# Rising From the Ashes: Voices of Rural Counselors During the Coronavirus (COVID-19) Pandemic

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**The global health and economic disaster caused by the coronavirus (COVID-19) pandemic has intensified mental health needs and subsequent demands on helping professionals. Counselors, in general, are at risk of experiencing both shared traumatic realities with clients and exacerbation of occupational stressors. For rural mental health counselors, who already face enhanced stressors related to rural service provision, the impact of COVID-19 is generally unknown. Through transcendental phenomenology, this study explores the experiences of 11 rural mental health counselors practicing in Texas during the COVID-19 pandemic. Two themes emerged, revealing experiences of systemic limitations as well as counselor growth and resilience. Findings provide implications for mental health counselor training, clinical practice, and advocacy.**

*Keywords*: **COVID-19 pandemic, rural, mental health counselors, transcendental phenomenology, resilience**

With over a million deaths in the United States alone (Centers for Disease Control and Prevention [CDC], n.d.) the novel coronavirus (COVID-19) pandemic created a mental health crisis that includes long-term fear, trauma, grief, isolation, and negative social patterns (Czeisler et al., 2020; Eisma et al., 2021; Elbogen et al., 2021; Prati & Mancini, 2021). The influx of mental health needs meant that practitioners had to meet the demand of providing quality counseling services for those struggling with COVID-19 pandemic–related symptoms. Mental health counselors and related professionals experienced significant increases in caseloads and the clinical severity of presenting symptoms (Czeisler et al., 2020) that added increased pressure to workload, risk of burnout, and compassion fatigue, all of which are natural occupational hazards even under typical circumstances (Litam et al., 2021; Posluns & Gall, 2020; Sprang et al., 2007).

Increases in service demand were especially problematic when considering the vast preexisting shortage of mental health service availability worldwide (Wainberg et al., 2017). For rural mental health counselors, who ordinarily experience increased mental health service shortages (Breen & Drew, 2012; Slama, 2004), these demands and lack of resources were likely more intensely highlighted as lockdowns and shelter-in-place orders further reduced service access while simultaneously increasing the need for it (Panchal et al., 2023; Prati & Mancini, 2021). Mental health professionals were suddenly forced to transition to teletherapy services, a modality not frequently used prior to the COVID-19 pandemic (Burgoyne & Cohn, 2020; Pierce et al., 2021).

Teletherapy completely reshaped the provision of counseling services and required practitioners to consider and navigate various concerns, including accessibility and advocacy issues for vulnerable populations, quality of therapeutic engagement, ethical and legal matters, financial issues, treatment effectiveness, experience limitations, and training limitations (Maurya et al., 2020). This was likely a greater adjustment for rural practitioners, as they were less likely to use this modality than their urban counterparts prior to the COVID-19 pandemic (Pierce et al., 2020). Teletherapy has its disadvantages and advantages. The disadvantages include increased complexity of ethical issues such as privacy, information security, and maintaining a professional environment and professional relationships

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(Burgoyne & Cohn; Pierce et al., 2021). However, teletherapy provides client accessibility to services, overcoming the most notable barrier of local practitioner shortages experienced more often by rural residents (Tarlow et al., 2020). Through teletherapy, rural residents can connect to counselors in larger populated areas, but internet connectivity to do so has been a challenge historically (Handley et al., 2014).

## Rural Mental Health

Practice and clinical topics related to rural populations are relatively sparse in empirical counseling literature, and this is especially true regarding rural mental health counselors during the COVID-19 pandemic. Existing research has established the enhanced hardships faced by rural populations, including more significant mental health presentations caused by mental health stigma (Slama, 2004) and a significant lack of mental health, medical, and transportation resources (Breen & Drew, 2012; Pullen & Oser, 2014; Slama, 2004). For rural counselors, this often means bulging caseloads, professional isolation, and more complicated cases than their urban counterparts.

Although not specific to COVID-19, Fruetel et al. (2022) documented the experiences of school and clinical mental health counselors responding to crises in rural areas. Findings indicated significant hardships such as isolation and lack of crisis stabilization resources. This highlights the fact that rural counselors continue to face significant mental health challenges in the community with limited institutional and professional support, placing further demands on existing providers and thereby increasing the risk of burnout and attrition (Litam et al., 2021; Sprang et al., 2007). To further complicate matters, the COVID-19 pandemic has exacerbated practitioner experiences of vicarious trauma, fatigue, and emotional disconnection as well as feelings of incompetence (Aafjes-van Doorn et al., 2020), which likely has a compounded effect for rural mental health counselors, who face additional geographic and cultural stressors (Breen & Drew, 2012; Pullen & Oser, 2014; Slama, 2004).

### Trauma and Resilience

For many counselors involved in trauma and crisis work, occupational hazards such as burnout, compassion fatigue, and vicarious trauma have been documented (Posluns & Gall, 2020; Sprang et al., 2007), but less is known about the complexities of sharing trauma and crisis simultaneously with clients. Bell and Robinson (2013) posited that such experiences evolve into a compounded experience for counselors, in which the interplay between both vicarious and direct trauma—known as shared traumatic reality—enhances the post-traumatic exposure counselors experience. The shared traumatic reality of the COVID-19 pandemic has likely intensified existing occupational hazards of stress, burnout, and compassion fatigue (Litam et al., 2021; Posluns & Gall, 2020; Sprang et al., 2007).

Examining only the negative experiences associated with long-term trauma and crisis work would be unidimensional, inaccurate, and ignoring the potential value in such meaningful work. Additionally, this one-sided position ignores the presence and value of resilience among practicing counselors. Resilience has been represented as the ability to adapt and maintain well-being during unfavorable conditions (Clauss-Ehlers, 2008) and more specifically, taking deliberate actions to sustain health during hardship (Litam et al., 2021). Fostering resilience is imperative for mental health counselors who often face vicarious trauma. Without self-care and the ability to cope positively, these professionals risk burnout and impairment (Posluns & Gall, 2020), the latter of which has strong ethical implications because it poses an emotional risk to clients (Bell & Robinson, 2013).

Lambert and Lawson (2013), who studied counselors providing services during Hurricanes Katrina and Rita, found that counselors treating survivors of those disasters experienced compassion fatigue

and burnout at no greater rates than counselors in general. Interestingly, those counselors who were both survivors and treatment providers experienced compassion satisfaction and post-traumatic growth, positive counterparts to compassion fatigue and post-traumatic stress, respectively. Similarly, Litam et al. (2021) found comparable results for counselors during the COVID-19 pandemic. Although occupational hazards such as compassion fatigue, vicarious trauma, and burnout were apparent for counselors in the sample, resiliency was a positive mitigating factor. It is important to note, however, that neither study examined multicultural issues as variables, and Litam et al. noted the absence of rural counselors as a significant limitation of their study.

Although not a study conducted with counselors, Wang et al. (2021) compared coping and adjustment in rural and urban individuals in North America. Despite adverse experiences among both groups, Wang et al. found several strengths in rural populations that were undetected in their urban counterparts, including enhanced coping and adjustment. These findings imply a cultural element to trauma and disaster response. In studies specific to counselors, Crumb et al. (2021) found strengths among rural school counselors providing disaster mental health services that included deepened empathy because of co-experience; Imig (2014) also found that despite difficulties, rural counselors found meaning in difficult work.

At the time of this study, we did not find additional research examining stress, resilience, or other quantitative or qualitative inquiries of rural mental health counselors' experiences during the COVID-19 pandemic. This paucity of literature necessitates our study, which aims to fill a gap in understanding the interplay of rural mental health constraints and COVID-19 response. Learning how rural mental health counselors manage the complexities of limited mental health and medical resources, increased service demand, and vicarious trauma is imperative to better prepare for future mass disasters while maintaining the health and well-being of practitioners. Additionally, this study provides a much-needed voice for rural counselors and can further advocacy efforts for rural communities.

## Method

The purpose of this study was to explore the experiences of rural mental health counselors during the COVID-19 pandemic and to develop a distinct picture of this population during long-term stress and disaster. We utilized a postpositivism paradigm, which allows for the acknowledgement of multiple perspectives while also striving for empirical rigor, to explore the universal experience of rural counselors during the COVID-19 pandemic (Guba & Lincoln, 1994; Hoshmand, 1996). To facilitate this exploration, we utilized a transcendental phenomenological methodology to capture the essence or true meaning of the phenomena of interest, the overall experiences, and the responses of the sample who share elements of an identity under similar conditions (Moustakas, 1994). Although postpositivism and transcendental phenomenology originate from different epistemological assumptions, one that emphasizes a reality that can be approximated through empirical observation and the other focusing on the essence of lived experience through subjective exploration, this study intentionally combined both to balance rigor and depth. Transcendental phenomenology and postpositivism have been found to complement each other through acknowledging multiple perspectives and having a top-down approach to research (Henderson, 2011; Hoshmand, 1996; Moustakas, 1994), and additional studies have utilized this paradigm and methodology (Eryaman et al., 2013; Hall et al., 2016). Nevertheless, to address potential incongruences, we utilized bracketing techniques to mitigate researcher bias and to ensure that the participants' experiences remained central to the study. In alignment with transcendental phenomenology, we aimed to explore the lived experiences of rural mental health counselors during the COVID-19 pandemic, focusing on the perceived impacts and responses. The research questions guiding this exploration were:

RQ1: What were the experiences of rural mental health counselors during the COVID-19 pandemic?
RQ2: What impacts, if any, did COVID-19 have on the lives of rural mental health counselors?
RQ3: How did rural mental health counselors respond, if at all, to the COVID-19 pandemic?

**Site and Sample Selection**

The sample criteria included Licensed Professional Counselors of all rankings—Licensed Professional Counselor-Associates (LPC-As), Licensed Professional Counselors (LPCs), and Licensed Professional Counselor-Supervisors (LPC-Ss)—who provided mental health counseling services in rural regions of Texas between March and December 2020. Texas was selected as a matter of convenience sampling (both Brandi M. Sawyer and Edith Gonzalez reside in Texas and are familiar with public license information) and because 76% of the state is considered fully rural. Additionally, Texas, like most other states, experienced government-mandated lockdowns, restricted social gatherings, and shuttered schools for most of 2020 (Friend, 2021; Limón, 2020), indicating that Texans experienced significant adversity from the pandemic. The criteria for rural regions were determined by the fiscal year 2022 definitions set forth by the Federal Office of Rural Health Policy (Health Resources and Services Administration, Federal Office of Rural Health Policy [FORHP], 2025).

Following approval for this study by the IRB, we obtained a list from the FORHP (2025) of counties in Texas with a completely rural status for fiscal year 2022 as an initial guide for sampling. Once the counties were identified, we used the Texas Behavioral Health Executive Council's online search tool to obtain the names of eligible participants. This information was then used in a Google search to find addresses and emails for potential participants. In sum, we compiled a list of LPCs from 198 of 200 counties. Two counties were eliminated, as Sawyer had worked extensively in these rural counties and the likelihood that she knew potential participants was significantly increased. Email addresses, when available, were the first method of contact for recruiting participants. When not available, paper flyers were mailed to available addresses. Participants who completed the study and the final member-checking procedure received a $50 Amazon gift card. All participant recruitment and data collection took place in August and September of 2022.

**Participants**

Following recruitment procedures, 12 individuals volunteered to participate in this study, 11 of whom completed individual interviews. Saturation of data, when no new themes emerged during interviews and analysis (Ando et al., 2014), was reached within the 11 participants; no additional participants were needed. Eight participants identified as female, two participants identified as male, and one participant identified as transgender male. Eight participants identified as White and three identified as Hispanic or Latino. Nine of the 11 participants had master's degrees and two held doctoral-level degrees. Years in counseling practice ranged from 1.5–30. Years in rural counseling practice also ranged from 1.5–30. Working environments varied across the 11 participants and included seven in group and private practice, three in agency and nonprofit settings, and one in an educational setting fulfilling a mental health counseling role. The sample consisted of the following current license categories: nine LPCs, one LPC-A, and one LPC-S.

**Data Collection**

Exploratory questions were designed to holistically capture the perceived impact of the COVID-19 pandemic, including the related thoughts, emotions, and behavioral responses as they align with the

research questions exploring general experience, impact, and response. Participants chose personalized pseudonyms for anonymity and engaged in a 45–60-minute semi-structured, open-ended interview exploring their experiences working during the COVID-19 pandemic. The interview protocol included the following questions:

1. What was it like to provide rural mental health counseling during the COVID-19 pandemic?
2. How did you respond to the COVID-19 pandemic?
3. What feelings do you experience about providing rural counseling during the COVID-19 pandemic?
4. How did the COVID-19 pandemic impact your personal life?

a. How did the COVID-19 pandemic impact your professional life?

5. What was it like providing teletherapy during the COVID-19 pandemic?
    a. What is it currently like providing teletherapy?
6. What is your perception of rural mental health counseling during the COVID-19 pandemic?
7. How do you see your rural mental health work in the future following the COVID-19 pandemic?

Interviews were conducted and recorded via Zoom. Transcripts were first generated through a transcription application, Otter, and then verified for accuracy.

**Data Analysis Procedures**

Following the procedures set forth by Moustakas (1994), we used thematic analysis to evaluate data using two cycles of inductive coding. Engaging in multiple levels of inductive coding allowed us to explore themes within participant experiences while minimizing preconceived biases, a process known as epoche. The steps of coding and analysis first included preliminary horizontalization, which involved reducing narrative data into smaller units but not yet grouping data based on shared meanings. Using a spreadsheet, we achieved this by taking participant transcripts line by line, summarizing them, and placing them into columns. The next step in analysis, phenomenological reduction, involved clustering data relevant to the research questions into categories of corresponding themes and considering these from a variety of perspectives. Clustering data was done first to efficiently manage the data in order to better recognize recurring themes. We evaluated the horizontal data in the spreadsheet and clustered data from textural descriptions in various statements until no new groupings emerged. Ancillary information irrelevant to the research questions was eliminated from further coding. The final coding procedure generated the broadest themes, which were grouped based on shared meaning derived from phenomenological reduction using imaginative variation. We evaluated and interpreted the context of all codes achieved in reduction until the final themes emerged.

**Strategies for Establishing Trustworthiness**

We took steps to ensure trustworthiness of the findings according to Lincoln and Guba's (1985) five tenets of trustworthiness: credibility, authenticity, transferability, dependability, and confirmability. Credibility and authenticity were achieved through in vivo and post-interview member checking to ensure accurate understanding or credibility of participant reports and by using two methods, providing ample opportunities for clarification. Another credibility validation tool, prolonged engagement, was achieved by having Sawyer interview, transcribe, check for accuracy, and conduct analysis, resulting in heightened awareness and understanding of the data. Triangulation with

Gonzalez, who has different professional and personal identities, aided in furthering the inductive and methodological nature consistent with transcendental phenomenology (Moustakas, 1994).

Transferability was achieved through inductive procedures and obtaining rich details about study findings. Dependability was achieved through a rigorous methodology as outlined in Moustakas's (1994) framework, which lends itself to examining multiple realities from an objective position. Multiple coding cycles additionally aided in dependability because they reduce abstract and biased findings. These same procedures also helped to achieve confirmability, enhancing objectivity in this qualitative research. We reduced researcher bias in interviewing and analysis through multiple coding cycles with rigorous methodology and triangulation (Lincoln & Guba, 1985).

### *Reflexivity*

Bracketing was used to achieve reflexivity as a means to isolate and understand participant experiences apart from existing presuppositions. Sawyer has a professional identification aligning with that of rural mental health counselors. For 14 years, she has practiced mental health counseling in rural Texas, and since the onset of the COVID-19 pandemic, has provided teletherapy. She is an LPC-S and National Certified Counselor (NCC) who lives in Texas and has roots in rural Texas. Sawyer led all aspects of the research study. Gonzalez served as an external auditor for data analysis and assisted with manuscript writing. She is a counselor educator, researcher, and LPC with extensive experience in qualitative research and previous teaching experience in a rural setting. Based on Sawyer's positionality, there were some apparent internal assumptions existing prior to the study. We assumed, based on personal and professional experiences, that participants would likely identify some hardships with rural service provision. Based on Sawyer's work with often resilient rural clients during the last 14 years, we assumed some strengths related to rural populations would likely be identified.

In addition to bracketing, Sawyer reviewed interview questions and reflected on their cognitive reactions to the questions prior to conducting the interviews in an attempt to be aware of and set aside suppositions about the topic. Following each interview, Sawyer again reflected on personal cognitive responses to the topics, making notes as needed, and regularly reflecting on potential biases and enhancing trustworthiness with Gonzalez to counter them. As a result of such reflection, during thematic analysis, we did line-by-line coding to minimize interpretive assumptions, yielding the most objective view of sample experiences possible.

## Findings

Thematic analysis rendered two themes as distinctly capturing the rural mental health counselor experience: systemic limitations and counselor growth and resilience. The codes within these themes had a 100% endorsement from the sample.

### Systemic Limitations

The theme of systemic limitations was defined by participants as resource limitations within their rural communities, including significant shortages of mental health and medical services as well as services for basic needs such as food, housing, and financial assistance. Furthermore, a large majority of these clients characterized resource limitations as being both preexisting as well as exacerbated by the pandemic. For many participants, COVID-19 conditions greatly impacted their ability to provide face-to-face counseling in already resource-limited communities. Internet connectivity deficits in rural communities, which are already dealing with limited resources, were also included in this theme.

Mental health care prioritization and a lack of mental health care availability for rural clients were among the most prominent topics in participant reports. Participants shared the idea that because basic health care and other needs remained unmet in their communities, mental health care was a lower-ranking priority during the COVID-19 pandemic. One noted that "mental health had to take a second seat because their basic needs were not being met." Another described that although mental health "maybe needed more," other responsibilities took priority because the "importance of [mental health] was not there." Additionally, one participant further addressed not just the need for mental health counseling services but the impact of the loss of services during the COVID-19 pandemic. She emphasized that these impacts were "more keenly" felt in rural areas due to baseline counseling resource limitations. Furthermore, one participant shared this perspective by noting the need for financial support for ongoing focus on parity in rural mental health care. Although this participant acknowledged the attention garnered by the COVID-19 pandemic for rural communities, she worried that the focus was waning too quickly.

In addition to mental health shortages, medical shortages were also prominent with rural clients. One participant, whose caseload was heavily comprised of transgender individuals, compared his experiences between metropolitan and rural areas, emphasizing the rural-specific difficulties for his clients. He went on to describe how the COVID-19 pandemic shutdowns led to a temporary loss of gender-affirming care in his community. He identified this experience as "particularly rough" for his clients who were "dealing with worrying about whether they would ever be able to access their gender-affirming health care or [have] it delayed a long time." Limitations in resources for basic survival were also impacted during the COVID-19 pandemic, as one participant described the deepened scarcity of financial and housing assistance as well as food bank supplies. He went on to describe his community as "one of the poorest in Texas, where poverty is pronounced," to emphasize the impact these resource shortages made in rural communities during this time.

In addition to health and other wellness services, internet connectivity deficits greatly impacted the ability for rural counselors to reach and provide services to rural clients. Nearly all participants identified geographical and/or financial barriers in rural communities obtaining internet connectivity necessary for everyday life during the COVID-19 pandemic. For those who could afford internet service, rural geography made consistent connectivity difficult. Some participants had to resort to primarily phone usage early in the COVID-19 pandemic. It was also noted that difficulties in connectivity impacted "already thin" mental health resources in rural communities and that "Wi-Fi is not as fast as it is in metro areas." Even when some counselors attempted to have face-to-face services, they were met with difficulties in sustainability. In describing the changes to her private counseling practice, one participant described having to shutter her face-to-face business, which never rebounded after the period of shutdown between March and June 2020, and begin providing teletherapy only. This meant that there was one less in-person practice operating in a rural area where mental health resources were already limited.

**Counselor Growth and Resilience**

The theme of counselor growth and resilience was defined as rural counselors' abilities to overcome significant adversities related to COVID-19 pandemic conditions in the context of their rural identification. Specifically, growth was defined as the ability to not only manage difficult circumstances but also to experience a change in themselves as an outcome of that experience. Resilience was defined as an ability to rebound or cope quickly in the face of adversity and, in the case of the COVID-19 pandemic, traumatic circumstances. Among the 11 participants, over half detailed a clear alignment

between rural-specific deficits, as noted in the theme of systemic limitations, and the need to respond in resilient ways. Two participants, for example, adjusted quickly to phone counseling without face-to-face contact when rural internet connectivity and Wi-Fi availability fell short. Relatedly, another provided face-to-face services throughout the COVID-19 pandemic as the only practitioner in her area who could meet this need.

All participants described significant adverse experiences, up to and including vicarious trauma, but also an ability to cope with or make meaning of the circumstance. Collectively, participants leaned into their challenges, and many described a sense of empowerment in meeting them. For example, one participant, like most other counselors in this study, struggled significantly with the idea of teletherapy service delivery. She had difficulty adjusting treatment for her caseload, which included children coping with trauma and their families. Despite the stress described, she grew to enjoy meeting these new demands. She not only described that she "likes a challenge" but also discussed a process of using cognitive flexibility in providing herself "grace" and coping with the sudden need to learn a new skill set.

Although the ability to pivot typical practice styles during desperate times was a notable element of rural counselor growth and resiliency during the COVID-19 pandemic, so was the ability to alter beliefs and personal philosophies in order to adapt to changing times. Participants described a shift in viewpoints and flexibility to teletherapy as a modality. Although initially and fundamentally opposed to the practice, one participant reflected on the ability of professionals to shift their views. In speaking on the revolution of teletherapy in counseling, she stated that an in-person counseling modality is "not the only practice . . . we have to be flexible . . . we can't be as old school anymore." Similarly, another participant, also speaking on behalf of himself and rural mental health counselors, described a positive component of the pandemic: trying new things and learning that they are beneficial. He illustrated this by describing his "work–life balance" since his employers retained remote working allowances initially issued during lockdown and stay-at-home orders.

Participants illustrated cognitive flexibility in response to changes within their working world, but cognitive flexibility only represented part of the growth and resiliency among this sample. As depicted in the theme of systemic limitations, most participants provided services to clients with intensely limited resources, which naturally impacted how they typically provide counseling. In efforts to be therapeutic for his often crisis-affected clients, a participant noted that most of his work in the early months of the COVID-19 pandemic was "just letting people know that however they're feeling is okay," and further described, "I am good at remaining calm when the person in front of me is not . . . and appear to have at least a reasonably soothing presence." Another participant closely mirrored these concepts in her statement that "it was, for me, a lot of just providing this space for people to have whatever feelings they had about it. And for that to be okay." Additionally, two more participants reflected the change in focusing on immediate needs versus long-term or abstract concepts in counseling. Both described staying abreast of current events to help clients process their concerns.

As mentioned earlier, a majority of the participants noted a direct connection between rural-specific resource deprivation and the need to respond with resilience. Consequently, many participants found themselves becoming an integral part of resource seeking and attainment, which was described as a notable deviation from their typical counseling role. One participant described responding by actively providing help to clients who needed food when there were shortages due to already limited resource closures. She described this process as case management and assumed an active role in ensuring resources were obtained, including "trying to find people that could go pick up groceries and drop off at their porches." Another similarly reflected that she did "a lot more social work . . . more connecting

people with resources and that sort of thing." She went on to note that as she adjusted her typical role from mental health counseling, the clients felt "cared for" and subsequently experienced a renewed encouragement to keep moving forward with counseling. Another participant additionally noted that gender-affirming care was already "quite difficult to find" in his rural community but became even more difficult to access due to the COVID-19 pandemic. In response, he sought out "updates through newsletters and Facebook connections with professionals" to ensure clients that the medical community was working to resolve the deficit. Collectively, these participant reports indicated that this sample of rural mental health counselors possessed the ability to shift their work and adapt to rapidly changing circumstances during the COVID-19 pandemic.

## Discussion

The study explored the experiences of rural mental health counselors during the COVID-19 pandemic, revealing that participants experienced both preexisting and exacerbated systematic limitations in addition to growth and resilience during the early and more impactful phases. Systemic limitations identified by participants spanned the spectrum of human needs from food, financial, medical, transportation, and housing resources to a near absence of mental health services in their respective rural communities. Unique to rural counseling, the mass implementation of teletherapy was met with limitations involving lack of connectivity and financial means to remain online. For many participants, connectivity concerns have persisted. Unfortunately, the dearth of services for basic needs also meant an increase in the need for mental health services to cope with those hardships.

The descriptions of rural resource and funding deprivation extend and support the findings of the rural counselor hardships from other qualitative studies (Breen & Drew, 2012; Imig, 2014). The findings from this study show that despite nearly a decade, systemic changes that would otherwise bolster the quality of life or resource availability in rural communities have not been actualized. Naturally, this has created enhanced stressors for this sample of rural mental health counselors who perceived these otherwise typical limitations in their work as being grossly exacerbated during the COVID-19 pandemic.

The findings related to growth and resiliency in this study align with previous findings on counselors' work in mass disasters (Lambert & Lawson, 2013). Most recently, Litam et al. (2021) found that counselor resiliency was associated with post-traumatic growth and compassion satisfaction, states that are in contrast with post-traumatic stress and compassion fatigue, which cause burnout. We suggest that finding one's purpose is critical for growth, which aligns with the descriptions provided by this sample of participants. Much like the rural counselors in this study, Posluns and Gall (2020) found that maintaining awareness, finding balance, and having a flexible coping style were key to overcoming hardship. Additionally, Pow and Cashwell (2017) found that emotion-focused coping skills such as mindfulness and emotional regulation techniques were effective at mitigating the traumagenic effects of disaster work among a sample of disaster mental health counselors. The findings, combined with those on resilience practices in the current study, strongly support counselors and clients emphasizing a greater role in resilience and positive coping during disasters.

Participants also described resilience in the form of strong personal and professional support from family, friends, and colleagues, which validated findings that both personal and professional support were important for coping with adverse conditions and experiences during the COVID-19 pandemic (Aafjes-van Doorn et al., 2020). This finding is interesting in light of prior research showing that rural counselors experience isolation (Breen & Drew, 2012; Imig, 2014). They are, however, consistent with the findings of Wang et al. (2021), which showed that social connections helped rural individuals cope

better than their urban counterparts during COVID-19, and Crumb et al. (2021), which indicated that social connection and rural community collaboration are helpful in coping after disaster.

Though not a theme that is uniquely tied to the rurality of the mental health counselor sample, it was evident that participants experienced intense levels of negative affect vicariously with their clients, especially during the earlier and more impactful parts of the COVID-19 pandemic. Such experiences included anxiety, uncertainty, depression, trauma, and helplessness. Findings from this study included echoes of prior research related to broader populations (Czeisler et al., 2020; Eisma et al., 2021; Elbogen et al., 2021; Prati & Mancini, 2021). In our study, these vicarious experiences intensified the natural occupational hazards (Lambert & Lawson, 2013; Litam et al., 2021) associated with professional health counseling practice and created a shared traumatic reality caused by mass disaster (Bell & Robinson, 2013). Additionally, uniquely rural hardships such as immense systemic limitations no doubt exacerbated these pandemic-related stressors as described by nearly all participants. This in turn necessitated the growth and resilience demonstrated by most of this sample in their descriptions of responding in creative and resilient ways.

**Implications**

Exploring the experiences of rural counselors during the COVID-19 pandemic reveals important training, clinical, and advocacy implications to consider. The findings emphasize the need for rural mental health counselors to adopt a more comprehensive approach that extends beyond traditional counseling roles. To effectively respond to sudden mass disasters or crises, like the COVID-19 pandemic, counselors must develop enhanced skills in case management, crisis intervention, referral coordination, and social service networking. Given the compounded challenges in rural settings, cultural competency training is vital for addressing the unique needs of these populations.

Mental health counselors should proactively familiarize themselves with available community resources and remain adaptable to extending services beyond conventional counseling modalities during crises. Counselors may consider expanding their training by attending workshops on advocacy and referral strategies and being more involved in networking with non-counseling resources within their clients' communities. For those providing teletherapy services across their state or in several states, there are a few issues to consider. In addition to consulting and abiding by state laws related to interstate practice, mental health counselors should consider the location of their remote clients and at least generally link them to resources in their own communities.

Although teletherapy has proven beneficial, relying solely on virtual services is not a comprehensive solution for rural communities that lack consistent broadband access. Federal funding for increasing rural internet connectivity has been explored, as the National Telecommunication and Information Administration (n.d.) has allocated over a quarter of a million dollars to aid in increasing broadband accessibility in rural areas. However, until broadband for all is an established reality, continued advocacy is necessary to ensure rural connectivity remains a national priority.

Rural mental health counselors can further support rural clients by promoting culturally relevant resilience practices that emphasize mindfulness and emotional regulation (Pow & Cashwell, 2017) as well as self-awareness, balance, and cognitive flexibility (Posluns & Gall, 2020). For rural clients, aiding in establishing social support may better foster resilience development. Counselors can help rural clients explore, develop, and strengthen their involvement across multiple systems, including family, church, school, and the broader community to increase their capacity to cope with adversity. Further, counselors can help rural clients identify and leverage existing community strengths to mitigate the impact of resource limitations.

Advocacy and leadership are needed for promoting systemic change to drive policy and clinical practice shifts in the counseling profession (Lee & Rodgers, 2009). Advocacy efforts should prioritize systemic changes at local, state, and national levels that target funding allocations, service accessibility, and infrastructure development in rural areas. Addressing chronic resource limitations in rural areas involves advocating for increased mental health and medical funding, expanding access to basic needs, and sustaining broadband infrastructure initiatives. Prioritizing mental health care includes boosting resources, reducing stigma, and ensuring that mental health services are affordable and accessible. In these efforts, counselors can collaborate with community leaders, social service agencies, and advocacy organizations to elevate rural mental health priorities within broader policy discussions.

Finally, rural mental health counselors should recognize and enhance personal cultural strengths to overcome natural occupational hazards associated with counseling work as well as the enhanced challenges that coincide with rural practice. To maintain their own well-being amid ongoing crises, rural counselors should also engage in professional development that fosters their resilience. Implementing peer support programs, attending networking events, and participating in supervision groups can provide essential emotional support and guidance. Additionally, involvement in local, regional, and state counseling associations can further reinforce counselors' sense of connection and reduce the isolation often associated with rural practice. This comprehensive approach will empower rural mental health counselors to better navigate the challenges they face and enhance their ability to support their clients.

**Limitations and Future Research**

Despite providing rich phenomenological data to understand the experiences of this sample during the COVID-19 pandemic and contributing to a relative paucity of research on this population, this study was not without limitations. Defining rurality is complex with no single definition capturing the multifaceted nature of such a culturally intricate group (Imig, 2014), and our study is no exception. For the purpose of generating accurate findings, a categorical and geographically based definition was selected. While the FORHP's (2025) fiscal year 2022 classifications were used and represented an enhanced and more accurate definition of rural areas compared to previous definitions, it neglected to consider the descriptive or cultural aspects of rurality. Defining COVID-19 and its parameters was also a limitation. Participants, much like society, have navigated the uncertain, mutating, and episodic nature of viral outbreaks; therefore, it is difficult to define as either a historical or current event 4 years later. At the time of the study, however, participants largely viewed the most impactful degree of the COVID-19 pandemic as having occurred in earlier phases, which is helpful in ameliorating this limitation. Conversely, the length of time between the identified impactful phases in 2020 and interview time in 2022 is an additional limitation. With the passing of nearly 2 years, retrospective reflections may impact the accuracy of participants' accounts of their experiences.

This study brings about several recommendations for future research. Future studies should continue to explore counselor experiences during mass and prolonged disasters. Despite being several years removed from the devastation of the COVID-19 pandemic, lessons of preparation and adaptability linger. In the last year, the United States has experienced Hurricane Helene in North Carolina and the Los Angeles wildfires, among hundreds of other disaster declarations (Federal Emergency Management Agency, n.d.). It is important to understand how counselors can care for their clients and themselves while navigating shared traumatic realities. Learning ways to foster resilience and post-traumatic growth is necessary to prevent counselor burnout and, ultimately, improve client care. For rural research specifically, replications of this study and related inquiries should continue to seek the most robust definition of culture; developing mixed methods approaches to capturing rurality would most likely overcome some limitations present herein. Rural cultural resilience should be a

continued exploration, as much research has highlighted primarily barriers and challenges with less emphasis on resilience (Fruetel et al., 2022; Imig, 2014; Pullen & Oser, 2014; Slama, 2004; Sprang et al., 2007). Lastly, comparative analyses should be done in the future to further determine the uniqueness of rural counselor growth and resilience, as identified as a theme in this study.

## Conclusion

The COVID-19 pandemic intensified mental health challenges in the United States, further straining an already overburdened health care system. Rural communities, which already experience fundamental disparities in resources and mental health care, were no exception. This study revealed both the struggles and resilience of rural mental health counselors in navigating the impacts of the COVID-19 pandemic in their communities. Identifying both exacerbated resource limitations and the need to cope and adapt with creativity and strength provides lessons for all counselors in the face of inevitable mass disasters. The findings underscore the importance of self-care, resilience-building, and leveraging community support during crises. Counselors should be well-versed in local resources and adopt broader roles. Given persistent disparities in rural health care access, ongoing advocacy remains essential.

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