terrible, sometimes it's easier to work with them. They're already meeting some of those basic needs on the Maslow’s hierarchy. And so we can immediately just go in and be like, ‘Let's work on self-actualization.’…I don't have to go through all these boxes of like, ‘Okay, are you safe? Do you have adequate housing? Are your kids safe? Do I have to refer you to somebody to make sure that you're safe?’”

“…with phone sessions, it would be really
easy to get distracted. It would be so much easier to just write up a case note while I'm in the session with the phone session with the client…”

Emotional barriers to interpersonal empathy

“I think now that people have experienced phone sessions, maybe that's just going to be their preference, even though it's not mine…I need to be with them…in the way that's most convenient for them, and no matter that it kinda sucks for me.”

 “…when you're already not that empathetic for a client because you're not in a good space mentally, it does become so much easier to neglect them, in a way. Which is what I kind of perceive as me doing case notes while I was in a session with them.”

“I've had to adjust to become more empathetic [in telephonic counseling], and it's still really hard…even just the other day it was really hard.”

“I think I was, in a lot of ways, not comfortable working from home. And so that made my job that much harder.”

“…I, just personally, don't like having a session over phone…I'm almost kind of forced to have one because it's…the last resort. I feel annoyed about that. I can feel myself becoming physiologically annoyed.
Having those bodily responses to that… it's still different to this day. And it's still a lot less empathy. And in this time, I’ve worked on myself a lot, and it's still not great.”

“It was so much harder to empathize with people when you had all of those layers of like, ‘I'm working from home and I don't like it, and I’m not doing well mentally.”

“…I was not in a good place mentally during [the beginning of the pandemic]. And so it was hard to empathize with clients to begin with.”

“I remember there were times when I was in a phone session and…I was honestly annoyed with this client, like, ‘Everyone is struggling right now. Why are you bringing this to me?’ Which is, like I said, that's a terrible attitude to have and it sucks. But…it would be really easy for me to be like, ‘Okay, I'm not going to have the energy to do their case note after the session is done. Why don't I just write it as we're talking?’ kind of deal. And so, all of those things, all of those layers contributed to a lot less empathy for my clients. It was really hard.”

“…I think I had to get really creative with my mental health in order to still be empathetic with clients.”
“…for the first time I kind of understood like,

‘I'm not really with my client right now’ when I was in

those kinds of sessions…it was just easy to type up a

note.”

“[Concurrent documentation] was, in a way,

neglect, because I'm not really with [clients].”

“I think the media, especially the first few

months of the pandemic before I kind of tried to turn it off

and distance myself from it, it just added to my own

fatigue and poor mental health…I was having a hard time

being empathetic with clients because of my mental

health, and the media just contributing to that…”

Objective empathy a

“I think [empathy] is absolutely foundational.

I'm a very big Carl Rogers fan. And I do a lot of

motivational interviewing, which motivational

interviewing is like person-centered, but with the

direction, a little bit more. So, it's necessary.”

Information from supervision as a supervision. I think, because everyone was losing their

source for shit about the pandemic, the supervision that I just got

objective empathy was also, like, everyone losing their shit (laughs) in just a

group supervision setting. But now that I'm thinking about
it, though, I never brought up phone sessions in supervision.”

“[Supervision] was just like, “Oh my God.

How do we see clients like this? This is horrible. We're miserable. Yeah, it was not getting to that next level of like, ‘…what would you recommend to see clients over the phone?’ (laughs)”

“…[supervisees] weren't having a lot of our safety needs met, and then we definitely weren’t having our social needs met. So yeah, we weren't getting to the more philosophical pieces…the peak end of counseling of…Maslow's Hierarchy of Needs. You have the bottom needs met so you can focus on the top. We didn't have all of those bottom needs met, so we were not focusing on some specific details.”

Information from COVID-related media as a source for objective empathy

a Master theme.
Interview 07

Participant 07 is a 27-year-old white male/non-binary master’s level clinician who works in an agency setting in Nevada, where he primarily provides individual outpatient counseling to adult and adolescent clients. Participant 07 has worked in the counseling field for 3 years, accumulating a total of 13 months of this time during the COVID-19 pandemic. On average, Participant 07 reported seeing 2 telephonic clients per week. Although this number does not meet the present study’s inclusion criteria of 10 clients per week, the researcher chose to include this participant in the study to enrich the data regarding what it is like for counselors who are less normalized to telephonic counseling to empathically respond to clients through this medium. When asked how comfortable he was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 07 indicated 7. Following completion of the interview, the researcher emailed Participant 07 to inquire into what gender pronouns would be preferred for use in the following narrative. The participant reported that he uses he/him pronouns in addition to they/them, and that he is comfortable with the use of he/him pronouns for narrative purposes in this study.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 07 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, his rights as a participant, and that she could withdraw from participation at any time. Participant 07 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 07’s experience empathizing with clients over the phone during COVID-19. The participant’s reported that
empathizing via telephone has been “mixed” for him. He illustrated his experience of using his imagining as a toll for empathy by providing the following example:

“My most regular telephonic client, for example, we started out our counseling relationship in person…And with him I think I've had a much easier time expressing empathy and picking up on stuff with him. And, to me, it's because I was already…familiar with him, and so when I'm talking to him over the phone, I find myself able to picture his expressions and I'm kind of imagining what he looks like, and his non-verbals and things as he's talking. With clients who I've been less familiar with in person, it has been more of a struggle, I think, to have that same level of understanding, and also expressing expression over the phone.”

The researcher further inquired into the participant’s experience of transitioning from face-to-face to telephonic counseling with a client, versus starting solely with telephonic counseling. Participant 07 shared that he experienced greater rapport with clients he had first seen in person, stating:

“…for me, I don't know if I feel like I have maybe a little less rapport with those clients who have never seen in person. Contracting with the person who I started out in person and then move to telephone, I feel like we established a pretty strong relationship in person from the get-go. We had probably six or seven sessions and then he switched to over the phone exclusively. So I feel like we built that initial rapport right away, whereas some of the other clients who have been just over the phone from the very start, I feel like we have been able to build rapport and through the expressions of empathy and receiving that from them. And I would say I would evaluate the relationships to be less strong.”
After this initial exploration, the researcher asked Participant 07 about his perspective on the role of empathy in the process of counseling. The participant shared that he identifies as a person-centered counselor who perceives empathy as “the most important thing in the counseling relationship”. He reported:

“…for me, I've always kind of identified as, primarily, a person-centered counselor. And empathy is a core tenet stemming from all of Roger’s writings, and what person-centered counseling is today. To me, I have always viewed empathy as the most important thing in the counseling relationship, and I think it serves as a way to build rapport, so that tools and strategies, techniques, no matter what your theoretical orientation are can be effective. Because I think if you can't empathize with your client, then you don't—you're not going to know what they need. So your interventions that you apply later might not be a good fit for them, or where they're at. And, to me, the expression of empathy is a vehicle for change in the counseling—in counseling. I strongly believe that, when people are able to be truly understood and listened to and have that expressed to them, I think that creates change.”

The researcher then asked Participant 07 about his thoughts on the importance of empathy. The participant reiterated his perspective on the essential nature of empathy, stating:

“…I truly believe [empathy] is essential in counseling. I think it’s one of the most important pieces of the counseling dynamic and, like I said, how people change…if you removed empathy from the whole counseling dynamic, I don't I don't think it would be counseling anymore…I think [empathy is] the first ingredient in the counseling.”

Following this further questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 07 had received supervision during her experience.
providing telephonic counseling during COVID-19. The participant commented that he had. He discussed that she had received supervision from multiple supervisors at his agency, in addition to one supervisor for licensure. Participant 07 shared that he had the opportunity to discuss telephonic cases in supervision, stating:

“…I have definitely talked about my telephonic clients [in supervision], specifically. Particularly, one of my adolescent clients who I have seen through telephonic counseling, regularly. Because that's a client I have had some more struggles with, connecting with over the phone, expressing empathy, and really knowing what to do, and creating change with them.”

The researcher then further inquired into Participant 07’s experience providing telephonic counseling to younger clients. The participant commented that it was significantly more difficult to provide this mode of counseling to younger clients. He said the following:

“I absolutely feel less effective over the phone with younger clients than I do with clients. To me, part of it is the comfort…that adults tend to have talking over the phone versus adolescence. There's a lot more awkward pauses when I'm working with my adolescent clients over the phone, and I feel like I have a harder time reading cues over the phone with my younger clients. Whereas with my adult clients, I feel like…it's more clear when they're pausing to think, or because they're wanting or expecting a response for me. Versus with the adolescent clients, I find that…we’re kind of interrupting each other more frequently, because the cues, to me, aren't as clear.”

The researcher followed up by asking Participant 07 what it is like for him to empathize with adult clients over the telephone. The participant described adult clients as being “easier to read” than adolescent clients. He stated:
“I feel like it's a lot easier to read even stuff like tone of voice and things with adult clients over the phone versus with adolescent clients, which then, of course, impedes your ability to empathize with them, because you're not quite as clear where they're at with things in the moment. And to me… it feels like a lot of it is the adolescents are just less comfortable phone conversation. And so picking up on like, ‘Okay, are you just being awkward right now, or are you upset or angry or irritated?’, is to me more difficult to get an accurate read on.”

Further commenting on the above differential, Participant 07 discussed how today’s adolescent social norms of video chat and texting rather than phone calls may have a bearing on their experience engaging as a client in telephonic counseling. He shared:

“‘My adolescent clients, they talk all the time. They're like, ‘Yeah, I'd never have a phone conversation with anybody.’ If anything, they're either FaceTime-ing or texting. FaceTime, and of course it's a completely different modality, because you’re on the video; a video feed in front of you. Whereas over the phone it's a whole different thing.”

The researcher then inquired into the topic of setting. Participant 07 reported that, near the beginning of the pandemic he had primarily delivered telephonic sessions from home. The participant then shared that his agency soon allowed clinicians to practice in the office setting without clients being physically present. When asked what it was like to empathically respond to clients when conducting telephonic counseling from home, Participant 07 shared that he felt “uncomfortable”, and that providing this mode of counseling in the office setting felt less isolating. He stated the following:

“‘There is something about doing counseling from my home, especially over the phone, that I just did not feel so comfortable with. When we were in person, but still didn’t have
in person clients, that felt, I don't know, so we were driving to a different setting. It was outside of our own home. We were in the building with other counseling professionals and people that we could go and consult with and gets supervision from in the moment. So it didn't feel as isolating as doing it from home. There was something just very reassuring about being in that environment versus being at home.”

The researcher then asked further into Participant 07’s experience providing telephonic counseling in an office space. The participant reiterated his perspective on the office harboring an environment of greater interpersonal support. He shared:

“[The office workspace was more tolerable] in support and also just being able to vent about frustrations about doing tele-therapy and phone sessions. That, I think, made the experience more tolerable…other people are having similar experiences over the phone and with tele-therapy, so we were able to feel like we weren't alone in that. And that definitely helped me feel better about it.”

Next, the researcher asked into Participant 07’s experience regarding COVID-related media. The participant discussed how media created a sense of immersion that prompted his to “check in” with his clients about the pandemic. He stated:

“…during the height of the pandemic, when…infection rates and everything were the worst, I was very immersed in media coverage of [the pandemic]. And it was something that was like kind of all-consuming for me, I would say at that point, because I was so immersed in the media coverage. And I know that made me bring more of the pandemic-related topics into session, because it, I think, just naturally, it was something that was on my mind…I have stopped being as immersed in the media coverage related to the
pandemic, specifically. And so I find myself, bringing it up less and bringing into session less.”

The participant then shared his experience of COVID-related media shifting to vaccine mandates, and how this experience affected his empathy toward clients. He commented:

“…as the media coverage has shifted more from the effects of COVID on society to a discussion around the vaccine and vaccine mandates and people who are refusing to get the vaccine, all the different beliefs around the vaccine, I find myself thinking about that a lot more with clients, and wondering where they’re at on that. If they are pro-vaccine, anti-vaccine, and how that might be impacting their specific lives. And I’m sure that that is a direct correlation with how the media coverage has shifted.”

The researcher then moved to the next research question, inquiring into Participant 07’s experience of transitioning from in-person to telephonic counseling. The participant discussed his initial dislike for the telephonic counseling medium and that, over time, both he and his clients felt more comfortable with this mode of counseling via process of “socialization”. He stated:

“For me, I hated [telephonic counseling] (laughs) at first. I really felt less effective. I felt like I was connecting less with my clients, I felt less confident in my abilities in my interventions through tele-counseling, and especially over the phone. We did some training on tele-counseling at the start of the pandemic, and… I still did not feel very confident going into it. I think one of the biggest things I struggled with was feeling like I knew as well how to fill a full session. I remember really, at the beginning, especially, feeling like my sessions…the pacing was so off…I feel like I was constantly looking down the clock, and I’m like, ‘Wow, it’s only been like two minutes’…I just felt
completely thrown off in that aspect. Eventually, I did get more comfortable with it, and I felt like I was able to pace my sessions better, and I felt more effective and competent in it as I became more familiar with it, and I think as clients became more used to it. I think there was a whole socialization process to teletherapy that all happened that the beginning of this, because most people had, from my understanding, never experienced tele-counseling before. So they were getting used to it, I was getting used to it as a counselor, and I think that combination made it a little painstaking, to be honest, at the beginning of this process.”

The participant then spoke to clients experiencing distractions in the home setting when receiving telephonic counseling. He said:

“…all of the distractions that are present when somebody's in their own home…Like dogs needing to be let outside or barking at something. Somebody ringing the doorbell, and they're like, ‘Wait a second, I need to go check that.’ All these things that normally wouldn't interfere or come into play in an in-person counseling session.”

Participant 07 then spoke to his own environmental distractions in delivering telephonic counseling in the home setting. He commented:

“…[there were] contaminations on my end as the counselor, too. Like my own distractions happening in my living space or wherever I was doing the session from. I think that's another piece of what made going into the office beneficial, where there were less distractions on my end. When I'm sitting at home, there's people walking outside the window, construction, people mowing the lawn, all kinds of stuff. Worried about my Internet connection at home versus in the office.”
Further inquiring into the topic of environmental distractions, the researcher asked Participant 07 how these distractions affected his empathic response toward clients. The participant shared that he found greater difficulty “staying in the moment” with clients when they were “pulled in and out of emotional expression”, stating:

“I found, personally, the distractions [in the client’s home] took away a lot from my ability to stay in the moment with the client and really connect with them and the emotions they were experiencing. Not only because…they were being distracted, so they would be, you know, expressing sadness or anger or something, and then all of a sudden, their door bell’s ringing and they're like, ‘Oh, hold on a second’ (laughs). So there was lot more interruptions in that, which I think then…people were pulled in and out of emotional expression, which made it confusing and harder to track, and understand where they were at. And then they would come back from the distraction, and the emotion would be different, because they just have to go deal with something and it pulled them out of it.”

Participant 07 this further spoke to his experience empathizing with clients via telephone, sharing that feelings of incompetence near the beginning of the pandemic made it more difficult for him to be present with clients. He shared:

“…during that transition period from when I was used to doing in-person to the start of doing telephone and tele-therapy sessions, because I was feeling less competent, I was more focused on that piece, than I was able to in…empathizing with their emotions and expressing that back to them, because I was also thinking about like, ‘Whoa, holy shit, I'm not being effective right now and then get in my head about that. And then I'm like,
‘Well. I just missed… a crucial ten to twenty seconds of what they were saying, and then

*I’m lost.’

Next, the researcher asked into the topic of SES. Participant 07 shared that he worked primarily with middle SES clients, with some upper and lower SES clients on his caseload. Due to his work predominantly involving middle SES clients, the participant reported that most of his clients choose telephonic counseling out of convenience, rather than necessity. He commented:

“I think the clients that I see over the phone, it's largely been more out of convenience for them than necessity. Because I think most [of] the clients I'm seeing over the phone, I think they kind of all have access to computers. But, for convenience reasons, are choosing to be over the phone…”

The researcher then moved to the next research question of the study, asking Participant 07 if there has been a difference form him in empathizing with clients face-to-face, versus telephonic counseling. The participant shared that he felt a greater sense of connection with clients in person than he did in telephonic counseling. He reported:

“I have noticed that I feel much more connected in person with people than over the phone, even with that client I was talking about, who, we started in person and we transitioned to over the phone. And there are sessions and moments in sessions, where I feel like we're not connecting as well as we were when we were face to face. And I think he can sense that as well, because, occasionally, he’ll throw out comments like, ‘Oh, are you even there? How you been tracking?’ And then I find I have to do some repair with that, because I wasn't expressing empathy as clearly as I think I do in person. That's never been an issue for me in person. That's something I identify as a strength of mine as a counselor: an ability to express empathy with people. So it was kind of a shock over the
phone, kind of being called out on that (laughs). And so, for me, it has been a pretty significant difference.”

Participant 07 spoke to experiencing greater difficulty outwardly expressing empathic response to clients via telephonic counseling. He shared:

“…my expressions of empathy are less frequent [in telephonic counseling], because I'm not able to use those nonverbal signals. So I am trying to use minimal nonverbals, and then paraphrases and stuff. But I feel like…typically, I rely on a balance of both…head nodding, smiling, facial expressions, all of that. And the minimal…verbal responses and things like, ‘Mhmhm’, ‘Yeah’, all of that. And over the phone, I feel like a little bit like I am doing the session with one hand tied behind my back at times, because you're only able to use verbal expressions of empathy.”

Next, the researcher asked Participant 07 what it has been like for him to empathize with clients via videoconferencing. The participant shared that empathizing through this medium was easier than phone, but felt less effective than in person. He stated:

“…[videoconferencing counseling was] a lot easier than over the phone. Still, I would say, less. I feel less effective in the video session expressing empathy, specifically, than in person. I feel like the biggest difference between in-person and videoconferencing, for me, is like, I don't have access to my full range of nonverbals still, because in in-person, I will adjust my body posture frequently to express empathy and lean in. And I feel like I can kind of do that, but it's a little awkward. I’m just like, (leans in toward camera) gonna press my face into the camera now. That doesn't have the same effect as fully adjusting your posture and leaning in. So, even over videoconferencing, no. You can nod, use
facial expressions, and use that to express empathy, but still can't do all the full range of nonverbal expression.”

The researcher then moved to the final research question of the study, inquiring into how Participant 07’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant shared that fear for his grandmother’s wellbeing impacted his empathy toward clients who had differing value sets from the participant regarding COVID-19 precautions. He reported:

“I’m thinking of my last remaining grand relative, my great aunt. And I was so, so worried about her throughout the whole pandemic. And fortunately, she's a person who's taking a lot of precautions and things and being as safe as she could be. And yet, of course, that's still not risk-free. And so when I got the sense that clients were against the vaccine, or not being very precautious, or just having a, very generally, a dismissive attitude towards the pandemic and people's experiences in it. That was definitely a barrier to expressing empathy. And I struggled to empathize with those clients. Now, of course, I have worked with a lot of clients who have very, very different value sets, beliefs about the world than me. And, you know, I would compare it to that. And I found myself having to check in with myself when I got that impression from a client. Like, ‘Okay, you're feeling a little irritated with this person right now; maybe a little angry. But it's not about your feelings about this. You need to be here for them, regardless of whatever their beliefs or values or whatever they're doing. It's your job to be here for them.’ So I think I went through this little back-and-forth process sometimes with clients, specifically related to their beliefs about the pandemic and the vaccine and everything.”
Participant 07 then further expressed his frustration toward clients who chose not to take COVID-related precautions, and how this experience precipitated avoidance of the topic of COVID-19 in session with clients. He stated:

“…to me it is absurd that people refuse to take public safety measures because it causes them a slight inconvenience…I understand people are truly afraid of the vaccine because of whatever the reasons are, but people who are just like, “Oh, it’s too much trouble for me to put on a mask or do these things.” I found myself getting very, very frustrated with them, because we're just talking about the general health of the world, and you can't be bothered to take some precautions that could save people's lives…I found myself steering away from the topic of COVID with clients who, I sensed, held those beliefs [of not exercising caution during the pandemic]. Though, of course, people who still wanted to process it, I tried to empathize with them and…stay with it, but I did notice that about some of my sessions.”

After Participant 07 shared that he had not tested positive for COVID-19 during the pandemic, the researcher asked the participant how remaining free from COVID-19 had affected his empathy toward clients. Participant 07 shared that he felt some judgement toward clients who had contracted COVID-19 and experienced minimal symptoms, and greater empathy for clients who had been hospitalized after testing positive. He commented:

“…I did find myself with [clients] who got COVID. I had that automatic thought, like, ‘Oh, you must not have been being as safe as you could be.’ Then check in with myself and like, ‘Okay. You don't know how they got COVID. They could have been being perfectly safe and got exposed still.’ But it was an automatic thought that came in that's sometimes interfered with empathy and in took away from that, if only briefly. I think I
was generally effective at checking in and then getting back into the moment with the client. I've worked with several clients who tested positive for COVID, and I've worked with several clients who were hospitalized for COVID…I found myself being less judgmental of the people who were hospitalized because I was so focused on empathizing and supporting them, because I’m like, ‘Wow, this was a really traumatic experience for you being on a ventilator in a parking garage hospital, surrounded by people who were literally dying’, versus, my adolescent client who got COVID had very minimal symptoms, stayed home for a week, and they were fine…I found myself having a lot more empathy for the people who had…a more intense experience with it, than the people who just kind of had it with minimal symptoms or effect on their life.”

Further speaking to his greater response toward clients who had been hospitalized after testing positive for COVID-19, Participant 07 shared that the shifting of these clients’ perspectives on the severity of COVID-19 also contributed to his greater empathic response toward these clients. He stated:

“…the people who I worked with who had severe symptoms with COVID and were hospitalized had very different perspectives after that experience. And they were then taking it very, very seriously and like, you know, ‘I almost died.’ They had very different perspectives on the pandemic, versus the people who caught it and were asymptomatic or had minimal symptoms. And I think it was easier, then, to empathize with the people who had that different perspective on COVID.”

In contrast to clients who had tested positive for COVID-19, Participant 07 shared that no one in his immediate social circle tested positive, generating the sense of a protective “bubble” for the client. When asked how living in this bubble impacted his empathy toward clients, the
participant shared that he felt a combination of judgement toward clients who had tested positive, and had an opportunity to recognize his own privilege regarding the bubble. He shared:

“…on some level, [clients contracting COVID] made me question the clients more who were exposed to COVID, because I have this very clear example around me of an environment which nobody had contracted COVID. We were all being as safe as we could be. And so on some level, I’m like, ‘Well, I know it's very possible to…create an environment in which people are not being regularly exposed to COVID.’ So then people were getting exposed and like, ‘Well what was your environment like? Were you putting yourself in a not great, environment?’ And, of course, not their fault in most cases. Somebody around them was not being safe…I am fairly privileged in where I live, where I work, to have less chance of being exposed to COVID. There's just certain communities in certain areas where it's not as possible to avoid being exposed. So [I'm] very, very fortunate in that.”

The participant then shared how his empathy for clients who had public-facing jobs grew during the pandemic due to their potential exposure to COVID-19. Participant 07 also recognized his privileged working remotely and safely. He shared:

“We're lucky [as therapists]. I mean, grocery employees, I can't even imagine the stress that was put on them, with the amount of people that they came into close contact with, who likely had COVID, or had been exposed to COVID. I was able, being in the counseling profession, like, we have the benefit of being able to do our services through tele-therapy and through telephone sessions. And so there's definitely some privilege, and just being fortunate that that's our field…I mean, service-oriented jobs, like either you're
unemployed or you're interacting with people in a close setting, and there's no way around that.”

When asked if he had quarantined himself from others during the pandemic, Participant 07 shared that he had self-imposed quarantine near the beginning of his agency job due to “allergy symptoms”, and that he was “overly cautious” about distancing himself from others when he had cold-like symptoms. The researcher followed up by asking the participant if quarantining impacted his empathy toward clients. Participant 07 shared that quarantining helped him to better empathize with clients who had also been out of work, and that it helped him to better understand his privilege of being able to miss work without financial crisis. He stated:

“…[quarantining] did make me empathize more, I think, with [clients] who experienced time periods when they couldn't work, and the stress that comes with that. Which, again, pretty privileged…I don’t have a lot of money, but I could afford to not be working for that week. Though I did do some phone sessions from home during that time, which, again, was very, very fortunate that I was able to do that. But yeah, having that experience, I think, definitely made it easier to connect with people and empathize with people who had how to stay home from school for two weeks, or had to stay home from their job for two weeks.”

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected his empathy toward clients. The participant reiterated his heavy consumption of media near the beginning of the pandemic, stating:

“I was reading constant articles about [the pandemic] throughout the day. I would say, on average, during the height of the pandemic, probably two plus hours per day. Especially
just kind of adding up would be like twenty minutes here, thirty minutes here, an hour here. It's kind of spaced out throughout the day.”

Next, the researcher asked Participant 07 how his initial saturation in COVID-related media consumption influenced his empathy toward clients. The participant reported that this degree of media consumption precipitated increased focus on the topic of COVID-19 in session and increased his sensitivity to the potential danger of COVID-19. He commented:

“…I feel like [the pandemic] it was something that I was constantly thinking about in my sessions, and I feel like I was constantly watching for signs that their symptoms or their experience might be related to the pandemic. So I feel like I was extra sensitive. And maybe extra empathetic, I guess, to that, because of the amount of media that I was consuming related to the pandemic. I mean, reading stories about families losing loved ones, and about the effects on the economy and all of these things on people's jobs. I think I was extra listening for that, and I feel like I was able to express empathy pretty effectively, because I felt like I was pretty well informed, because of the media coverage, and I was consuming it from multiple different sources. I was trying to kind of balance it out, so it wasn't getting just one perspective on things.”

As a final question of the interview, the researcher invited Participant 07 to speak to any lived experiences that he had not yet had the opportunity to discuss. The participant shared that he had nothing further to add. The researcher thanked Participant 07 for his participation in the study. The interview with Participant 07 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 8 provides a visual representation and review of these phrases of significance from the narrative above.
Table 8

Participant 07 Phrases of Significance

<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective empathy (a)</td>
<td>“To me, I have always viewed empathy as the most important thing in the counseling relationship, and I think it serves as a way to build rapport…”</td>
</tr>
<tr>
<td>Identification</td>
<td>“…[quarantining] did make me empathize more, I think, with [clients] who experienced time periods when they couldn't work, and the stress that comes with that.”</td>
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<tr>
<td>Imagination</td>
<td>“My most regular telephonic client, for example, we started out our counseling relationship in person…And with him I think I've had a much easier time expressing empathy and picking up on stuff with him. And, to me, it's because I was already…familiar with him, and so when I'm talking to him over the phone, I find myself able to picture his expressions and I'm kind of imagining what he looks like, and his non-verbals and things as he's talking.”</td>
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| Intuition                   | “I feel like it's a lot easier to read even stuff like tone of voice and things with adult clients over the phone versus with adolescent clients, which then, of
course, impedes your ability to empathize with them, because you're not quite as clear where they're at with things in the moment.”

“…for me, I don't know if I feel like I have maybe a little less rapport with those clients who have never seen in person. Contracting with the person who I started out in person and then move to telephone, I feel like we established a pretty strong relationship in person from the get-go. We had probably six or seven sessions and then he switched to over the phone exclusively. So I feel like we built that initial rapport right away, whereas some of the other clients who have been just over the phone from the very start, I feel like we have been able to build rapport and through the expressions of empathy and receiving that from them. And I would say I would evaluate the relationships to be less strong.”

“I have noticed that I feel much more connected in person with people than over the phone, even with that client I was talking about, who, we started in person and we transitioned to over the phone. And there are sessions and moments in sessions, where I feel like we're not connecting as well as we were when we were face to face.”
“...I feel like I have a harder time reading
cues over the phone with my younger clients. Whereas
with my adult clients, I feel like...it's more clear when
they're pausing to think, or because they're wanting or
expecting a response for me. Versus with the adolescent
clients, I find that...we’re kind of interrupting each other
more frequently, because the cues, to me, aren't as clear.”

“...[regarding client silence over the phone],
it's like, 'Are you pausing to think, or you're just not
gonna say anything for the next five minutes?''

“...my expressions of empathy are less
frequent [in telephonic counseling], because I'm not able
to use those nonverbal signals. So I am trying to use
minimal nonverbals, and then paraphrases and stuff. But I
feel like...typically, I rely on a balance of both...head
nodding, smiling, facial expressions, all of that. And the
minimal...verbal responses and things like, 'Mmhmm',
'Yeah', all of that. And over the phone, I feel like a little
bit like I am doing the session with one hand tied behind
my back at times, because you're only able to use verbal
expressions of empathy.”
Felt-level experience

“[The office workspace was more tolerable] in support and also just being able to vent about frustrations about doing tele-therapy and phone sessions.”

“I’m thinking of my last remaining grand relative, my great aunt. And I was so, so worried about her throughout the whole pandemic.

“…I am fairly privileged in where I live, where I work, to have less chance of being exposed to COVID.

“We're lucky [as therapists]. I mean, grocery employees, I can't even imagine the stress that was put on them, with the amount of people that they came into close contact with, who likely had COVID, or had been exposed to COVID. I was able, being in the counseling profession, like, we have the benefit of being able to do our services through tele-therapy and through telephone sessions.

“I self-quarantined in the few moments…when I had some symptoms that could be related to COVID.”

“I feel like I tried to be responsible through the pandemic when I had any kind of cold symptoms. I feel like I was probably overly cautious about it.”
“For me, I hated [telephonic counseling] (laughs) at first. I really felt less effective. I felt like I was connecting less with my clients, I felt less confident in my abilities in my interventions through tele-counseling, and especially over the phone…Eventually, I did get more comfortable with it, and I felt like I was able to pace my sessions better, and I felt more effective and competent in it as I became more familiar with it, and I think as clients became more used to it. I think there was a whole socialization process to teletherapy that all happened that the beginning of this, because most people had, from my understanding, never experienced tele-counseling before. So they were getting used to it, I was getting used to it as a counselor, and I think that combination made it a little painstaking, to be honest, at the beginning of this process.”

“There is something about doing counseling from my home, especially over the phone, that I just did not feel so comfortable with. When we were in person, but still didn’t have in-person clients, that felt, I don't know, so we were driving to a different setting. It was outside of our own home. We were in the building with other counseling professionals and people that we could
go and consult with and gets supervision from in the moment. So it didn't feel as isolating as doing it from home. There was something just very reassuring about being in *that* environment versus being at home.”

“…during that transition period from when I was used to doing in-person to the start of doing telephone and tele-therapy sessions, because I was feeling less competent, I was more focused on that piece, than I was able to in…empathizing with their emotions and expressing that back to them, because I was also thinking about like, ‘Whoa, holy shit, I'm not being effective right now and then get in my head about that. And then I'm like, ‘Well. I just missed… a crucial ten to twenty seconds of what they were saying, and then I’m lost.’”

“…during the height of the pandemic, when…infection rates and everything were the worst, I was very immersed in media coverage of [the pandemic]. And it was something that was like kind of all-consuming for me, I would say at that point, because I was so immersed in the media coverage.”

Interpersonal empathy a “I think if you can't empathize with your client, then you don't—you're not going to know what they need…I strongly believe that, when people are able
to be truly understood and listened to and have that expressed to them, I think that creates change.”

Understanding the client’s lived experience

Understanding barriers to counseling

“…because of [my client’s] work schedule, he was no longer able to do [in-person sessions]. So then we switched to telephone sessions.”

“I think the clients that I see over the phone, it's largely been more out of convenience for them than necessity. Because I think most [of] the clients I'm seeing over the phone, I think they kind of all have access to computers. But, for convenience reasons, are choosing to be over the phone…”

“My adolescent clients, they talk all the time. They're like, ‘Yeah, I'd never have a phone conversation with anybody.’ If anything, they're either FaceTime-ing or texting. FaceTime, and of course it's a completely different modality, because you’re on the video; a video feed in front of you. Whereas over the phone it's a whole different thing.”
Understanding clients’ SES situations

“…my impression would be that clients who are lower SES might have less access to a laptop or computer and might be more likely to only be able to do over-the-phone sessions.”

Environmental barriers to interpersonal empathy

“…all of the distractions that are present when somebody's in their own home…Like dogs needing to be let outside or barking at something. Somebody ringing the doorbell, and they're like, ‘Wait a second, I need to go check that.’ All these things that normally wouldn't interfere or come into play in an in-person counseling session.”

“I found, personally, the distractions [in the client’s home] took away a lot from my ability to stay in the moment with the client and really connect with them and the emotions they were experiencing…people were pulled in and out of emotional expression, which made it confusing and harder to track, and understand where they were at. And then they would come back from the distraction, and the emotion would be different, because they just have to go deal with something and it pulled them out of it.”
“...[there were] contaminations on my end as the counselor, too. Like my own distractions happening in my living space or wherever I was doing the session from. I think that's another piece of what made going into the office beneficial, where there were less distractions on my end. When I'm sitting at home, there's people walking outside the window, construction, people mowing the lawn, all kinds of stuff. Worried about my Internet connection at home versus in the office.”

| Emotional barriers to interpersonal empathy | “I've worked with several clients who tested positive for COVID, and I've worked with several clients who were hospitalized for COVID...I found myself being less judgmental of the people who were hospitalized because I was so focused on empathizing and supporting them, because I’m like, ‘Wow, this was a really traumatic experience for you being on a ventilator in a parking garage hospital, surrounded by people who were literally dying’, versus, my adolescent client who got COVID had very minimal symptoms, stayed home for a week, and they were fine...I found myself having a lot more empathy for the people who had...a more intense experience with it, than the people who just kind of had it with minimal symptoms or effect on their life.” |
“…when I got the sense that clients were
against the vaccine, or not being very precautious, or just
having a, very generally, a dismissive attitude towards the
pandemic and people's experiences in it. That was
definitely a barrier to expressing empathy. And I
struggled to empathize with those clients.”

“…to me it is absurd that people refuse to
take public safety measures because it causes them a
slight inconvenience…I understand people are truly afraid
of the vaccine because of whatever the reasons are, but
people who are just like, “Oh, it’s too much trouble for
me to put on a mask or do these things.” I found myself
getting very, very frustrated with them, because we're just
talking about the general health of the world, and you
can't be bothered to take some precautions that could save
people's lives.”

“…I did find myself with [clients] who got
COVID. I had that automatic thought, like, ‘Oh, you must
not have been being as safe as you could be.’ Then check
in with myself and like, ‘Okay. You don't know how they
got COVID. They could have been being perfectly safe
and got exposed still.’ But it was an automatic thought
that came in that's sometimes interfered with empathy and
in took away from that, if only briefly. I think I was
generally effective at checking in and then getting back
into the moment with the client.”

“…the people who I worked with who had
severe symptoms with COVID and were hospitalized had
very different perspectives after that experience. And they
were then taking it very, very seriously and like, you
know, ‘I almost died.’ They had very different
perspectives on the pandemic, versus the people who
catched it and were asymptomatic or had minimal
symptoms. And I think it was easier, then, to empathize
with the people who had that different perspective on
COVID.”

“…on some level, [clients contracting
COVID] made me question the clients more who were
exposed to COVID, because I have this very clear
example around me of an environment which nobody had
contracted COVID.

“…I found myself steering away from the
topic of COVID with clients who, I sensed, held those
beliefs [of not exercising caution during the pandemic].
Though, of course, people who still wanted to process it, I
tried to empathize with them and...stay with it, but I did notice that about some of my sessions.”

Objective empathy a “…for me, I've always kind of identified as, primarily, a person-centered counselor. And empathy is a core tenet stemming from all of Roger’s writings, and what person-centered counseling is today.”

“...I truly believe [empathy] is essential in counseling.”

“I think [empathy is] the first ingredient in the counseling.”

Information from supervision as a source for objective empathy “…I have definitely talked about my telephonic clients [in supervision], specifically. Particularly, one of my adolescent clients who I have seen through telephonic counseling, regularly. Because that's a client I have had some more struggles with, connecting with over the phone, expressing empathy, and really knowing what to do, and creating change with them.”

Information from COVID-related media as a source for objective empathy “…[heavy consumption of COVID-related media] made me bring more of the pandemic-related topics into session, because it, I think, just naturally, it was something that was on my mind…”
“…as the media coverage has shifted more from the effects of COVID on society to a discussion around the vaccine and vaccine mandates and people who are refusing to get the vaccine, all the different beliefs around the vaccine, I find myself thinking about that a lot more with clients, and wondering where they're at on that.”

“…I feel like [the pandemic] it was something that I was constantly thinking about in my sessions, and I feel like I was constantly watching for signs that their symptoms or their experience might be related to the pandemic. So I feel like I was extra sensitive. And maybe extra empathetic, I guess, to that, because of the amount of media that I was consuming related to the pandemic.”

*Master themes.*

**Interview 08**

Participant 08 is a 49-year-old white female master’s level clinician who works in both an agency and a private practice setting in Pennsylvania. In both settings, the participant provides individual and family outpatient counseling to adults and children. Participant 08 has worked in the counseling field for 3.5 years, accumulating a total of 30 months of this time during the COVID-19 pandemic. On average, Participant 08 reported seeing 8 telephonic clients per week.
When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 08 indicated 10.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 08 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 08 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 08’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“I would say, at first, [telephonic counseling] was hard…there's no body language; silence is hard to hold, especially. I'm working with trauma clients, so…what are they emoting in the moment? So I would say that was, at first, hard to understand what was happening, which made it difficult to support, validate, like I mean I'm empathizing throughout, but all the normal things we would do, I found more difficult.”

Participant 08 continued by sharing that, as she continued to deliver telephonic counseling to clients, she gradually felt more comfortable with the medium. She commented:

“…[telephonic counseling was difficult] at first, but over time I feel like I got more comfortable, and I would say things like, ‘What's happening for you right now?’ I would ask more targeted, direct questions…or acknowledge like, ‘So I can't see you, and I'm here’, or if I could hear them crying, I might say something like, ‘I'm here with you. I'm
here…I think, at first, I would say a good six to eight weeks, [telephonic counseling] was hard. *Hard.*”

The participant then commented on an “energy” felt between counselor and clients in the face-to-face setting that cannot be replicated in distance counseling. She stated:

“…I really believe that there's this dynamic, if you want to call it ‘energy’…that’s palpable with clients in a room. And so, finding that when we weren't in a room took me some time to figure that out.”

Participant 08 then spoke further to her use of narration as a means of compensating for the dearth of visual contact with the clients. She shared the following:

“I would say things like, ‘So, how do you feel about that?’ Or, ‘What do you think about what I just said?’ Or something like that…get some level of feedback happening…literally describing, like, ‘Tell me what your-’ and moving more into narration, almost.”

The researcher then asked Participant 08 about her thoughts on the importance of empathy. The participant stated her belief in empathy functioning as a critically important bridge in the process of counseling. She quickly created an illustration of this bridge and shared it with the researcher. This illustration can be observed in Figure 2 below. The participant stated:

“I think that empathy is like a bridge toward therapeutic relationship. So I feel like unconditional positive regard as part of that, right? Empathy toward whatever the person's going through, non-judgment, I think those things lead to our bridge that allows for the therapeutic relationship to occur. And then work can happen (laughs).”
Following this questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 08 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had, and that she felt frustrated when calls would drop during telephonic supervision. She shared:

“At times there could be frustration [in supervision]. Especially in the early pieces when nobody knew what the hell they were doing. And not everybody's bandwidth was up to speed. You'd be in the middle of processing something and then calls would drop. And I found that frustrating, but definitely workable. And we would just reconnect…but I did feel like sometimes it interrupted the process… when it didn’t, it’s been great…”

Speaking further to her experience as a supervisee, Participant 08 shared that she felt less frustrated in her LPC supervision and agency group supervision than in her agency individual supervision, as calls were dropped less frequently in the first two of these modalities. She commented:
“I had an outside LPC supervisor and *that* worked well. When I would get group supervision, *that* worked well. But when I got individual supervision within the agency, that's what didn't work well. And I think it was that specific supervisor’s connection was always going in and out. They often were driving. That drove me crazy… for the most part, it was great…it was just was frustrating, because…you would drop in the middle.”

Participant 08 went on to draw a parallel between losing connection in supervision and losing connect in the process of telephonic counseling. She shared that this was a frustrating experience for both counselor and client, stating:

“…with some clients, they had to be in their cars, because that was the only space they had. And they wouldn't be driving, but sometimes it would be enough that they would get frozen. And, for the most part, we could work through that, but…there are times when you're processing something pretty heavy or emotionally laden, and then suddenly…they can't reach you and it just ended up…frustrated clients too. *And* me, for that matter.”

The researcher then inquired into the topic of setting. Participant 08 reported that her ratio of home/office work has fluctuated throughout the pandemic, stating that the ration was at 50/50 at the time of the interview. She shared the following:

“…I worked primarily from [home], from March ‘til…July. And then we saw clients for a couple of months in the office. I would say 25% of my clients wanted to be in person; 75% wanted to stay virtual. And then, in the fall through spring, we went back hundred percent virtual. And then, this spring, I'd say it's 50/50 now. 50% in the office; 50% virtual. And in private practice—I do private practice, too—and that's 100% virtual.”
The researcher followed up by asking Participant 08 what it was like for her to provide telephonic counseling in the home setting. As a mother and wife, Participant 08 shared that she had to be vigilant in “boundary-ing” her roles at home. She stated:

“…doing therapy in the home, period, there was a window of time where I had to figure out what that looked like in terms of boundary-ing…I'm married and I have a now-10-year-old son. So, you know, negotiating that the office space was going to be mine, and getting white noise machines…my kid was in cyber school, so he was in the next room working. Husband's working from home out of the living room or out of the dining room. So kind of navigating and renegotiating what that looks like on days that I'm in session. Resetting some family rules around like, ‘Anytime mom’s in the office with the sound machine on, we do not come into the office ever.’…I think there's also been times where the anxiety would get heightened if I would hear my kiddo melting down from school, or having a tantrum. But, over time, I embraced it, and it became a piece of…authenticity of like, ‘Yep, real life happens for me too.’”

Following up on the concept of boundary setting, the researcher asked Participant 08 if the different needs for boundary setting in the home setting versus the office setting impacted her empathic response toward clients. The participant shared that her initial distractions and anxiety around working in the home setting impacted her experience. She shared:

“…the initial transition into [telephonic counseling], I think that caused some distraction for me at home. And not that I wasn't there, but…It caused anxiety for me that I needed some supervision around. And just knowing that [home distractions were] there and acknowledging it was there before I could seem to like, ‘Okay, yeah, shit’s going to happen here too. My dog’s gonna bark, people are going to ring the doorbell, my kid’s
going to have friends over.’ All those things are now normalized…at the beginning, I had such angst about, ‘What is this going to do for the client?’ Like, ‘What's happening for the client?’ I was taking on the anxiety, basically, of the client, instead of just acknowledging it or asking what was happening for the client.”

Next, the researcher asked into Participant 08’s experience regarding COVID-related media. The participant shared that COVID-related media caused her to have greater sensitivity toward clients’ experience regarding the universality and impact of the pandemic. She reported:

“I would have to remind clients, you know, like six months in like, ‘Oh, remember we're still in a pandemic, on top of all this other stuff that's happening for you? Of course you're anxious’…I would get a single update a day in my inbox kind of thing that I would read in the morning and then that would be it. But I think, if anything, maybe [that made me] more empathetic…it depends on what phase [of the pandemic]it was…I feel like…in the beginning it would be empathetic toward what they were feeling and feeling overwhelm and anxiety and isolation and all those things. And then later on…it would be like, ‘Why am I not doing better?’ And I'm like, ‘I don't know, because you're by yourself and you're living in a pandemic like we all are…of course that's where you are.’”

The researcher then moved to the next research question, inquiring into Participant 08’s experience of transitioning from in-person to telephonic counseling. The participant shared that she found her initial into telephonic counseling disorienting, stating:

“I would say [switching to telephonic counseling] was jarring. I felt like a new counselor again, actually, trying to figure it all out again, somehow. I lost my footing, especially with the phone. Especially with the phone.”

The researcher followed up by asking Participant 08 if she had become more acclimated
to telephonic counseling with the passage of time. The participant shared that, through process of adaptation, she currently feels “equally comfortable” with face-to-face and videoconferencing counseling. However, she reported that she continues to place telephonic counseling “slightly below” both face-to-face and videoconferencing counseling due to lack of visual contact with the client in this medium.

Next, the researcher asked into the topic of SES. Participant 08 shared that she worked with clients “across the board” regarding SES, spanning from lower to upper SES. When asked if the pandemic had caused greater disruption to the lives of lower SES clients, the participant shared that it had. She reported:

“…[lower SES clients had a] fear of scarcity. And/or fear of access [to resources] was a big topic with a lot of clients, at least in the beginning.”

The researcher followed up by asking Participant 08 if lower SES clients had experienced greater difficulty accessing videoconferencing sessions, as opposed to telephonic sessions. The participant reported that they had not due to the modern prioritization of smartphones. She stated the following:

“The thing that [lower SES clients] all seem to have in common is having access to a phone, is a high priority for them. I think ‘cause it’s like a lifeline… Even my homeless client had a phone.”

The researcher then inquired into Participant 08’s experience empathizing with clients via differing mediums, first asking what it is like for the participant to empathize with clients in a face-to-face setting. The participant discussed that her penchant for visual communication presented a barrier in telephonic counseling. She shared:
“I'm a very visual communicator. I've got stuff like this (pulled out trauma response diagram) laying all around…I very much think that when we can put something in writing for people who are sending in a trauma response, it can be really, really helpful. That was a huge barrier with phone…I would say, for me, barriers were not only…visual feedback, but also being able to draw and show something, or have the client draw something and show me. Yeah, huge, huge barrier at first.”

The researcher then asked Participant 08 what it was like for her to empathize with clients via telephonic versus videoconferencing counseling. The participant stated that she found herself adapting to videoconferencing sessions more quickly, and that she found providing counseling to children through this medium was far more achievable than through telephonic counseling. She commented:

“I feel like, with video, I very quickly became adapted, like using little note cards (holds empathy bridge note card to screen)...I work with kids and adults, so also having kids doing things on their end...if we were doing some sort of art directive, them holding it up for me to be able to see it. So I just feel like it became much more normalized, where with phone, I will say that there's no way I could have done sessions with kids on just a phone. No way. No way. But at least with video I could still hold sessions. I mean, I saw kids as little as four years old. And I can't imagine. That wouldn't have happened on the phone...I could have maybe done [telephonic counseling] with maybe ten [year-old clients] and up. But all of them had video access...”

The researcher then moved to the final research question of the study, inquiring into how Participant 08’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. After sharing that she had not tested
positive for COVID-19, the researcher asked how this factor impacted her empathic response toward clients who had tested positive. The participant discussed that empathizing with clients who had tested positive was akin to her empathizing with clients who had other lived experiences that the participant had not lived through herself. She shared:

“I don't think [clients having COVID-19] devalued anything, if that makes sense. I think I was maybe empathetic to what they were going through, but I don't know that that would have been any different than anything else they would have been going through…”

Next, the researcher asked Participant 08 if she had been exposed to COVID-19. The participant shared that all her extended family had tested positive for COVID-19 and that she had been exposed to COVID-19 on three occasions, which precipitated feelings of frustration with her family. She shared the following about her differing perspectives toward family and clients on this matter:

“…with clients, I was empathetic [when they were diagnosed with COVID-19]. With my family, I was super judgmental (laughs).”

The researcher followed up by asking further into these differing perspectives. Participant 08 shared that this factor was influenced by fulfilling her role as therapist and her son being placed at risk by the choices of her family members. She shared:

“…when I'm in the mode of therapist, I'm in the mode of therapist… my clients were always co-respectful, so the clients would wear masks. My family was anti-maskers; anti-vaxers. So I think there’s some core belief differences in values between some members of my family and me. And I would say what it really boils down to is putting my son at risk. So my son wasn't at risk, that's a ‘me thing’, with clients. It isn't just me with my extended family…less understanding and empathetic for sure.”
When asked if she had quarantined herself from others during the pandemic, Participant 08 shared that she and her family had quarantined collectively on one occasion. When asked if her experience quarantining had impacted her empathy toward clients, the participant reported that her empathy “didn’t shift based on COVID” and was essentially “the same thing” as it would have been otherwise.

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected her empathy toward clients. When asked how much COVID-related media she had consumed at the beginning of the pandemic, Participant 08 shared that she had initially experienced a saturation in COVID-related media, which she later tapered. She commented:

“…those first two weeks [of the pandemic], I was [watching COVID-related media], not 24/7, but a lot. A lot of consumption, and then I would say then I started moving off of TV and video down to digital media coverage that way into, finally, just like subscription-based coverage over time…I remember even last summer… I would check a couple times a day to see what the stats looked like… my media consumption also correlated to the school year, because of having a son in school. So trying to make decisions about like, ‘When are we going to send him in person? Are we going to do cyber? What does that look?’ And we had to re-decide every nine weeks. So I would say it would spike during those windows of time and then go back down…since spring of this year, it's like I don't even really pay attention to [COVID-related media], honestly. Like a little bit, but not much.”

As a final question of the interview, the researcher invited Participant 08 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant further
spoke to her appreciation for the increased opportunities that telehealth practices offer both clients and counselors, sharing:

“I think the one thing that was surprising for me is how effective telehealth was and is. To the point that I think, with some clients, it was more effective than in person. And the only thing that I can attribute that to, or at least a factor, is that they're in their homes, and they're comfortable...for some clients...they're sitting there talking about things and they're petting their cat, or their dog’s next to them, or they're...covered up with their favorite blanket. There was something more vulnerable that could happen that was surprising to me...once I got to the place of figuring out how to tune in to myself more at home to understand what was happening with the client, that also helped...I think [telephonic counseling] created more access for clients. We're having this ongoing discussion at the agency of like, “Are we going to still offer it? Are we going to force clients to come in?” And I’m like, ‘We can't force clients to come in. This is ridiculous’. It's so much more access for people than what they had previously.”

At the end of the interview, the researcher thanked Participant 08 for her participation in the study. The participant shared that she had no further information about her lived experience to add to the interview. The interview with Participant 08 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 9 provides a visual representation and review of these phrases of significance from the narrative above.
<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective empathy a</td>
<td>“I think that empathy is like a bridge toward therapeutic relationship.”</td>
</tr>
<tr>
<td>Identification</td>
<td>“…I think there's also been times where the anxiety would get heightened if I would hear my kiddo melting down from school, or having a tantrum. But, over time, I embraced it, and it became a piece of…authenticity of like, ‘Yep, real life happens for me too.’”</td>
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<tr>
<td>Imagination</td>
<td>“…I would say things like, ‘What's happening for you right now?’ I would ask more targeted, direct questions…or acknowledge like, ‘So I can't see you, and I'm here’, or if I could hear them crying, I might say something like, ‘I'm here with you. I'm here.’”</td>
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<tr>
<td></td>
<td>“…literally describing…moving more into narration, almost.”</td>
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<tr>
<td>Intuition</td>
<td>“I would say things like, ‘So, how do you feel about that?’ Or, ‘What do you think about what I just said?’ Or something like that…get some level of feedback happening.”</td>
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</tbody>
</table>
|                        | “…I really believe that there's this dynamic, if
you want to call it ‘energy’…that’s palpable with clients in a room. And so, finding that when we weren't in a room took me some time to figure that out.”

“…I will say that there's no way I could have done sessions with kids on just a phone. No way. No way. But at least with video I could still hold sessions. I mean, I saw kids as little as four years old. And I can't imagine. That wouldn't have happened on the phone.”

“I would say, at first, [telephonic counseling] was hard…there's no body language; silence is hard to hold, especially. I'm working with trauma clients, so…what are they emoting in the moment?”

“I would say, for me, barriers were not only…visual feedback, but also being able to draw and show something, or have the client draw something and show me. Yeah, huge, huge barrier at first.”

Felt-level experience “I would say [switching to telephonic counseling] was jarring. I felt like a new counselor again, actually, trying to figure it all out again, somehow. I lost my footing, especially with the phone. Especially with the phone.”
“…[telephonic counseling was difficult] at first, but over time I feel like I got more comfortable…

“…I think, at first, I would say a good six to eight weeks, [telephonic counseling] was hard. *Hard.*”

“…just knowing that [home distractions were] there and acknowledging it was there before I could seem to like, ‘Okay, yeah, shit’s going to happen here too. My dog’s gonna bark, people are going to ring the doorbell, my kid’s going to have friends over.’ All those things are now normalized…at the beginning, I had such angst about, ‘What is this going to do for the client?’ Like, ‘What's happening for the client?’ *I* was taking on the anxiety, basically, of the client, instead of just acknowledging it or asking what was happening for the client.”

“…once I got to the place of figuring out how to tune in to myself more at home to understand what was happening with the client, that also helped.”

*Interpersonal empathy* a “Empathy toward whatever the person's going through, non-judgment, I think those things lead to our *bridge* that allows for the therapeutic relationship to occur. And *then* work can happen (laughs).”
“I don't think [clients having COVID-19]
devolved anything, if that makes sense. I think I was
maybe empathetic to what they were going through, but I
don't know that that would have been any different than
anything else they would have been going through…”

“…[my empathy for clients] didn't shift based
on COVID, if that makes sense.”

“I think the one thing that was surprising for
me is how effective telehealth was and is. To the point
that I think, with some clients, it was more effective than
in person. And the only thing that I can attribute that to, or
at least a factor, is that they're in their homes, and they’re
comfortable…for some clients…they're sitting there
talking about things and they're petting their cat, or their
dog’s next to them, or they're…covered up with their
favorite blanket. There was something more vulnerable
that could happen that was surprising to me.”

Understanding barriers to
counseling

“…[technological issues were] something we
had to actually work through, not around. We would be
like, ‘Oh, well that was shit. Let's try that again. Do you
want to do that on the phone? Do you want to move to
phone?’…maybe it led to more empathy because we had
to work through that together.”
“…I think [telephonic counseling] created
more access for clients. We're having this ongoing
discussion at the agency of like, “Are we going to still
offer it? Are we going to force clients to come in?” And
I’m like, “we can't force clients to come in. This is
ridiculous”. It's so much more access for people than what
they had previously.”

Understanding clients’ SES situations
“…[lower SES clients had a] fear of scarcity.
And/or fear of access [to resources] was a big topic with a
lot of clients, at least in the beginning.”

“The thing that [lower SES clients] all seem
to have in common is having access to a phone, is a high
priority for them. I think ‘cause it’s like a lifeline… Even
my homeless client had a phone.”

“I can remember early on, trying to get [a
lower SES client] access to a mask…I'm not a social
worker, but I'm also like, ‘Okay…They're an elderly
client; they need a mask.’”

“…with some clients, they had to be in their
cars, because that was the only space they had.”
Environmental barriers to interpersonal empathy “…the initial transition into [telephonic counseling], I think that caused some distraction for me at home. And not that I wasn't there, but…It caused anxiety for me that I needed some supervision around.”

“…doing therapy in the home, period, there was a window of time where I had to figure out what that looked like in terms of boundary-ing.”

“…I'm married and I have a now-10-year-old son. So, you know, negotiating that the office space was going to be mine, and getting white noise machines…my kid was in cyber school, so he was in the next room working. Husband's working from home out of the living room or out of the dining room. So kind of navigating and renegotiating what that looks like on days that I'm in session. Resetting some family rules around like, ‘Anytime mom’s in the office with the sound machine on, we do not come into the office ever.’”

Emotional barriers to interpersonal empathy “…with clients, I was empathetic [when they were diagnosed with COVID-19]. With my family, I was super judgmental (laughs).”
“…when I'm in the mode of therapist, I'm in
the mode of therapist… my clients were always co-
respectful, so the clients would wear masks. My family
was anti-maskers; anti-vaxers. So I think there’s some
core belief differences in values between some members
of my family and me. And I would say what it really boils
down to is putting my son at risk. So my son wasn't at
risk, that's a ‘me thing’, with clients. It isn't just me with
my extended family…less understanding and empathetic
for sure.”

Objective empathy
“…I think [empathy] is front and center…”
“…[empathy is] at the heart of [counseling],
and maybe foundational.”

Information from
supervision as a source for objective empathy
“At times there could be frustration [in
supervision]. Especially in the early pieces when nobody
knew what the hell they were doing. And not everybody's
bandwidth was up to speed. You'd be in the middle of
processing something and then calls would drop. And I
found that frustrating, but definitely workable. And we
would just reconnect…but I did feel like sometimes it
interrupted the process… when it didn’t, it’s been
great…”
“I had an outside LPC supervisor and *that* worked well. When I would get group supervision, *that* worked well. But when I got individual supervision within the agency, that's what didn't work well. And I think it was that specific supervisor’s connection was always going in and out. They often were driving. That drove me crazy… for the most part, it was great…it was just was frustrating, because…you would drop in the middle.”

Information from COVID-related media as a source for objective empathy

“I would have to remind clients, you know, like six months in like, ‘Oh, remember we're still in a pandemic, on top of all this other stuff that's happening for you? Of course you're anxious…’”

“I would get a single update a day in my inbox kind of thing that I would read in the morning and then that would be it. But I think, if anything, maybe [that made me] more empathetic.”

“it depends on what phase [of the pandemic]it was…I feel like…in the beginning it would be empathetic toward what they were feeling and feeling overwhelm and anxiety and isolation and all *those* things. And then later on…it would be like, ‘Why am I not doing better?’ And I'm like, ‘I don't know, because you're by yourself and

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you're living in a pandemic like we all are…of course
that's where you are.”

\textsuperscript{a}Master theme.

\textit{Interview 09}

Participant 09 is a 29-year-old African American female master’s level clinician who works in an agency setting in Pennsylvania, where she provides individual outpatient counseling to “all age groups”. Participant 09 has worked in the counseling field for 3.5 years, accumulating a total of 19 months of this time during the COVID-19 pandemic. On average, Participant 09 reported seeing 28 telephonic clients per week. When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 09 indicated 10.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 09 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 09 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 09’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“At first, [empathizing via telephonic counseling was] very, very challenging…I had four people I would talk to on the phone, and I felt like it was just natural. So, my dad who
calls me the most, my boyfriend, my sister, my mom. And those are, coincidentally, the only numbers I know by heart, aside from my own. So, for me, it was like, ‘Oh God…I'm not a Zoom talker, I'm not a phone talker. How do I do this? And it's really necessary, because how else can I administer therapy?’ So it was a very steep learning curve, because, even when you're missing a visual picture, you can kind of see when someone's about to talk like they do like an ‘Uh’, and they kind of wait for you to speak…this fear was loading for me [regarding the pandemic]. And it was like, ‘Great, so I have to kind of put my stuff away and be a container and figure out the phone. It was very, very challenging. Very challenging.”

Participant 09 then spoke to her experience transitioning from in-person to telephonic sessions near the beginning of the pandemic. The participant shared that her agency directed counselors to limit “cross contamination” and prepare to shift to remote counseling. As she gained further exposure to telephonic counseling, Participant 09 shared that she became more comfortable with the medium. She stated:

“…in my head, I was like, ‘Well it's great I have the option, but I also hate talking on the phone’ (laughs). Once I got better at it and I learned how to just dive in, my perception changed a little bit, and I was like, ‘Oh, this is great…””

The participant then discussed how she incorporated telephonic counseling as a backup when she experienced poor connection in videoconferencing counseling with clients. She shared:

“…if there's some kind of delay on my side, if there's a delay on their side, and it's too disruptive for the session…I'm going to call you on the phone, because I can…many people within my agency were like, ‘Hmm, I don't know. I'll bill fifteen minutes [for a session], that's all we could do.’ And I'm like, ‘No, I don't care. I’m gonna document it in
my notes. Fifteen minutes we were on the video, something happened with the connection, I call [the client] on the phone, and that's what we did…I'm not going to waffle under these conditions, now that I am safe and you're safe, and where we need to be, and we know where we're going to be for the next indefinite amount of time.”

Further speaking to her adaptation to telephonic counseling, Participant 09 shared that providing counseling through this medium precipitated greater overall comfort speaking on the phone in both her personal and professional life. She commented:

“…[in the present day], none of [telephonic counseling] feels awkward to me. If you decided to come to my office or we were talking on the phone now, I would feel just as comfortable. And that helps me feel connected to people. Because I'm not limited. I could be anywhere, and I can connect with anyone, now that I've gotten over…my angst around it.”

Participant 09 then shared that the intersection of telephonic counseling and her own navigation of the pandemic precipitated greater impetus for reaching out to her loved ones. She said the following:

“I've had so many people tell me that during the pandemic. Like, ‘Wow [participant name], thanks for—it's so nice to hear your voice’. And it's like, part of it I'm saving my time, but I also feel comfortable offering that side of myself.”

After this initial exploration, the researcher asked Participant 09 about her perspective on the role of empathy in the process of counseling. The participant discussed that she sees empathy as being the “bull’s eye” in the process of counseling. She stated:

“I think what I visualize now is like a bull's eye, like you play darts. I think [empathy] is the center, or something very close to it…I've always been more nuanced, more
emotional, more sensitive. I'm thinking around things, and I think you need that as a therapist… emotionally speaking, so much of our functioning, and this is what differentiates us from animals, comes from that piece of being communicative, emotional. We have mirror neurons. We are wired to socially kind of sum each other up as well. Emotional quotient, EQ, is a thing.”

The participant continued her commentary on empathy, discussing how she strives to achieve a balance between “putting myself away”, self-disclosure, and using her theoretical orientation as a tool for moderating these factors. She shared:

“…if I'm entering into this field, and it's time for me to be there for my clients. I have to, not put myself away to a point where it's detrimental, but I have to take some of my angst and just kind of leave it by the door. And, for me, I think I lovingly am putting it down, I'm lovingly putting it away. I'm not locking myself up, because I still like to be authentic with my clients. They know about my life. I think I use disclosure in a way that is educational and, like, making my points about certain conceptual things, CBT concepts, etc. But there's a method to my madness, but I'm not this veneer, ‘Don't even ask about my life’, kind of thing, because, how can I really relate to you if I'm essentially pushing you away too? And empathy is taking a more initiative, I think, on a clinical side, going, ‘…let me try to understand you so I can use what I know about CBT or narrative therapy’, which are two orientations I tend to use.”

Following this questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 09 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had received both individual and group supervision during the pandemic, but that casework was not discussed in
the group setting. She reported feeling “very, very grateful” for the supervision, but that she desired a more “process-y” supervision than the more solution-focused brad of supervision that she received.

The researcher then inquired into the topic of setting. Participant 09 reported that she had primarily delivered telephonic sessions from home near the beginning of the topic, and that this setting had its distractions and limitations. She commented:

“…the majority of [telephonic counseling] was from home….for a time, I worked in the kitchen…where you can sit and have counter space to eat there if you want. So I worked there, and part of the reason I worked there was because I noticed that…I had the best connection at that specific window, so I had to work out there. When my roommate would come home, he would go to the refrigerator and just walk behind. I would tell my clients, ‘I have my earbud in. He's not going to hear anything. You might see somebody walk past, but he has to eat. I'm not going to banish him to his room. It's still confidential.’”

The participant went on to discuss her experience reentering the office, and how she found this experience to be a welcome departure from working exclusively from home. However, she commented that she found herself working from home again after another counselor tested positive for COVID-19 at her agency, and that she experienced greater emotional distress upon her second confinement to the home setting. She shared:

“…at July 2020, we were starting to come back in [to the agency]. I was starting to come in almost every day. And I was like, ‘Well, I gotta get out of the house, this is great. I was kind of getting to a space where I'm like, ‘Oh, the numbers are down, it's summer. I don't care. I just need to get out of the house…we hired a new therapist at the time, who ended
up contracting COVID from his husband, so we had to re-quarantine again… for the next year, I was still working from home. And it really hit me, like, Spring. There was a point where like I felt like I had a delayed stir-craziness about it, where it felt like Groundhog Day, because, then I was just in a room, and my room is…small, but it's not so small that it's creepy small, but…I remember I'd go to bed, and I'd wake up, and I'd be like, ‘I know what I'm going to do. It's Monday. I see these clients. I know these hours I work.’…it really started bothering me. So then, eventually, I was starting to come in in-person by August/late July just to work from the office.”

When asked how working primarily from home affected her empathy toward clients, Participant 09 shared the increased sense of intimacy brought about by counselors and clients being in their respective homes during telephonic counseling sessions. She stated:

“…something shifted with the way that I could sort of grasp something, or theorize or clarify with [clients], and I don't know what that is, but having them see my room and be in my house, and I see their space and I'm in their space whenever they show me of it…I had a client for a minute, who would deliver meals on wheels, and I'd be in the car with them and we're just driving around, and it was just like, ‘Oh my God, this feels very intimate…I'm in your house; you're in mine.’ And, I tell you what, the last year I've made my bed was because I had to I have somebody kind of staring at it behind me. It's just like when I didn't do that, I'm like, ‘Oh God, there are my pillows…and my cat just sleeping at the end of the bed.’ It just felt very intimate [with clients] and I guess, maybe unconsciously, I felt like I can ask these questions. I can get deep, I can be wrong, I can take a little more risk, and not worry that it'll damage the rapport, because it's like, ‘If the
world's on fire and it ends, where else can we go, you know?…if we're all gonna die, you know, it felt like I have nothing to lose; take that risk.”

Next, the researcher asked into Participant 09’s experience regarding COVID-related media, and how consumption of such media impacted her empathy toward clients. The participant shared that her empathy “grew” upon her consumption of COVID-related media, prompting her to ask into COVID-related concerns. The participant then shared that she sought to regulate this consumption due to resultant anxiety. She stated the following:

“But during the pandemic…hearing about the George Floyd trial, or the protests…Hearing about COVID, obviously, and how the numbers are changing. If something major was happening in the news, and I heard of it, it rouses my anxiety too much to go seek it out. I don't watch the news, I don't listen to the radio, I don't watch the nightly news. God, I feel like that'd be worse for my anxiety. But if I catch wind of [COVID-related media], and…there's this big buzz around it, I tend to ask my clients, ‘What are your thoughts? How do you feel about this?’ And I give them an opportunity to have their feelings and have their thoughts. Because I don't think it would be, I don't want to say unethical, but I don't think it would be entirely equitable. It feels wrong to be like, ‘I don't want to talk about this, so we won't acknowledge it’, because it's not really my style, it's not my therapy. If you want to talk about it, I have to find a way to engage with it. So I found myself leading myself and saying, ‘I know this sucks, but where are people at?’ And ‘How are you feeling these days? I know the numbers have spiked right now with the variants. Are you okay? What are your thoughts?’, if I knew my clients were particularly hypervigilant and tracking it…”

The researcher then moved to the next research question, inquiring into Participant 09’s
experience of transitioning from in-person to telephonic counseling. The participant commented on the fear she experienced regarding COVID-19 during this transition, and how it affected her experience. She shared:

“That's where a lot of my fear was starting…as we were transitioning to telehealth. And, weirdly enough, [my fear] had nothing to do with like, ‘Will I have a job?’, because I didn't even think about that aspect of it either. I was like, ‘We just got to take one thing, one stupid thing at a time, because this is a moment where I really am staring down some kind of tangible mortality, whether it's my own; people I really love. Both my parents are kind of in a vulnerable spot with it, too. Just the big, existential question around it. I was just like, ‘Oh my God, I can't even. How am I supposed to sit with this, knowing that four of the closest people to me on a daily basis if they got it, it would not look good?’ And so I had a lot of fear that I carried into [telephonic sessions during the pandemic], so I imagine those sessions were stilted and awkward. I noticed I just couldn't stand silence, so if my clients didn't have anything to say, I would just be like (pensively waiting).”

Next, Participant 09 discussed her experience of navigating silence in face-to-face, videoconferencing, and telephonic sessions. She commented that she found silence more difficult to navigate when having visual contact with the client due to the pressure she felt she was exerting on the client by staring at them in silence, stating that this was especially uncomfortable in videoconferencing sessions. She said the following:

“…if it's someone on video, I'm literally just staring at you, you know what I mean? (laughs). So I don't like to do that to people. In person, I kind of angle my chairs, where we're…it's more of like a proxemics thing, where it's like, ‘Well, I'm on your side.’…there's something kind of unconsciously adversarial, just like staring someone in
the face. At least in body; in person. So what started off as me kind of copying my therapist’s room style, I did more research and I found that this is actually less off-putting. So even in my day today, I’m not looking at someone face-to-face, waiting for them to talk, and playing that kind of game with them. I think when I think it all out, and I say it that way, probably the video is more difficult. But eventually people just learned how to talk, or I learned how to sit with it. But at first it was a lot harder for video, for me, because I don't like staring at people or making them feel like they have to talk, you know what I mean?”

Next, the researcher asked into the topic of SES. Participant 09 shared that she worked primarily with lower SES clients who either received sessions free of charge or had a minimal copay. When asked how working primarily with this SES demographic impacted her empathic response, Participant 09 commented that she was able to glean a deeper understanding regarding the resilience of these clients. She commented:

“…I think I always had an understanding…not from experience, necessarily, but like an understanding that [lower SES clients’] worldview is shaped in some way, by not having the same opportunities as me, not having the same things that I had growing up…. There's just this survival…people are more resilient than I give them credit for being…instead of looking at [lower SES clients] as victims of a system, it's like, ‘No, they're actually quite self-directed, and if they need me, they'll ask.’ If I have a resource, I'll provide it. But otherwise, there's deep processing that really took place, and does take place in my sessions with my clients.”

When asked whether lower SES clients experienced barriers to videoconferencing sessions, Participant 09 shared that lack of internet connectivity precipitated a greater barrier that
lack of a smart phone, as these devices have become more ubiquitous across all SES levels. She shared:

“If something happened in session and I couldn't get online for some reason; Doxy has updates and I can't get on because the servers are down, or whatever, I'm going to call you on the phone. But if I did primarily phone sessions with clients, that was because they didn't have the Internet for whatever reason. They didn't have great connectivity. Their technology didn't support it…I think a barrier, honestly, for some, had been having Internet available. Not necessarily having Internet available, because homeless people have smartphones, you know what I mean? It's more like if their technology isn’t updated, you know? Like, that kind of thing. Some kind of technological issue. I would just call you and use the phone.”

The researcher then transitioned to the next research question, inquiring into any differences noted in the delivery of counseling mediums during the pandemic. The researcher began by asking Participant 09 if there were any differences between empathizing with clients in person versus over the telephone. The participant shared that she did not experience any significant differences in empathizing with clients through these two modalities, as remaining disciplined in her empathic response helped her telephonic empathic response to be equitable to that observed in face-to-face counseling. She said the following:

“No, [I don’t find there to be a difference in empathizing over the phone versus in person] because, I think, as I got better at using technique and thinking through. I did a lot of online trainings, and that kind of thing, learning how to conceptualize a bit how to use a specific tool with someone and open things up. I think my…ability to empathize and kind of invite clients to go deeper, really it got better, because I felt like I could
always connect with people, but I feel more confident from a therapeutic standpoint, how to do that. And it happened somewhere between March of 2020 and right here, right now.”

Next, the researcher asked Participant 09 if there was a difference in her empathic response via telephone versus videoconferencing. The participant commented that there were differences “in some ways”, but that the main variable in these differences stemmed from the client’s comfortability with either medium. She noted one client who would have likely been taken aback by a videoconferencing invitation, and that “it just works over the phone” with this client. She provided a counterexample by discussing another client who felt greater comfort with the videoconferencing modality, stating, “she is comfortable, and we do video”.

The researcher then inquired further into Participant 09’s experience of empathizing with clients via videoconferencing. The participant shared that videoconferencing counseling allotted more information in session than telephonic counseling due to visual contact with the client. She also noted that transitioning from in-person counseling to videoconferencing was less jarring than a transition to telephonic counseling due to its greater similarity in therapeutic contact. She stated:

“…clients that I tend to do more video sessions with are almost grandfathered in. So I have done more video sessions with them, because I had already seen their faces, and I think I still wanted to have that face, because entering the pandemic, I…believed, like anybody else, like, ‘Face-to-face is best. The closest way to do that is video, then. I gotta be able to get more of that information.’”

Without further prompting, Participant 09 proceeded to discuss that she finds intake
sessions with clients best to be conducted in person, more so than other sessions with clients. She found that in-person sessions were best for initial rapport building and expectation setting with the client. She shared:

“I find that I need to do [intakes] in person, because…I boil it all down, again, to that therapeutic rapport, and I explain to my people, generally, like, ‘I want you to understand what is happening [in counseling]…’…I think that intake is the first point of contact and if I'm not able to really make that with you in person and explain a little bit about my…informed consent. Like, ‘Here's what I do. Here's where I went to school. Here's my agency, some of our policies.’ I rushed through a lot of [intake paperwork] on the phone… And it was just very like touch-and-go, I think, for intakes during [the pandemic]…now, with new [in-person] clients, I feel like I'm back on the ball. I'm like, ‘Ooh, let's go’, you know what I mean? Versus being on the phone, where I'm just like, ‘Mmhmm’, writing at my desk, just waiting for you to tell me the things. And if I'm feeling really rattled that day, I might put on a YouTube video and mute it of people pulling taffy. And I'm just trying to get through it, you know?…[telephonic intakes] felt messier. They fill schlocky, and I noticed that I wasn't as dialed in for an intake over the phone. And even for the ones that I did on video, because even then, I'm trying to talk to you, but I'm looking down at my questions. It just really didn't sit well with me.”

The researcher then moved to the final research question of the study, inquiring into how Participant 09’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant began by sharing her “survival mode” precipitated by the immediate risks of the pandemic. She commented:
“…moving into a space [during the pandemic] where I was operating on an emergency mode, a survival mode, my anxiety really got to primal place. And I hadn't been there in years. So getting back to that space made me think, ‘Now I get it. Some days you really aren't in the mood. You are just showing up, and that's fine’, because I did that a few times for work, you know, when I was scared about what was happening. Scared for my family and scared for myself; scared for this nation.”

The researcher then asked Participant 09 about her experience regarding possible COVID-19 exposures, and how they might have influenced her experience. The participant shared that she experienced a possible COVID-19 exposure on a long bus ride, and that she “didn’t want to know” her COVID-19 status due feelings of fear precipitated by the event. She shared:

“…on the train I sat next to guy who coughed and coughed and coughed, and coughed, and coughed for like eight hours or something like that. And my roommate and I got sick at the same time. It didn't feel like a cold that I had ever had before. I got feverish. I got a little delusional, like a fever-y kind of thing. And I couldn't tell. In one sense, ‘Am my working myself up? Is this an anxiety response? Or am I really this feverish? I don't know for a fact. I had really weird sinus pain. And I felt like I couldn't catch breath at some points, so maybe [I had been exposed to COVID-19], but, again, I didn't know how much of it is me working myself up, because I didn't want to, for whatever dumb reason, I didn't want to get tested. I took enough time off work that I was just, like, ‘I'm gonna wait ‘til I'm better, and then I'm going to come back. But I was so anxious. I didn't want to know. I really didn't want to know…”
When asked if this fearful experience impacted Participant 09’s empathy toward clients, she commented on the natural and universal fear of illness. She said the following:

“…if you're sick or you're worried [that you might be sick]…it's something so human and so natural, I think, to us as therapists, and I think as people. It goes without saying. It's like, ‘Is the sky blue?’”

When asked if she had quarantined herself from others during the pandemic, Participant 09 shared that she had done so on several occasions when exposures occurred at her agency. The researcher then asked the participant how this experience affected her empathy toward clients. The participant shared that she found it easier to empathize with the anxiety entailed in the waiting period during quarantine. She commented:

“…undoubtedly, yes [quarantining impacted my empathy toward clients who had also quarantined]. I think of it like a metaphor for: you're just waiting, you know? You're in a holding space. You just have to be patient…I hate being patient, so that's the other thing. I just have to wait for time to pass, and especially if I'm anxious about it. So when I tell my clients, ‘Here's the boundary. Here's what we have to do here. I can't see you sooner. I'm booked. I'm not going to make extra time.’ I have a feeling, in a sense, of just being held until a next opportunity is available.”

The researcher then briefly revisited the topic of COVID-related media, and how consumption of this content affected her empathy toward clients. When asked how much COVID-related media she had consumed at the beginning of the pandemic, Participant 09 reiterated that she consciously limited her media intake to “not a lot”. The participant then shared that she did consume “a lot” of media concerning the George Floyd trial. Being of African
American race, Participant 09 shared that she had dialogue with clients in session on this topic. She reported:

“…I'm just now getting into some of that [COVID-related media] because I feel grounded enough to face it. But I did watch a lot about George Floyd… I engaged personally and in session with people about that intersectional stuff around race, stuff about police, you know? All of the dynamics. Because…I'm interested to hear about that. I love the psychology about that. I have to have some kind of dialogue about that, so I talked a lot about those things in session, and I looked into it more in my personal life, because I'm interested in it.”

The researcher followed up by further asking Participant 09 if the topic of race had played into her sessions with clients during the pandemic. The participant reported that it did, and that the George Floyd trial caused her to further acknowledge her African American heritage, and the turbulence that this race was experiencing in the US at the time. She commented:

“…by the time all that stuff with George Floyd came around, I think, for the first time, I really did own my ‘Fuck white people’ space around it. Just sort of looking around and being like, ‘You know what? I really am tired for me and everybody that came before me because, why are we dealing with this?’…it's like, ‘[Racial oppression] wouldn't happen to me. I have a veneer.’ But then it's like, “No, no, no, you could just be shot in your bed.’ It's like, ‘That's the prerequisite’, you know? It's like, ‘Great, now I feel like I have a different target on my back there, too, and I have to own it.’ I have to really have that fear, have that anger [regarding racial oppression], and talk about it in session with my clients.”
As a final question of the interview, the researcher invited Participant 09 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant discussed her perspective on the importance of self-care for counselors, especially in the midst of disaster event such as the COVID-19 pandemic. She stated:

“I feel like [self-care] is part of the human experience, but it's a necessary tool, as necessary as a paint brush is to a painter if you're a therapist, you know what I mean? And we give of ourselves so hard. So, so hard. But another thing that prepared me is having a very routine, structured self-care that's programmed into my life…There's a difference between having enough energy to get where I need to go and turn my body and brain off, versus having the energy and enthusiasm to get there, and that's what we get from self-care, you know? I didn't stop going to the gym. Well I did stop going to the gym, but I didn't stop exercising, you know? From March until June my gym reopened, and I wore a mask…I'm trying to be mindful about drinking; substance use. I smoke cigarettes every now and then, but…I say to my clients, I'm like, ‘Listen, I'm not telling you, you need to be a saint, because there's different forms of self-care.’ There's a hedonic approach, which is where those substances: alcohol, cigarettes, weed, if you like that, all of that stuff falls under, versus eudaimonic, and that prefix ‘eu’ in Greek is pertaining to something positive, happy, good, you know? So I look at it as more proactive versus less proactive. If I am really sad and really fucked up at the end of the day, I'm going to make sure I eat, I'm going to make sure I go to the gym the day it's assigned for that, make sure I go to my own therapy. And do all of the proactive things that are going to give me a little more ego reserve, literal energy, what my body and mind might need…[self-care] is so important. We won't get burnt out, you know? And I don't
speak in uncertainties, but you have a higher likelihood of getting burnt out with more hedonic approaches than you do with a more eudaimonic approach, or more proactive approach…”

At the end of the interview, the researcher thanked Participant 09 for her participation in the study. The participant shared that she had no further information about her lived experience to add to the interview. The interview with Participant 09 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 10 provides a visual representation and review of these phrases of significance from the narrative above.

As a final question of the interview, the researcher invited Participant 05 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant shared that she had nothing further to add. The researcher thanked Participant 05 for her participation in the study. The interview with Participant 05 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 6 provides a visual representation and review of these phrases of significance from the narrative above.

Table 10

*Participant 09 Phrases of Significance*

<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
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<tr>
<td>Subjective empathy a</td>
<td>“We have mirror neurons. We are wired to socially kind of sum each other up as well”</td>
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<tr>
<td>Identification</td>
<td>“…I engaged personally and in session with people about that intersectional stuff around race, stuff about police, you know? All of the dynamics. Because…I'm interested to hear about that. I love the</td>
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dialogue about that, so I talked a lot about those things in
session, and I looked into it more in my personal life,
because I'm interested in it.”

“I have to really have that fear, have that
anger [regarding racial oppression], and talk about it in
session with my clients.”

“…if you're sick or you're worried [that you
might be sick]…it's something so human and so natural, I
think, to us as therapists, and I think as people. It goes
without saying. It's like, ‘Is the sky blue?’”

“…undoubtedly, yes [quarantining impacted
my empathy toward clients who had also quarantined]. I
think of it like a metaphor for: you're just waiting, you
know? You're in a holding space. You just have to be
patient…I hate being patient, so that's the other thing. I
just have to wait for time to pass, and especially if I'm
anxious about it. So when I tell my clients, ‘Here's the
boundary. Here's what we have to do here. I can't see you
sooner. I'm booked. I'm not going to make extra time.’ I
have a feeling, in a sense, of just being held until a next
opportunity is available.”
“I think, in general, and this is less to do with therapy and more of what the pandemic has sort of helped me realize as a human: the ways that we're more connected.”

“I'm not locking myself up, because I still like to be authentic with my clients. They know about my life. I think I use disclosure in a way that is educational…”

Imagination n/a

Intuition “At first, [empathizing via telephonic counseling was] very, very challenging… And it's really necessary, because how else can I administer therapy?’ So it was a very steep learning curve, because, even when you're missing a visual picture, you can kind of see when someone's about to talk like they do like an ‘Uh’, and they kind of wait for you to speak.”

“No, [I don’t find there to be a difference in empathizing over the phone versus in person] because, I think, as I got better at using technique and thinking through. I did a lot of online trainings, and that kind of thing, learning how to conceptualize a bit how to use a specific tool with someone and open things up. I think my…ability to empathize and kind of invite clients to go
deeper, really it got better, because I felt like I could
always connect with people, but I feel more confident
from a therapeutic standpoint, how to do that. And it
happened somewhere between March of 2020 and right
here, right now.”

“I find that I need to do [intakes] in person,
because…I boil it all down, again, to that therapeutic
rapport…”

Felt-level experience “…by the time all that stuff with George
Floyd came around, I [was] sort of looking around and
being like, ‘You know what? I really am tired for me and
everybody that came before me because, why are we
dealing with this?’”

 “…it's like, ‘[Racial oppression] wouldn't
happen to me. I have a veneer.’ But then it's like, “No, no,
no, you could just be shot in your bed.’ It's like, ‘That's
the prerequisite’, you know? It's like, ‘Great, now I feel
like I have a different target on my back there, too, and I
have to own it.’”

 “…then there's the bigger side of what it
means to be connected to people, because the question
then becomes, ‘Am I really isolated if someone is a phone
call away?”

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“..at July 2020, we were starting to come back
in [to the agency]. I was starting to come in almost every
day. And I was like, ‘Well, I gotta get out of the house,
this is great.’”

“…I felt like I had a delayed stir-craziness
about [quarantining during the pandemic], where it felt
like Groundhog Day…”

“…this fear was loading for me [regarding the
pandemic]. And it was like, ‘Great, so I have to kind of
put my stuff away and be a container and figure out the
phone. It was very, very challenging. Very challenging.”

“…weirdly enough, [my fear] had nothing to
do with like, ‘Will I have a job?’, because I didn't even
think about that aspect of it either. I was like, ‘We just got
to take one thing, one stupid thing at a time, because this
is a moment where I really am staring down some kind of
tangible mortality, whether it's my own; people I really
love.”

“…moving into a space [during the
pandemic] where I was operating on an emergency mode,
a survival mode, my anxiety really got to primal place…I
was scared about what was happening. Scared for my
family and scared for myself; scared for this nation.”
“…maybe [I] had been exposed to COVID-19, but, again, I didn't know how much of it is me working myself up, because I didn't want to, for whatever dumb reason, I didn't want to get tested. I took enough time off work that I was just, like, ‘I'm gonna wait ‘til I'm better, and then I'm going to come back. But I was so anxious. I didn't want to know. I really didn't want to know…”

“That's where a lot of my fear was starting…as we were transitioning to telehealth.”

“…at first [receiving telephonic supervision] was difficult. Made more aggravating and annoying because it's like, ‘You should know how to do this by now. Don’t you know how to use a…phone, or something?’

“…in my head, I was like, ‘Well it's great I have the option, but I also hate talking on the phone’ (laughs). Once I got better at it and I learned how to just dive in, my perception changed a little bit, and I was like, ‘Oh, this is great…”

“…the telephone is now my friend.”
“…[in the present day], none of [telephonic counseling] feels awkward to me…now that I've gotten over…my angst around it.”

“…[telephonic intakes] felt messier. They fill schlocky, and I noticed that I wasn't as dialed in for an intake over the phone.”

“It just felt very intimate [with clients] and I guess, maybe unconsciously, I felt like I can ask these questions. I can get deep, I can be wrong, I can take a little more risk, and not worry that it'll damage the rapport, because it's like, ‘If the world's on fire and it ends, where else can we go, you know?…if we're all gonna die, you know, it felt like I have nothing to lose; take that risk.’”

“…another thing that prepared me is having a very routine, structured self-care that's programmed into my life.”

“I had a lot of fear that I carried into [telephonic sessions during the pandemic], so I imagine those sessions were stilted and awkward. I noticed I just couldn't stand silence, so if my clients didn't have anything to say, I would just be like (pensively waiting).”

“I rushed through a lot of [intake paperwork]
on the phone… And it was just very like touch-and-go, I think, for intakes during [the pandemic]…now, with new [in-person] clients, I feel like I'm back on the ball.”

“But during the pandemic…hearing about the George Floyd trial, or the protests…Hearing about COVID, obviously, and how the numbers are changing. If something major was happening in the news, and I heard of it, it rouses my anxiety too much to go seek it out.”

“…I'm just now getting into some of that [COVID-related media] because I feel grounded enough to face it. But I did watch a lot about George Floyd.”

Interpersonal empathy  
“…empathy is taking a more initiative, I think, on a clinical side, going, ‘…let me try to understand you so I can use what I know about CBT or narrative therapy’, which are two orientations I tend to use.”

Understanding the client’s lived experience  
“…if I'm entering into this field, and it's time for me to be there for my clients. I have to, not put myself away to a point where it's detrimental, but I have to take some of my angst and just kind of leave it by the door. And, for me, I think I lovingly am putting it down, I'm lovingly putting it away.”
“…something shifted with the way that I could sort of grasp something, or theorize or clarify with [clients], and I don't know what that is, but having them see my room and be in my house, and I see their space and I'm in their space whenever they show me of it…I had a client for a minute, who would deliver meals on wheels, and I'd be in the car with them and we're just driving around, and it was just like, ‘Oh my God, this feels very intimate…I'm in your house; you're in mine.’”

“…if I did primarily phone sessions with clients, that was because they didn't have the Internet for whatever reason. They didn't have great connectivity. Their technology didn't support it.”

“…there's one client that I've seen…He likes the phone [counseling sessions], he has kids, he's busy, he's an IT guy. And that's what works…. I guess I sort of see like, ‘Where is this person?’, in my version of meeting them where they are. It's like, ‘Alright, that works’.”

“…instead of looking at [lower SES clients] as victims of a system, it's like, ‘No, they're actually quite self-directed, and if they need me, they'll ask.’ If I have a resource, I'll provide it. But otherwise, there's deep
processing that really took place, and does take place in my sessions with my clients.”

“I think a barrier, honestly, for some, had been having Internet available. Not necessarily having Internet available, because homeless people have smartphones, you know what I mean? It's more like if their technology isn't updated, you know? Like, that kind of thing. Some kind of technological issue. I would just call you and use the phone.”

“…I think I always had an understanding…not from experience, necessarily, but like an understanding that [lower SES clients’] worldview is shaped in some way, by not having the same opportunities as me, not having the same things that I had growing up…. There's just this survival…people are more resilient than I give them credit for being.”

Environmental barriers to interpersonal empathy

“When my roommate would come home, he would go to the refrigerator and just walk behind. I would tell my clients, ‘I have my earbud in. He's not going to hear anything. You might see somebody walk past, but he has to eat. I'm not going to banish him to his room. It's still confidential.’”
Emotional barriers to interpersonal empathy

Objective empathy a “I think what I visualize now is like a bull's eye, like you play darts. I think [empathy] is the center, or something very close to it…”

Information from supervision as a source for objective empathy “…I did receive supervision. That is the one thing I'm very, very grateful for, because if there was ever a time I needed it, it was during the pandemic.” “We still regularly got [group supervision], but it's not productive. People don't really talk about their casework as a group.” “…[my current supervisor] gives me a space to be process-y, but there's still this solution-focused, like, ‘Think of it this way.’…”

Information from COVID-related media as a source for objective empathy “…if I catch wind of [COVID-related media], and…there's this big buzz around it, I tend to ask my clients, ‘What are your thoughts? How do you feel about this?’ And I give them an opportunity to have their feelings and have their thoughts.”

a Master theme.
Interview 10

Participant 10 is a 61-year-old white/Jewish female master’s level clinician who works in a private practice setting in Pennsylvania, where she provides individual, couples, and family outpatient counseling to adults. Participant 10 has worked in the counseling field for 30 years, accumulating a total of 20 months of this time during the COVID-19 pandemic. On average, Participant 10 reported seeing 40 telephonic clients per week at the height of the pandemic, and that she was seeing about 10 per week at the time of the interview. When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 10 indicated 4.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 10 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 10 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 10’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:

“[Telephonic counseling] has been a lot harder. I'm definitely more of an in-person therapist, I guess you'd say. It almost feels like…kind of like missing one of your senses, because I found when people are crying, sometimes I just go sit next to them on the couch, you know? Just sit next to them and sort of be president and hand them a tissue, or even ask permission to pat them on the shoulder, depending on what it is. All those
elements of physical presence or absence…I would definitely say as far as showing empathy…everything really has to be verbal [in telephonic counseling]. And there’s a lot of things in therapy that are not only verbal.”

After this initial exploration, the researcher asked Participant 10 about her perspective on the role of empathy in the process of counseling. The participant discussed that she sees empathy as a combination of exhibiting care for the client and ensuring that they also receive support outside of sessions, rather than the counselor “taking on” the client’s difficulties. She shared:

“I would say [the role of empathy in the process of counseling is] to exhibit care and concern for someone…[it’s important] that you're emphasizing in helping them make friends, and not being their friend. Or that, if they're needing support in other ways, that they're talking about ways that they can gain support outside of sessions and not becoming that support or taking on those feelings yourself. I think there's always two people in the room, but I think it's important to always be sure that, as much as you are pulling and wanting to know. You're always supporting that person in getting that outside of sessions, in addition to what they’re getting in sessions.”

The researcher then asked Participant 10 about her thoughts on the importance of empathy. The participant stated her belief in the importance of being present with the client, and that burnout therapists who are not able to be present with their clients should likely tend to their own needs prior to reengaging with clients. She stated:

“I think that if somebody gets to a place…I’ve heard burnt out therapists, they're annoyed with the client or they were leery of someone, or find what they’re saying annoying, or messed up or something. I guess that that's when they should really take a very long vacation or maybe stop seeing clients.”
The participant went on to describe the therapeutic atmosphere present in her office setting, and how this atmosphere helps to set the tone of empathy. She commented:

“Even when people come into my office, I always say they put their feet up or take their shoes off or bring the dog, as long as the dog doesn’t come into my office. Breastfeed, I don’t know, whatever it is you have to do. I have a lot of purple in my office, and I’m like, ‘You’re in the purple now. This is the purple. Just relax. You can just come in’…I wear my jeans, they call me [shortened version of name]. I just want people to come in with their tea and just sit down. I think all of it, the tone when they walk in, sets empathy.”

Following this questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 10 had received supervision during her experience providing telephonic counseling during COVID-19. Being a seasoned practitioner of thirty years, the participant shared that she had not received supervision during the pandemic. The researcher followed up by asking Participant 10 if she had delivered supervision during the COVID-19 pandemic. The participant reported that she had, commenting on her experience providing supervision to a supervisee who had been engaging exclusively in telephonic sessions:

“…[my supervisee] went from in-person to just the phone…it's basically making you blind. If somebody's silent, are they getting a glass of water? Are they crying? Did they step off to go somewhere? That’s extra, extra challenging.”

The researcher then further inquired into Participant 10’s experience providing supervision to a clinician providing telephonic sessions to clients. The participant spoke to her input regarding the provision of narration and therapeutic space for clients in telephonic counseling. She stated:
“Well, I could see [my supervisee]…I talked to her about narrating a little bit more…asking questions. Maybe you don’t see someone crying. If someone were upset and you weren’t sure, maybe you could…ask verbal cues. But being respectful of allowing therapeutic silence on the phone. On the phone we tend to fill ourselves with words, but that it’s ok to be quiet, just like we would in person. We don’t have to have words on the phone. We can be quiet and just be ok with that.”

Participant 10 then further spoke to her own experience providing telephonic sessions to clients when they were not able to access videoconferencing sessions. She commented:

“I did have…[clients] that did not have Wi-Fi or had privacy issues or had a flip phone. So we did do phone calls….. The most important thing to me was to have that client have access…”

The researcher then asked Participant 10 what it was like for her to not receive supervision during the pandemic. The participant shared that she and her late husband used to provide supervision to one another, and that she would often imagine what advice he might have given to her. She shared:

“…[my late husband and I] used to provide supervision for each other. We would kind of talk about our clients… I was missing him a lot…that was very isolating. I have some friends that are therapists, but it was challenging…Sometimes I’d just kind of picture what my husband might say me, which was super helpful.”

Without further questioning, Participant 10 went on to discuss conducting couples therapy via telephonic counseling, and how the couples modality was impacted by the medium of telephonic counseling. She shared the following:
“I do a lot of couples work, and that was really hard to do telephonically, because people would talk over each other. There were times when people would just stop listening to me…in the office [in person], sometimes I would stand up, or I could do something to help people sort of stop arguing with somebody…I also do court-order co-parenting, which is worse because they can’t stand each other and they’re talking over each other and they’re mean. One time, this one particular couple, they were married, they had this terrible fight, and the wife went into the kitchen. So I was in the living room on the computer. And I'm just at a computer, I can't move. And then he followed her in the kitchen and they proceeded to have this massive fight in the kitchen. And I couldn't do anything. I’m like, ‘Hello?’ It was almost like an SNL skit. It was very hopless, you know? It was kind of funny in a way. I mean it was sad but funny at the same time. I’m like, ‘Hello, are you coming back?’ And then the wife comes back and she goes, ‘Well, that wasn't helpful for you.’ And I thought, ‘Well, I wasn't in the room!’…and as time goes on, I think you get a little more used to the bumps and bruises.”

The researcher further inquired into Participant 10’s experience providing couples counseling via telephone, asking the participant what it was like to empathize with couples through this medium. The participant stressed the importance of physical presence in couples counseling, and how the absence of this factor precipitated greater difficulty in the delivery of telephonic couples counseling. She commented:

“[Empathizing with couples via telephonic counseling] was particularly hard. Physical presence in couples is very, very important. I didn’t think it was as effective…couples, a lot of the time [during the pandemic], didn’t have childcare. We would be talking about something very important, and the child would come in and ask a question. But just the
ability to sort of regulate what people say [in couples telephonic counseling], in the sense of how they're hearing something. I have exercises that I do to kind of demonstrate. I have an active listening thing. I do this sort of thing with your molding hearts. They're very physical with people facing each other. Some of those things are just really hard to do. And, again, when I'm just a voice, I'm like the TV. If they're in a moment and they're arguing about laundry or whatever it is, or something much worse, sometimes they would just ignore me, which, in the office, doesn’t happen.”

Participant 10 then discussed a similar difficulty that permeated her telephonic sessions with families. She reported a particular example that illustrated this challenge:

“…I would even do family counseling. I'm doing that now, with two parents and an adult daughter, and the daughter lives in another state, and the parents have here. And it’s very challenging. They have trouble hearing the other person's emotions sometimes. Again, hearing me and helping to navigate it. Very, very tough.”

Participant 10 then shared that her home and private practice are located close together, “sixty-four steps” apart. Inquiring further into this experience, the researcher asked the participant if this proximity made her private practice feel like an extension of home. Participant 10 reported that she stives to make her home and private practice “very different” in terms of environment for purposes of separation. She commented:

“…I'm very careful that my office does feel very different from my home space. So, my office is very lavender and purple…my house is all these different shades of grey…so it feels very different….even when I walk across the street, I use the walk as a way to cleanse. Even when I was just in my office all the time and I wasn't doing virtual…I usually don’t wear a coat because I like the cold air. Just kind of breathing through and
kind of losing the energy of my office. So by the time I walk to my home, which is a three minute walk at most, I’ve left whatever was there…my office where I am [at home], the only thing I do in this room is I do [counseling].”

Further speaking to the concept of living space, Participant 10 spoke to the greater access to treatment that clients have to telephonic counseling, regardless of the client’s home location in relation to the therapist’s office. She said the following:

“…I still have clients that could live three or four hours away and be my client because they didn’t have to drive to me now. So I still have people that can’t drive here, but they have insurance that I’m a provider for…So we opened the door for people that may be living in remote areas, or people that maybe can't leave their house…I have people that had sleeping babies that, you know, they will have an eight o'clock at night appointment after their baby went to sleep, and they can have their appointment and not have to drive here…I got to meet people I never would’ve met.”

The researcher then inquired into the topic of setting. Participant 10 reported that she was “one of the last holdouts” regarding continuing to see clients in person near the beginning of the pandemic until she experiences two COVID-19 exposures from clients in the same week. She reported that this event precipitated a full transition to working from home. She shared the following:

“I was lucky, because I hung in there longer than I should have. In the beginning [of the pandemic], nobody knew what was going on….at the beginning it was just so unbelievable that I thought it was going to be like the bird flu or something…people would ask me and I was like, ‘Oh’, like everybody…”A couple of weeks’, right? So I kind of hung in there, and…I actually had, in the same week, two COVID exposures
from clients. I didn't get it, thank God, but that frightened me, and I shut down. I was probably one of the last holdouts, probably towards the end of March. And then when I had those two in the same week [I shut down].”

The researcher then asked Participant 10 about the locations from which she delivered telephonic counseling sessions. The participant shared that she delivered all of her telephonic and videoconferencing sessions from the home setting. She reported that she has a room in her house specifically dedicated to distance counseling. She reported:

“All my virtual and telephonic were in my home…I have this room downstairs…all that’s in here…there’s a poster, there's a spare bed in case my grandchildren sleep over or something. But all it is, is a desk and there's cat beds. I have two cats. It's an empty room, basically. It just has this chair and desk, you know, not a lot in it…I don't do anything in here…except therapy. So when I’m not doing counseling, I don’t share my home space with my office space, even when I’m on an appointment at home.”

The researcher followed up by asking Participant 10 if working in a room exclusively dedicated to counseling felt like working in an office environment. The participant shared that she was intentional about creating a sense of separation between the rest of her home and the space designated for remote counseling, but that this scenario was not optimal in comparison to working in her office space. She shared:

“…there was a period of time I guess at the very beginning [of the pandemic]…I had another room mate too...he lived in this room down here [where telephonic sessions were later conducted]…so we had to sort of arrange that. If I was in the living room doing therapy, he had to be in his room with the door closed at night. Or I used to have to sit on my bed sometimes and keep my door closed, so we took turns. That was hard, because it
was very hard to, especially when it was my room, to do therapy…I would just take my computer stuff, though, and I’d pack it all away. I didn't want it near my bed or anything. As soon as I was done, I tried to create it with a little space. But then when [former tenant] moved out, I knew I wasn't gonna rent it to anybody else. And this works much better, to have separation. It didn't feel as good and sometimes it was hard. I found it a little bit hard sometimes…it’s like sitting on your office couch or something. It wasn’t as great.”

Participant 10 then commented about the increase in her caseload precipitated by the pandemic and insurance companies waiving copays and deductibles. She reported that she had to be intentional about adjusting her caseload to a more manageable size as she continued to navigate the changing counseling landscape. She shared the following:

“During the pandemic I was seeing at least 40 people a week, it was way too much. So now I’m down to 32. I’d like to really get it to, like, 30, but I don’t know if that’s going to be possible…I cut down during the pandemic when it was straight telehealth because…when people didn't have copays or deductibles, people that would normally come every month or every three weeks just because of the cost, starting to come in every week. And so I couldn't say to them, ‘Well, I can't do that.’ So what happened was that I ended up having many more people in a week. So now once they started to charge co-pays and deductibles again, things went back. Unfortunately, for clients, in the way of mental health. But in terms of my mental health (laughs), it kind of regulated things a little bit…I could’ve had 80 people a week. It was uncontrollable…even now it’s still bad. I’ll get five or six calls a day…I'd write their name and phone number down and…I’d send them to someone else.”
The researcher followed up by asking Participant 10 if seeing “at least 40” clients per week affected her empathic response during the pandemic. The participant shared that seeing this volume of clients precipitated greater difficulty remaining present in session with clients. She commented:

“…as much as physically possible, I’m very dedicated to being present….certainly the people that saw me Monday morning probably weren't getting the same quality of therapist on Friday morning from me [due to being overloaded with clients], because what happens is I was having…sort of micro distractions, I call them. I would be listening to somebody and then, all of a sudden, they'd say like two sentences and I didn't hear it. And I was paying attention, but I guess my brain just needed a break and sort of left for a second, without my permission. And what I would do, then, is, I would say, ‘I'm sorry, you were cracking up a little bit’ (laughs). So I’d say, ‘Could you repeat that?’ But that started to happen to my focus. That was a lot of people…that was challenging.”

The participant added to the above dialogue by sharing that engagement in self-care activities “outside” of the office helped her to minimize the occurrence of “micro-distractions”. She shared that her overwork did not precipitate annoyance or indifference with clients, but that the primary consequence was that of distraction.

Next, the researcher asked into Participant 10’s experience regarding COVID-related media. The participant shared that she watched “a lot of CNN” in the morning and at lunch. When asked how consuming this volume of COVID-related media affected her empathy toward clients, Participant 10 shared that she found this experience humanizing and humbling as a therapist. She said the following:
“…it’s interesting, because therapists, we went into the pandemic just like everybody else, without any warning or knowing anything. The expectation was that we need to support people. So people were asking us the very questions that we were asking ourselves. And so instead of trying to reassure people, we just sat with them. And that is scary. ‘Let’s just sit with being scared…what can we do?’…Some of the best advice that I got, which helped me in empathy and supporting others in this pandemic: ‘Just be present. You be you. If you tear up, then you tear up. It’s human.’ I think it was the best advice that anyone’s ever given me about being a therapist. That was transformative…in this case with the pandemic, with me not trying to go over, ‘It's okay’, or trying to get them out of it, which is very invalidating anyway, is to sit with them. And then it's really big, and it is really challenging, and it is really lonely. And it is all these things. And we don't know what's going to happen, and just to really be human about it. And I think that, sometimes, that just for people to feel that somebody sees it, and listens to it, and not going, ‘At least this’, or ‘at least that’. It was helpful in that experience that I had [regarding death of my husband]. I just was me, and people, like I said, there were sessions, especially those first couple of weeks, some of my clients, they just wanted to know how I was…in some ways, I sometimes would be worried about me being by myself. And I would talk about that just a little bit. I’d tell them the supports I had, and I’d ask them what they had. We’d sit in it together, instead of me knowing all the answers, because I don’t.”

The researcher then moved to the next research question, inquiring into Participant 10’s
experience of transitioning from in-person to telephonic counseling. The participant shared her experience of fear and calling her clients to suddenly transition them to remote sessions. She reported:

“I called my clients up that week. I freaked out, got tested, I was okay. Checked on my clients, the two people who were positive, they were both ok, and I still see both of them (laughs). So I just called my clients and I made that transition…I remember calling everybody for the following week…and just called people over the weekend for the next week, and just said, ‘Hey, I just had this scare…I don’t want anybody to get sick…’ I was just honest. I said, ‘We need to keep ourselves safe’, and they said, ‘Well, when can we go back to in-person?’ And I said, ‘Five minutes after it’s safe. Five minutes, I promise…””

Next, the researcher asked into the topic of SES. Participant 10 shared that her office is located in an “upper middle class” neighborhood, and that she sees many clients from this demographic. The participant also shared that she sees clients who are “definitely blue-collar, such as bus drivers. The researcher followed up by asking the participant what group(s) of clients tended to have greater interest in telephonic counseling. The participant reported that clients who lacked Wi-Fi or smartphones tended to opt for telephonic sessions more frequently. She commented:

“…people that live in big apartment buildings, students that sort of lived in fussy dorms that didn't always have great Wi-Fi in middle of God knows where, in a country college somewhere. Or…people that lived in big apartment buildings in the city, the Wi-Fi wasn’t great. So that was harder and more challenging, but we figured it out…sometimes
we would just do on the phone. I would say there were some people who didn’t have good access to Wi-Fi struggled more…but we didn’t have a choice, right?”

The researcher then moved to the next research question, asking the participant if she noted any differences in her empathic response between differing counseling mediums. The research began by asking into any differences noted in empathic response in face-to-face and telephonic counseling. Participant 10 reported that physical presence and visual contact with the client renders empathic response easier in face-to-face counseling. She stated:

“…you get to use physical signals when you have just so much more in your tool belt when you're when you're in person, right? You can stand up, you can sit next to [the client], you can hand them something. You can share something with them. We have things I share with people sometimes, images, or read them a poem, it depends what it is. I’ve done mindfulness, it’s much better than do it in person. Mindfulness, like guided imageries. So, again, people are on the phone and…you run into not knowing always what that silence means. Are they thinking? Are they upset about what you said? Do they feel like that doesn't fit for them? You can see it on people's faces, you know? Or are they really be impacted by what you said?…it's almost like doing therapy blindfolded. It’s hard. I’d say visual is, I’d say, half, if not three-fourths of what you do.”

Next, the researcher asked Participant 10 what it is like for her to empathize with clients via videoconferencing. The participant once again commented on the lack of physical presence with the client in session, and how this can present as a barrier to empathy in session. She reported:

“…I think a lot of empathy has to do with physical presence. There’s a tremendous amount that can be communicated by just sitting next to someone…maybe giving a pat
on the shoulder or something. When you’re just looking at someone straight on [in videoconferencing counseling]…you’re trying to do what you would physically with words…you can do it, you can say, ‘Hey, I’m sitting here with you.’ Sometimes I would…say things like, ‘I just wish that I could be sitting next to you right now, during this time, giving you a hug.’ I would send people virtual hugs. Sometimes people would have this wonderful success, and in person, I stand up and cheer for them and clap my hands…it’s not as palpable.”

The researcher then moved to the final research question of the study, inquiring into how Participant 10’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. Participant 10 shared her experience of clients interjecting political dialogue regarding COVID-19 into sessions, and that she chose not to “interfere and influence” such opinions presented by clients in session. She stated the following:

“I think [I’m] just kind of riding along with what [clients] are feeling. I do not interfere and influence. People that are choosing not to be vaccinated, I’m not there for that. The only thing I'll tell them is that I can't see them in person if they’re not vaccinated. So I have said a couple times that, honestly, I feel flattered that they decided to get vaccinated so they could see me in person…I try to stay very carefully treading…I have one particular client that is very, very Trump…and he knows that I’m not. And I've known him forever. He's one of my 15-year people. And I just said. ‘…we have to agree to disagree’, I kind of said lightly. And I said, ‘Let's focus on how all this is affecting you. How is it to be angry all the time? Let’s try to look at your dial.’ But I just feel like I’ve just sat and people in the place that people are when they're there.”
Next, the researcher asked Participant 10 what it has been like for her to empathize with clients on the concept of COVID-19 “not going away”. The participant discussed that she works to help clients “live around” the pandemic, as they must do in other aspects of life. She commented:

“I sit with it, and I’m just [participant name]. I’m just like, ‘I think we’re gonna have to live around it.’ And then I talk about other things that we live around. We do live around things. We live around grief, we live around fear, we live around insecurity. People live around a lot of things, and sometimes we just have to sit next to something… we just talk about what that means, and how to live next to something that's hard, because we do that all the time. So we kind of make it about what other things they've sat next to. And it’s really hard, and if they’ve done that, this is a hard thing, but we can sit next to it, maybe.”

The researcher then asked Participant 10 if she had tested positive for COVID-19. The participant shared that she had not tested positive, but that she “worried about” exposure to COVID-19 “a couple of times”. She commented that she was able to administer an at-home COVID-19 test to herself and found that she had not contracted COVID-19. She shared the following about this experience:

“I worried about [the possibility of having COVID-19] a couple of times. I had times when I felt very fatigued. And just recently…I had a little bit of a cold, and so I tested myself and I was negative. And then a couple times I got scared, because I was fatigued. But it just kind of got better. And I didn’t have any other symptom, nothing. So yeah, I think anytime anybody feels under the weather now, that's the first thought we have. All of us. ‘Do I have COVID?’ In fact, a few of my clients will go, ‘Oh, you know, I felt ill, but I don’t have COVID’, because they immediately tested themselves. And around here,
middle class, upper middle class, everybody's got tests now… they can afford them. One box with two tests is $23, so if you’re not able to spend $23, then you’re going to have that. But if you’re from here, people can do that. So people can test themselves often here now.”

The researcher followed up by asking Participant 10 if not testing positive for COVID-19 affected her empathy toward clients. The participant shared that she could sense her clients’ sense of fear regarding COVID-19 in session. She shared the following:

“I think [my clients] were very frightened, and I could really hear that. I think that when I felt scared that I had [COVID-19]…It's very frightening, because it's not so much, because people have been vaccinated, that I’m dying. It’s the long-haul syndrome and some other things that can happen. It can be very scary…just sitting in that [client’s] fear like you know, ‘Am I gonna die?’…I remember one man, he kept thinking, ‘Can I breathe? Can I breath?’ And I think he was having almost panic attacks. He could breathe, but he was afraid he couldn’t. And just kind of sitting in that fear with them, saying, ‘I can’t even imagine that. It must’ve been terribly frightening.’ And I know I that the times when I thought I did [have COVID-19], it was very scary. And just sitting with that. Just sitting with it. And I had people that really did happen, I mean, I had people call me up just saying, ‘Oh my God, [participant name], I just tested positive for COVID.’ And I'm like, ‘Oh my gosh, how you feeling? What's going on? What’s your plan?’”

The participant went on to comment that her own experience living alone increased her awareness toward the possibility of clients contracting COVID-19 when living alone. She shared that she worked with these clients to develop “sick packs” as a precautionary measure. She reported:
“I have [clients] who have family, or if they’re by themselves...I've encouraged people to have sick packs at home. So what I do is I have a carton that has rice in it, that ready-made microwave rice (laughs). Chicken noodle soup, Afrin, ginger ale, like, random whatever, Motrin, all in one box. So if they were to get sick alone...you have those things, it can be good. It’s given people a little more confidence in the sense of like, ‘Okay, I have things and if I start to get really sick, I know I have them. I have a little sick pack.’”

When asked if she had quarantined herself from others during the pandemic, Participant 10 shared that she had not, due to her ability to quickly administer at-home COVID-19 tests to herself. The researcher followed up by asked the participant how the absence of her own quarantining affected her empathic response toward clients who underwent quarantine themselves. Participant 10 shared that she was able to sit with her clients in their loneliness despite her dissimilar experience. She commented:

“I think that it was very difficult [for clients to quarantine during the pandemic]. Especially if they lived by themselves, it could be very, very isolating...Just sitting with them in that in that loneliness and sort of adding, if it’s appropriate, some general conversation. I think people are hungry for that when they’re just sort of alone and isolated or whatever, in quarantine.”

As a final question of the interview, the researcher invited Participant 10 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant shared that she had nothing further to add. The researcher thanked Participant 10 for her participation in the study. The interview with Participant 05 provided many phrases of significance that related to
the analytical categories noted earlier in the chapter. Table 11 provides a visual representation and review of these phrases of significance from the narrative above.

**Table 11**

*Participant 10 Phrases of Significance*

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<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
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<tbody>
<tr>
<td>Subjective empathy a</td>
<td>“I would say [the role of empathy in the process of counseling is] to exhibit care and concern for someone.”</td>
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<tr>
<td>Identification</td>
<td>“…I think a lot of us felt isolated…”</td>
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<td></td>
<td>“I think anytime anybody feels under the weather now, that's the first thought we have. All of us. ‘Do I have COVID?’”</td>
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<td></td>
<td>“…it’s interesting, because therapists, we went into the pandemic just like everybody else, without any warning or knowing anything. The expectation was that we need to support people. So people were asking us the very questions that we were asking ourselves. And so instead of trying to reassure people, we just sat with them. And that <em>is</em> scary. ‘Let’s just sit with being scared…what can we do?’”</td>
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<td></td>
<td>“I sit with it, and I’m just [participant name].”</td>
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I’m just like, ‘I think we’re gonna have to live around it.’

And then I talk about other things that we live around. We do live around things. We live around grief, we live around fear, we live around insecurity. People live around a lot of things, and sometimes we just have to sit next to something.”

“I think that when I felt scared that I had [COVID-19]…It's very frightening, because it's not so much, because people have been vaccinated, that I’m dying. It’s the long-haul syndrome and some other things that can happen. It can be very scary.”

“I know I that the times when I thought I did [have COVID-19], it was very scary. And just sitting with that. Just sitting with it. And I had people that really did happen, I mean, I had people call me up just saying, ‘Oh my God, [participant name], I just tested positive for COVID.’ And I'm like, ‘Oh my gosh, how you feeling? What's going on? What’s your plan?’”

“…[the pandemic] is really big, and it is really challenging, and it is really lonely. And it is all these things. And we don't know what's going to happen, and just to really be human about it.”

“I’d tell them the supports I had, and I’d ask
them what they had. We’d sit in it together, instead of me knowing all the answers, because I don’t.”

Imagination

“…that was part of [telephonic counseling, is just sometimes asking more questions than I normally would…”

Intuition

“One [client] I saw outside [during the pandemic]…sometimes we were outside and we could look at each other, and we’d be on the phone, just to be physically present. Just far enough apart that it was okay, and we wore masks… as time went on it got colder (laughs). In the summer it was good. We could be outside and stuff.”

“…I think a lot of empathy has to do with physical presence. There’s a tremendous amount that can be communicated by just sitting next to someone…maybe giving a pat on the shoulder or something.”

“I would even do family counseling. I’m doing that now, with two parents and an adult daughter, and the daughter lives in another state, and the parents have here. And it’s very challenging. They have trouble hearing the other person's emotions sometimes. Again, hearing me and helping to navigate it. Very, very tough.”
“I would definitely say as far as showing empathy…everything really has to be verbal [in telephonic counseling]. And there’s a lot of things in therapy that are not only verbal.”

“[Empathizing with couples via telephonic counseling] was particularly hard. Physical presence in couples is very, very important. I didn’t think it was as effective…”

“[telephonic counseling] is almost like doing therapy blindfolded. It’s hard. I’d say visual is, I’d say, half, if not three-fourths of what you do.”

“I think [my clients] were very frightened, and I could really hear that.”

“I thought, ‘Oh my gosh, what if I had been exposed, and didn’t know, and then [my clients] came in and that would be bad…””

“[Returning to my office] was just such an exuberance, like, ‘Oh my God, this is us in person.’ I got back after not being in my office for almost a year.”

“I'm definitely more of an in-person therapist, I guess you'd say. It almost feels like…kind of like missing one of your senses, because I found when people
are crying, sometimes I just go sit next to them on the
couch, you know?”

“I do a lot of self-care…I try to take as much
care of myself as I can outside of the office.”

Interpersonal empathy a “…it's not my place to decide how fast they
should go, or slow, or to have some opinions about that.
It’s to sit in that stuckness with them…”

“On the outside, sometimes people are very
angry. That’s a lot of pain. Sit with that pain. And be like,
‘I see you. I see you.’ I just stay there.”

“I think that, at some level, when we're in the
room with someone, that we need to sit with them in
whatever is going on for them, and be supportive, and
fully present for whatever they need, and to have that
caring and space.”

Understanding the client’s “…sitting next to something that’s a little
lived experience scary…”

“…I remember one man, he kept thinking,
‘Can I breathe? Can I breath?’ And I think he was having
almost panic attacks. He could breathe, but he was afraid
he couldn’t. And just kind of sitting in that fear with them,
saying, ‘I can’t even imagine that. It must’ve been terribly
frightening.’”
“I think that it was very difficult [for clients to quarantine during the pandemic]. Especially if they lived by themselves, it could be very, very isolating…Just sitting with them in that loneliness and sort of adding, if it’s appropriate, some general conversation. I think people are hungry for that when they’re just sort of alone and isolated or whatever, in quarantine.”

“I think [I’m] just kind of riding along with what [clients] are feeling. I do not interfere and influence. People that are choosing not to be vaccinated, I’m not there for that. The only thing I'll tell them is that I can't see them in person if they’re not vaccinated.”

Understanding barriers to counseling

“I did have…[clients] that did not have Wi-Fi or had privacy issues or had a flip phone. So we did phone calls….. The most important thing to me was to have that client have access…”

“…we opened the door for people that may be living in remote areas, or people that maybe can't leave their house…I have people that had sleeping babies that, you know, they will have an eight o'clock at night appointment after their baby went to sleep, and they can have their appointment and not have to drive here…I got to meet people I never would’ve met.”
“…sometimes we would just do on the phone.
I would say there were some people who didn’t have good
access to Wi-Fi struggled more…but we didn’t have a
choice, right?”

Understanding clients’ SES situations “…around here, middle class, upper middle
class, everybody’s got tests now… they can afford them.
One box with two tests is $23, so if you’re not able to
spend $23, then you’re going to have that. But if you’re
from here, people can do that. So people can test
themselves often here now.”

Environmental barriers to interpersonal empathy “…couples, a lot of the time [during the
pandemic], didn’t have childcare. We would be talking
about something very important, and the child would
come in and ask a question.”

“…when I’m not doing counseling, I don’t
share my home space with my office space, even when
I’m on an appointment at home.”

“…it was very hard to, especially when it was
my room, to do therapy…I would just take my computer
stuff, though, and I’d pack it all away. I didn't want it near
my bed or anything. As soon as I was done, I tried to
create it with a little space.”
“I do a lot of couples work, and that was

*really* hard to do telephonically, because people would
talk over each other. There were times when people
would just stop listening to me…”

“…there are a ton of [couples that telephonic
counseling] varies with, especially court-ordered co-
parenting, which, that’s when you get *extremely*
structured.”

| Emotional barriers to interpersonal empathy | “During the pandemic I was seeing at least 40 people a week, it was way too much. So now I’m down to 32. I’d like to really get it to, like, 30, but I don’t know if that’s going to be possible.” |
| Objective empathy | “…[it’s important] that you're emphasizing in helping them make friends, and not being their friend. Or that, if they're needing support in other ways, that they're talking about ways that they can gain support outside of |
sessions and not becoming that support or taking on those feelings yourself.”

Information from supervision as a source for objective empathy

“…[my supervisee] went from in-person to just the phone…it's basically making you blind. If somebody's silent, are they getting a glass of water? Are they crying? Did they step off to go somewhere? That’s extra, extra challenging.”

“Well, I could see [my supervisee]…I talked to her about narrating a little bit more…asking questions. Maybe you don’t see someone crying. If someone were upset and you weren’t sure, maybe you could…ask verbal cues. But being respectful of allowing therapeutic silence on the phone. On the phone we tend to fill ourselves with words, but that it’s ok to be quiet, just like we would in person. We don’t have to have words on the phone. We can be quiet and just be ok with that.”

“…[my late husband and I] used to provide supervision for each other. We would kind of talk about our clients… I was missing him a lot…that was very isolating. I have some friends that are therapists, but it was challenging…Sometimes I’d just kind of picture what my husband might say me, which was super helpful.”
Information from COVID-related media as a source for objective empathy

*a Master theme.

**Interview 11**

Participant 11 is a 32-year-old white female master’s level clinician who works in an agency setting in Pennsylvania, where she primarily provides individual outpatient counseling to children. Participant 11 has worked in the counseling field for 12 years, accumulating a total of 18 months of this time during the COVID-19 pandemic. On average, Participant 11 reported seeing 10 telephonic clients per week. When asked how comfortable she was providing telephonic counseling on a scale of 1-10 (10 being most comfortable), Participant 11 indicated 6.

The interview was conducted via Zoom Videoconferencing. Prior to the interview, Participant 11 electronically signed and emailed to the researcher a consent form (Appendix B) detailing the process, her rights as a participant, and that she could withdraw from participation at any time. Participant 11 indicated her awareness of these policies and that she wished to continue participation in the study. The participant also completed and submitted the demographic questionnaire (Appendix A) prior to engaging in the interview.

The researcher began the interview by broadly inquiring into Participant 11’s experience empathizing with clients over the phone during COVID-19. The participant’s response was the following:
“...[telephonic counseling] has been a bit of a challenge and learning growth. And as far as elaborating on the challenge [of telephonic counseling], not being able to get the full effect. Really have to fine-tune those listening skills, understanding tones...I've lucked out that I've had pretty consistent clients, so I can kind of read their emotions, or their tone within the phone session. But it has been a challenge because you don't really have that ability to see the person, even on video, non-verbals that they're giving you, like if they're using their hands while talking. I'm just giving an example since I'm doing it (gestures with hands). You don't have the capability of doing that. And then in addition, [you] don't really have the capability of having that person-to-person relationship, like your in-person sessions. So it's just been a little bit of a challenge and a journey. So kind of going based on the journey and learning growth, [telephonic counseling] has really fine-tuned my counseling skills, because I have to be very observant and adherent to the client’s tone of voice...it's all basically sound...”

Participant 11 then shared her experience working with a court-ordered client, and how she finds it easier to “sell” therapy to such clients in the face-to-face setting. She then added that video may also be “a little bit easier” to sell to clients than telephonic counseling.

After this initial exploration, the researcher asked Participant 11 about her perspective on the role of empathy in the process of counseling. The participant discussed that she sees empathy “walking in somebody’s shoes” and made a clear delineation between sympathy and empathy. She stated the following:

“...empathy is just basically the ability to walk in somebody's shoes. To kind of understand their perspective of things. It's usually confused with sympathy, so a lot of people will get confused with sympathy, where it's like kind of pity. So it's not pity. I just
want to reiterate I don't see empathy as pity or sympathy, but just basically being able to
walk that journey with that client, understand their story, is how I perceive empathy.”

The researcher then asked Participant 11 about her thoughts on the importance of
empathy. The participant shared that empathy helps counselors to approach their clients from a
position of understanding and care, rather than that of fear and judgement. She reported:

“I believe that it's really important to empathize, because you have that ability to really
understand that person and not see them as…‘a danger to society’, mentally unstable,
mentally insane. So I think that it's really important to practice empathy, because I view
people as humanistic. So you're a human at the end of the day, and it's not my place to
judge. You might live a different lifestyle than I do, and that's okay, but it makes me have
that understanding a little bit deeply. So I think that [empathy] is really important,
because if we go…as a punitive like, ‘Oh, well you did this wrong, you did that wrong,
you did this wrong’, [clients] are less likely to get more change.”

Participant 11 then added her perspective on the importance of boundaries regarding
empathic response to clients. She stated:

“…I believe that when you're able to create that empathic relationship, the therapeutic
alliance becomes stronger. Obviously setting boundaries. I'm very big on boundaries. So
I’m not going to be kind of enmeshed in their issues and feel like I’m literally going
through their problems…I really do stick to my boundaries, too. Just because I am
empathic, it doesn't mean that I'm going to allow you to kind of walk all over me, I guess
(laughs)...I set my boundaries because I am a highly empathic person myself. I can feel
the emotions.”
Following this questioning into the participant’s thoughts on empathy, the researcher asked into whether Participant 11 had received supervision during her experience providing telephonic counseling during COVID-19. The participant commented that she had received a combination of telephonic and videoconferencing supervision at her agency. The researcher followed up by asking the participant what it was like to receive telephonic supervision. Participant 11 shared that her pre-existing rapport with her supervisor made for a seamless transition to distance supervision. She commented:

“I don’t think [telephonic supervision] was that bad, mainly for this whole fact of a lot of our sessions, to start off, were over video. So, we had this supervisor-supervisee relationship that was quite established. So when we would have those conversations…it didn't really seem like it was over the phone (chuckles). It did kind of still feel like it was that highly interactive video conversation…”

Next, the researcher asked if receiving supervision impacted her experience delivering telephonic counseling. The participant reported that supervision develop her telephonic counseling skills and preparedness. She stated:

“…when you're doing supervision on the phone, you're developing those [counseling] skills. And then we haven't really done any role-playing or anything… but I think that it has prepared me for [telephonic counseling], might say.”

Asking further into Participant 11’s experience in supervision, the researcher inquired into whether the participant felt supported near the beginning of the COVID-19 pandemic. The participant shared that she had been working a drug and alcohol counseling job at the time, and that “the relapse rates were so high” and “the fear of people dying was just so significant”.

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Unfortunately, Participant 11 shared that she did not feel supported in supervision during this experience and reported, “that’s a conversation to be left where it needs to be”.

Respecting the participant’s wish, the researcher moved on to the topic of setting. Participant 11 reported that, in all three counseling jobs she worked during the pandemic, she was required to work from an office setting. However, the participant also shared that she delivered telephonic sessions from home while quarantining and awaiting COVID-19 test results. The participant also shared that her first two counseling jobs during the pandemic did not allow telephonic counseling sessions, and that her current job allows counseling through this medium. The researcher followed up by asking Participant 11 what it had been like losing visual contact with clients in her transition to telephonic counseling. The participant commented on her increase attentiveness to the client’s voice, stating:

“…I have to really revisit those listening skills, and hearing tones…completely based upon the sound. I can tell if a person's laughing, I can tell if the person is crying, which is really cool…you don't see the person crying, but you can hear (sniffles)...it's like, ‘Oh, okay. I can tell this person is crying.’ Unfortunately, I can't do my usual pass-a-box-of-tissues, unfortunately. So yeah, [telephonic counseling] was a growth edge. So it's like, ‘How do I show that compassion and that empathy to that person when they're crying? I really have to fine tune my verbal confirmation, my verbal reflections.”

Participant 11 went on to share the “laid back nature of telephonic session, and that this dynamic helped to promote relaxation in session. She commented:

“I know [with] video chats, I will sometimes be like, ‘Oh my gosh, my hair doesn't look right. This doesn't look great. This isn't centered’, or little things like that I'm actually gotten to be a lot better at. So with phone sessions, you don't have to sit there and worry

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about [how you look]. You could be just kind of more laid back and relaxed. I can sit
down on my couch at work and talk on my phone, rather than having to sit in my chair.
But I don't try to be that really relaxed person that I'm out of touch with my clients. I'm
very attentive and very have what I like to say great listening skills, but they've had to be
established really a lot over the last year and a half…”

Commenting further on the lack of visual contact with the client in telephonic counseling,
Participant 11 discussed how this factor sometimes precipitated a “laissez-faire kind of
mentality” regarding session boundaries. The participant shared that she strived to enforce
boundaries as needed when clients presented in this way. She stated:

“…when [a client] is in their own environment, there's more of that laissez-faire kind of
mentality, and a lot more distractions, especially if that person has children. I get a lot of
parents, so they have children, a screaming baby in the background, a dog barking. So
there's a lot to fine tune, which has really led me to be a stronger therapist, like, setting
my boundaries. Like, ‘Hey, you know what? I really don't like this idea of you
abandoning your child while this person is crying and screaming, so would you like to
schedule a new session a different day when you have a babysitter?’ Or I've gotten some
people driving. And I'm like, ‘No, no. No thank you. I will not condone that…I'll give
you choices: you'll need to pull over the vehicle, or we can reschedule an appointment.’
So with phone sessions it's a little bit harder to decipher if somebody's driving, but you
can always tell when somebody's driving. You hear that background noise, that ‘Rrrr.’”

The researcher then asked further into Participant 11’s experience of boundary setting in
telephonic counseling. The participant shared that she did not tolerate clients pushing boundaries
regarding “what they could get away with” such as driving during session. She commented:
“…people test each other out. I think that's a normal kind of thing for some people to do…you gotta really have clear, set boundaries. Like, ‘This is not what I will tolerate. I will not tolerate you being on the phone while you're driving. That's a safety issue.’ Get some pushback (chuckles). ‘Oh, [participant name], I'm pulled over.’ ‘Are you really?...I'm gonna hang up this phone a couple seconds if we don't make a decision. That's just what's gonna happen.’ Normally, I'm pretty good at that. ‘Okay, okay, okay. I'll pull over.’”

Next, the researcher asked into the topic of SES. Participant 11 shared that she worked primarily with clients at the “poverty line level”, only taking Medicaid insurance in her current job. The researcher followed up by asking the participant if this primary demographic precipitated a greater amount of telephonic counseling sessions with clients. Participant 11 reported that lack of Wi-Fi and embarrassment of poor living space precipitated a greater number of lower SES clients choosing telephonic sessions. She said the following:

“I could probably pinpoint a couple [clients] off the top of my head, that I do want to say [have limited access to videoconferencing sessions due to lower SES]. Either because they don't want me to see what their place looks like, or they don't have Internet…So that's been a barrier. And I think amongst all jobs, especially the one at first, during the pandemic, I had a lot of no-shows, and a lot of non-attendance, because people not having their Internet connected. I was in inner-city Harrisburg, so the socio-economic status, I want to say, is the average, at least like $10,000 a year…It was a systemic issue in which everybody was struggling financially to get internet…”

The researcher then moved to the next research question of the study, inquired into Participant 11’s experience empathizing with clients via differing mediums. The researcher
began by asking the participant is she had noted differences in her empathic response toward clients in face-to-face versus telephonic counseling. Participant commented on the attentiveness to non-verbals offered in face-to-face counseling, stating:

“\[In person\]…you get that holistic view of that [client]. You see their nonverbals. You can tell if they're rolling their eyes. You can tell if they seem distracted. If they have other things going on…in person, you can still get those non-verbals and stuff. But then on phone, you don't get that…”

The researcher then inquired into any differences noted in videoconferencing versus telephonic counseling regarding empathic response toward clients. Participant 11 reported that working with Medicaid clients who lacked familiarity with technological mediums such as videoconferencing precipitated technological trouble-shooting that detracted from counseling sessions with clients. She shared:

“…I think [telephone] was a little bit easier [than videoconferencing] , mainly because people know how to operate a phone, and how to make phone calls, how to receive phone calls, versus Zoom. I did hit a lot of barriers…there can be some developmental disabilities, some cognitive deficits, and that inability to problem solve…it that much harder for that individual to figure out Zoom. So, particularly, I was doing a lot of troubleshooting. I don't know how I managed it, but multiple people calling at once: ‘I can't get into Zoom. I don't know what I'm supposed to be doing.’ ‘Okay, well I'll send you another link, and what you do is you copy the invitation code into the website, and then you'll copy and paste the password when it asks for the password.’…it takes a little bit of time out of your day, you know what I mean?...it definitely was some challenges that I was not expecting to face. So kind of came in as, like, curveballs at me.”
Asking further into Participant 11’s experience with videoconferencing, the researcher inquired into whether technological barriers encountered in videoconferencing impacted her empathic response toward clients. Despite these barriers occurring, the participant shared that she was able to remain present and attentive with her clients via videoconferencing. She reported:

“I don't think [technological difficulties impacted my empathy toward clients]. I’m not gonna lie, it did take a lot of time out of our session, which I myself would get a little frustrated with, just because I like to give that person my undivided attention for the full amount of, you know, 38, 45, 53 minute—whatever session we're kind of talking about. I like to give them my undivided attention, and when I'm troubleshooting and it's taking about 10-15 minutes, that's taking 10-15 minutes out of our session. So I think that it might not have directly impacted the empathy, but it directly impacted my ability to provide them the full services that they needed.”

The researcher then moved to the final research question of the study, inquiring into how Participant 11’s own personal experience regarding the pandemic influenced her empathic response to clients in the delivery of telephonic counseling. The participant shared, “…I really don't think [my own experiences regarding the pandemic] has impacted my empathy”. However Participant 11 discussed that she could relate to the sense of overwhelm felt by other helping professionals, such as physicians, stating, “…I could really relate to physicians feeling very overwhelmed and very burnt out and feeling very defeated…”.

The researcher followed up on the topic of burnout, asking Participant 11 if burnout impacted her empathy toward clients. The participant reiterated her experience of overwhelm, worry for clients, and navigation of a pandemic that she did not have concrete answers for. She stated:
“Oh, goodness gracious. Absolutely, [I did experience burnout during the pandemic].

Burnt out city. So how have I been impacted? Well I obviously had to tap out of addictions, because I worried all the time, ‘What would happen if someone died on my caseload?’...I would feel terrible...I did definitely burn out, because between everybody coming to me and, ‘Why is [the pandemic] happening?’...It's like you feel like you’re put on this high pedestal. And, like, ‘I can't answer that. I wish I knew. I can't answer it, I'm sorry.’ And then I was going through my own personal issues too, so it was kind of an added stressor. But we powered through, we made it, I survived, I learned from it, I grew from it, nobody died....I did have a relapse, a client that relapsed. But I had a very supportive team, so that was very good, because I was like, ‘What did I do wrong? How could I have prevented this? I thought I called him, probably too many times, to do welfare checks, and here he is, overdosed and knocked out in his house. But it wasn't my fault.”

The researcher then asked Participant 11 if she had ever tested positive for COVID-19. The participant shared that she had not. The researcher followed up by asking Participant 11 how remaining COVID-free impacted her empathy toward clients as she navigated the pandemic. The participant discussed that her avoidance of COVID-19 caused her to question why her clients had tested positive and she had not, as she reported multiple close exposures without contracting COVID-19 herself. She commented:

“I think that [not contracting COVID-19] made me feel like I was more healthy than not. How do I describe that? My mom and I have had this conversation, where we think I might have the enzymes that are antibodies to COVID, because how many people I’ve been in contact, very close contact, with that have tested positive, and I still haven't
gotten it. I will be completely frank and honest. I'm not vaccinated…But I was just really
digging deep into like, ‘Well, why them and why not me?’ You know what I mean?
‘What makes me so special?’…I was like, ‘Wow, I feel bad for these people’, because
I’ve had a lot of clients that tested positive, and I’m just like, ‘What makes it so that I
didn't get it?’”

After Participant 11 shared that she chose to not receive the COVID-19 vaccination. The
researcher asked the participant how this decision impacted her interactions with clients.
Participant 11 shared that she was opened to discussing this information with clients in session,
but that only one such conversation surfaced in her sessions. She reported:

“[COVID-19 vaccination] is a very political conversation. I think I may have told one
client, and we kind of discussed it…I didn't get into detail about why, because I have
very close family members that have almost died of it after the vaccine…if they would
ask, like, ‘Hey, are you vaccinated?’ I would blatantly say, ‘No, I'm not.’ I've had only
one person ask me. And we can talk about it, we can discuss it. And I take all
precautions. I take that stuff very seriously because I know that I am not vaccinated. But
it's a tough situation…”

Participant 11 then shared that she chose to abstain from the COVID-19 vaccination due
to her father becoming critically ill after receiving the Johnson and Johnson vaccine. She
commented that this was a “scary situation”, and she did not wish to risk a similar situation
occurring for her due to genetic similarity to her father. The researcher offered his condolences
and asked Participant 11 if this situation had any impact on her empathic response toward clients.
The participant shared that she sees one client who has a sick father, and that the participant’s
own similar situation facilitated a sense of identification with the client. She shared:
“Yeah, [my own experience of almost losing a family member impacted clients who experienced a similar situation]…I have one person, particularly, right now, that her father is not in the greatest shape. So it's kind of like this fine line that I’m walking that I’m trying to not allow countertransference to influence as well. But I can really see and feel what she's going through, because she has this very strong relationship with her father. And it hurts her to see her dad sick. I’m like, ‘I get it, I really do. I 100% get it. This is a tough time. Seeing anybody you love hurting or in pain is probably one of the hardest things a person can experience and knowing that there's really nothing you can do. I'm not saying it's the worst thing ever, but it's pretty hard.’”

The researcher then asked Participant 11 if exposure to COVID-19 on several occasions had impacted her empathy toward clients. The participant shared that her empathy was not directly impacted by this experience, but that she felt a sense of “enlightenment” from her navigation of these exposures, and “an appreciation for life”. The participant continued on to report the death of her cousin, and how this experience impacted her empathy toward clients and precipitated compassion fatigue, stating:

“…my cousin passed away from COVID. So yeah, it hit home. She was vaccinated. She was a teacher. She was an amazing human being. So, did that change my views? Yeah. It changed how empathetic I was. Yeah, because I've seen people die as a result. It makes me have more empathy if someone else's loved one has some complications, as a result of COVID. But also kind of caused a little bit of a burnout, too. Er no, I think compassion fatigue would be the most appropriate word…that feeling of, like, you're so compassionate, but you're just exhausted, because the problem is so much bigger than
what you can handle. So yeah, I think compassion fatigue is probably an appropriate
word.”

The researcher then revisited Participant 11’s single experience of quarantining during
the pandemic, inquiring into how this experience impacted her empathy toward clients. The
participant shared that this experience did not “directly” impact her empathy toward clients, but
that it “probably led to me being a little bit more nervous”. The participant followed this
statement up by discussed how she put the wellness of others ahead of her during the pandemic.
She shared:

“…we say, ‘You can’t give from an empty cup; you have to have your mask on first,
before you give somebody else a mask.’ I wasn't taking care of myself. I came last. I did.
I was last person.”

The researcher then inquired into Participant 11’s consumption of COVID-related media,
and how consumption of this content affected her empathy toward clients. When asked how
much COVID-related media she had consumed at the beginning of the pandemic, Participant 11
shared that she strongly regulated her media intake in the interest of mental health, but remained
exposed enough to remain informed on pertinent topics.

“I'm really not much of a media person. I’ve kind of always been that way, just because I
think that watching the news is very depressing… Don't get me wrong, I'm very for
remaining up to date on what's going on in the world, but I do also, which psychology
supports, that too much of it will drag you down…it can drag the strongest down…I try
not to watch too much of it. So, at the beginning of it, I watched just enough to keep me
up to date on things, so that, in the event clients would come in and want to you know
discuss certain things, I wouldn't be like a deer in the headlights that's like, ‘I have no
idea what's going on in the world’ (chuckles). Like, ‘Oh yeah, they came out with a new vaccine?’ And, even to this day, I’m pretty up to date on things. Like, ‘Okay, there's a vaccine that's out for five-year-old’s.’ But, at the beginning, I really did pull away from it strongly, because I knew that it would essentially consume my life, and I would be dragged down and would probably burn out quicker.”

As a final question of the interview, the researcher invited Participant 11 to speak to any lived experiences that she had not yet had the opportunity to discuss. The participant shared her perspective on the importance of self-care, recognizing the universality of the COVID-19 pandemic, and seeking social support from family.

“…in my grad program, there was a large emphasis on self-care, so I really wish I would practice it a little bit more than I do, but progress notes call my name, and papers call my name, and they’re a little bit higher on my hierarchy. Hopefully this week I’ll be able to just take a little bit of time to myself and just relax (chuckles)…I think [therapists are] ingrained in, ‘Oh, we’re supposed to be strong, we have to be strong for our clients, and if we show any sense that we have doubt in ourselves, we're not a good therapist.’ At the end of the day, we're still people, too, you know what I mean? We’re going through real issues, we could have experienced some real issues. A client dying of COVID. Like, me personally, family members dying of COVID. Family members almost dying of COVID one after another, after another. And I had to brush my own grief to the side and continue powering, moving through. So yeah, it's been pretty tough. I've lucked out that I have an amazing family. God really graced me, so if I ever am feeling overwhelmed or anything, I’m just like, ‘Hey cousin, can you give me a couple seconds?...tell me something cool. Send me a funny emoji or a funny meme or something, just to get me laughing.’…I think
that there definitely can be some people who are like, ‘Oh yeah, we’re therapists, we’re not supposed to feel stuff’, or ‘We're supposed to be strong. We have be strong for clients.’ And it's like, ‘No, it's okay if we have a couple cries ourself, you know? Do what we practice. It is okay to not be okay sometimes.’”

At the end of the interview, the researcher thanked Participant 11 for her participation in the study. The participant shared that she had no further information about her lived experience to add to the interview. The interview with Participant 11 provided many phrases of significance that related to the analytical categories noted earlier in the chapter. Table 12 provides a visual representation and review of these phrases of significance from the narrative above.

**Table 12**

*Participant 11 Phrases of Significance*

<table>
<thead>
<tr>
<th>Analytical categories</th>
<th>Quotations of significance</th>
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<tbody>
<tr>
<td>Subjective empathy a</td>
<td>“…I believe that when you're able to create that empathic relationship, the therapeutic alliance becomes stronger.”</td>
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<tr>
<td>Identification</td>
<td>“…if they would ask, like, ‘Hey, are you vaccinated?’ I would blatantly say, ‘No, I'm not.’ I've had only one person ask me. And we can talk about it, we can discuss it. And I take all precautions. I take that stuff very seriously because I know that I am not vaccinated. But it's a tough situation…”</td>
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“Yeah, [my own experience of almost losing a family member impacted clients who experienced a similar situation]… I can really see and feel what she's going through, because she has this very strong relationship with her father.”

“…my cousin passed away from COVID. So yeah, it hit home. She was vaccinated. She was a teacher. She was an amazing human being. So, did that change my views? Yeah. It changed how empathetic I was. Yeah, because I've seen people die as a result. It makes me have more empathy if someone else's loved one has some complications, as a result of COVID.

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<tr>
<th>Imagination</th>
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<tbody>
<tr>
<td>Intuition</td>
<td>“[My empathic listening skills] were definitely put to the test [in telephonic counseling]…it pushed me.”</td>
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“I’ve lucked out that I've had pretty consistent clients, so I can kind of read their emotions, or their tone within the phone session.”

“…kind of going based on the journey and learning growth, [telephonic counseling] has really fine-tuned my counseling skills, because I have to be very
observant and adherent to the client’s tone of voice…it's all basically sound…”

“…I have to really revisit those listening skills, and hearing tones…completely based upon the sound. I can tell if a person's laughing, I can tell if the person is crying, which is really cool…you don't see the person crying, but you can hear (snifflies).”

“…[telephonic counseling] was a growth edge. So it's like, ‘How do I show that compassion and that empathy to that person when they're crying? I really have to fine tune my verbal confirmation, my verbal reflections.”

“…as far as elaborating on the challenge [of telephonic counseling], not being able to get the full effect.”

“…[you] don't really have the capability of having that person-to-person relationship, like your in-person sessions. So it's just been a little bit of a challenge and a journey.”

“…I think it's a little bit easier to sell therapy when you're in face-to-face [sessions]. And then maybe over video is a little bit easier [than telephonic counseling]…”
“…[telephonic counseling] has been a challenge because you don't really have that ability to see the person, even on video, non-verbals that they're giving you, like if they're using their hands while talking.”

“In person…you get that holistic view of that [client]. You see their nonverbals. You can tell if they're rolling their eyes. You can tell if they seem distracted. If they have other things going on…in person, you can still get those non-verbals and stuff. But then on phone, you don't get that…”

Felt-level experience

“Oh my gosh…talk about chronic anxiety [regarding the pandemic].”

“[Being exposed to COVID-19 gave me] appreciation for life, because COVID is a serious thing. Lives are being taken…”

“Do what we practice. It is okay to not be okay sometimes.”

Interpersonal empathy

“…empathy is just basically the ability to walk in somebody's shoes.”

“…I view people as humanistic. So you're a human at the end of the day, and it's not my place to judge. You might live a different lifestyle than I do, and
that's okay, but it makes me have that understanding a little bit deeply.”

Understanding the client’s lived experience

Understanding barriers to counseling “…I think [telephone] was a little bit easier than videoconferencing, mainly because people know how to operate a phone, and how to make phone calls, how to receive phone calls, versus Zoom.”

Understanding clients’ SES situations “…I had a lot of no-shows, and a lot of non-attendance, because people not having their Internet connected. I was in inner-city Harrisburg, so the socio-economic status, I want to say, is the average, at least like $10,000 a year…It was a systemic issue in which everybody was struggling financially to get internet…”

Environmental barriers to interpersonal empathy “…when [a client] is in their own environment, there's more of that laissez-faire kind of mentality, and a lot more distractions, especially if that person has children.”

“…people test each other out. I think that's a normal kind of thing for some people to do…you gotta really have clear, set boundaries. Like, ‘This is not what I will tolerate. I will not tolerate you being on the phone while you're driving. That's a safety issue.’”
“…with phone sessions, you don't have to sit there and worry about [how you look]. You could be just kind of more laid back and relaxed.”

Emotional barriers to interpersonal empathy

“…we say, ‘You can’t give from an empty cup; you have to have your mask on first, before you give somebody else a mask.’ I wasn't taking care of myself. I came last. I did. I was last person.”

“The relapse rates were so high, and I felt the pressure and the burden on my shoulders.”

“Oh, goodness gracious. Absolutely, [I did experience burnout during the pandemic]. Burnt out city. So how have I been impacted? Well I obviously had to tap out of addictions, because I worried all the time, ‘What would happen if someone died on my caseload?’…I would feel terrible.”

“…I did definitely burn out, because between everybody coming to me and, ‘Why is [the pandemic] happening?’…It's like you feel like you’re put on this high pedestal. And, like, ‘I can't answer that. I wish I knew. I can't answer it, I'm sorry.’ And then I was going
through my own personal issues too, so it was kind of an
added stressor.”

“…that feeling of, like, you're so
compassionate, but you're just exhausted, because the
problem is so much bigger than what you can handle.”

“…I could really relate to physicians feeling
very overwhelmed and very burnt out and feeling very
defeated…”

“…I had to brush my own grief to the side
and continue powering, moving through. So yeah, it’s
been pretty tough.”

Objective empathy *a*  “I'm very big on boundaries. So I’m not going
to be kind of enmeshed in their issues and feel like I’m
literally going through their problems…”

Information from  “…when you're doing supervision on the
supervision as a phone, you're developing those [counseling] skills.”
source for

Information from COVID-  “…I watched just enough [COVID-related
related media as a media] to keep me up to date on things, so that, in the
source for event clients would come in and want to you know
objective empathy discuss certain things…”
Cross-Case Analysis

Table 13 contains a summary of the cross-case analysis regarding themes of similarities pertaining to participants’ empathic response to clients via telephonic counseling during COVID-19. Participants shared many similar themes and sub-themes and views across the eleven interviews. Table 13 illustrates these themes and sub-themes that were common across cases interviews. When discussing their thoughts on the importance of empathy in counseling and the role of empathy in the process of counseling, all participants shared information that resonated with the themes of subjective, interpersonal, and objective empathy. Within the theme of subjective empathy, all but one participant discussed identification with client’s COVID-related experiences, 7/11 discussed using imagination to supplement for the lack of visual contact with clients, all participants discussed how telephonic counseling affected empathic intuition, and all participants discussed how the pandemic affected their felt-level experience during telephonic counseling with clients. Within the theme of interpersonal empathy, 8/11 participants discussed better understanding clients’ lived experiences via telephonic counseling, all participants discussed better understanding client’s barriers to counseling through this medium, and all participants discussed better understanding clients’ SES situations through telephonic counseling. Additionally, all participants commented on their experience of environmental barriers to interpersonal empathy and all participants discussed their experience of emotional barriers to interpersonal empathy. Within the theme of objective empathy, all participants discussed using information gleaned from supervision to better empathize with clients and all but two participants discussed using information received from COVID-related media as a means of better empathizing with clients.
### Table 13

**Cross-Case Analysis & Common Themes**

<table>
<thead>
<tr>
<th>Analytical categories and subcategories</th>
<th>01</th>
<th>02</th>
<th>03</th>
<th>04</th>
<th>05</th>
<th>06</th>
<th>07</th>
<th>08</th>
<th>09</th>
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<td>X</td>
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<td>X</td>
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<tr>
<td>Felt-level experience</td>
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<td>Understanding barriers to counseling</td>
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<td>Understanding clients’ SES situations</td>
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<td>X</td>
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<tr>
<td>Environmental barriers to interpersonal empathy</td>
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<tr>
<td>Emotional barriers to interpersonal empathy</td>
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</tbody>
</table>
Information from supervision as a source for objective empathy

Information from COVID-Related Media as a source for objective empathy

\[^a\text{Master theme.}\]

**Chapter Summary**

This chapter illustrates the process the researcher used to explicate this study’s data while reviewing the eleven interviews. This chapter described the interview data in narrative form and the phrases of significance that emerged in each interview. These phrases of significance were initially collected without the use of the research questions and then later were related to the research questions to identify relevant information to the study’s purpose. Several tables were also included in this chapter to provide visual representations of the significant phrases of the interview data. The chapter finishes with a cross-case analysis of the phrases of significance within the explicated main categories.

The three main themes and eleven subthemes provided context to understand the elements that were consistent throughout the eleven interviews. It is the researcher’s hope that this study will be useful to parties interested in what it is like for counselors to empathically respond to clients via telephone during a pandemic event such as COVID-19. The use of Clark’s (2010) integral model of empathy allowed the researcher to organize participants’ narratives on
empathic into thematic categories and better understand their experiences. The main themes illustrated in this study illustrate common experiences that counselors underwent as they attempted to empathically respond to clients via telephone during the COVID-19 pandemic. The common categories described in this chapter and explicated from the interviews are discussed in Chapter 5.
CHAPTER V: DISCUSSION

Introduction

In this study, the researcher interviewed eleven counselors in the field to inquire into their lived experience of empathizing with client via telephonic counseling during the COVID-19 pandemic. The overarching objective of this study was to unearth the narratives of these participants as a means of better understanding the phenomenon of empathizing with clients over the telephone during COVID-19. The researcher strived to approach interviews with an unbiased view as a means of allowing participants to speak freely and accurately to their experiences with telephonic counseling, both positive and negative. In doing so, the researcher hoped to use participant reflections to help the counseling field better understand the phenomenon of empathizing with clients via telephonic counseling during COVID-19.

The eleven narratives in this study illustrated a variety of experiences regarding counselor’s empathic response toward clients via telephonic counseling during COVID-19. As mentioned in Chapter IV, three master themes and eleven subthemes emerged from the participants’ narratives. The present chapter discusses these themes, which are organized by the research questions that were designed at the beginning of this research project. The responses and themes that pertain to these questions are discussed in order of the supplemental questions and are followed by the implications that these themes have with respect to the mental health profession. The chapter concludes with an examination of the limitations of the study, the questions that was generated by the research, and suggestions for future research that may provide additional clarity in this area of exploration.
Discussion of the Findings

Three master themes and eleven subthemes emerged from the eleven participant interviews. The study’s research questions, informed by a review of the literature, prompted the participant’s responses. The research questions and semi-structured questions provided an organizational framework for gathering participant perspectives (Appendix D). This section discusses these master themes and respective subthemes within the context of the theoretical lens of the study and each of the specific questions. Implications to the mental health counseling field are discussed as it relates to how the reader and other parties can apply the master themes and respective subthemes in better understanding what it is like for counselors to empathically respond to clients over the telephone during a disaster event such as COVID-19.

Clark’s Integral Model of Empathy

Clark’s (2010) integral model of empathy is a theoretical lens that allows researchers to divide the general term “empathy” into more specific categories of empathic response. The model delineates the terms subjective, interpersonal, and objective empathy. Clark (2010) defines subjective empathy as “a counselor’s awareness of his or her sensibilities and internal reactions in response to the experiencing of a client” (p. 349) and divides the concept into four parts through which counselors empathize with their clients: identification, imagination, intuition, and felt-level experiencing. Clark (2010) states that interpersonal empathy helps the counselor to “empathically understand the phenomenological experiencing of a client and demonstrate a sensitive attunement to the perceptual field of the individual” (p. 350) and that objective empathy “relies on a consensus of judgments from reputable reference groups composed of individuals external to a client’s frame of reference” (p. 351). Clark’s (2010) integral model of empathy is the primary underpinning for the study and is inexorably linked to
all the themes delineated by the research. The theory specifically speaks to the nuances of counselors’ empathic response toward clients, which had a significant effect on participants’ ability to describe their experience in this study. All three master themes of this study are informed by Clark’s (2010) integral model of empathy and can be observed below. Because Clark’s (2010) integral model of empathy is a pre-existing theoretical model that has previously been used to conceptualize the process of empathy, it easily encapsulated the responses of participants.

**Theme #1: Subjective Empathy**

Throughout the participant interviews, all participants discussed views and expressions of empathy consistent with Clark’s (2010) idea of subjective empathy. The emergence of this theme was likely precipitated by the universal nature of the pandemic, as it caused counselors to understand the fear and panic of their clients through the lens of their own experience. Several participants spoke to empathy as facilitative to caring for the client. This was evidenced by phrases such as, “If I don’t have empathy for my clients, I probably wouldn’t care about their outcomes” (01) and “I think people who have more empathy—it’s easier for them to give themselves in that therapeutic dynamic” (02). Several participants also described empathy as a sense of connectedness with the client, using phrases such as “to exhibit care and concern for someone” (10) and “like a bridge toward therapeutic relationship” (08). Additionally, other participants spoke to empathy as a means of building and maintaining the counseling relationship. Participants commented, “you build the [therapeutic] alliance through empathy and you can maintain it through empathy” (04), “to strengthen that [counseling] relationship, empathy is needed” (06), “I think [empathy] serves as a way to build rapport…” (07), and “when you’re able to create that empathic relationship, the therapeutic alliance becomes stronger” (11).
These participant responses reflect the importance of empathy in the formation of the therapeutic alliance with the client. This finding aligns with Reese et al.’s (2016) commentary on empathic accuracy serving as an important variable in the formation of the therapeutic alliance.

Some participants further spoke to the importance of empathy with considerable reverence, sharing comments such as, “I think that empathy is counseling” (05) and “I don’t know that it’s possible to do this job unless you have the ability to empathize” (02). However, in the spirit of caution, two participants discussed the phenomenon of being “stuck” in empathy with the clients, which aligns with Stillars’ (1997) own caution regarding the counselor being closed off to new possibilities in developing the illusion of understanding another person. Participant 04 discussed avoiding getting “stuck in the emotion” of the client’s experience and Participant 03 discussed that empathy can “take you actually out of doing something that could be therapeutic” with the client when the counselor becomes “too invested”. Lastly, Participant 10 cautioned about empathy saturation causing burnout in therapists and Participant 06 discussed that counselors exhibit a “different” type of empathy toward clients that they do toward friends and family. These participant responses reflect that empathy is a tool that should be used with therapeutic intention to help clients make progress toward their goals in therapy.

Further speaking to participant’s experiential factors, participants who experienced similar events as their clients, such as losing a loved one or being isolated from their family, found it especially easy to subjectively empathize with those clients. Participants whose experiences varied widely from certain clients reported that they were able to use their imagination to find a point of subjective commonality with their clients. These findings reflect the hermeneutic process of subjective empathy, as counselors may incorporate imaginative
processes in scenarios in which they are not able to personally identify with a client’s reported experience.

Within the theme of subjective empathy, several subthemes emerged: identification, imagination, intuition, and felt-level experience. These subthemes were directly influenced by the existing subcategories within Clark’s (2010) concept of subjective empathy. Each of these subthemes will be addressed throughout this discussion under their appropriate research question.

**Theme #2: Interpersonal Empathy**

Further looking to Clark’s (2010) model of integral empathy, all participants discussed empathic interactions with clients that aligned with the concept of interpersonal empathy. This theme was likely precipitated by the universal practice of counselors empathizing with their clients in an interpersonal manner. During the COVID-19 pandemic, counselors strived to understand the uniqueness of their clients’ experience from a non-biased perspective, a task that likely proved difficult due to accomplish during such personally trying times.

Many participants in this study discussed empathy as a means of improving their understanding of clients’ reported experiences, effectively having “the ability to walk in somebody’s shoes” (11). Additionally, several participants discussed their views on empathy as informative to counseling interventions. One participant (09) commented, “…let me try to understand [the client] so I can use what I know about CBT or narrative therapy…” and another (03) described empathy as a helpful asset throughout the process of counseling. Moreover, several participants discussed empathy as setting the stage for effective counseling. Participant 10 discussed the importance of sitting with the client in their “stuckness” prior to therapeutic progress being made and Participant 11 discussed that empathy helps to set a less punitive
atmosphere for clients. Participant 04 further added to this phenomenon, commenting, “empathy, being able to express that and have that felt by our clients. I think that’s where a lot of the healing work takes place…” Participant 07 further spoke to the informative bearing of empathy on counseling intervention, and empathy acting as a vehicle for change in the process of counseling. He stated:

“I think if you can’t empathize with your client, then you don’t—you’re not going to know what they need. So your interventions that you apply later might not be a good fit for them, or where they’re at. And, to me, the expression of empathy is a vehicle for change in the counseling—in counseling. I strongly believe that, when people are able to be truly understood and listened to and have that expressed to them, I think that creates change.”

The above dialogue of participants suggests that empathy may be informative to therapeutic interventions, a finding that aligns with Zayas et al. (2002). Counselors are indeed not going to know what the client needs if they do not take time to empathize with the client’s given situation. Thus, empathy can function as a vehicle for change throughout the process of treatment.

In addition to gleaning an improved understanding of the client, several participants spoke to the caring therapeutic environment that empathic attendance can provide for clients. For example, all but one participant (09) commented on empathy as facilitating a therapeutic environment in counseling. This finding aligns with Reese et al.’s (2016) commentary on empathy as a crucial component in developing a working alliance in the provision of telephonic counseling. Participant 06 spoke to the greater level of care that clients may receive in therapy than with others in everyday life, which may be facilitated by counselor empathy. She stated,
“…people tend not to get a lot of empathy from other people in their life, and so when their counselors can provide that I think that…can be completely life changing.” The participant also discussed that counselors exhibit a “different” type of empathy toward clients that they do toward friends and family. In this way, participants in this study were able to delineate between simply listening to another person’s experience and actively empathizing in the role of counselor. It is likely that the intentional role of counselor is important when engaging in interpersonal empathy, as such empathic practice requires counselors to set aside their personal lives in favor of better understanding the client’s lived experience.

Moreover, other participants discussed empathy as creating a space for counselors to sit with the client, stating, “we need to sit with [the client] in whatever is going on for them, and be supportive, and fully present for whatever they need, and to have that caring and space” (10), “I think if people aren’t empathetic and creating that space, I think a lot of people wouldn’t make connections” (03), “[if] I can’t fully relate to their situation, that doesn’t mean that I can’t hold the space” (03), and “I have to…just kind of leave it by the door. And, for me, I think I lovingly am putting it down, I’m lovingly putting it away” (09). These statements align with Hartley’s (1995) definition of empathy as simply “being with the client” (p. 19). From the perspective of interpersonal empathy, participants discussed here creating a therapeutic space in which the client can be heard and recognized in an interpersonal manner. Creation of this space may require greater intentionality in telephonic counseling, as the traditional aspect of a face-to-face office setting is absent.

Furthermore, several participants discussed how empathy can help to facilitate a sense of trust and safety in the counseling relationship. For example, Participant 01 commented, “I think [empathy] is what helps the client feel like they can trust you to be able to open up…” If the
counselor can help the client to realize their own intrinsic worth through process of showing compassion and empathy as Barnett and Mann (2013) discuss in the literature, a sense of trust is likely fostered in the relationship. Participant 02 also spoke at length to empathy foster trust in the therapeutic alliance. She stated:

“...bottom line, I mean, counseling is a relationship, so I think if you can build that relationship with the client, you build their trust. You spend time with them and get them to a place where they feel as though they are safe. I don’t think that process can happen without empathy.”

Perhaps this sense of trust and safety is the foundation on which a successful therapeutic alliance may be established. If a client does not feel a basic sense of trust and safety, it is likely that the client will be closed off and protect any sort of vulnerability. In this way, creating the foundation of safety may set the stage on which interpersonal empathy may take place.

Despite the high praise for an interpersonal sense of empathy in counseling reported above, six of the eleven participants issued cautions regarding the use of empathy in the process of counseling. Participant 05 cautioned that empathy may be “not something that everyone has” and Participant 02 discussed the vicarious pain that can be precipitated by empathy, stating, “I think sometimes having a lot of empathy can make life harder...you see the flip side of that, the shadow side which can be very painful...” The participants here spoke to a sense of realism in counseling regarding empathic engagement with clients. In times of catastrophe such as the COVID-19 pandemic, counselors may find themselves overwhelmed by the struggles of their clients, resulting in burnout, compassion fatigue, and vicarious exposure. This caution aligns with a similar warning documented by Thompson et al. (2014).
Speaking further to experiential factors, this study found that younger participants placed greater emphasis on therapeutic techniques and strategies, whereas the two older participants in the study reported more emphasis on “being with” their clients in the spirit of interpersonal empathy. The oldest participant in this study seemed most comfortable with interpersonally engaging with her clients, helping them to “live around” the pandemic. It is likely that more experienced counselors feel less pressure to “prove” themselves and therefore feel greater comfort in sitting with the client where they are currently at.

Within the theme of interpersonal empathy, several subthemes emerged: understanding the client’s lived experience, understanding barriers to counseling, understanding clients’ SES situations, environmental barriers to interpersonal empathy, and emotional barriers to interpersonal empathy. Each of these subthemes will be addressed throughout this discussion under their appropriate research question.

**Theme #3: Objective Empathy**

All participants in this study discussed empathy in a manner that aligns with Clark’s (2010) concept of objective empathy. The emergence of this theme was likely precipitated by the ongoing stream of COVID-related media that counselors were able to look to better understand their clients’ fears and anxieties regarding the pandemic in an objective sense. Additionally, widespread mental health symptomology precipitated by the pandemic likely stoked counselor analysis of clients’ lived experiences and interventions that might best help them.

Several participants discussed an objective acknowledgement of empathy as important in the process of counseling. Rogers (1951) classically posited accurate empathic understanding as one of the core conditions necessary to achieve successful therapeutic outcomes. The participants’ commentary on the importance of empathy was reflective of this stipulation.
Participants shared their perceptions of empathy as “the number one driver” (01), “essential to counseling” (07), “like a bull’s eye” in the process of counseling (09), and “the baseline of what any therapeutic relationship…should be” (05). All but two participants (05, 08) spoke to the bearing of counselor empathic response on treatment progress. This is reflective of prior research finding that empathic response is a predictor of psychotherapy treatment outcomes (Elliott et al., 2011). Aligning with this prior research, the above participant responses suggest that counselors view empathy with high acknowledgement in the field.

Although it can be argued that empathy is universally needed across all modes of counseling (Feller & Cottone, 2003), two of the participants (06, 07) identified as person-centered therapists, which likely further informed their reverence for the concept of empathy. The finding that all participants viewed empathy as important to the process of counseling was unsurprising, as many researchers (Gesn & Ickes, 1999; Schmid, 2001; Thomas & Fletcher, 1997; Rogers, 1951) have historically spoken to the importance of empathy. However, one participant (03) added a note of caution to her views on empathy, stating, “I think it’s not enough to just have empathy. It’s a good starting point.” The above comments here speak to a need for intentionality when empathizing with clients, informed by goal-oriented treatment and theoretical disposition.

Further speaking to experiential factors, participants who felt more overwhelmed by COVID-related media appeared to exhibit greater avoidance of such content, thereby limiting such media as a potential source for objective empathy. Most participants began the pandemic by consuming “too much” COVID-related media and gradually tapered down to minimal consumption. Additionally, participants who reported a positive experience in supervision generally reported a greater ability to use the information gleaned from supervision as a source
for objective empathy regarding their clients. These stipulations will be further explored within the subthemes on objective empathy.

Within the theme of objective empathy, several subthemes emerged: information from supervision and information from COVID-related media. Each of these subthemes will be addressed throughout this discussion under their appropriate research question.

Implications

Application to the field. Given the accuracy of the integral model in this study, it is likely that counselors in the field may find it helpful to look to Clark’s (2010) model as a means of conceptualizing their empathic responses to clients. Additionally, counselor education programs and counselor trainings may find it beneficial to address the integral model in their educational materials. The researcher did not have an awareness of Clark’s (2010) integral model until he began research for the present study and has found this model to be informative to both this project and his present clinical work with clients.

The finding that empathy is important in the field of counseling has been established across a multitude of studies and has been echoed in the present study. Counselors in the field may wish to pursue training and education regarding administering various forms of empathy with clients, in addition to empathizing with clients from a variety of demographics. Counselor education programs and training organizations may find empathy an important topic to implement in their curricula and training options.

Importance. Because all participants in this study discussed views of empathy that align with Clark’s (2010) concepts of subjective, interpersonal, and objective empathy, it can be implicated that the integral model of empathy posits an effective model for holistically explaining the counselor’s experience of empathizing with clients. This finding of the study is of
considerable importance, as it illustrates the applicability of Clark’s (2010) integral model across a variety of counselor scenarios. It should be clarified that the researcher did not explain the integral model to participants or use any of its terms specifically. Instead, the researcher was able to categorize participants’ organic responses using Clark’s (2010) integral model.

**Research Question #1**

The first research question for this study is “What is it like for counselors to empathically respond to clients’ reported experiences through the medium of telephonic counseling during COVID-19?” The purpose of this question was to broadly inquire into the participants’ lived experience of empathizing with clients through the medium of telephonic counseling during the COVID-19 pandemic with no leading questions. Participants collectively discussed two subthemes related to their empathic response to clients via this medium during the pandemic: imagination, which fell under the master theme of subjective empathy, and understanding the clients lived experience, which fell under the master theme of interpersonal empathy. A description of these subthemes can be observed below.

**Subtheme #1b: Imagination**

As mentioned earlier in this study, Clark (2010) describes the process of imagination as the counselor being able to recall times in which they experienced emotions and events reported by the client, which helps to facilitate “imaginary associations” (p. 349). Because telephonic counseling involves no visual contact with clients, it is likely that counselors must simply imagine what their clients look like and what body language they are expressing when they are speaking with the counselor. Although in-person counseling demands imagination of client’s various scenarios to begin with, telephonic counseling demands imagination in the present moment.
Looking back to Clark’s (2010) definition, Participant 02’s general philosophy on empathy aligned with the process of imagination. This was evidenced in the following comment:

“…if you can somehow relate, you don’t have to directly experience it. I didn’t directly experience it, but I do know I can imagine how painful that would be to not have had my sibling there to support me. That’s the same feeling…everyone has, if you have a sibling and they’re supportive and you don’t have them anymore, that’s a universal it’s going to be painful. So I could imagine how awful that would be.”

In this above quote, Participant 02 speaks to the importance of imagination as an empathic tool for counselors. During the COVID-19 pandemic, it is likely that many counselors strived to empathize with clients who had radically differing experiences that their own. In the wake of such differences, it is likely that counselors must rely on imaginative efforts to empathize with the client’s situation.

Beyond Clark’s (2010) definition of imagination, participants reported that a more literal sense of imagination was required when interacting with clients via telephonic counseling. Participants had to imagine clients’ experiences in their lifeworlds of home life, work life, and so forth, as previously described by Schutz and Luckmann (1973), rather than visual interacting with the client in an office space. This factor afforded participants a look into the daily lives of clients that is usually unavailable to the process of face-to-face psychotherapy, a stipulation further echoed by Cole et al. (1998). Participants made comments on imagination such as, “at certain times, I would try to close my eyes and visualize the client in front of me” (01), “…[lack of visual contact] gives us more freedom of building whatever visual we want to…” (02), and “how is [my intervention] being received?” (04). Participant 07 reported that it was easier for him to imagine telephonic clients that he had previously seen in person. He commented:
“My most regular telephonic client, for example, we started out our counseling relationship in person...And with him I think I’ve had a much easier time expressing empathy and picking up on stuff with him. And, to me, it’s because I was already...familiar with him, and so when I’m talking to him over the phone, I find myself able to picture his expressions and I’m kind of imagining what he looks like, and his non-verbals and things as he’s talking. With clients who I’ve been less familiar with in person, it has been more of a struggle, I think, to have that same level of understanding, and also expressing expression over the phone.”

Regarding the above quote, it is likely that counselors who transitioned clients from a face-to-face to telephonic modality experienced greater ease in imagining the client’s visual appearance and mannerisms in comparison to situations in which the counselor began telephonic sessions with a client who they had never physically seen before. One participant (08) in this study commented that she could sit next to one of her purely telephonic clients in a public space and might never be aware of it. Such unfamiliarity with the client may place a barrier between counselor and client in terms of imaginative efforts.

Many participants discussed having to “check in” with the client due to the lack of non-verbal visuals in session. This observation aligns with Schmid’s (2001) description of empathy as “an ongoing joint checking” (p. 3). Participants made comments such as “we would constantly have to do check-in questions” (01), “having to use more specific language to say, ‘what are you feeling?’, ‘what are you doing right now?’” (02), “I would ask more targeted, direct questions” (08), “moving more into narration, almost” (08), and “asking more questions than I normally would” (10). Participant 02 discussed her experience of processing her response to clients out
loud as a means of checking in with the clients, which later translated into face-to-face sessions. She stated:

“I think I’m right. I think I’m reading it right, but now I have to actually say words. Be like, ‘Wow! I am listening to your story, and this is what I’m feeling.’…Initially it was a very awkward process to have to say out loud, but then ultimately I ended up liking it and I feel like I still use some of those skills”

Based on the above comments, it is likely that counselors administering telephonic counseling must verbally check in with client to compensate the absence of visual contact in the session. The absence of visual cues may necessitate verbal inquiry into how the client received an intervention, how the client is feeling, where the client is at physically, and so forth. It is likely that counselors experienced such experiential ambiguity during telephonic counseling due to the absence of visual contact and had to use such narrative strategies as a form of compensation.

Furthermore, multiple participants in this study discussed how they checked in with clients as a means of assessing the quality of the session regarding the client’s experience. Participants reported, “[I would ask], ‘what's happening with you after I've said this thing?’ to give me some information” (02), “[I would] check in with clients over the phone. ‘How is this going for you? Are you feeling supported? Are you getting what you need?’” (04), and “I would say things like, ‘So, how do you feel about that?’ Or, ‘What do you think about what I just said?’” (08). This ongoing quality control checking is reflective of Rosen’s (2020) reporting that clinicians should routinely ask their patients about their comfort level with receiving virtual care and address concerns about the modality. Based on the above comments, it is likely that counselors must routinely check in with clients regarding the quality of the session, as counselors
so not have visual confirmation such as head nods to indicate the client’s receptivity to given interventions.

**Subtheme #2a: Understanding the Client’s Lived Experience**

Within the master theme of interpersonal empathy, all but three participants discussed gleaning a greater understanding of clients’ lived experiences via telephonic counseling. Because clients were able to access telephonic counseling from the home environment, telephonic counseling afforded counselors an auditory closeness to the client’s natural living space. Counselors were able to hear client’s immediate responses to household stressors, gleaning a more accurate understanding of these stressors than they previously had access to. This factor likely contributed to participants’ commentary regarding better understanding clients’ living situations via telephonic counseling.

Six of the eleven participants discussed advantages to clients being in their natural environment during telephonic counseling. Several participants spoke to the increased insight that telephonic counseling afforded regarding the client’s daily comings and goings in their natural environment. This finding aligns with Van Manen’s (2016) position that people are generally able to be their most authentic selves in the home setting and that home is “where we can be what we are” (p. 102). Participants shared comments such as “you’re able to really see what that’s like for the client and their natural environment” (01) and “[telephonic counseling] was a wakeup call, in terms of people’s experiences” (02). However, in the spirit of understanding the client’s experience from an unassuming position, several participants discussed that they chose to exercise humility in their empathic response toward clients. Participants reported their humility with comments such as, “I truly don’t know what it’s like” (01, 11) and “I can’t even imagine that” (10). Participant 02 further added to this stipulation by
discussing how clients helped her to better understand their experiences through their dialogue in session. She reported that such dialogue “helped me understand” clients’ experiences better, rather than presuming such understanding of clients, and that sometimes it was a “challenge” at times to patiently wait for clients to disclose such information in session. The above comments reflect a need to strive for balance in telephonic sessions regarding accumulating a greater understanding of the client’s natural environment through auditory exposure and approaching from a place of humility.

Due to the politicized nature of COVID-19, several participants reported that they were able to better understand clients’ political points of view from a nonbiased perspective. Some participants discussed the empathic value in the action of “just acknowledging where they’re at” (04) and “just kind of riding along with what [clients] are feeling” (10) regarding clients’ political dialogue. Some participants also acknowledged their role as an unbiased party, stating “it’s not my position to want to change that” (04) and “I’m not there for that” (10) regarding personally conflicting with the client’s political affiliation. Based on these participant responses, it is likely that counselors have the capacity to interpersonally acknowledge clients’ lived experiences when navigating politically charged times such as the COVID-19 pandemic.

Regarding understanding clients’ lived experience, participants who reported working with lower SES clients also reported a greater appreciation for understanding their clients’ living environment at home. Participants who worked primarily with middle to high SES clients did not share this level of enthusiasm, as the home environments of clients were likely of greater similarity to their own. Factors such as lack of space to engage in sessions and chaotic living environments served as a “wake-up call” for participants who worked with clients who lived in poor conditions.
Implications

Application to the field. In telephonic counseling, counselors are forced to verbally check in with clients on a frequent basis due to the lack of visual contact with the client. Regardless of the modality (e.g., face-to-face, videoconferencing, etc.) it is likely that the practice of having to verbally check in with clients may help counselors to better understand and communicate in session. Therefore, limiting visual interface with clients could possibly constitute a method of practicing verbal check-in skills for counselors. This practice could be facilitated by educators in the classroom or supervisors in the field.

Counselors are often left to their own imaginary renderings regarding the immediacy of a client’s natural environment. In telephonic counseling, however, counselors can afford a more direct interaction with the client’s lived experience. This environmental factor, then, may be a unique benefit to engaging in telephonic counseling, as opposed to providing in-person counseling in a traditional office space. Counselors in the field may benefit from considering telephonic counseling as an avenue for helping clients to overcome environmental-based situations such as agoraphobia and hoarding, as such the telephonic medium would allow counselors to engage with clients while they are in the very space that they reference in sessions.

Importance. The findings to this initial research question are important to the field of counseling, as they highlight the counseling techniques that telephonic counseling encourages counselors to use. Greater imaginative efforts from counselors across a variety of modalities could help counselors to check in with clients more regularly and deepen their empathy toward clients via process of imagination.

Moreover, the findings of this study regarding gleaning a greater understanding of the client’s lived experience via telephonic counseling may help the field to incorporate more
experimental methods to better understand client’s home environments, such as incrementally conducting telephonic sessions from home. Perhaps moving beyond the office setting in an intentional manner might help counselors to better understand the daily lives of their clients.

**Research Question #2**

The second research question for this study is, “What has it been like for counselors to transition from in-person to telephonic counseling regarding empathic response toward clients during COVID-19?” The purpose of this question was to inquire into what it has been like for counselors to transition from the modality of in-person counseling session to those conducted over the telephone during the COVID-19 pandemic. Participants collectively discussed three subthemes related to the navigation of this transition: understanding barriers to counseling and understanding clients’ SES situations, both of which fell under the master theme of interpersonal empathy, and information from supervision, which fell under the master theme of objective empathy. A description of these subthemes can be observed below.

**Subtheme #2b: Understanding Barriers to Counseling**

As mentioned above, the sudden transition from in-person to telephonic counseling unveiled barriers to in-person sessions that might not have been previously recognized by counselors. Barriers to treatment such as lack of transportation were suddenly removed when clients began telephonic sessions with their counselors. This dynamic likely contributed to the participants gleaning a better understanding regarding clients’ barriers to in-person sessions.

Across the literature, many researchers (Imel et al., 2017; Lester, 1977; Mallen & Vogel, 2005; Perednia and Allen, 1995; Reese et al., 2016; Smucker Barnwell et al., 2012) have found that telephonic counseling allows for easier access to care for clients. Reflective of this stipulation, all participants in this study discussed that they better understood clients’ barriers to
in-person counseling sessions in their provision of telephonic counseling. For example, all participants commented on telephonic counseling increasing clients’ access to treatment. Participant 01 encapsulated this theme with her statement, “we've…been able to creatively help clients that wouldn't have been helped prior”. Several participants discussed the increased attendance rates that they observed in their transition to telephonic counseling. Participants shared comments such as, “it’s so much more access for people than what they had previously” (08) and “I had people’s attendance rates skyrocket because of COVID and their ability to attend therapy because all of those other barriers were reduced” (01). The improved attendance rates that participants reported aligns with Mohr et al.’s (2008) findings regarding decreased attrition rates in telephonic counseling sessions. Based on the above participant responses, it is indeed likely that telephonic counseling facilitates improved client access to treatment, as barriers such as limited transportation and commute time are eliminated when incorporating this modality.

Participants shared that telephonic counseling allowed clients to overcome various barriers to treatment in counseling. One such barrier was that of transportation to session. Telephonic counseling provides clients with the option of accessing sessions from the comfort of their own home. In this sense, clients are not required to have access to a means of transportation to an office setting, in which face-to-face sessions typically occur. Participants reported that this was especially beneficial to clients who lived in remote areas, sharing comments such as, “we opened the door for people that may be living in remote areas” (10), “Imagine being able to save [a long] drive and being able to still get the kind of quality of care…I think about rural communities; clients who have transportation issues” (01), and “[clients] genuinely have transportation barriers that are very, very real, and we have a way to overcome them” (03). Participants’ responses regarding increased access to care for clients living in remote areas aligns
with Meadows et al.’s (2015) finding that increased location remoteness was consistently associated with lower service use regarding face-to-face psychotherapy.

Further circumventing barriers observed in face-to-face sessions, participants discussed that telephonic counseling sessions offered greater accommodation to clients’ schedules. Participants no longer had to account for time spend traveling to and from an office setting to access sessions. Participants shared comments such as, “because of [my client’s] work schedule, he was no longer able to do [in-person sessions], so then we switched to telephone sessions” (07), “[my client’s] kids were home, and she wanted to go on a walk and talk…So she ended up having a phone session” (06), “I have people that had sleeping babies…they can have their appointment and not have to drive here” (10), and “[telephonic counseling] is still meeting [clients] where they're at and they're still able to get therapy, when they otherwise might not have been able to” (01). Several participants also shared that some clients adopted a preference for the telephonic modality over both face-to-face and videoconferencing. Participants shared comments such as, “there’s one client that I’ve seen…He likes the phone [counseling sessions], he has kids, he’s busy” (09) and “A lot of [clients] were very happy to not have to travel or leave their house or whatever it might be” (03).

In addition to overcoming barriers that are observed in accessing face-to-face counseling, participants reported that telephonic counseling eliminated barriers that clients may experience in accessing videoconferencing sessions. One such barrier was lacking Wi-Fi. This finding aligns with the CDC’s (2021) caution to practitioners that limited access to resources, such as computers, smartphones, and Wi-Fi may present a barrier to access for clients. Participants shared comments such as, “if I did primarily phone sessions with clients, that was because they didn’t have the Internet for whatever reason” (09), “I did have…[clients] that did not have Wi-Fi
or had privacy issues or had a flip phone, so we did do phone calls” (10), and “some clients had the worst Internet ever. It was awful….we would have…sessions over the phone” (06). The above participant responses suggest that, even if clients have access to technological devices such as computers and smartphones, they may nonetheless face a barrier to treatment due to lack of Wi-Fi.

Even if a client possessed a device that could access videoconferencing sessions and was part of the 74% of US households that have Internet access (US Department of Commerce, National Telecommunications and Information Administration, 2020), participants reported that technological barriers could nevertheless arise. Several participants discussed that they used telephonic counseling as a backup if clients experienced technological issues with videoconferencing. Participants shared comments such as, “I ultimately switched some clients over to using the phone, it was when I tried using Doxy, and I tried using zoom…phone was the next best thing” (06) and “…if there's some kind of delay on my side, if there's a delay on their side, and it's too disruptive for the session…I'm going to call [the client] on the phone, because I can” (09). As an additional stipulation to technological barriers, Participant 11 discussed that videoconferencing sessions presenting more learning barriers to clients with developmental disabilities and cognitive deficits, She stated the following:

“…I think [telephone] was a little bit easier [than videoconferencing], mainly because people know how to operate a phone, and how to make phone calls, how to receive phone calls, versus Zoom. I did hit a lot of barriers…there can be some developmental disabilities, some cognitive deficits, and that inability to problem solve…it that much harder for that individual to figure out Zoom.”
The above quotation suggests that intellectual barriers may stand in the way of clients accessing videoconferencing sessions. Clients who are less socialized to using technological devices and problem solving with such devices may find engaging in videoconferencing to be an unfamiliar and intimidating process. Conversely, clients will likely find greater familiarity with and accessibility to telephonic sessions. In this sense, presenting telephonic counseling as an option for clients may offer reasonable accommodation to clients’ level of intellectual function.

Additionally, many participants discussed an improved sense of comfort reported by clients in telephonic sessions. This finding aligns with several authors’ (Bollnow, 1960; Heidegger, 1971) commentary on home as the secure inner sanctity in which we can feel protected and by ourselves. For example, Participant 03 discussed that she was “very happy to be able to provide that to the people who, counseling would normally be a stressor; it no longer had to be a stressor”, as her mandated clients no longer had to drive to face-to-face sessions when telephonic counseling became an option. Participant 08 further spoke to this sense of comfort, stating, “they’re sitting there talking about things and they’re petting their cat, or their dog’s next to them, or they’re…covered up with their favorite blanket”. Participants also discussed that telephonic counseling provided a “buffer” or “barrier” to the stress and exposure typically observed in face-to-face counseling. Participants shared comments such as, “[clients] almost appreciated having a little bit of a buffer, a little bit of an emotional or psychological distance by not showing their face” (04) and “having…that invisible barrier of not being in person or face-to-face, it allowed people to feel completely safe to be completely authentic and transparent” (05). Participant 02 further added to this stipulation, discussing that counselors may use varying degrees of telephonic counseling to gradually exposure clients to the full experience of face-to-face psychotherapy. She commented, “…if you have someone with social phobia, why not
incorporate [telephonic counseling] into the process of therapy? Have that be a gradual exposure process”.

The above participant responses suggest that telephonic counseling may help to accommodate clients’ varying levels of comfortability with the counseling process. For some clients, receiving counseling from a foreign, clinical environment may present feelings of overwhelm that they are not yet prepared to encounter. Telephonic counseling may help to provide a scaffolding process that considers clients’ individual levels of preparedness regarding engaging in the counseling process. From a pragmatic standpoint, the telephonic modality could help to decrease no-shows and cancellations precipitated by clients’ lack of comfortability. From a treatment-based perspective, telephonic counseling could help clients to gradually overcome their own level of discomfort regarding engagement in the counseling process.

Several participants also discussed the reduced stigma that clients reported in telephonic sessions. This finding aligns with Wilson et al.’s (2017) position that receiving services from home may help to reduce the stigma associated with mental health services. Participant 01 spoke to her clients’ emotional reaction to this stigma, stating, “there’s that added layer of nervousness that I think people feel in whatever therapy office, just because of what it is”. By contrast, Participant 05 discussed the decreased sense of stigma inherent in telephonic counseling, stating, “I felt like I was the most connected with them that I had ever been because they felt like they could just be authentic, just themselves, and I couldn’t judge them”. Although it has mitigated in recent years, the stigma associated with counseling services prevents many clients from accessing treatment who otherwise may have benefitted from the counseling process. The above participant responses suggest that telephonic counseling may help clients to overcome the stigma associated with the counseling process due to its estrangement from a traditional clinical setting.
**Subtheme #2c: Understanding Clients’ SES Situations**

In addition to gleaning an increased understanding of clients’ barriers to in-person counseling sessions, all participants reported a greater understanding of client’s SES situations in their provision of telephonic counseling. This finding aligns with other claims in the literature that mental health services via telephone may allow clients to receive such services with fewer financial barriers (Brenes et al., 2011; Reese et al., 2006). During a massive disaster event such as a global pandemic, it is likely that lower SES clients will be affected more severely, as they have less access to protective factors such as finances and living space. This factor likely contributed to several participants in this study reporting that their lower SES clients were more significantly affected by the COVID-19 pandemic.

Perhaps a more obvious finding in this subtheme was lower SES clients having limited access to resources such as technology and Wi-Fi. Under particularly grave circumstances, clients might not have access to a phone, let alone more advanced forms of technology. This experience was illustrated by Participant 02, who stated that she sometimes worked with “people not having phones, or their phones malfunctioning, or their phone was turned off because they can’t pay for it”. Participant 07 spoke more toward lower SES clients lacking access to additional technologies, stating, “clients [who] are lower SES might have less access to a laptop or computer and might be more likely to only be able to do over-the-phone sessions” (07). Adding to this notion, Participant 05 discussed that working primarily with lower SES clients had a bearing on the amount of phone sessions she did. She then commented, “[If I worked with higher SES clients], I think that there’s probably a good chance it would be more video sessions”. The above participant responses suggest that sheer lack of technology may be a barrier to clients.
accessing videoconferencing sessions, which may ultimately necessitate accessing treatment via telephonic counseling.

Additionally, Participant 11 commented that lack of Wi-Fi in client homes precipitated attrition in her caseload, stating, “I had a lot of no-shows, and a lot of non-attendance because people not having their Internet connected” (11). This barrier was echoed by Participant 09, who stated, “I think a barrier, honestly, for some, had been having Internet available”. Two participants (08, 09) discussed the phenomenon of homeless clients having access to phones, however, both participants commented that these clients may nonetheless lack access to Wi-Fi, retaining a barrier to videoconferencing sessions. In such cases, the client was able to access telephonic sessions but not videoconferencing sessions. During an age in which face-to-face sessions were not a possibility, the telephonic medium was the only option for these clients. As Participant 10 stated, “the most important thing to me was to have that client have access”. As mentioned earlier in this study, these participant responses suggest that, even if clients have access to technology such as computers and smartphones, they may nonetheless find access to videoconferencing impossible due to lack of Wi-Fi.

Several participants also commented that some lower SES clients chose to engage in telephonic rather than videoconferencing counseling due to the client’s living environment. For example, Participant 01 shared that one of her clients had to “go into their car and not have it running, but just sitting in their car, because they don’t have their own space”. Her clients did not have a “nice home office” from which to engage in videoconferencing sessions. Therefore, telephonic sessions were the preferred medium. Participant 11 shared a similar experience, stating that some clients against videoconferencing sessions due to a sense of embarrassment regarding their living environment. As the participant shared, “they don’t want me to see what
their place looks like”. These participant responses suggest that clients in the field may wish to engage in telephonic counseling due to lack of physical space available in their living environment. If a client has to leave the house and engage in sessions from a location such as a parked car, it is likely that telephonic counseling may be more easily accessed than videoconferencing, which may be compromised due to the client being out of Wi-Fi range.

Two participants (06, 07) reported working primarily with middle to upper SES clients. Both participants reported primarily delivering videoconferencing sessions to their clients, as their clients had greater access to resources needed to engage in videoconferencing counseling. However, both participants also reported regularly engaging in telephonic counseling with clients who chose this medium in the interest of convenience, rather than necessity. As Participant 07 stated, “I think the clients that I see over the phone, it’s largely been more out of convenience for them than necessity”. Participant 06 noted a similar experience, stating that some middle to upper SES clients chose to have poor Wi-Fi in their home as a financial choice, rather than a necessary dearth. She stated, “It’s more of the option to have good or bad Wi-Fi [for higher SES clients]…They just might not care. It’s just not as much of a priority to them”. Based on the above participant responses, counselors in the field may encounter clients in the field who wish to engage in telephonic counseling out of preference, rather than necessity. Factors such as level of comfortability regarding engagement in the counseling process and living environment may bear on a clients’ preference regarding engage in telephonic counseling, as opposed to other mediums.

Several participants also shared that working with lower SES clients during COVID-19 presented greater focus on the fulfillment of basic needs. Participants were not often afforded the experience of helping these clients toward a sense of “self-actualization”, as Participant 06
stated. Instead, “a lot of the therapy was focused on just the day-to-day” (01). Much of this day-
to-day navigation was impacted by financial concerns. Participant 03 commented on such
corns, such as “‘Am I going to keep my house? Am I going to be able to pay my bills?’, et
cetera”. Coupling these concerns with the global pandemic likely further exacerbated clients’
difficulties. As Participant 02 stated, “anytime you have a crisis in general, people in poverty get
hit harder”. This led to a “fear of scarcity. And/or fear of access [to resources]” (08). To remain
sensitive to such experiences, participants assumed an approach that focused on the fulfillment of
basic needs. As Participant 04 commented, “‘your power shut off; your water’s turned off. We
can’t do any of that work together until we figure out those basic needs’”. Because of this
dynamic some participants felt as though their role as counselor overlapped with a that of a
social worker. Participant 11 illustrated this point, sharing, “I felt a little bit like a social worker.
Like, ‘Hey, I’m trying to connect you with these services’”.

The above participant comments on focusing on more basic needs of lower SES clients
during COVID-19 suggest that lower SES client were more severely impacted by the pandemic.
As such, counselors likely had to attend more to baser needs than engage in counseling from the
angle of introspection and self-actualization. From an interpersonal perspective, providing
telephonic counseling to lower SES clients likely helped counselors to better understand the
unique struggles of such clients during the pandemic.

Subtheme #3a: Information from Supervision as a Source for Objective Empathy

In the sense of objective empathy, all participants discussed that they were able to use
supervision as a means of better understanding clients’ lived experiences and as a means of
staying grounded during the pandemic. During an otherwise uncertain time, it is likely that
receiving supervision helped counselors to remain grounded and better navigate the pandemic.
from the perspective of a counselor. Supervision likely helped counselors to objectively understand clients’ struggles and identify strategies and techniques that might help clients better navigate the COVID-19 pandemic. Such factors likely brought about the emergence of this subtheme.

Four participants (01, 02, 04, 07) spoke highly of their experience in supervision, five (03, 08, 09, 11) reported a more neutral experience, and two (05, 06) participants reported a negative experience in supervision. Several participants discussed how supervision helped them to navigate the newness of telephonic counseling and better empathize with clients’ experiences in an objective sense. Participants made comments such as, “[lack of visual contact with clients] would cause a lot of uncertainty with me. That was important for me to process in supervision” (03), “there was also ongoing supervision with my supervisor because weird situations, like, what happens when a client is driving their car, or you can hear them ordering fast food in the background?” (01), and “[supervision] has been really helpful for getting me through those stuck points” (04). From a supervisor perspective, Participant 10 spoke to her experience helping her supervisee navigate the newness of telephonic counseling. Specifically, the participant discussed how she helped her supervisee to use greater narration in her sessions to compensate for no visual contact with clients, which aligns with subtheme #3c explored earlier in the discussion. She shared:

“Well, I could see [my supervisee]…I talked to her about narrating a little bit more…asking questions. Maybe you don’t see someone crying. If someone were upset and you weren’t sure, maybe you could…ask verbal cues.”
The above quotation highlights the importance of the supervisory role during a crisis event such as the COVID-19 pandemic. Although supervision provides a vital function in counseling during more normal times, it is especially crucial during times of mass disaster and uncertainty. This finding speaks the importance of supervisor preparedness during a disaster event, in addition to the importance of counselors seeking out supervision during such times.

Additionally, several participants discussed that supervision helped them to facilitate improved confidence and skill in their delivery of telephonic counseling and objective acknowledgement of clients’ presenting concerns. Participant 02 discussed how her receipt of telephonic supervision provided a model of sorts regarding her own provision of telephonic counseling, stating, “having that model of how [my supervisor] approached our supervision”. Participant 07 discussed that he was able to discuss his telephonic cases in supervision, and that he able to do so allowed him to “feel very fortunate to have had a good supervision support network throughout COVID”. This statement resonated with Participant 11’s own experience, as she commented that supervision “prepared me for [telephonic counseling], might say”. The above participant responses suggest that counselors looked to supervision as a means of bolstering their confidence and objective understanding of clients’ experiences.

Lastly, two participants in this study operated in supervisory roles at their respective practices. These participants reported providing support to supervisees during the pandemic, which resulted in more emotional exhaustion. Less experienced participants reported engaging as supervisees in the supervisory process, noting an improvement in their groundedness and confidence in their receipt of supervision. Based on these findings, it is likely that counselors in the field who did not receive supervision during the pandemic may have experienced a considerable deal of uncertainty regarding their progression through the pandemic in the role of
counselor during the pandemic, underscoring the importance of supervision during a disaster event such as COVID-19.

Implications

Application to the field. The COVID-19 pandemic was an unexpected event that suddenly forced counselors across the world to adopt remote modalities, such as telephonic counseling. Many participants in this study reported a pervasive sense of anxiety and discomfort in this sudden transition from face-to-face to telephonic counseling. To mitigate such anxiety and discomfort, agencies and practices may wish to properly train counselors in telephonic counseling before allowing them to pursue the modality. This training may help counselors to familiarize themselves with best practices in telephonic counseling and barriers that they may encounter when providing this mode of counseling to clients. Such training could also be provided in counselor education programs to help counseling students to familiarize themselves with telephonic counseling prior to incorporating the medium in the field.

Moreover, agencies and practices in the field may wish to gradually transition counselors between modalities, such as face-to-face, telephonic, and videoconferencing counseling. Participants in this study reported that much of their anxiety was precipitated by the suddenness of their transition to telephonic counseling. Counselors in the field may wish to gradually shift between modalities, rather than suddenly transitioning all sessions to another modality such as telephonic counseling.

Furthermore, participants in this study reported that clients negotiated fewer barriers in accessing telephonic counseling than in face-to-face counseling. It is likely that many clients find it impossible to access face-to-face sessions due to barriers such as lack of transportation and geographic distance. In remote and low-income areas, clients may benefit from agencies and
practices offering telephonic sessions, as these clients may face significant barriers regarding accessing in-person appointments.

Another implication gleaned from participant responses is that telephonic counseling provides greater accommodation to clients’ schedules than in-person counseling. Factoring in working hours with a client’s commute time from home, to work, to a counseling office, to back home again may render in-person counseling an unrealistic addition to their schedule. Telephonic counseling, however, could help to eliminate additional commuting on the part of the client and provide access to counseling services to clients who had previously viewed such services as a logistical impossibility.

To the above implications, one might argue that videoconferencing counseling can just as readily eliminate transportation and scheduling barriers. However, another barrier identified by participants in this study was lack of Wi-Fi. Without Wi-Fi, clients are not able to access videoconferencing services, and with poor Wi-Fi, these services are rendered impossible on a nearly equal level. This stipulation was reflected by the participants (06, 07) in this study whose clients chose poor Wi-Fi as a financial convenience, rather than a necessity. In such cases, the counselor is forced to switch to telephonic counseling and continue future sessions through this medium. If telephonic counseling were rendered unavailable or unreimbursed by insurance companies, however, counseling in any sense would be made impossible. This notion of technology as a barrier is further reflected by other researchers (Cipolletta et al., 2018; Etzelmueller et al., 2018; MacMullin et al., 2020) who have found that the most significant barrier to using technology in counseling may be the technology itself, and that technical difficulties experienced in the provision of telehealth services may be damaging to the therapeutic alliance (Lustgarten & Elhai, 2018).
Participants in this study also implicated that telephonic counseling offers clients a greater sense of safety and reduced stigma. This finding aligns with several authors in the literature (Lester, 1977; Reese et al., 2002) who reported that the lack of visual contact unique to telephonic counseling may grant a perceived anonymity to clients that accelerates disclosure in session. When clients are required to drive to an unfamiliar office environment, they may feel anxious and stigmatized. Receiving telephonic counseling in the privacy of their own home, however, may help client to feel a reduced sense of shame and stigmatization. For clients who feel especially weary of being stigmatized, such as public figures, telephonic counseling may be an effective means of promoting confidentiality and limiting public awareness of their treatment.

Another implication gleaned in this study is that telephonic counseling may be especially helpful to lower SES clients. Due to limited access to resources such as Wi-Fi, living space, technology, and transportation, telephonic counseling may help to reduce barriers to treatment for lower SES clients. If telephonic counseling universally lacks insurance reimbursement and other levels of systemic approval, lower SES clients will likely receive greater system barriers to treatment, whether these barriers are intended or not.

Another finding of this study is that lower SES clients were more significantly affected by the COVID-19 pandemic due to fewer protective factors, such as adequate living space, finances, and technology. Therefore, counselors may find it necessary to incorporate level 1 (Rosen, 2020) crisis interventions when working with clients who have been deeply affected by future disaster events. Clients who are less immediately impacted by such events may benefit from counselors imparting level 2 interventions (Rosen, 2020), as these clients are likely not experiencing immediate crises.
Participants in this study also reported that they found a sense of comfort and groundedness in the process of supervision. With the help of supervision, training, and education, counselors may find greater ease in transitioning from in-person counseling to the telephonic medium. In future disaster events akin to the pandemic, counselors may find supervision to be a source of security and comfort in otherwise uncertain circumstances.

**Importance.** Systemic problems such as widespread poverty and global pandemics are largely out of any counselors’ scope of control. However, facilitating accessible treatment in response to such events is well within the parameters of both agencies and individual practitioners. Counselors have the power to allow clients greater access to treatment via telephonic counseling, an important finding of this study. Without telephonic counseling, clients may be met with barriers regarding transportation or technological deficits. Therefore, telephonic counseling provides a service to clients who might have otherwise been obstructed from access.

Additionally, telephonic counseling allows counselors a first-hand, auditory experience of a client’s home environment. In an office environment, counselors are left to their own imaginative resources as a means of depicting a client’s natural home environment. This study, however, found that counselors can glean a more intimate understanding of the client’s everyday lived experience via telephonic counseling. This finding could be important to counselors in their empathic efforts to better understand clients’ everyday lived experiences.

Moreover, this study found that counselors may find the experience of supervision to be grounding in the navigation of a large-scale disaster event, such as COVID-19. This finding is important to the field, as practices and agencies alike may place emphasis on supervisory efforts when crises occur that impact a community, if not the entire world.
Research Question #3

The third research question for this study is, “Is there a difference in counselors’ empathic response regarding face-to-face and telephonic counseling during COVID-19?” The purpose of this question was to inquire into any differences that participants observed in their provision of empathy in telephonic and face-to-face counseling. Participants collectively discussed two subthemes related to the difference in empathizing with clients through these mediums: intuition, which fell under the master theme of subjective empathy, and environmental barriers to interpersonal empathy, which fell under the master theme of interpersonal empathy. A description of these subthemes can be observed below.

Subtheme #1c: Intuition

Because telephonic counseling involves only a vocal channel of communication with the client, gathering an intuitive understanding of the client is likely different than empathic engagement observed in face-to-face counseling. This stipulation was reflected in the responses of participants, as all participants in this study discussed differing intuition regarding empathic response toward clients in telephonic counseling. Generally, counselors are adapted to combining information channels regarding both visual and auditory input. Absence of the visual channel likely contributed to participants in this study discussing differences in intuitively empathizing with clients when engaged in telephonic counseling.

Six of the eleven participants discussed the topic of greater emphasis on vocal tonality in the delivery of telephonic counseling sessions. This finding was reminiscent of Kraus’s (2017) commentary on paralinguistic vocal cues, which play a prominent role in accurate judgements (Hall et al., 2005). Several participants discussed greater attentiveness to the tone of their clients’ voices over the telephone, making comments such as, “without the visuals you have to really
focus on the tone of [the client’s] voice” (01), “I had to do a lot more listening to the details of stories” (02), and “I have to really revisit those listening skills, and hearing tones” (11).

Participant 07 added a further layer of complexity to this stipulation, commenting on greater difficulty interacting with the paralinguistics of adolescent clients than with adult clients. He stated:

“I feel like it’s a lot easier to read even stuff like tone of voice and things with adult clients over the phone versus with adolescent clients, which then, of course, impedes your ability to empathize with them, because you’re not quite as clear where they’re at with things in the moment. And to me…it feels like a lot of it is the adolescents are just less comfortable phone conversation. And so picking up on like, ‘Okay, are you just being awkward right now, or are you upset or angry or irritated?’, is to me more difficult to get an accurate read on.”

The above quotation illustrates the layers of nuance inherent in intuitively empathizing with clients via telephonic counseling. Factors such as client’s social adaptation to the telephonic medium and their personal level of comfortability may bear on the content that is made available to the counselor in session. Speaking more broadly to the other participant comments above, counselors likely had to pay greater intention to the paralinguistics of clients in telephonic sessions due to the absence of visual contact.

In addition to placing greater emphasis on hearing the tones of clients, several participants commented on their greater attentiveness to vocal delivery through telephonic medium. In this way, participants increased their focus on both content and valence (Ickes, 1990) in their vocal interaction with clients. Participants reported experiences such as, “you have to show [the client] your emotion and what you're emoting through…the ups and downs of the
voice” (02), “I really had to become more conscious of my tone, my delivery…you really have to lean into it” (04), and “I really have to fine tune my verbal confirmation, my verbal reflections” (11). Participants further added to this topic by discussing their growth in the direction of greater emphasis on vocal tonality. This was evidenced by statements such as “your only sense that we have available is speech, so that tightened” (02) and “the journey and learning growth, [telephonic counseling] has really fine-tuned my counseling skills” (11). Moreover, Participant 03 shared that writing process notes on a notepad during telephonic sessions helped her to stay grounded and attentive to the client’s voice. She stated:

“…when I was keeping the notes, it really did keep me grounded and focused in the session, and trying to stay attuned to the client. It was almost my version of direct eye contact and not taking notes in an in-person session…with telephonic, if I’m intently looking at my notes and kind of tracking things, I’m not looking at them because we’re already not looking at each other (laughs).”

The above participant responses suggest that the intuitive engagement with clients via telephonic counseling involved verbal output of the counselor, in addition to input. Just as the counselor is limited to the content and valence of the client’s voice, so too is the client to the voice of the counselor. As such, counselors likely had to be aware of the nuances of their vocalizations, as they were not able pair them with body language.

Across the interviews, all participants reported thoughts on visual versus verbal empathy. In telephonic counseling, the counselor does not have visual contact with the client, cutting off the avenue of visual empathy. Therefore, the counselor is left with only verbal empathy when providing counseling through this medium. For many participants, this dynamic precipitated a perceived barrier between counselor and client. Participants shared comments such as
“[telephonic counseling] was very impersonal, not even seeing somebody—seeing their face” (03) and “I’m a very visual communicator….that was a huge barrier with phone” (08). Additionally, several participants discussed a sense of disconnect with clients that presented a barrier to empathy. Participants shared comments such as, “what are they emoting in the moment?...[it was] hard to understand what was happening” (08), “are they really be impacted by what you said?…it’s almost like doing therapy blindfolded” (10), and “I can open my mouth to start to speak, I can even get half a sentence out and sometimes clients will still steamroll over” (04). Speaking further to a greater sense of difficulty regarding empathizing with clients via telephonic counseling, participants shared comments such as, “it was so hard to sometimes read their emotions accurately when you couldn’t see anything with them” (06), “[telephonic counseling] was hard…there’s no body language (08), “you don’t have [visual contact in telephonic counseling]…it puts…your empathy to the test in that way” (02), and “you don’t really have that ability to see the person…non-verbals that they’re giving you” (11).

The above commentary on the lack of visual empathy in telephonic sessions suggests that lack of visual contact with the client did indeed present a barrier to empathy. It is likely that verbally checking in with clients was necessitated by the presence of this barrier. Although lack of visual content seemingly caused sessions to become more difficulty, this factor did not present an impassable barrier. Rather, lack of visual contact presented a barrier that demanded greater investigation in a verbal sense from counselors.

Additionally, some participants reported greater empathic accuracy toward clients they could see. Participants shared responses such as, “I think there’s just so much more value to be able to see a person as they’re speaking, versus hear” (01) and, “it was probably easier for me to empathize with people that I could visualize” (03). Participant 10 placed particular emphasis on
visual empathy, stating, “I’d say visual is…half, if not three-fourths of what [counselors] do”. These participant responses suggest that counselors’ empathy toward clients largely benefits from visual contact with the client. This finding aligns with other researchers’ (Egan, 2014; Ekman, 1982; Hill & Stephany, 1990) consensus that physical signals are important sources of information for identifying and understanding emotions.

A possible reason that participants spoke so highly to the importance of visual empathy was that having this channel of communication in conjunction with verbal empathy may facilitate increased empathic understanding. As Participant 06 stated, “sometimes clients will have a tone of voice that doesn’t really reflect their facial expression or their body language”. This response echoes a caution posited by several authors (Aviezer et al., 2012; Harris & Birnbaum, 2015; Russell, 2018) regarding the potential for increased misunderstandings and miscommunications due to reduced face-to-face context present in telephonic counseling, such as body cues and facial expressions. Use of visual empathy, then, may be considered along with the client’s verbal input as a means of gleaning better understanding of the client’s experience. This notion is reflective of Max Pagès’ (1974) idea of expressive pluralism and Hall and Schmid Mast’s (2007) comment that “having more channels can increase redundancy and also increase the likelihood that relevant information will occur in at least one of the channels” (p. 444).

Further speaking to the benefit of a more holistic empathic approach, participants reported comments such as, “there’s a lot of things in therapy that are not only verbal” (10) and “as counselors, I think we’re taught to look at the entire client when we’re talking to them” (06). Participant 07 shared his view of verbal and visual empathy as equally important channels of communication, sharing, “nonverbals, and then paraphrases and stuff. But I feel like…typically, I rely on a balance of both”. These comments suggest that counselors may benefit from a balance
of both visual and auditory content in session regarding empathic response, and aligns with Archer and Akert’s (1980) finding that visual and auditory cues produce roughly equal levels of empathic accuracy.

Because telephonic counseling does not allow for such a holistic approach, several participants offered their critique on the matter. Participants shared comments such as, “you can read the subtext so much more clearly face-to-face versus over the phone” (04), “physical presence in [counseling] is very, very important. I didn’t think [telephonic counseling] was as effective” (10), and “in person, you can still get those non-verbals and stuff, but then on phone you don’t get that” (11). Some participants also commented on their experience of silence in telephonic counseling and how it was different from previous experiences in face-to-face counseling. Participants shared responses such as, “silence is hard to hold” (08) and “you run into not knowing always what that silence means. Are they thinking? Are they upset about what you said?” (10). The above participant comments suggest that various subtleties in telephonic counseling may be missed due to the lack of visual engagement with the client, and that silence may be more ambiguous due to the counselor not knowing the causation of the client’s silence.

Several participants also commented on the limited expression of visual empathy that they had access to in telephonic counseling. In face-to-face counseling, counselors have the option to lean forward in their chair, nod their head, and furrow their brow to convey a sense of concern and empathy. In telephonic counseling, however, counselors do not have this option. As Reese et al. (2016) comment, telephonic counseling does not afford counselors the “benefit of the doubt” (p. 262) regarding appearing as though they are empathically responding to the client through use of body language. Participants shared comments such as, “you get to use physical signals when you have just so much more in your tool belt when you’re when you’re in person”
“I think it’s fairly easy to empathize in-person, because you have to, right? As a clinician, you have to engage. Just reading [the client’s] body language, their expressions. They could do the same thing for us. So, it’s kind of like an act. You have to click that act up. Whether you want to be empathetic or not, you have to. Because they physically see all responses from your body. So it’s more of a controlled empathy.”

The above quotation speaks to a kind of pressure that counselors may feel to present as visually empathic in face-to-face sessions. In the absence of visual contact with clients, the client may be left to assume how the counselor is empathically responding to them, just as the counselor is left to a similar state of ambiguity regarding the client’s response to interventions. As such, the counselor may wish to exercise intentionality regarding their use of minimal encouragers in session such as “uh huh”, and verbally confirm their presence with the client by saying phrases such as, “I’m with you”.

Across the interviews, all participants commented on a sense of separation from the client that they experienced in telephonic counseling. Participant 06 summarized progressive degrees of separation from face-to-face, to videoconferencing, to telephonic counseling. She shared:

“There’s multiple degrees of separation through telehealth, and seeing someone on Zoom, but not being in the physical space with them, that’s one less degree. And then when you do it on the phone, that is even one less degree than something through Zoom or Doxy, because you can’t see their face at all.”
It should be noted here that Participant 06 incorporated telephonic counseling as a secondary option to videoconferencing counseling, perceiving the medium as lacking in comparison to both face-to-face and videoconferencing counseling. It is likely that her work with middle to high SES clients precipitated this perspective. Although perceiving telephonic counseling in “degrees of separation” from face-to-face counseling has merit, it may also be reductive to rank it in such simplistic fashion. That is, telephonic counseling offers unique benefits that no other modality does, such as presenting a visual buffer for the client, and therefore should not but simply held in regard as definitively “less than” other modalities.

Further speaking to the topic of feeling separated from the client, participants shared comments such as, “I feel much more connected in person with people than over the phone” (07) and “[you] don’t really have the capability of having that person-to-person relationship [in telephonic sessions] like your in-person sessions” (11). Adding further commentary on this notion, Participant 09 shared the greater sense of separation that she felt from her clients when she conducted telephonic intakes. She shared, “[telephonic intakes] felt messier. They fill schlocky, and I noticed that I wasn’t as dialed in for an intake over the phone”. This finding aligns with Glueckauf et al.’s (2018) finding that therapists reported that they were “slightly or not at all confident” they could provide telehealth services without an initial in-person assessment. Regarding these participant comments, it is likely that the sudden, unexpected transition from in-person to telephonic counseling contributed to participants’ experience of telephonic counseling being “messier” and less personal.

Participants also commented that a lack of nonverbal verbal cues further added to the perceived sense of separation from the client. Participants shared comments such as, “there is that lens of separation with being able to have that experience and be able to read the nonverbal
cues” (01) and “[lack of visual contact] creates more of a barrier” (02). Participants also commented that being in a separate physical space than the client contributed to a perceived sense of separation from the client. Participants shared comments such as, “there’s nothing like engaging with a person in their space” (05), “not knowing where someone’s at physically [can be a barrier]” (03), “it’s a lot easier for me to be with a client in person than to really be with a client…over the phone or virtually” (06), and “I can’t do my usual pass-a-box-of-tissues [in telephonic counseling]” (11). Based on these participant comments, it is likely that the physical separateness between counselor and client observed in telephonic counseling precipitated the perception of empathic separateness from the client. Previously receiving training and experience exclusive to face-to-face counseling may have contributed to this perception of separateness.

Additionally, participants voiced a concern regarding a sense of ambiguity regarding whether the counselor and client were “with” one another during a telephonic counseling session. Participants shared comments such as, “I think we’re together. I think we’re in the same place right now, but I’m not 100% sure” (04) and “[my client] will throw out comments like, ‘Oh, are you even there?'”. Perhaps one further deviation in separation from a sense of ambiguity is a certainty of disconnection from the client. Participants commented on this experience, sharing comments such as, “there were times when [clients] would just stop listening to me” (10) and “there are times when you’re processing something pretty heavy or emotionally laden, and then suddenly…[the client] can’t reach you” (08). Traditional face-to-face counseling involves the counselor and client in the same office space with no technological medium connecting the two. Suddenly removing visual contact and sharing the same physical space, and adding potential technological issues likely contributed to participants’ sense of ambiguity and potential disconnection when proving telephonic counseling.
Several participants in this study discussed that they took preventative measures regarding the sense of separation experienced with certain clients via telephonic counseling. For example, Participants 07 and 08 shared that they chose not to engage in telephonic sessions with children due to clients of this age not achieving success through this medium. As Participant 08 stated, “there’s no way I could have done sessions with kids on just a phone”. This finding suggests that counselors may wish to exercise intentionality regarding what clients they deem appropriate candidates for telephonic counseling. That is, if a client is not intellectually capable of engaging in sessions with no visual contact, or simply does not feel comfortable with the medium, the counselor may wish to pursue other modalities that would better fit the given the client’s interest and abilities.

As discussed in Chapter II of this study, several studies in the literature (Dilley et al., 1971; Hall & Schmid Mast, 2007; Reese et al., 2016) show no significant difference in voice-only content versus other modalities, and two studies (Gesn & Ickes, 1999; Kraus, 2017) show greater empathic response to voice-only content than other modalities. One potential limitation of these studies is that they do not consider the growth process that may occur for counselors regarding empathizing clients via face-to-face counseling to doing so via telephonic counseling. They pose such experiences as static variables to be compared. In the present study, however, the participants shared that their empathy in telephonic counseling was far from a static phenomenon, as it changed and grew. Participants made statements such as, “[telephonic counseling] made me a better counselor” (02) and “[My empathic listening skills] were definitely put to the test [in telephonic counseling]…it pushed me” (11). Moreover, Participant 05 discussed how she had to increase her focus and engagement in sessions through the telephonic
medium, saying, “[in telephonic counseling], you have to be super engaged. You have to really be present”.

**Subtheme #2d: Environmental Barriers to Interpersonal Empathy**

Another notable difference between in-person and telephonic counseling is that telephonic counseling does not take place in a traditional office space. Environmental distractions may occur on both the client’s and counselor’s end, which may interfere with the counselor’s efforts to interpersonally empathize with the client. This experience was reflected by participants in their interviews, as all participants reported that environmental barriers occurred in telephonic counseling that interfered with their empathic response toward clients. For example, several participants discussed the difficulty they experienced in establishing a therapeutic environment through this modality. Participants shared comments such as “[telephonic counseling] required more focus and more emphasis than if I would just sit in a room with somebody where it feels more natural” (03) and “I have had to work a lot harder to create that space and presence to be there present with clients [in telephonic counseling]” (05).

As a means of facilitating therapeutic space via telephonic counseling, some participants spoke to an increased sense of intentionality that was required. Participants shared comments such as, “keeping diligent notes as I was talking was really my way of creating intentional space and tracking” (03) and “I’m having to completely put blinders on for a second, especially in those moments where they’re needing a lot of empathy, and just sit with just them” (04).

In traditional face-to-face counseling, sessions take place in a structured office space that is separate from the homelife of the counselor. In telephonic counseling, however, the counselor may engage in sessions from home, a place in which distractions may more easily occur. The
above participant comments suggest that counselors may wish to be intentional about creating a space at home from which they may engage in telephonic counseling with optimal focus.

Once a therapeutic environment was established in telephonic counseling, participants reported that they experienced distractions in their environment that could decrease their focus in session. Participants reported distractions such as, “I can try to fix my hair or do something small” (01), “let me organize this quick” (03), and “it would be so much easier to just write up a case note while I’m in the session with the phone session with the client” (06). Other distractions were external to the participants’ own choices, such as “people walking outside the window, construction, people mowing the lawn” (07) and “…my kids were sometimes [at home during telephonic sessions]. If he got TV on or music, it’s easy to get distracted…” (05). Participant 01 commented on this matter by simply stating, “distractions, whether it’s in your office, or whether it’s in your home—it’s definitely weird”. These comments further speak to the importance of counselors establishing a sense of intentionality and focus regarding engagement in telephonic counseling from the home setting.

Another distraction that occurred for participants was that of conflicting roles in the home setting. During the COVID-19 pandemic, adults and children alike were instructed to shelter in place as a means of slowing the spread of the virus. Because of this protocol, many therapists worked from home with spouses, children, and others habituating in the same house that telephonic sessions were being provided in. This dynamic precipitated conflicting roles for many therapists, a notion that was captured by the participants of this study. Participants shared comments such as, “I have to be really mindful of how I transition from the rest of my day-to-day life and all my other roles…and move just into the counselor role” (04) and “As a counselor and as a parent, I’m not the same at all. Or even as a counselor and a wife. I wear a different hat
and I play a different role” (05). These responses are likely reflective of counselors’ experience with overlapping roles when providing telephonic counseling in the home setting.

As a means of more effectively navigating the above distractions, participants reported a variety of strategies that they employed. Several participants reported choosing to work from an office setting when able as a means of transitioning into “the counselor zone” (03) and reducing distractions. Participant 03 reported that the routine of working from an office space “was helpful” and Participant 06 shared that she was “not comfortable working from home”, which further spurred the drive toward office work, as opposed to working from home. Regarding the reduction of distractions in the office setting, participants shared comments such as, “[being in the office] helped me keep my attention and focus” (03) and “there were less distractions on my end [in the office]” (07). As an alternate approach to navigating distraction in the home setting, Participant 08 reported use of “boundary-ing” time and space in her household for remote sessions, using white noise machines, and “resetting some family rules” regarding when her children were allowed to enter her home office space. Further adding to at-home strategies, Participant 10 discussed exclusively using her home office space for therapy, echoing the “boundary-ing” reported by Participant 08. The above participant comments regarding the need for establishing appropriate boundaries is likely reflective of counselors’ experience of needing to set clear boundaries between home and work life when providing telephonic counseling from the home setting.

Some participants also discussed that reframing their experience of telephonic counseling helped to mitigate their experience of at-home distractions. For example, Participant 11 discussed that acknowledging benefits afforded by lack of visual contact precipitated greater relaxation and decreased distractibility, stating, “with phone sessions, you don’t have to sit there
and worry about [how you look]. You could be just kind of more laid back and relaxed”.

Participant 08 added to this stipulation by commenting that normalization of environmental distractions helped to facilitate decreased anxiety for both herself and her clients, stating, “My dog’s gonna bark, people are going to ring the doorbell, my kid’s going to have friends over.’ All those things are now normalized”. Perhaps engaging in such reframing strategies of telephonic counseling may help counselors to mitigate anxiety and negative perceptions regarding the medium and help to garner improved adaptation in the provision of telephonic counseling.

**Implications**

**Application to the field.** As mentioned above, participants in this study reported greater comfortability delivering telephonic counseling with increased exposure. Individual practitioners and agencies alike may wish to acknowledge the exposure piece when incorporating telephonic sessions with clients. If counselors initially feel uncomfortable with telephonic sessions, they may find greater mastery of the medium by simply conducting more sessions. It is also possible that clients may increase their comfort with the telephonic medium through a similar process of exposure.

Speaking further to greater mastery over the telephonic medium, several participants in this study reported placing greater focus on the client’s verbal reporting than they had done in face-to-face sessions. It is possible that eliminating the visual channel may help students and clinicians in the field to practice empathizing with client’s verbal reporting, as they may examine this single information channel in greater depth. Counselor education programs and supervisors in the field may find such a practice to be beneficial for their learners.

Because telephonic counseling affords a considerable amount of freedom for both counselors and clients, setting appropriate boundaries with clients at the outset of therapy may be
of particular importance. Participants in this study reported experiences such as clients attempting to engage in sessions while driving their cars, grocery shopping, and spending time with their families. Bearing this stipulation in mind, agencies and practices in the field may wish to establish policies to ensure that appropriate therapeutic boundaries are followed to promote the safety and confidentiality of clients. An example of such boundary setting could be a counselor helping the client to identify a single, confidential space from which they could receive telephonic sessions.

Speaking further to the topic of boundary setting, practices in the field may benefit from setting policies for counselors regarding appropriate boundary setting for themselves. That is, ensuring that counselors are delivering telephonic counseling from a confidential space with minimal distractions may help to ensure that sessions entail optimal confidentiality and effectiveness. The action of counselors establishing such boundaries themselves may also provide clients with modeling for appropriate boundary setting in telephonic sessions.

Lastly, participants in this study reported fewer distractions when providing telephonic counseling from the office environment, as opposed to home. Considering this finding, agencies and practices in the field may wish to establish policies that encourage counselors to work from an office space to a reasonable extent. Doing so may help to limit distractions and role contamination on the part of the counselor.

**Importance.** The COVID-19 pandemic forever changed the field of counseling. Instead of counseling being restricted to a face-to-face office setting, clients may now access counseling services from the comfort of their own home via telephone or videoconferencing. Bearing this stipulation in mind, counseling agencies and individual practitioners will want to know notable differences between traditional, face-to-face counseling and the less familiar telephonic
counseling. The results of this study will help to further inform the field of differences between these modalities from the perspective of the counselor.

Regarding the lack of visual engagement with the client via telephonic counseling, this study highlighted the perspectives of counselors in the field on this matter. Whether it is precipitated by necessity or preference, counselors in the field are likely to engage in telephonic counseling for the foreseeable future and will want to know what differences are precipitated by this lack of visual contact with the client. This study helps to delineate several differences through the exploration of participants’ lived experiences.

Another notable difference between face-to-face and telephonic counseling is a changed therapeutic environment. Counselors in the field will want to know what environmental distractions may be present in their home and the homes of their clients when delivering telephonic counseling. The participants in this study helped to describe many prospective distractions that may occur, and the factors that may precipitate these factors. Counselors may look to these lived experiences to inform their own choices regarding the incorporation of telephonic counseling.

**Research Question #4**

The fourth research question for this study is, “How have counselors’ own personal experiences regarding COVID-19 influenced their empathic response to clients in the delivery of telephonic counseling?” Previous research has found that navigating a disaster event may precipitate trauma symptoms such as anxiety, depression, stress, and insomnia (Goldmann & Galea, 2014; Kessler et al., 1995; Norris et al., 2002). Informed by these findings, the purpose of this question was to inquire what it has been like for counselors to provide telephonic counseling during the COVID-19 pandemic while navigating their own personal navigation through this
global pandemic. Participants collectively discussed four subthemes related to the bearing of their own navigation of the COVID-19 pandemic on their empathic response to clients via telephonic counseling: identification and felt-level experience, both of which fell under the master theme of subjective empathy, emotional barriers to interpersonal empathy, which fell under the master theme of interpersonal empathy, and information from COVID-related media, which fell under the master theme of objective empathy.

Subtheme #1a: Identification

The COVID-19 pandemic was a major event that effected people on a global scale, counselors not withheld. It is likely that the universal nature of the pandemic influenced the sense of identification with clients that participants reported in this study. Clark (2010) states that identification involves “sufficient commonality of experiencing to evoke a level of identification” (p. 349) in the therapeutic encounter. In their own navigation of the pandemic, counselors likely achieved this “sufficient commonality”, as they navigated the very same disaster event as their clients. It is likely that this commonality facilitated the sense of kinship between counselor and client identified by Stewart (1956) in their empathic efforts with clients.

Regarding the concept of identification, participants reported shared dialogue with clients such as, “‘We are all in this together. It’s up to everyone to make these changes’” (01), “I don’t think [COVID-19] is going to go away” (10), and “you’re trying to help them through something that you don't understand yourself” (01). Several of the participants also discussed a sense of connectedness that they experienced with clients based on the common experience of navigating the COVID-19 pandemic. This finding aligns with Buber’s (1978/1950) classical stipulation that it is not possible to acknowledge what is empathetically understood without bringing oneself into play as a person. Participants shared phrases such as having a “genuine connection” with clients
(01) and sharing a common “launchpad” (02) regarding the pandemic. Participants also shared that they shared common emotional experiences with their clients, such as “confusion, concern, overwhelming feelings” (03), worry about potential illness (09), and having to “live around” the pandemic (10). Moreover, Participant 05 reported that she shared a sense of emotional solidarity with clients regarding navigating the pandemic as an African American. She reported, “that could have easily been me” regarding the struggles experienced within this community. Although the concept of empathic identification is regularly incorporated by counselors, the above participant comments suggest that counselors especially identified with clients during the COVID-19 pandemic due to the universality of this global disaster event.

Several participants also identified that solidarity in experience helped to facilitate better empathic understanding of clients’ situations. For example, some participants (07, 09) identified that they found it easier to empathize with clients who had quarantined due to navigating this experience themselves. Other participants (03, 04, 10, 11) found it easier to empathizing with clients’ fears based on their own experiences with COVID-related fear. Participant 02 mentioned that, after almost experiencing a change in her supervisor at her agency setting, she developed a newfound empathy for clients who navigated far more impactful changes during the pandemic. She shared the following:

“I can’t imagine how my clients feel if they don’t have financial stability, if they don’t have a social support, if their mental health is unstable. All these things. And I’m upset because my supervisor is changing. So, yeah. It gave me, certainly, empathy but also perspective.”
The above participant comments suggest that counselors may engage in empathic identification with clients even if there is considerable difference in experience. Although the COVID-19 pandemic affected people on a global scale, the nuances of its impact on individuals is vast. Despite major differences in experience, counselors might find common ground with clients, such as navigating unexpected changes, and empathize based on this overlap in experience, however small it might be.

Across the interviews, all but three participants discussed that they found their role as therapist to be more humanized during the COVID-19 pandemic and that they felt greater liberty to self-disclose during sessions with clients. Regarding the humanization piece, participants shared comments such as “I felt more seen” (01), “we were all coping with the same thing” (02), “real life happens for me, too” (08), and “at the end of the day, [therapists] are still people, too” (11), and “the pandemic has sort of helped me realize, as a human, the ways that we’re more connected” (09). Participants reported that they acknowledged their humanity in telephonic sessions with clients during the pandemic, speaking to their own experiences with child rearing (08) and emotional struggle (10, 11). As Participant 01 stated, “everyone’s changed in some way, even [the client’s] therapist”. Acknowledgement of participants’ humanity also entailed the dismissal of the narrative that the therapist operates as a sort of non-human mechanism to help others. Participants spoke to the dismissal this “fake narrative” (05), such as the therapist being seen as “this kind of mechanism” (01), a “superhero” (05), and having to be “strong” (11). The above participant comments likely indicate the greater humanization of counselors during the COVID-19 pandemic due to the universality of the experience. Dismissing the false narrative that counselors are “superheroes” may help to facilitate greater self-care and balance in the lives of counselors as they navigate the stressors of their own lives.
In addition to acknowledging their humanity as a therapist, participants spoke to an increased sense of self-disclosure during the COVID-19 pandemic. Participants shared that increased self-disclosure “comes with the territory” (01) and was used to “normalize” (03) navigation of the pandemic. Participant 02 shared that she felt “more comfortable sharing more details about what was going on” and shifted from being “very anti-self-disclosure” to using self-disclosure as a method for normalization and validation. Participants also discussed that self-disclosure was used to foster a sense of therapeutic connection with clients as both client and therapist navigated the pandemic. Participant 01 shared that self-disclosure helped her to “really be able to connect” with clients. Participants 02 and 09 discussed that refusing to self-disclose any information during the pandemic could have “damaged the relationship” and could have resulted in “pushing away” the client. Based on these participant responses, it is likely that counselors found self-disclosure especially useful during the pandemic, as it may have afforded opportunities for social modeling and normalization of COVID-related stress.

*Subtheme #1d: Felt-Level Experience*

Beyond simple recognition of commonality, participants in this study reported that their own navigation of the COVID-19 pandemic affected their felt-level experience when empathizing with clients. When counselors navigate an event as pervasively disruptive as COVID-19, they may experience an overwhelming sense of fear that may impact their empathic response toward clients. Counselors may fear for the health of their loved ones, their clients, and themselves, each of which may bear on their felt-level experience. An abrupt transition to telephonic counseling during a global pandemic and oversaturation of COVID-related media likely further exacerbated counselors’ sense of disruption and unease. It is likely that these
factors influenced participants’ felt-level experience as they navigated telephonic counseling during the pandemic.

In this study, all participants reported that their own personal experiences regarding COVID-19 affected their felt-level experience when empathizing with clients. Because the COVID-19 pandemic can be defined as a “modern disaster” (Rosen, 2020, p. 175), victims of the disaster are likely to experience psychological problems such as specific psychological problems, nonspecific distress, health problems and concerns, chronic problems in living, and psychosocial resource loss (Norris et al., 2002) The participants in this study, in addition to their clients, echoed the above symptomology in their navigation of the pandemic. For example, Participant 06 stated, “…[the pandemic] was really hard. It was hard on myself; it was hard on my clients. It was just hard across the board and very mentally taxing and draining”. Further speaking to this phenomenon, Participant 05 shared her experience of personal loss during the pandemic. She commented:

“I lost three loved ones during COVID, and they all died tragically and quickly. Not from COVID, but during COVID, so that has been very traumatic for me, as a person. Super shook up about it. I still haven’t recovered, and I don’t know if I will anytime soon to be quite honest.”

The above quotation illustrates the many layers of disruption that counselors may experience during a pandemic such as COVID-19. Pre-existing stressors may be exacerbated, and sudden loss can present debilitating grief. Such experiences may significantly impact the felt-level experience of counselors, affecting their empathic response toward clients.

Rosen (2020) commented on the pervasive sense of fear and danger that individuals may experience in their navigation of the COVID-19 pandemic. This finding aligns with Participants
discussed emotional experience such as feeling “really nervous” (01), experiencing “chronic anxiety” (11), and operating in “emergency mode” (09). Participants shared their overwhelm with comments such as, having to “kind of put my stuff away and be a container and figure out the phone” (09), and experiencing thoughts such as, “if I’m sick, where are my clients going?” (01). These participant comments suggest that navigating a global pandemic such as COVID-19 may precipitate feelings of fear and anxiety that may pervade the daily work of the counselor.

A specific fear that surfaced in many of the interviews was that of involuntary transmission of COVID-19, which aligned with Kamp et al.’s (2020) comments about transmission-based fears regarding the virus. Several participants voiced fears regarding inadvertently transmitting the virus to family members. Participants reported statements such as, “I just didn’t want to pass [COVID-19] indirectly to someone close to me” (02), “I got worried about how I may have affected other people, but not knowing.” (03), “I was so, so worried about [my great aunt] throughout the whole pandemic” (07), and “If I were to expose [my high-risk family to COVID-19], how would I feel?” (04). Participant 10 also mentioned her fear of unintentionally exposing her clients to COVID-19, stating, “I thought, ‘Oh my gosh, what if I had been exposed, and didn’t know, and then [my clients] came in and that would be bad’”. Participant 04 also shared his fears regarding unintentional transmission of the virus to strangers. He shared:

“And then also, the idea of, ‘Who am I exposing that I don’t know? Am I exposing someone who is immunocompromised, or someone who is in an extremely high-risk category?’ So that was hard for me.”
The above participant comments speak to counselors’ fear of the unknown during the COVID-19 pandemic. During the pandemic, a widespread fear persisted regarding whether one had inadvertently encountered COVID-19 in one’s daily life. An extension of this fear was worrying about unknowingly spreading the virus to friends and family after the virus had been transmitted. It is likely that such worries affected counselors’ felt-level experience when empathically engaging with client during the pandemic.

Other participants spoke to the felt-level experience of fear during the transition from in-person to telephonic counseling. For example, Participant 09 stated, “That’s where a lot of my fear was starting…as we were transitioning to telehealth”. For some participants, some of this fear stemmed from perceived incompetence regarding transitioning into the newness of telephonic counseling. Participants captured their unease with statements such as, “What is this supposed to look like? What am I supposed to do?” (04) and “I would say [switching to telephonic counseling] was jarring. I felt like a new counselor again” (08). During the COVID-19 pandemic, counselors were suddenly and unexpectedly forced from traditional face-to-face counseling to remote work, in addition to having to navigate a general sense of fear and anxiety regarding the pandemic. These concurrent disruptions likely further contributed to counselors’ felt-level experience as they provided telephonic counseling during COVID-19.

An additional precipitant of fear and anxiety reported by participants was an overwhelming sense of isolation. During the COVID-19 pandemic, many people were isolated in their homes due to quarantine and shelter-in-place measures. The isolation that participants experienced likely precipitated feelings of burnout, as sustaining relationships serves as a protective factor to burnout (Stamm, 2002), which many of the participants were deprived of. Participants described their isolation during the pandemic as “the biggest challenge” (02) and
like “Groundhog Day” (09). Participant 01 spoke directly to her burnout, stating, “I think there’s the level of burnout that you have from not being able to see your coworkers” and Participant 06 shared a similar sentiment, commenting, “…I was not in a good place mentally. I was focusing on like, ‘Oh my God, I haven’t seen a human being other than my husband in like a week. What am I doing?’” Participant 11 identified as a “very family-oriented person”, which precipitated greater sensitivity to her isolation during the pandemic. Perhaps further exacerbating this sense of burnout and isolation was restriction to interventions such as telephonic counseling when navigating this isolation, a factor that Baron and Cohen (1982) cautioned about in the literature.

Perhaps one beneficial biproduct of the participants’ own sense of fear and concern during the pandemic was that, in some cases, it helped the participant to develop greater empathy and compassion for clients. For example, Participant 10 shared that she encouraged clients to create “sick packs” at home, which was informed by her own experience living as a widow during the pandemic. Additionally, Participant 06 shared that she waived cancelation fees for clients who cancelled therapy sessions due to illness, as her fear regarding illness had increased during the pandemic. Due to the sudden and traumatic nature of the pandemic, it is likely that many counselors in the field exercised a more lenient empathic approach toward clients/ 

Across the interviews, all participants reported that COVID-related media was a precipitant of anxiety. This finding aligns with Rosen’s (2020) observation that COVID-related media may serve to exacerbate anxiety, depression, and other mental health problems. Because the pandemic was a new experience for all those navigating through it, several participants reported keeping up to date with COVID-related media as a means of staying informed. Participants reported comments such as, “I watched just enough to keep me up to date on things” (11), watching media as a means of “tracking the map across the world” (04), checking “a couple
times a day to see what the stats looked like”, and keeping up to date with other media events such as the George Floyd trial (09). Participant 08 shared that, as a mother, her media consumption “correlated with the school year”, as schools experienced a considerable deal of fluctuation at the time regarding COVID-related precautions and responses. These participant comments suggest that, if used in moderation, disaster media may be useful to counselors in keeping up to date on world events.

Although media was a useful tool for remaining up to date regarding the progression of the pandemic, several participants reported experiencing a sense of oversaturation pertaining to COVID-related media. Most participants reported consuming a greater quantity of media early in the pandemic and tapering this quantity due to subsequent overwhelm. Regarding this initial quantity, participants reported amounts such as, “all day, every day” (04), “two plus hours per day” (07), “a lot” (10), and simply “too much” (10). Emotionally, this oversaturation appeared to have taken a toll on participants. Participants reported emotional responses such as, “very depressing” (11), bringing up a “stuck feeling” (01), “really scared” (02), “all-consuming” (07), and “worse for my anxiety” (09). These participant comments suggest that overexposure to media could potentially exacerbate counselors’ feelings of anxiety and fear, a factor that could overwhelm the felt-level experience of counselors.

Moreover, several participants reported that COVID-related media precipitated feelings of worry regarding their clients’ wellbeing. Participants shared comments such as, “I was worried for my clients” (01) and “Will [one of my clients] get COVID? What’s going to happen to them?” (03). Further adding to this stipulation, Participant 02 discussed that limiting consumption of COVID-related media precipitated decreased worry for her clients, stating, “I think steering clear of [COVID-related media] brought down, individually, my anxiety for some
Additionally, some participants discussed that oversaturation of COVID-related media hindered their empathy toward clients. Participants reported comments such as, “my empathy kind of started to kind of seize up” (05) and “I was having a hard time being empathetic with clients because of my mental health, and the media just contributing to that” (06). This commentary further speaks to the potential emotional overwhelm precipitated by COVID-related media, and that regulating disaster media intake may help to mitigate such feelings of overwhelm.

In response to a heightened sense of anxiety precipitated by COVID-related media, many participants reported reducing media use. Participants reported comments such as, “as time went on, I tried to reduce it” (01), “I backed off” (02), and “I had to just stop listening to the media after a while” (06). Several participants discussed that reduction of COVID-related media was a result of self-prescribed advice, such as “What is looking at [COVID-related statistics] going to do? Help provide clarity or a sense of safety or security?” (03) and “we probably should not have the news on 24/7 anymore” (04). Participant 08 reported a gradual reduction from television news to digital media coverage, to subscription-based media. In his reduction of COVID-related media, Participant 04 shared that he engaged in overcorrection, reporting “I think I’ve swung too far the other way now”. These comments further speak to the need for counselors to moderate the quantity of disaster media consumed as a preventative measure to emotional overwhelm.

In addition to navigating the COVID-19 pandemic, Americans experienced racial tension in the country following an episode of police brutality against an African American male named George Floyd. This is pertinent information to mention in this study, as two of the participants (05, 09) were African American. Both participants commented on the additional adversity that the George Floyd situation precipitated. For example, Participant 09 commented, “You know
what? I really am tired for me and everybody that came before me because, why are we dealing with this [racial oppression]?”” Further echoing this frustration, Participant 05 shared her feelings of overwhelm brought about by racial tension in the country, stating:

“I don’t have the privilege or luxury to be able to disconnect from [my race]. I can’t take my skin off. I can’t change the reality of what God created me to be. This is who I am. But I have to constantly fight for my existence to be acknowledged or my experiences to be validated; not even validated, to just be acknowledged. It’s very taxing. And it was too much. It was too much.”

Regarding the above participant comments, it is likely that African American counselors experienced an additional layer of adversity precipitated by racial unrest in the US during the COVID-19 pandemic. The combination of widespread fear brought about by the pandemic and civil unrest caused by the murder of George Floyd likely contributed to an overall sense of overwhelm for African Americans. It is also likely that adding the additional factor of adapting to and providing telephonic counseling further exacerbated this ongoing sense of overwhelm.

Despite the pervasive sense of fear and anxiety reported by participants, many participants reported the presence of several protective factors that helped them to navigate their felt-level experience during the pandemic. One such protective factor was participants’ gradual adaptation to the telephonic medium of counseling, which aligns with Rosen’s (2020) comment that “clinicians have been forced to adapt and change” (p. 183) due to the COVID-19 pandemic. Several participants discussed how ongoing exposure to telephonic counseling helped them to better adapt to delivering the medium. This phenomenon was captured succinctly by Participant 05, who stated, “I think that [telephonic counseling] is a different type of exposure”. Other participants made comments such as, “I was able to adapt” (02), “I actually had to get
comfortable using the phone pretty quickly because of COVID” (04), “I’ve had to adjust to become more empathetic [in telephonic counseling]” (06), “eventually, I did get more comfortable with it” (07), and “over time I feel like I got more comfortable” (08). One participant (03) offered a counterpoint to the exposure conceptualization, stating that it was easier for her to empathize with clients near the beginning of the pandemic because it was “fresh and new”, and that this eagerness to empathize gradually waned with the novelty of the pandemic. The above participant comments suggest that ongoing adaptation to the telephonic counseling medium may serve as a protective factor to counselors’ felt-level experience of overwhelm and lack of familiarity with the medium.

Participant 07 spoke to the “socialization process” that he observed with regard to therapists adapting to telephonic counseling. This process, however, was not without struggle. Several participants spoke to this challenge, issuing statement such as, “at first, I would say a good six to eight weeks, [telephonic counseling] was hard. Hard” (08) and “At first, [empathizing via telephonic counseling was] very, very challenging” (09). After a prolonged exposure process, however, participants reported greater comfort with the telephonic medium. Participant 09 shared her increased comfort with the following comment:

“…[in the present day], none of [telephonic counseling] feels awkward to me. If you decided to come to my office or we were talking on the phone now, I would feel just as comfortable. And that helps me feel connected to people. Because I’m not limited. I could be anywhere, and I can connect with anyone, now that I’ve gotten over…my angst around it.”

It should be noted here that, prior to the COVID-19 pandemic, use of the telephone in the
counseling process was largely delegated to scheduling and briefly checking in with clients. Therefore, it is likely that transitioning from this dynamic to engaging in full telephonic counseling sessions with clients did indeed entail a socialization process for both counselor and clients. Based on the above participant comments, it is likely that counselors were gradually socialized into using the telephone as a therapeutic modality, and not simply a bridge leading to face-to-face sessions.

An additional element to the adaptation process to telephonic counseling appears to be the willingness behind the adaptation. This phenomenon was discovered in the varying degrees of participants’ willingness to adapt to the medium. For example, some participants (01, 09) reported that they quickly involved themselves in trainings to bolster their effectiveness in telephonic counseling. Other participants (06, 07), however, exhibited resistance to the change, issuing comments such as “I hated [telephonic counseling] (laughs) at first” (07) and “part of me is even hoping that maybe I just will never have another phone session again” (06). Regardless of their initial response to telephonic counseling, all participants reported putting forth effort to adapt to the medium. Participants worked to provide “a new structure” in telephonic sessions (02), increased focus and intention regarding “how” they empathically engaged with clients over the phone (03), willingly provided telephonic sessions if it was “convenient” for the client (06), adjusted the “pace” of sessions (07), added to their therapeutic “skills” in their provision of telephonic counseling (09), and perceived telephonic counseling as an opportunity for a “learning growth” (11). Further adding to the phenomenon of learning and adapting, Participant 10 spoke to a creative adaptation to telephonic counseling that she made with one of her clients. She discussed that she stood outside with this client at a significant distance and used the phone as a means of verbal communication. She commented, “we could look at each other, and we’d be
on the phone, just to be physically present”. These participant comments suggest that, based on their level of willingness, counselors may operate on a continuum spanning from fully embracing the adaptation process to telephonic counseling to fully resisting this process.

In addition to adaptation functioning as a protective factor, another protective factor that surfaced across the interviews was financial wellness. Returning briefly to the topic of COVID-19 testing, Participant 10 discussed, “one box with two tests is $23” and that she was able to regularly afford the purchase of these tests. Being that the participant was able to afford regular testing, she likely facilitated decreased anxiety around her testing status regarding COVID-19. Further speaking to financial wellness as a protective factor, other participants issued statements such as, “financially, I knew it was going to work out” (03) and “I’m in, thankfully, a very safe financial spot, regardless of how many clients I see every week” (06). Another protective factor that emerged in the interviews was that of setting. For example, Participant 07 spoke to the safety he felt in his home setting, stating, “I am fairly privileged in where I live, where I work, to have less chance of being exposed to COVID”. This statement stood in contrast to Participant 05’s experience, as she reported living in a lower SES area. She commented, “honestly, I’m probably one only people in the hood that hasn’t had COVID”. A final protective factor that emerged was physical health. Participant 02 illustrated this factor is her comment, “[The pandemic] affected me more emotionally than I was ever concerned about it physically. But that's also just the privilege of knowing that I have a healthy family”. Based on the above participant comments, it is likely that access to protective factors such as finances, living space, and physical wellbeing may help counselors to regulate their felt-level experience when navigating a disaster event such as the COVID-19 pandemic.
As alluded to earlier in this discussion, an additional protective factor to felt-level fear and anxiety was found in participants’ experiences as supervisees. Participants commented on the grounding effect that supervision allotted in a time that was otherwise unpredictable. This finding aligns with Sommer and Cox’s (2005) position that collaborative supervision and a supportive work environment may help to improve counselors’ ability to cope with their work and Sommers-Flannigan and Sommers-Flannigan’s (2017) identification of consultation and supervision as a means of mitigating overwhelm and compassion fatigue in counselors. For example, Participant 02 discussed that supervision helped her to stay “grounded” and “balanced” and functioned as a “lifeline”. Participants 04 and 06 discussed that they sought emotional support in supervision, saying phrases such as “I remember supervision… it felt like there was a period where I was like, ‘Anyone who would listen’… I don’t understand why my clients are [disregarding COVID precautions]” (04) and “[Supervision] was just like, ‘Oh my God. How do we see clients like this? This is horrible. We’re miserable.’” (06). Participant 09 voiced a similar emotional need for supervision during COVID-19, stating, “if there was ever a time I needed [supervision], it was during the pandemic”. Lastly, Participant 11 commented that her pre-existing face-to-face relationship with her supervisor helped to facilitate a seamless transition to telephonic supervision, stating, “we had this supervisor-supervisee relationship that was quite established, so when we would have those conversations… it didn’t really seem like it was over the phone (chuckles)”. The above participant comments suggest that the receipt of supervision may help counselors to regulate their felt-level experience when navigating a disaster event such as COVID-19.

As a final protective factor, participants also shared that, once they were able to return to their office settings during the pandemic, they were able to seek social support from coworkers
in the office setting. Participants reported being able to “vent about frustrations about doing teletherapy and phone sessions” (07) and “bounce ideas off of and grow as a person and as a counselor” (02). Furthermore, Participant 03 expressed her gratitude for being able to begin seeing clients in person once again, and Participant 09 shared the simple yet powerful thought she experienced regarding her return to the office, “I just need to get out of the house”. These comments suggest that engagement in telephonic sessions from an office setting may help to facilitate improved social support for counselors in their navigation of disaster events.

**Subtheme #2e: Emotional Barriers to Interpersonal Empathy**

Although navigation of the same global pandemic precipitated a sense of commonality and identification with clients for counselors, the sense of overwhelm inherent in navigating the pandemic presented a potential barrier to empathizing with clients. Experiences such as persistent fear and loss of loved ones have the potential to detract from a counselors’ ability to lend themselves to their clients empathically. Such potential barriers likely influenced participants’ lived experience, likely bringing about participants’ commentary on emotional barriers to interpersonal empathy.

Within the master theme of subjective empathy, all participants in this study identified emotional barriers to empathizing with their clients as they provided telephonic counseling during the COVID-19 pandemic. A general sense of compassion fatigue and emotional overwhelm due to the pandemic was identified as one of these barriers. Seven of the eleven participants discussed the topic of compassion fatigue across the interviews. Although compassion fatigue has been historically considered a unique occupational hazard in counseling trauma victims (Devilly et al., 2009), the ubiquitous nature of COVID-19 may render trauma work a more inevitable experience for counselors due to the potential trauma caused by disaster
events (Goldmann & Galea, 2014; Sayed et al., 2015). Many participants reported a general sense of overwhelm in their provision of telephonic counseling during COVID-19. Participants reported experiences such as, “I wasn’t in a position where I wanted to feel it anymore” (01), “I couldn’t carry anything else” (05), “I was not in a good place mentally” (06), “it was way too much” (10), and “I felt the pressure and the burden on my shoulders” (11). Participant 04 added to this sense of overwhelm, sharing comments such as, “clients…are requiring more headspace” and “it feels like I’m using more cognitive resources to try to stay with [clients]”. These comments suggest that emotional overwhelm may indeed present a barrier to counselors in their efforts to empathize with clients, particularly in a time of crisis.

During the COVID-19 pandemic, many insurance companies waived copays as a means of allowed clients increased access to services. Although this change was generally beneficial to clients, it precipitated increased demand on the part of the therapist. Participant 10 spoke to this experience, sharing that many clients who would ordinarily be seen once or twice per month opted to be seen weekly due to the absence of a copay. The participant also shared that this lack of copay precipitated a dramatic increase in clients seeking therapy, commenting, “I could’ve had eighty people a week. It was uncontrollable”. Based on the participant’s comments, it is likely that the increased access to care brought on by the pandemic contributed to counselors’ experience of overwhelm and compassion fatigue.

Participants spoke to other variables that bore on their compassion fatigue. Participants spoke to empathy saturation (01), emotionally bringing personal experiences into session (05), and discomfort with the telephonic modality (07). During COVID-19, many avenues to self-care such as exercising at the gym were blocked off due to lockdown procedures. Participant 06 spoke to this experience, sharing, “a big piece of my self-care is exercise. And, at the beginning a
pandemic, you couldn’t go to a gym”. The above participant comments suggest that counselors’ compassion fatigue was exacerbated by personal stress related to the pandemic, having to suddenly transition to telephonic counseling, and lacking access to coping avenues that were previously accessable.

Of the eleven participants, two discussed having to step away from the counseling profession for a period because of compassion fatigue. Participant 05 shared that the combination of losing multiple loved ones during COVID-19 and navigating the racial tension in the US following the murder of George Floyd culminated to a point at which she “had to quit counseling” for a four-month period. Moreover, Participant 11 shared that worrying about whether her clients in addictions would die of a relapse during the pandemic caused her to “tap out of addictions” and move on to mental health counseling. Stepping away following an increased amount of stress aligns with Thompson et al.’s (2014) observation that “compassion fatigue and burnout occur when individuals see the environment as taxing or exceeding their personal coping resources” (p. 62). Stepping away also meant that these participants were able to address their own mental health needs, rather than neglecting them in favor of their clients’. Participant 11 poignantly addressed this state of self-neglect, commenting:

“…we say, ‘You can’t give from an empty cup; you have to have your mask on first, before you give somebody else a mask.’ I wasn't taking care of myself. I came last. I did. I was last person.”

The above participant comments speak to the importance of counselors tending to their own wellness during a time in which the wellness of clients was systemically compromised. During a time of widespread disaster such as the COVID-19 pandemic, it is likely that counselors may need to regulate their involvement in the progression for the betterment of their
own mental health and that of their families. Perhaps making such concessions could provide social modeling for clients to engage in a similar prioritization of wellness.

Likely in relation to the experiences of compassion fatigue and overwhelm, another emotional barrier to empathy identified by participants was difficulty being present with their clients. Across the eleven interviews, eight participants commented on their difficulty being present with clients during telephonic counseling. Several participants discussed that they felt preoccupied by the COVID-19 pandemic during their telephonic sessions with clients. Participants shared comments such as, “it’s harder for me to stay fully present if I’m focusing more on COVID risk” (01), “we already only have this many cognitive resources, but then at the beginning of COVID it was only like, that many (brings hands together)” (04), and “I just found myself being less patient…in quarantine” (05). Additionally, Participant 06 discussed that her exhaustion from the pandemic precipitated difficulty writing notes at the end of her workday, leading her to concurrently write notes during her sessions with clients. She went as far as to consider this concurrent documentation as being neglectful of clients regarding therapeutic presence, reporting, “[concurrent documentation] was, in a way, neglect, because I’m not really with [clients]”. These participant comments illustrate the degree of cognitive resources required in the navigation of a global pandemic, and that counselors face this demand just as their clients do. Therefore, in the navigation of a major disaster event such as COVID-19, counselors may experience increased difficulty remaining present with clients.

Because telephonic counseling involves no visual contact with the client, the counselor is free to visually engage with whatever might be available in their immediate physical environment. For some participants, this dynamic led to a sense of groundlessness that detracted from therapeutic presence. Participants shared comments such as, “what are we supposed to be
focusing on…to stay present with the client?” (01) and “it was very easy to kind of get distracted by other things” (03). It is possible that such an emotional experience of groundlessness could precipitate detraction from empathic involvement with clients. Therefore, improved comfortability with the telephonic medium may help to facilitate improved empathic response toward clients.

In addition to a perceived sense of groundlessness, several participants discussed a sense of restlessness in telephonic counseling that negatively impacted therapeutic presence. For example, two participants (07, 10) discussed “micro-distractions” precipitated by “getting in my own head” and the mind needing a “break”. During such distractions, participants reported experiences such as, “I just missed… a crucial ten to twenty seconds of what they were saying, and then I’m lost” (07) and “I would be listening to somebody and then, all of a sudden, they’d say like two sentences, and I didn’t hear it” (10). Additionally, Participant 09 reported a sense of restlessness regarding silence in telephonic counseling and conducting intake through the medium. As mentioned above, it is likely that lack of familiarity with the telephonic medium precipitated feelings of restlessness for counselors during the pandemic, which likely affected their empathic response. Effective grounding and intentionality during telephonic sessions may help to mitigate feelings of restlessness and improve empathic response.

As mentioned above, the COVID-19 pandemic was a highly politicized event in the US, in which social choices of others were viewed with increased sensitivity and criticism. Across the interviews, eight participants reported their empathy toward clients being influenced by the COVID-related social choices of the clients outside of session. For example, several participants reported diminished empathy toward clients due to such social choices. Participants shared comments such as, “I had a couple of clients who used [the pandemic] to become social
butterflies…I felt like my empathy was starting to lessen with some of those people” (01), “that was hard for me to empathize with people who were, it felt like, diametrically opposed to my philosophy at that point in time” (04), “maybe [COVID-related negligence] did impact my empathy” (05), and “when I got the sense that clients were…having, very generally, a dismissive attitude towards the pandemic and people’s experiences in it, that was definitely a barrier to expressing empathy” (07). As a counterpoint to difficulty empathizing with clients who engaged in social choices that did not align with the counselor’s value system, Participant 04 shared that he found it difficult to empathize with clients who abided by these concerns “in the most professional way” due to the “interest convergence” that occurred in these scenarios. Generally, these participant responses suggest that counselors may experience a barrier to empathizing with clients who oppose their political point of view when politics are discussed in session. Conversely, counselors may also have trouble remaining politically impartial if clients share a similar political disposition,

In addition to having trouble empathizing with clients due to their social choices, several participants voiced outright frustration due to these social choices. Participants reported comments such as, “[clients are] knowingly really putting [their] neighborhood at risk at this point. It’s just it’s really unsettling” (01), “I did have a period where I had to work through my own frustration of, ‘Why is it so hard for people to inconvenience themselves temporarily, so that we can get back to…something that is less restrictive later on?’” (04), and “to me it is absurd that people refuse to take public safety measures because it causes them a slight inconvenience” (07). Participant 11 offered a counterpoint to this sense of frustration. After her father had a near-death experience following receipt of a COVID-19 vaccine, this participant adamantly refused to receive a vaccine. Thus, the participant approached clients from a place of less frustration due to
her own caution regarding the COVID-19 vaccine. Similar to the commentary in the previous paragraph, these participant responses suggest that counselors may experience frustration if politically contumacious topic surface in session that the counselor is opposed to.

Although social choices precipitated frustration and difficulty empathizing for many of the participants, other participants discussed that they used the differing social choices of the client as an opportunity to engage in perspective taking. Participant 03 shared that she could “understand why they would want that” regarding clients choosing to abstain from quarantining, Participant 08 discussed having greater understanding toward clients regarding social choices than toward family due to her role as therapist, and Participant 10 discussed that she allowed vaccinated client to be seen in person, but that she “let people have the choice” regarding whether they felt comfortable receiving the COVID-19 vaccine. Additionally, Participant 04 discussed that he was able to gradually increased a nonbiased approach toward client regarding political and social choices. He stated:

“I’m getting more of a handle on what it means for me to show up as a counselor in this time where everything's up in the air and just be present and just validate folks where they are.”

The above participant comments suggest that counselors have the capacity to approach politically heated topics in sessions from a non-biased perspective. Even if counselors firmly hold a given political stance, they may nonetheless bracket their opinion in favor of gleaning a better understanding of the client’s point of view and lived experience. It is likely that the utility of interpersonal empathy is noted in such an unbiased approach toward client experience.
Subtheme #3b: Information from COVID-Related Media as a Source for Objective Empathy

During the pandemic, COVID-related content dominated media outlets such as television and social media. It is likely that having regular exposure to COVID-related media contributed to participants discussing how COVID-related media functioned as a source for objective empathy. The overwhelming influx of COVID-related media also likely contributed to participants discussing that oversaturation of such media could also be harmful to empathy.

Across the interviews, all but three of the participants identified that COVID-related empathy helped to facilitate a sense of empathy with clients. Use of Clark’s (2010) integral model of empathy helped the researcher to thematically make sense of this phenomenon as objective empathy. As mentioned above, Clark (2010) defines objective empathy as a form of empathy that “relies on a consensus of judgments from reputable reference groups composed of individuals external to a client’s frame of reference” (p. 351). In this case, the “reputable reference groups” refer to various media sources. That is, exposure to COVID-related media provided participants with information that helped them to better understand and empathize with their clients’ experiences. For example, Participant 01 discussed that she had several clients who worked in the restaurant industry and that consuming social media on the topic of this population encouraged her to consider “how it must be like for them and how they were treated”. Moreover, Participant 04 discussed that consuming COVID-related media “helped me be more empathetic when working with my older adults” and that “I had more exposure to where they’re coming from”. Participant 05 shared that consuming such media “gave me a new level of empathy for those in a lower SES” and Participant 08 shared that receiving daily COVID-related updates to her email made her “more empathetic”. Based on these comments, it is likely that counselors in
the field were able to look to COVID-related media as a means of better understanding clients’ COVID-related stressors.

In addition, several participants discussed that that COVID-related media triggered an emotional empathetic response toward clients. Participants discussed that being exposed to such media encouraged them to “really feel for [clients]” (01) and acknowledge the “overwhelming” nature of the pandemic (03). Participant 08 also discussed that she would sometimes help clients to contextualize their anxiety, stating, “remember we’re still in a pandemic, on top of all this other stuff that’s happening for you? Of course you’re anxious.” Due to the anxiety-inducing nature of disaster media, it is likely that an overlap with felt-level empathic response occurred for counselors when objectively empathizing with clients via COVID-related media. Therefore, COVID-related media may have been a tool for counselors to look to as a means of better understanding clients’ lived experience and emotional turmoil during the pandemic.

Participants also reported that exposure to COVID-related media precipitated increased awareness of COVID-related concerns in session. Participants reported acknowledging the “common ground” regarding mutual navigation of the pandemic (02), being “extra empathic” regarding clients’ navigation of the pandemic (07), and asking into clients’ thoughts and feelings on the latest “buzz” regarding COVID-19 (09). These participant responses suggest that exposure to COVID-related media influenced the content of telephonic sessions in the direction of COVID-19. It is likely that ongoing exposure to such media played a considerable role in the topic of many sessions.

As a counterpoint to COVID-related media facilitating increased empathy, a few participants discussed that frustrations precipitated by this media diminished empathy toward clients. For example, Participant 04 discussed that media coverage on COVID-related negligence
“could have been a little bit detrimental to my empathy” and Participant 05 reported that the “toxic” political climate during the pandemic made it “harder and harder to have empathy”. These participant responses suggest that exposure to COVID-related media may have been detrimental to counselor empathy if the counselor had oversaturated in such media. Perhaps this finding speaks to the importance of balance regarding counselors’ engagement in research for the benefit of the client and self-care in the emotional interest of the counselor.

Implications

**Application to the field.** In the absence of a global pandemic or a sudden shift between counseling modalities, the profession of counseling is already beset with occupational hazards such as burnout, compassion fatigue, and vicarious traumatization. Such major events only exacerbate pre-existing risks. As such, counselors in the field may wish to be especially cautious of their own mental health during future disaster events. If counselors overburden themselves with clients and do not care for their own mental health in their navigation of a disaster event such as COVID-19, it is likely that their ability to empathize with clients will suffer. Therefore, if counselors pace their work with self-care and effective coping, they may help to ameliorate compassion fatigue and improve their ability empathize with clients.

Moreover, participants in this study reported greater burnout and anxiety when isolated from social supports such as friends, family, and co-workers. If counselors feel isolated from supports such as coworkers and loved ones, they will likely experience a greater sense of anxiety and unease regarding navigation of a disaster event such as COVID-19. However, if counselors are afforded such social supports, this overwhelming sense of isolation may be mitigated.

Per participant responses, counselors may benefit from visually engaging in process notes during the telephonic session, or mindfully grounding themselves during the session. It is likely
tempting for counselors to restlessly seek visual stimulation from multiple sources during a telephonic session, which could ultimately result in distractions from the session. However, if counselors can calmly ground themselves during telephonic counseling, it is likely that their feelings of restlessness and groundlessness may be mitigated.

This study found that counselors’ ability to empathize with clients may be affected by their political stance, especially in a politically contentious time such as the COVID-19 pandemic. Therefore, counselors may benefit from exercising a nonbiased perspective when providing counseling during a politically heated time. Alternatively, counselors may wish to calmly redirect the conversation to non-political matters if the counselor feels emotionally triggered by the given political topic. Entities such as counselor education programs, agencies, and practices may wish to provide training to counselors regarding non-biased listening and redirection skills. Such training may help counselors to adeptly navigate such politically sensitive dialogue in the field.

This study also found that counselors may present with increased self-disclosure when they have navigated the same disaster event as their clients. As mentioned above, identification is a tool that can be used for counselors to empathize with their clients (Clark, 2010). Bearing this stipulation in mind, counselors may find appropriate self-disclosure to be especially useful when both the counselor and client are navigating a similar crisis. Such self-disclosure could be used as a form of social modeling for the client and could help to normalize emotional responses to the given disaster event. Counselor education programs, agencies, and practices may wish to educate counselors on effective self-disclosure, and how it can be used appropriately to the benefit of the client across a variety of situations.
**Importance.** The counseling literature has long since expounded upon the importance of understanding the hazards of burnout, compassion fatigue, and vicarious traumatization. Moreover, previous literature has explored the impact of disaster events on the welfare of both counselors and clients. Given the newness of the COVID-19 pandemic and the dearth of research on the topic of telephonic counseling, this study provides important information on how counselors’ personal experiences impacted their empathic response toward clients via telephonic counseling during the COVID-19 pandemic. Understanding how various factors, such as social isolation, widespread fear, and an unexpected transition to an unfamiliar medium affect counselors’ ability to empathize may be informative to both practitioners and researchers as the field progresses into the permanently changed landscape of post-COVID counseling.

The results of this study indicate that counselors may experience barriers to empathizing with clients due to their own emotional experiences during disaster events such as COVID-19. Better understanding these barriers and how to mitigate them could be of importance to the field, as a counselor’s ability to be present and empathize with their clients is crucial to treatment progress.

Regarding counselors’ personal experiences during the COVID-19 pandemic, this study also indicated that counselors may engage in self-reflective processes such as identification and self-disclosure. This finding speaks to the humanization of the counselor in a universally impactful event such as COVID-19. This result may be of importance to the field, as the topic of counselor self-disclosure has been a frequented topic among both researchers and practitioners in the field.

It has been universally understood by many that disaster media may have adverse effects on the mental health of individuals. COVID-related media, however, brought a new level of
overwhelm to disaster media. This study illuminated the double-edged sword that disaster media may present to counselors, as they may find such media to be both informative regarding world events that clients are navigating and potentially deleterious to their own mental wellness.

**Limitations to the Study**

This qualitative study inquired into the lived experiences of eleven participants who provided telephonic counseling during the COVID-19 pandemic. Participation was limited to counselors who possessed a master’s degree or above in field of counseling, provided counseling at an outpatient level of care, providing telephonic counseling during the COVID-19 pandemic for at least six cumulative months. Participants were recruited through networking with professionals at conferences, posting in social media groups, and emailing various counselors in agency and private practice settings. The reason for these diverse recruitment strategies was to recruit the most diverse sample possible.

One limitation of this study was that eight of the eleven participants were in their late twenties. This homogenizing factor likely had some degree of bearing on the results of this study. It is possible that counselors in their twenties have a differing perspective on the use of the telephone than counselors in other age brackets. This younger age group may have also limited fear regarding contracting COVID-19, as most of the participants did not report pre-existing health concerns. This factor brought about greater reported concern for elders (e.g., parents, grandparents, etc.) than the participants themselves. Lastly, the younger age of participants entailed less cumulative counseling experience, which may have presented less contrast between prior work in face-to-face counseling ad engagement in telephonic counseling.

Another limitation of this study was that most participants worked in agency settings, as opposed to private practice. Seven participants worked exclusively in an agency setting, two
worked in both agency and private practice settings, and only two worked exclusively in a private practice setting. Of the participants working in private practice settings, one contracted into an existing practice and one owned and operated her own practice. The participant owning her own practice was the only one who had the burden of choosing for herself how to navigate changes brought about by the pandemic, rather than administrative forces making these choices instead. Thus, the greater number of counselors working in agencies may have some bearing on the results of this study.

A third limitation to this study was the lack of geographic variance among participants. Seven participants were from Pennsylvania, two were from Ohio, one was from Florida, and one was from Nevada. Most participants being from Pennsylvania may have influenced the results of this study, as Pennsylvania may have enforced differing allowances regarding telephonic counseling and social distancing than other states. Although some variance was afforded by participants from other states, the lived experiences of counselors from many other US states were left unexplored.

Another limitation of this study was that nine of the eleven participants were white. Although a degree of diversity was afforded by the two African American participants in this study, most participants derived from white culture. The inclusion of two African American participants yielded cultural influences such as the murder of George Floyd. Therefore, the inclusion of other cultural backgrounds may have allotted a broader exploration of such lived experience.

A fifth limitation of this study was that seven of the eleven participants were pursuing degrees in Counselor Education and Supervision from various universities. Pursuit of this
academic degree may have some bearing on the counselor identity of these participants, who may ultimately wish to pursue an academic career, as opposed to one that is clinically oriented.

A sixth and final limitation concerns the contextual nature of this study. This study explored counselors’ experience of empathically responding to clients via telephonic counseling during COVID-19. Readers interested in a definitive comparison of face-to-face empathy versus telephonic empathy will be wise to incorporate the context of the global pandemic into the findings of this study. Participants were suddenly forced into telephonic counseling to varying degrees, were forced to work from home, and were largely in a state of fear and worry regarding the COVID-19 pandemic. As such, the results of this study should not be taken to prove a one-to-one comparison between face-to-face versus telephonic empathy without the incorporation of this context.

**Implications for Future Research**

This research project generated many possibilities for future research on telephonic counseling, empathy, and disaster counseling.

One finding of this study was that participants who experienced greater exposure to telephonic counseling reported greater comfort with the medium. As mentioned above, most literature on telephonic counseling has measured effectiveness in an isolated, one-to-one sense (Bee et al., 2008; Castro et al., 2020; Coughtry & Pistrang, 2008; Mohr et al., 2008). Social psychology literature measure empathic response to differing inputs such as visual and verbal offer a similar limitation in their results (Dilley et al., 1971; Gesn & Ickes, 1999; Hall & Schmid Mast, 2007; Kraus, 2017; Reese et al., 2016). Thus, future research on acclimation to the telephonic medium may provide a more accurate depiction regarding what it is like for counselors to consistently incorporate this modality in everyday clinical work.
Another finding of this study discovered that participants who perceived telephonic counseling as a necessary transition, rather than a last resort, presented with greater acceptance of the medium. Participants who provided a minimal, “last resort”, number of telephonic sessions reported feeling frustrated and disgusted with the medium. Considering this finding, it may be illuminating for researchers to further explore how differing degrees of necessitation of telephonic counseling bear on counselors’ attitude toward the medium.

As mentioned above, participants in this study were suddenly forced into telephonic counseling due to the occurrence of a global pandemic. Future research may find it beneficial to explore the lived experiences of telephonic counselors in a normal, everyday, sense. In this way, variables precipitated by the global pandemic may be kept at bay in the findings of this future research.

The population of concern in this study was counselors providing telephonic counseling during COVID-19. As such, a possible future direction for research could be exploring the lived experience of clients in their receipt of telephonic counseling during this period. Variables such as acceptance of the medium, perceived effectiveness, etc., could be observed in a comparative sense to those of counselors.

**Questions Generated by the Research**

In qualitative research, more questions are generated than answers (Creswell & Poth, 2016). This inquiry generated the following questions as possible avenues for future research:

1. Does increased exposure to telephonic counseling precipitate greater comfortability with the medium?
2. Does a perceived necessity of telephonic counseling facilitate greater acceptance of the medium?
3. Does perceiving telephonic counseling as a “last report” option generate resistance to the medium?

4. Does the therapist’s attitude toward telephonic counseling affect the client’s experience in counseling?

5. Is concurrent documentation during telephonic counseling more helpful or hurtful to the process of treatment?

6. Is disaster-related media helpful or harmful to counselors’ empathy toward clients who are disaster victims?

7. To what degree does individual preference bear on a counselor’s comfort with telephonic counseling?

Conclusions

This study sought to explore the lived experience of counselors’ empathic response to clients via telephonic counseling during COVID-19. Each of the participants acknowledged providing telephonic counseling to clients at an outpatient level of care. The findings of this study illustrated a variety of positive and negative reactions to telephonic counseling and its intersection with empathic response and navigation of the COVID-19 pandemic. This study provided context to factors previously researched pertaining to empathic response via telephonic counseling and thoroughly investigated participant narratives as a means of highlighting experiences that were absent from the current literature.

This study included eleven participants in semi-structured interviews conducted via Zoom Videoconferencing. Participant disclosure about their experience empathically responding to clients during COVID-19 provided detailed information regarding both the uniqueness and universality of their experiences. The data of the study was delineated from the participant
interviews and informed by the four research questions, from which three master themes and eleven subthemes emerged. In these themes, participants were able to discuss how both the telephonic counseling medium and the COVID-19 pandemic affected their empathic response toward clients. The participants identified the increased need for imaginative efforts and clarification in telephonic counseling, in addition to a more intimate understanding of the client’s daily lived experience due to telephonic counseling typically occurring in the home setting. Participants also reported that they were able to glean an increased understanding of clients’ barriers to in-person counseling and SES situations in the transition to telephonic counseling, and that receiving supervision helped to instill a sense of groundedness and objective empathy in their provision of telephonic counseling.

Moreover, participants in this study reported that telephonic counseling demanded greater emphasis on vocal tonality and did not afford the same level of intuitive empathy observed in in-person counseling due to the absence of visual contact with the client. Participants also reported environmental barriers to counseling due to contaminations in the home settings of both the client and counselor. Additionally, participants discussed that their own navigation of the COVID-19 pandemic precipitated a greater sense of identification and self-disclosure with clients. However, participants also shared that fear and overwhelm precipitated by the COVID-19 pandemic negatively affected their felt-level experiencing regarding empathy, and that this factor precipitated emotional barriers to interpersonal empathy. Lastly, participants discussed that, although COVID-related media functioned as a source of objective empathy toward clients, oversaturation of such media had an adverse effect on empathic response.

This study’s findings illustrate that transitioning from in-person to telephonic counseling may be jarring to counselors due to the absence of visual contact with the client and potential
environmental contaminations. The findings also indicate that counselors may be more likely to be receptive to telephonic counseling if it is acknowledged as a necessary medium, rather than a “last resort” measure. This study found that counselors who perceive telephonic counseling with this “last resort” mentality will likely foster resistance to the medium. The study also found that counselors will likely increase comfortability and effectiveness with telephonic counseling as they continue to accrue exposure to the medium. Although most participants placed empathizing with clients in person as easier than empathizing via telephonic counseling, several participants commented on the increased ease of telephonic counseling via exposure.

Additionally, this study found that counselors’ subjective empathy toward clients during a disaster event such as COVID-19 may function as a “double-edged sword”, as commonality in experience may be of benefit to empathic response, but trauma precipitated by the disaster event itself may result in compassion fatigue and empathy saturation. Moreover, counselors may find that their own fears and concerns during a disaster event may produce a barrier to interpersonal empathy, as setting aside their own experience may be emotionally difficult during such a time. Regarding objective empathy, counselors may find yet another double-edged sword during a disaster event, as exposure to COVID-related media may provide both an informational channel for empathy and a source of emotional overwhelm.

Overall, this study showcases the variability of counselors’ empathic via the telephonic counseling medium based on factors such as disaster-related stress, environmental contaminations, and comfort with the telephonic counseling medium. Moreover, the study highlights the greater level of understanding that counselors may glean regarding clients’ barriers to in-person counseling in their provision of telephonic counseling. If entities such as counseling agencies, individual practitioners, and insurance companies can recognize how these various
factors bear on telephonic counseling, perhaps these entities can make informed decisions regarding the incorporation of the telephonic medium, and its impact on empathic interactions between counselor and client.
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Appendix A

Demographic Questionnaire

1. Education level: ______________

2. Age: ______________

3. Gender: ______________

4. Race/Ethnicity: ______________

5. Licensure: ______________

6. Total number of years accumulated as a practicing counselor: ______________

7. Have you provided any telehealth counseling services prior to COVID-19?: (Y/N)
   a. If you responded “yes”, please briefly describe your experience providing telehealth counseling services prior to COVID-19:
      ____________________________________________________________

8. Number of cumulative months spent conducting telephonic counseling post-COVID-19: 
   ______________

9. Average number of telephonic counseling clients seen per week: ______________

10. On a scale of 1-10 (10 being most comfortable), how comfortable are you in providing telephonic counseling?: ______________

11. Hours of supervision currently received per week: ______________

   *If you are interested in participating in the study, please provide us with your preferred e-mail and phone contact information:

   Email: ______________

   Phone: ______________

   *only collected in solicitation for participation in interviews for this study. This item will be omitted for the on-line survey demographic questionnaire.
Appendix B

Informed Consent

DUQUESNE UNIVERSITY
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE:

“I Hear You”: Exploring the Lived Experience of Counselors’ Empathic Response to Clients when Conducting Telephonic Counseling during COVID-19

INVESTIGATOR:

Michael Sickels, M.S.Ed., LPC, NCC
Doctoral Candidate, School of Education
412-715-8938, sickelsm@duq.edu

ADVISOR:

Dr. Debra Hyatt-Burkhart
Department Chair, Associate Professor, School of Education
412 396-5711, hyattburkhard@duq.edu

SOURCE OF SUPPORT:

This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

STUDY OVERVIEW:

This is a research project being conducted by a doctoral candidate in the Counselor Education and Supervision Program at Duquesne University. The purpose of this study is to investigate the lived experiences of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19. You are being asked to participate in an interview that will last approximately 1 hour to 1.5 hours. Participation in this study would require some level of comfort talking about your personal experiences as a telephonic counselor in the workplace during COVID-19. Risks associated with participation are minimal and no greater than would be encountered in day-to-day conversations.
PURPOSE:

The purpose of this study is to investigate the lived experiences of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19. In this study, empathic response is defined as Attending to the emotional and mental state of another person in a way that is attuned with the feelings and meanings of the individual’s experience (Clark, 2014; Zaki, et al., 2009).

In order to qualify for participation, you must:

- Possess a master’s degree in counseling
- Currently (or recently have been) providing telephonic counseling at an outpatient level of care
- Have provided telephonic counseling during COVID-19
- Not have provided telephonic counseling services prior to the beginning of COVID-19
- Have accumulated at least six months total experience providing telephonic counseling
- Currently (or recently have been) providing telephonic counseling to at least 10 clients per week

PARTICIPANT PROCEDURES:

If you provide your consent to participate, you will be asked to participate in an individual interview via Zoom. The interviews will be audio and video recorded so that they can later be transcribed. Interviews will take approximately 1 hour to 1.5 hours to complete. During the interview, you will be asked questions about your personal experiences as a telephonic counselor empathically responding to clients during COVID-19. Following the transcription of the interviews and data analysis, I will provide a summary of the themes from your interview to you via email. You will be given the opportunity to provide feedback to me about whether your interview data has been interpreted accurately. These are the only requests that will be made of you.

RISKS AND BENEFITS:

There are minimal risks associated with participating in this study, but no greater than those encountered in everyday life. There are no direct benefits to participating in this study, however you may experience positive psychological effects from having your experience validated by others and knowing that you assisted in the research study.

COMPENSATION:

There will be no compensation in exchange for participating in this study. However, participation in this study will not cost you anything.
CONFIDENTIALITY:

Your participation in this study, and any identifiable personal information you provide, will be kept confidential to every extent possible, and all data will be destroyed within five years of the completion of the study. All written and electronic forms of data and study materials will be kept secure. Electronic data (electronic transcriptions, researcher journals) will be stored in a password protected folder on a password protected computer. Video/audio recordings will be stored in a password protected folder on a password protected computer and will be destroyed within five years of the completion of the study. Transcriptions will be deidentified using pseudonyms. Paper records (field notes, printed documents, consent forms, other study materials) will be stored in locked filing cabinet only accessible to the investigator. All results will be reported in aggregate. All direct quotes from participants will be presented using pseudonyms. All written and electronic documentation will be destroyed within five years of the completion of the study. Additionally, any publications or presentations concerning this research will only use data that is combined with all subjects; therefore, no one will be able to determine how you responded. All direct quotes from participants will be presented using pseudonyms.

The Zoom platform is HIPAA compliant for covered entities (Zoom, 2020). In the use of Zoom, privacy features remain in the control of the meeting host and approved participants at the discretion of the host. These features include entrance to the meeting, screen sharing, and recording abilities. Each meeting link is generated only for the purposes of each specific interview and the waiting room is enabled to allow for the meeting host to verify participants prior to entry. Following participant entrance to the meeting, the host can lock the room to prevent any further entry. Zoom protects data at the application level using an advanced encryption system (Zoom, 2020). For more information visit https://zoom.us/docs/doc/Zoom-hipaa.pdf.

RIGHT TO WITHDRAW:

You are under no obligation to start or continue your participation in this study. You may withdraw at any time without penalty or consequence by emailing your desire to cease participation to the principal investigator. Previously collected data will be immediately destroyed and will not be included in the data analysis, final report, or any subsequent publications.

SUMMARY OF RESULTS:

At the completion of the study, a summary of the study’s results will be provided to you at no cost. You may request this summary by contacting the researchers. The information provided to you will not be your individual responses. Rather, the information will summarize the total findings of the research project.

FUTURE USE OF DATA:
Any information collected that can identify you will not be used for future research studies, nor will it be provided to other researchers.

COVID-19 CONSIDERATIONS

I understand that the researcher(s) running this study have put in place the following guidelines to address concerns related to COVID-19:

- Participant interviews are all being conducted virtually via zoom.

VOLUNTARY CONSENT:

I have read this informed consent form and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw at any time, for any reason without any consequences. Based on this information, I certify I am willing to participate in this research project.

I understand that if I have any questions about my participation in this study, I may contact Michael Sickels at sickelsm@duq.edu or 412-715-8938 or Dr. Debra Hyatt-Burkhart at hyattburkhartd@duq.edu or 412 396-5711. If I have any questions regarding my rights and protections as a subject in this study, I can contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board for the Protection of Human Subjects at 412.396.1886 or at irb@duq.edu.

________________________________________________________________________
Participant’s Signature                                           Date

________________________________________________________________________
Researcher’s Signature                                           Date
Appendix C

Email to Program Directors Requesting to Recruit Participants for the Study

Subject: “I Hear You”: Exploring the Lived Experience of Counselors’ Empathic Response to Clients when Conducting Telephonic Counseling during COVID-19

Dear [Program Director's Name],

My name is Michael Sickels, and I am a doctoral candidate at Duquesne University. I am contacting you to request permission to recruit outpatient therapists for participation in a research study. I am conducting this study as part of the requirements for my doctoral degree in counselor education and supervision. I am interested in exploring the lived experiences of counselors’ empathic response to clients when conducting telephonic counseling during COVID-19. Much of the current research on telehealth interventions has focused on the videoconferencing medium, which could precipitate the effective marginalization of lower socio-economic status clients, as these clients likely have less access to computers, smartphones, and Wi-Fi. Moreover, few studies have explored the specific concern of empathic response in telephonic counseling, and no prior studies have explored this specific concern within the context of COVID-19. I am contacting you because you are listed as the [position] for [insert program name]. If you could, please forward the paragraph below (along with the attached informed consent document) and distribute the flyer describing the study, its intent, and requirements for participation. I thank you in advance for your assistance and am very appreciative. This study has been approved by Duquesne’s Institutional Review Board for the Protection of Human Subjects.

E-mail to Participant
You are being asked to participate in a research project that seeks to investigate the experiences of counselors’ empathic response to client when conducting telephonic counseling during COVID-19. This is a research project being conducted by a third-year doctoral candidate for his dissertation work in his Counselor Education and Supervision program at Duquesne University. You are being asked to participate in an interview that will last approximately 1 to 1.5 hours. Attached to this e-mail you will find the informed consent document for the study that explains, in detail, the purpose of the study and other important details. If you are interested in participating, please follow the link below in order to complete a brief demographic questionnaire. If you fit the sample characteristics regarding the delivery of telephonic counseling, you will be contacted the researcher in order to schedule your interview. This study has been approved by Duquesne University Institutional Review Board. Simply click on the link below, or cut and paste the entire URL into your browser to access the questionnaire:
[Insert survey link here]

Thank you for your time and consideration,

Michael Sickels, M.S.Ed., NCC
sickelsm@duq.edu
Doctoral Candidate, Duquesne University
*Clicking on the survey link will direct participants to the Brief Demographic Questionnaire (Appendix A)*

Appendix D

**Semi-Structured Interview Prompts**

1. What has it been like for you to empathically respond to clients’ reported experiences through the medium of telephonic counseling during COVID-19? (RQ 1)
   a. What is the role of empathy in the process of counseling?
   b. What are your beliefs on the importance of empathy?
   c. Did you receive supervision during your provision of telephonic counseling? If yes, what was the medium through which supervision was delivered?
   d. Did you work primarily from home, or from an office? How did your work setting(s) influence your experience?
   e. How did media coverage of COVID-19 influence your empathic response toward clients?

2. What has it been like for you to transition from in-person to telephonic counseling regarding empathic response toward clients during COVID-19? (RQ 2)
   a. Did your empathic response to clients change after the transition? If yes, how so? If no, why not?
   b. Is there a particular SES group of clients that you primarily work with? How has this factor influenced your experience?

3. Is there a difference in your empathic response regarding face-to-face and telephonic counseling during COVID-19? (RQ 3)
   a. What is it like for you to empathize with clients in person?
   b. What has it been like to empathize with clients over the telephone?
c. What has it been like for you to empathize with clients over videoconferencing?

4. How have your own personal experiences regarding COVID-19 influenced your empathic response to clients in the delivery of telephonic counseling? (RQ 4)

e. Did you ever test positive for COVID-19 or suspect that you had COVID? How did this factor influence your experience?

f. Were you ever exposed to COVID-19? How did this factor influence your experience?

g. Did you have to quarantine yourself from others? How did this factor influence your experience?

h. How much media coverage did you consume per day regarding COVID-19? How did this factor influence your experience?
Recruitment Flier

PARTICIPATION NEEDED

Therapists who are (or recently have been) delivering telephonic counseling to clients during COVID-19.

Study: “I Hear You”:

Researcher:
Michael Sickels, LPC, NCC
Doctoral Candidate
Duquesne University
Counselor Education and Supervision
sickelsm@duq.edu

In the age of COVID-19, telephonic counseling is being used more now than ever before. Therefore, we have an opportunity to better understand what it is like for counselors to conduct counseling through this medium.

What has it been like for you to empathize with you clients via telephone? You could help to contribute to an expanding wave of research, as there has been little research conducted on the medium of telephonic counseling.

If you are (or recently have been) conducting telephonic counseling with clients at an outpatient level of care during COVID-19, WE WOULD LIKE TO HEAR FROM YOU. I may want to interview you for 1 to 1.5 hours to discuss your experience for my dissertation study.

Participation is voluntary and confidential. If you are interested in participating, please contact me at sickelsm@duq.edu. We will set up a Zoom videoconferencing interview at a time that is convenient for you.

This study has been approved by the Institutional Review Board (IRB) of Duquesne University, verifying its ethical treatment of participants.