

Mental health symptoms, well-being and experiences of the COVID-19 pandemic: A mixed-methods practice-based study

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Abstract

The COVID-19 pandemic necessitated abrupt and substantial changes in daily life, and public health strategies intended to protect physical health can negatively affect mental health and well-being, especially for individuals with pre-existing mental health challenges. For this study, we surveyed a sample of clients ($N = 94$) in the summer of 2020 from a community mental health clinic in the northeast United States. A mixed-methods, concurrent triangulation design was used to (a) identify client subgroups on indicators of mental health (i.e. anxious and depressive symptoms) and emotional, psychological, and social well-being using latent profile analysis (LPA), and (b) within these subgroups, examine qualitative, thematic patterns in self-described challenges, benefits and learning related to the pandemic. The LPA revealed five distinct subgroups with various levels of symptoms and well-being, including *Stagnant* (moderate symptoms/moderate well-being), *Languishing* (high symptoms/low well-being), *Flourishing* (low symptoms, high well-being), *Fortitudinous* (high symptoms, moderate well-being) and *Mobilized* (moderate symptoms, high well-being). These divergent subgroups support the need to conceptualise mental health symptoms apart from well-being and assess for heterogeneous constellations of such constructs among psychotherapy clients. Thematic analysis offered additional insight into pandemic experiences within each subgroup, including attention to psychological, emotional, behavioural/lifestyle, relational, physical and ecological/contextual dimensions of self-experience, as well as the ways clients had adjusted to the pandemic's circumstances. Findings support nuanced conceptualisations of positive mental health and offer insight into coping and adaptation during this public health crisis.

KEYWORDS

COVID-19, mental health, mixed-method, practice-based research, well-being

1 | INTRODUCTION

The 2019 novel coronavirus (COVID-19) pandemic has led to unprecedented loss and change. Since December 2019, the virus has caused over 5 million documented deaths globally, including almost

800,000 in the United States alone (Johns Hopkins University, 2021). To mitigate the spread, public health officials recommended mask wearing, physical distancing and limiting operations of non-essential businesses. While protecting physical health, quarantine and isolation are known to have especially deleterious impacts on mental

health (Henssler et al., 2021), and an emerging body of literature documents the pandemic's negative effects (e.g. Pfefferbaum & North, 2020). However, there is a specific need for research on psychotherapy clients' functioning in the pandemic context, as those with psychiatric diagnoses are at greater risk of negative psychological impacts during epidemics, natural disasters and community threats (Esterwood & Saeed, 2020; Yao et al., 2020).

Positive mental health is more than the absence of symptoms, however. Well-being is a multidimensional construct that can relate to mental health in complex ways (O'Connor et al., 2012, 2015). Further, individual experiences of the pandemic vary not only in functioning as measured by mental health and well-being indicators but also in what feels uniquely challenging, beneficial or even conducive to new learning and growth. With an eye towards capacities for resilience, efforts to identify how people have fared during this public health crisis should include nuanced attention to diverse sets of experiences. To examine psychotherapy clients' functioning and adaptation in the ever-changing pandemic context, this study employed a concurrent triangulation mixed-methods design to identify subgroups of clients based on mental health symptoms (hereafter, symptoms) and indicators of well-being, and to assess clients' perceived challenges, benefits and areas of self-learning related to the COVID-19 pandemic.

1.1 | COVID-19 pandemic mental health effects

The current public health crisis has introduced unique stressors to daily life. Restrictions that protect the public have also created significant disruption, and changing government restrictions, dynamic scientific understanding and ongoing multiple waves of infection have contributed to an ever-changing 'normal'. Research from the 2002–2004 SARS epidemic documented the vulnerability of some populations in times like these, noting that 'while psychological consequences are widespread, not all individuals are affected universally' (Douglas et al., 2009, p. 3). Studies conducted during previous outbreaks suggest that healthcare workers, people with prior mental health challenges, those with fewer social and economic resources or those who are impacted more directly (e.g. becoming sick, losing a loved one) are at heightened risk for chronic psychological distress (Esterwood & Saeed, 2020). Since the beginning of the pandemic, researchers and public health experts have raised alarm about rising mental health concerns, including depression, anxiety, traumatic stress, insomnia, substance abuse, intimate partner violence and suicidality (Pfefferbaum & North, 2020). A study conducted across 194 cities in China in early 2020 found that 54% of participants reported moderate to severe psychological impacts, with 29% describing moderate to severe anxiety. A meta-analysis of community-based studies conducted during the pandemic found depression to have a 25% prevalence rate (Bueno-Notivol et al., 2020). In particular, people with mental health vulnerabilities are likely to be 'more substantially influenced by the emotional responses brought on by the COVID-19 epidemic' (Yao et al., 2020, p. e21), including prolonged

Implications for Counselling Practice and Policy

1. This study supports the need to assess for diverse presentations along mental health symptoms and well-being dimensions in psychotherapy clients; these neither are synonymous constructs nor necessarily inversely related.
2. Clients' pandemic experiences vary, and therapy may attend to what clients have experienced as beneficial or what they have learned about themselves, in addition to what has been challenging.
3. This study offers insight into beneficial client adaptation processes during a markedly disruptive time, including identifying and employing relational resources, using active coping strategies or finding meaning for adversity.
4. The pandemic's effects may have disproportionately affected clients with marginalised identities or who are economically disadvantaged, and policy initiatives should seek to attend to those who have been most vulnerable to short- and long-term inequities created or exacerbated by the pandemic.

isolation imposed by stay-at-home orders, while potentially having less access to treatment (Simon et al., 2020). While a number of community studies have measured mental health in convenience samples, clinical populations are underrepresented.

Groups who experience systemic oppression, such as racial/ethnic minorities and economically disadvantaged individuals, are also at increased risk on multiple levels (Martin-Howard & Farmbry, 2020). The pandemic has disproportionately affected Black, Indigenous and People of Color (BIPOC) communities, where individuals are more likely to die from COVID-19 infection (Thakur et al., 2020). Tangible (e.g. financial security) and internal (e.g. loss of control over one's life) losses can create and perpetuate adversity, as vulnerable persons often have less access to resources needed to regain stable functioning (Hobfoll, 2011). Historically disadvantaged populations often have less access to healthcare, resulting in pre-existent conditions; rely on hourly/service positions, which have been hardest hit by economic downturn; reside in smaller living spaces and more population-dense areas, making physical distancing difficult; and may experience discrimination in seeking treatment. Women have also left the workforce at exponentially higher rates because of childcare needs (Madgavkar et al., 2020).

While some groups may be more vulnerable to negative effects, others may maintain stable functioning or improve or grow under the pandemic's circumstances, and a variety of risk and protective factors may influence these outcomes (Mancini, 2020). Despite their unique vulnerability, psychotherapy clients present as heterogeneous subgroups, and more nuanced conceptualisations of their experiences are necessary for effective treatment planning during and following this public health crisis.

1.2 | Coping and adaptation in disaster situations

There has long been interest in how people fare in response to widespread disaster. While situations like the COVID-19 pandemic impose new circumstances and experiences, they also invoke a need for individual and systemic coping and adaptation. Evidence suggests that epidemics can adversely affect mental health and well-being, but considerably less is known about how people adapt to the unique effects of infectious disease outbreaks relative to natural and human-caused disasters. Coping strategies involve active 'efforts to regulate emotions, behaviours, cognitions, psychophysiology, and environmental aspects' in response to stress (Morales-Rodríguez & Pérez-Mármol, 2019, p. 2). Adaptive coping takes many forms. Emotion-focused coping can help manage difficult affect and reduce feelings of isolation, problem-focused coping is well-suited for challenges over which one has some control, and meaning-based coping may be optimal in situations of chronic hardship (Folkman & Greer, 2000). Research investigating responses to disasters have salient application to infectious disease outbreaks. Subjective appraisals (e.g. the pandemic is a threat versus a challenge) can affect responses to stress (e.g. paralysed with fear versus rallying internal resources to adapt; Lazarus & Folkman, 1984), and perspectives (e.g. perceived risk) can impact willingness to follow recommendations (e.g. wearing a mask; Rogers & Prentice-Dunn, 1997).

Researchers conceptualise adaptive responses to adversity in a variety of ways. Resilience is sometimes defined as bouncing back, that is, resuming and maintaining stable functioning despite adversity (Herrman et al., 2011). Smith (2020) emphasised the need to distinguish 'bouncing back' from 'going beyond' (p. 84), with the former referring to resilience and the latter thriving or post-traumatic growth. Bonanno and Diminich (2013) differentiated types of resilience, distinguished by whether the outcome was in response to chronic adversity or single-incident trauma. Such conceptualisations largely frame resilience as an outcome and predominantly a characteristic of an individual that can be directly (e.g. Smith, 2020) or indirectly assessed via measures of symptoms and/or indicators of well-being. However, defining resilience in this way fails to capture systemic factors and the variety of ways people adapt and respond to adverse situations.

Resilience has more recently been defined as a process. Walsh (2020) conceptualised resilience as a socio-ecological construct dynamically unfolding at family and community levels, and Ungar and Theron (2020) describe it as the interaction among 'biological, psychological, social, and ecological systems ... that help individuals to regain, sustain, or improve their mental well-being' (p. 441). Such formulations draw attention to individuals' relational contexts and the ways in which individual-contextual interactions promote resilience. Wong (2011) suggested a process definition of resilience that went beyond bouncing back, and posited resilience as stemming from the dynamic interaction of an individual's internal capacities and contextual factors to foster positive growth and eudaimonic well-being, which he defined as 'meaning plus virtue' (p. 75). In fact, Wong suggested that meaning-making was central to resilience and

introduced spirituality as potentially important to meaning-making. Like Wong (2011), Walsh (2020) has recognised the role of virtues (e.g. hope), meaning-making and spirituality in the process of resilience towards positive growth.

Fortitude may be an aspect of a process definition of resilience with particular salience during the pandemic. The term fortitude refers to 'positive (fortigenic) appraisals of one's self, family, and external sources of support' (Pretorius & Padmanabhanunni, 2021a, p. 159), and some definitions emphasise this capacity when 'a positive outcome is not guaranteed (i.e. terminal illness) or may be difficult for a prolonged period (i.e. disaster impacted populations)' (Van Tongeren et al., 2019, p. 7). Several studies have demonstrated the positive influence of fortitude on reduced mental health symptoms and greater subjective well-being (for a review, see Pretorius & Padmanabhanunni, 2021a), and emerging literature suggests the importance of fortitude during this public health crisis. Early in the pandemic, Pretorius and Padmanabhanunni (2021b) found that loneliness and anxiety indirectly predicted life satisfaction through fortitude in a sample of South African undergraduate students. In the context of community disasters, fortitude was found to indirectly predict lower symptoms through facilitating meaning-making (Zhang et al., 2021). These findings suggest an interplay of coping, symptoms and well-being, as fortitude appears to buffer the negative effects of adversity by helping people re-appraise ongoing hardship within the context of their worldview.

1.3 | Mental health and well-being

Dual-factor models of flourishing that attend to symptoms *and* well-being represent an emerging trend in psychotherapy research (Fosha & Thoma, 2020; Jankowski et al., 2020; Rusk et al., 2018; Trompetter et al., 2017). Mental health care typically focuses on reducing symptoms and improving *hedonic* well-being, or a subjective state of positive affect; however, a diversity-sensitive approach to treatment prioritises holistic forms of emotional, psychological and social well-being that fit with clients' values and concerns. *Eudaimonic* well-being is a widely studied construct that includes psychological and social well-being dimensions, such as healthy relational connections, a sense of meaning and purpose in life, self-acceptance and contributions to community well-being. Keyes (2005) foundational work demonstrated that symptoms and well-being tend to be inversely related; however, these dimensions can constellate within individuals in complex ways (O'Connor et al., 2012, 2015). As an example, an individual with severe symptoms might have a sustaining life purpose, or someone may have few symptoms but lack a sense of meaning or social connection. Positive mental health, or *flourishing*, has been defined as the clinical goal of reducing symptoms *and* promoting greater subjective and eudaimonic well-being, but there is currently a lack of empirical evidence documenting treatment effectiveness for flourishing (Jankowski et al., 2020).

Research is beginning to investigate relationships between mental health, well-being and capacities for resilience during the pandemic. In a European study early in the COVID-19 outbreak, resilience was

associated with less perceived stress and greater well-being, controlling for demographics and health vulnerabilities (Kavčič et al., 2020). The authors proposed that resilience may 'inoculate individuals against elevated stress levels and decreased mental health, as well as weaken the negative impact of potential risk factors' (Kavčič et al., 2020 p. 2). However, with the pandemic lasting more than a year, bouncing back from adversity may be less feasible, particularly in communities with pervasive social structural disadvantages. Zhang et al. (2020) found that spiritual fortitude buffered the association between resource loss and mental health distress during the pandemic. Relatedly, emerging evidence from Columbia and South Africa during lockdown suggests that positive religious coping and cultivating hope can support mental health by buffering the psychological toll of pandemic-related spiritual struggles (Captari et al., 2020). Further, Landi et al.'s (2020) study on coping during lockdown in Italy found psychological flexibility, openness to inner discomfort and engaging in values-based actions attenuated the negative effects of health-related anxiety on psychological functioning. These findings highlight the need to attend to divergent ways clients may be affected by, and respond to, the pandemic's effects.

The complex relationship between mental health and well-being invokes a need to employ person-centred data analytic approaches (e.g. Burton et al., 2018), which explore diversity within a sample by identifying subgroups based on similar scores on multiple constructs. The resulting subgroups are 'homogeneous within a given category and are heterogeneous across categories' (Muthén & Muthén, 2000, p. 883). Most of the pandemic-related literature so far has employed variable-centred analytic methods, which examine group-level associations among constructs across a sample. Employing person-centred analyses to examine mental health and well-being may provide a more nuanced understanding of pandemic functioning and help identify groups of clients with unique treatment needs. Further, most of the literature has reported quantitative findings exclusively, which effectively depicts broad trends but has not captured the variety of ways the pandemic has uniquely affected people's lives or how they have responded. There are likely a variety of risk and protective factors that influence how clients fare (Mancini, 2020), and while there has been justifiable attention to pandemic-related challenges, inquiring about benefits and learning may offer insight into factors and processes relevant for pandemic functioning.

1.4 | The current study

The purpose of this study was to examine psychotherapy clients' functioning and adaptation in the early months of the COVID-19 pandemic. A mixed-methods, concurrent triangulation design was used (Hanson et al., 2005), whereby quantitative and qualitative data were collected at the same time, given equal priority and analysed so results from each method informed interpretation of the other's results. Given the exploratory nature of the study and person-centred analysis, and evidence that symptoms and well-being are distinct

dimensions that can be related to each other in different ways in clinical samples (e.g. Jankowski et al., 2021), our first aim was to use person-centred analysis to empirically identify distinct subgroups on indicators of symptoms, specifically self-reported severity of depressive and anxious symptoms, and levels of emotional (i.e. hedonic or subjective well-being), and psychological and social well-being (i.e. eudaimonic well-being). Our second aim involved using qualitative data analyses to describe client experiences of coping and adaptation during the early phase of the pandemic. Our final aim was to integrate quantitative and qualitative findings in the interpretation phase, by (a) examining responses to the COVID impact item by subgroup, and (b) descriptively comparing subgroups on our coding of participants' responses to the questions about challenges, benefits and learning during the pandemic.

2 | METHOD

2.1 | Study participants

Participants were outpatient clients at a psychodynamic-oriented community mental health clinic in a large urban area of the north-eastern United States. Ninety-five clients completed the study measures. Clients whose mental health diagnoses included symptoms of psychosis or severe forms of dissociation (e.g. dissociative identity disorder), and whose responses suggested that they were in a dissociative state at the time of data collection, were excluded from the analysis. One such case was identified and subsequently dropped from the dataset. The remaining clients ($N = 94$) ranged from 20 to 81 years old ($M = 41.53$, $SD = 15.35$), and they identified as female (66%), male (27.7%), transgender (1%), genderqueer (2.1%), and other or more than one gender (e.g. 'intersex and bigender tending to female', 3.2%). Their sexual orientations included heterosexual (67%), bisexual (12.8%), gay (7.4%), lesbian (2.1%), pansexual (2.1%), asexual (1%), and other or more than one sexual orientation (e.g. 'bisexual/polyamorous', 7.4%). A majority of clients identified their race as White (76.6%), whereas others identified as Asian (6.4%), Black or African American (6.4%), Middle Eastern/North African (2.1%), biracial (4.3%) or unreported (4.3%). Five (5.3%) reported being Hispanic or Latino/a.

2.2 | Procedures

The study clinic assesses mental health, well-being and indicators of virtue and flourishing as part of ongoing clinical routine outcome monitoring (Lambert et al., 2018). Four questions about the pandemic's effects were added to the previously established battery of measures. In mid-May 2020, clients received an encrypted email from a university-sponsored, HIPAA-compliant survey tool, REDCap (Harris et al., 2009, 2019), and were directed to an online form where they reviewed consent information and completed the measures. Data were collected over four weeks.

TABLE 1 Bivariate correlations among mental health and well-being variables

Measure	1	2	3	4	5	6
1. Depression	-					
2. Anxiety	0.71**	-				
3. Emotional well-being	-0.55**	-0.38**	-			
4. Psychological well-being	-0.57**	-0.53**	0.75**	-		
5. Social well-being	-0.56**	-0.45**	0.72**	0.80*	-	
6. COVID-19 pandemic impact	-0.36**	-0.27*	0.27*	0.16	0.14	-

* $p < .05$; ** $p < .01$.

2.3 | Measures

2.3.1 | Depression

The Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002) assessed depressive symptoms. The PHQ is a 9-item self-report measure frequently used in psychiatric and medical settings (e.g. Arroll et al., 2010; Beard et al., 2016) to assess symptoms of major depression. Clients reported symptom severity for each item (e.g. 'little interest or pleasure in doing things') on a 4-point scale ranging from 0 (*not at all*) to 3 (*nearly every day*). Internal reliability for the PHQ-9 in this study was $\alpha = 0.87$. Higher sum scores represented greater levels of symptoms.

2.3.2 | Anxiety

The Generalized Anxiety Disorder scale (GAD-7; Spitzer et al., 2006) assessed anxiety symptoms using a 4-point, 7-item measure with response items ranging from 0 (*not at all*) to 3 (*nearly every day*). Sample items include 'feeling nervous, anxious, or on edge' and 'feeling so restless that it's hard to sit still'. Internal reliability for the GAD-7 in this study was $\alpha = 0.89$. Higher sum scores represented greater symptoms.

2.3.3 | Well-being

The 14-item Mental Health Continuum-Short Form (MHC-SF; Lamers et al., 2011) assessed three dimensions of well-being: hedonic/emotional (EWB; three items; e.g. 'happy'), eudaimonic/psychological (PWB; six items; e.g. 'confident to think and express your own ideas and opinions') and eudaimonic/social (SWB; five items; e.g. 'that you had something important to contribute to society'). Participants rated frequency of each feeling on a 6-point scale ranging from 1 (*never*) to 6 (*every day*). Internal reliability scores for the MHC-SF subscales were $\alpha = 0.86$ (EWB), $\alpha = 0.87$ (PWB) and $\alpha = 0.82$ (SWB). Higher sum scores on each subscale represented greater well-being.

2.3.4 | COVID-19 impact

Similar to Klaiber et al.'s (2021) rating of pandemic-related stress, a single item assessed the overall impact of the COVID-19 pandemic

on clients' lives on a sliding scale ranging from 0 (*negatively*) to 100 (*positively*).

2.3.5 | COVID-19 challenges, benefits and learning

Participants responded to three questions about their functioning during the pandemic and were encouraged to be as detailed as possible: (a) 'In your own words, what, if anything, has been most challenging about the ways the COVID-19 situation has impacted you?'; (b) 'In your own words, what, if anything, has been most beneficial about the ways the COVID-19 situation has impacted you?'; and (c) 'In reflecting on the changes that have been involved in trying to deal with the COVID-19 situation, what have you been learning about yourself?'

2.4 | Data analysis plan

2.4.1 | Quantitative

The aims of the quantitative analysis were to: (a) identify different client subgroups based on symptoms and well-being early in the pandemic context, and (b) describe and interpret the subgroups to inform the qualitative analysis. We used latent profile analysis (LPA) to identify client subgroups based on the similarity of their responses across the two symptom measures and three well-being domains. Table 1 presents bivariate correlations for the key study variables. The number of subgroups was determined by lowest Akaike Information Criteria (AIC) and Bayesian Information Criteria (BIC) values. BIC was also used to test the assumption of local independence (Asparouhov & Muthén, 2014). Consistent with Celeux and Soromenho's (1996) recommendations, we also considered an entropy estimate above 0.80 as an acceptable level of separation between classes.

We examined the clients' response to the COVID impact item and available demographic variables, specifically age, race, gender and sexual orientation, as predictors of class membership using the automated 3-step method (R3STEP in Mplus; Asparouhov & Muthén, 2013; Vermunt, 2010). This automated method allows dichotomous or continuous covariates to be included in the model without influencing the enumeration phase and uses multinomial logistic regression to assess whether an increase in a given

Number of classes	AIC	BIC	Entropy	# Classes <5%
2-Class	2625.35	2589.59	0.87	
3-Class	2532.94	2588.89	0.89	
4-Class	2503.44	2574.65	0.89	
5-Class	2477.93	2546.41	0.87	
6-Class	2467.92	2569.65	0.90	1
7-Class	2466.72	2583.49	0.87	2

TABLE 2 Model fit indices for latent profile analysis model selection

Abbreviations: AIC, Akaike Information Criteria; BIC, Bayesian Information Criteria.

covariate is associated with a higher probability that a participant belongs to one subgroup over another (Asparouhov & Muthén, 2013; Vermunt, 2010). Data were cleaned (e.g. assessed for outliers) in SPSS v24 before being exported to Mplus v8.4 for all statistical analyses.

2.4.2 | Qualitative

Procedures outlined for thematic analysis (Braun & Clarke, 2006) informed the process of identifying the range of client experiences. Without knowledge of LPA subgroup membership, we (first and second authors) immersed ourselves in the data by inductively reading participants' responses to the open-ended questions about challenges, benefits and self-learning. Several meetings followed to discuss observations and potential patterns, which informed the development of preliminary codes. Through this process, we identified six dimensions of experience and subsequently organised clients' responses along these dimensions: psychological (cognitive effects and processes), emotional (named or implied feelings), relational (relevant to interpersonal effects), physical (bodily well-being and health), ecological/systemic (physical location and surroundings) and behavioural/lifestyle (routines, activities and vocational/educational arrangements). These dimensions provided structure and served as major themes, into which we sorted preliminary codes as sub-themes (e.g. isolation/loneliness as a form of relational challenge; see Tables 4–6). After organising the preliminary codes along these dimensions, we independently coded the data a second time in NVivo 12.6.0 (released 2019); inter-coder reliability estimates within each of the major themes were all greater than 0.90. Finally, we met to discuss discrepancies and reach consensus on the final sub-theme codes for each participant's response.

Next, we integrated the LPA subgroup membership into the analysis to identify trends within and differences across subgroups. First, we sorted the responses by LPA subgroup membership and each read all responses within each subgroup. Each of us distilled our understanding of the essence of each subgroup's experience into a summary paragraph. We then met to compare and discuss our observations before reaching a consensus about how to summarise the patterns within each subgroup. The numerical frequencies of themes (see Tables 4–6) helped corroborate these summative interpretations. In addition to considering symptom and well-being levels

as measured for the LPA, the results from the qualitative analysis, detailed below, informed each subgroup's name.

3 | RESULTS

3.1 | Quantitative

After assessing model fit indices for two-, three-, four-, five-, six- and seven-class models, a five-class model was selected as best fitting the data (see Table 2). We made our decision based on the lowest BIC value, which indicated that a 5-class solution was the best fit. The BIC appears to be the most commonly used and best performing tool for enumeration in mixture modelling contexts (Nylund-Gibson & Choi, 2018; Sterba, 2016). In addition, the size of one subgroup in the 6-class solution contained only 4% of the total sample ($n = 4$), which fell below a recommended minimum of 5% per class, and two subgroups below this threshold in the 7-class model (Masyn, 2013). Furthermore, two classes in the 6- and 7-class solutions were deemed comparable across indicators; that is, no qualitative differences existed, so we deemed the 5-class solution as best fitting the data. Further, the assumption of local independence was not violated after comparing BICs for a model with uncorrelated indicators (BIC = 2546.41) to one with correlated indicators (BIC = 2554.23).

We labelled subgroup 3, our reference class, *Flourishing*, given that they reported the lowest symptom levels and highest ratings across all three well-being dimensions, consistent with prior clinical research employing person-centred analyses of client data (Jankowski et al., 2021). We labelled subgroup 1 *Stagnant*, given that they scored mid-range on symptoms and well-being indicators. Also consistent with prior research (Jankowski et al., 2021), we labelled the second subgroup *Languishing*, given their high symptom levels and lowest levels of well-being across subjective, social and psychological well-being dimensions. Subgroup 4 reported comparable levels of symptoms as the *Languishing* and comparable levels of eudaimonic well-being as the *Stagnant*, but higher subjective well-being than the *Stagnant*, yet generally scoring mid-range on well-being. Such a pattern of higher well-being despite higher symptoms has been defined as resilience (Jankowski et al., 2021). However, we opted for the narrower label *Fortitudinous* because fortitude primarily refers to contexts of prolonged adversity (Van Tongeren et al., 2019) and has been used in prior research on the

ongoing COVID-19 pandemic as a context of prolonged adversity (Pretorius & Padmanabhanunni, 2021b), and because the qualitative data suggested positive self (i.e. benefiting from engaging with activities, projects and learning) and other (i.e. appreciating time with their quarantine 'pod') appraisals despite high symptoms. Subgroup 5, we labelled *Mobilized* because of its seeming engagement with active coping (e.g. developing new hobbies; Lin, 2016). This subgroup reported comparable symptom scores as the *Stagnant*, but reported greater well-being across dimensions relative to the *Stagnant*. The *Mobilized* class also reported significantly lower well-being across all dimensions compared to the *Flourishing*, and comparable levels of emotional and social well-being as the *Fortitudinous*, and yet higher levels of psychological well-being relative to the *Fortitudinous*. See Table 3 for descriptive statistics of indicator variables, class specific means and significant differences.

Covariate analysis using the automated 3-step (R3STEP) method found five significant associations. Relative to the *Flourishing* subgroup, clients were less likely to be (a) heterosexual (0 = sexual minority, 1 = heterosexual) in the *Mobilized* subgroup (OR = 0.08, $p < .01$), (b) White (0 = racial minority, 1 = White) in the *Stagnant* subgroup (OR = 0.08, $p < .01$), (c) White in the *Languishing* subgroup (OR = 0.003, $p < .01$) and (d) heterosexual in the *Languishing* subgroup (OR = 0.01, $p < .01$). Finally, clients were more likely to appraise the impact of the pandemic as negative in the *Languishing* subgroup relative to the *Flourishing* subgroup (OR = 0.84, $p < .01$), whereas each of the other subgroups were no more or less likely to belong to that particular subgroup relative to the *Flourishing*, suggesting that each of the other subgroups did not differ from the *Flourishing* in their appraisal of the impact of the pandemic on their functioning. Age and gender did not significantly predict subgroup membership.

3.2 | Qualitative

Participants described a variety of pandemic-related challenges, benefits and categories of self-learning. Tables 4–6 provide detailed information about study themes, including how frequently they emerged in the sample and in each subgroup. Below, we highlight

the most salient themes and offer our syntheses of each subgroup's experiences, recognising there is greater nuance and detail than space allows.

3.2.1 | Class 1: Stagnant ($n = 15$)

The *Stagnant* subgroup reported low symptoms and well-being, suggesting minimal suffering but equitably minimal flourishing. These clients reported multiple challenges, including feelings of fear, anxiety and worry (40%), leaving home as difficult or threatening (33.3%), relational isolation or loneliness (26.7%), loss of normal routine and coping (20%) and experiencing home as constricting (20%). While they reported some benefits and new learning, relative to other subgroups, *Stagnant* clients seemed to experience the pandemic passively and struggled to cope. One client wrote, 'I need routines. I am unsure where my professional identity lies and need to re-connect to what gives meaning to my life in order not to feel lost in my concerns about work or about COVID-19 in general'. Few (13.3%) described engaging with activities, projects or learning, and 26.7% indicated the pandemic offered no benefits at all. Despite this, they identified the benefits of independence and alone time (26.7%), creatively connecting through technology (20%), connecting with nature (20%), and a slower pace and simpler routine (20%). Primary areas of self-learning included reframing or adapting to the pandemic's changes (26.7%), awareness of their need for and value of relationships (26.7%), appreciating introversion and alone time (20%), awareness of personal strengths (20%), and facing and processing difficult emotions (20%). While not a formal theme, we observed that the *Stagnant* subgroup used more catastrophic or absolute language (e.g. 'everything is more difficult') relative to the other subgroups, which could suggest less capacity to make adaptive meaning.

3.2.2 | Class 2: Languishing ($n = 8$)

Languishing clients reported high symptoms and low well-being. Of all the subgroups, these individuals appeared most relationally

TABLE 3 Full sample and class-specific descriptive statistics and differences between classes on indicator variables

Indicators	Full sample ($N = 94$)			Class 1 ($n = 15$)	Class 2 ($n = 8$)	Class 3 ($n = 28$)	Class 4 ($n = 12$)	Class 5 ($n = 31$)
	M	SD	Range	Stagnant M	Languishing M	Flourishing M	Fortitudinous M	Mobilized M
Anxiety	6.20	4.76	0–21	5.29 ^a	12.61 ^b	3.04 ^c	13.42 ^b	4.82 ^a
Depression	6.83	5.24	0–27	6.75 ^a	16.26 ^b	2.44 ^c	12.58 ^b	5.92 ^a
EWB	9.46	3.26	0–15	6.08 ^a	3.18 ^b	12.24 ^c	9.44 ^d	10.45 ^d
PWB	19.49	6.32	0–30	14.90 ^a	7.75 ^b	25.71 ^c	16.27 ^a	21.05 ^d
SWB	11.20	5.44	0–25	7.36 ^a	2.83 ^b	17.22 ^c	8.55 ^{ad}	11.18 ^d

Note: Values with different superscripts in same row represent significantly different values at $p \leq .05$.

Abbreviations: EWB, Emotional well-being; PWB, Psychological well-being; SWB, Social well-being.

TABLE 4 Challenges reported by mental health clients during the pandemic

Challenges	Sample quote	Sample (N = 94), %	Class 1 (n = 15), %	Class 2 (n = 8), %	Class 3 (n = 28), %	Class 4 (n = 12), %	Class 5 (n = 31), %
Behavioural and Lifestyle							
Changing roles & boundaries	'Not feeling like I have any boundaries between work and home.'	6 (6.4)	0 (0.0)	1 (12.5)	4 (14.3)	0 (0.0)	1 (3.2)
Economic hardship	'I was already behind on rent and other expenses before the COVID-19 situation, and am even more behind and stressed now.'	6 (6.4)	1 (6.7)	1 (12.5)	1 (3.6)	0 (0.0)	3 (9.7)
Loss of normal coping & routine	'My outlets such as the gym, work, or just going into the city have been taken from me.'	21 (22.3)	3 (20.0)	1 (12.5)	6 (21.4)	4 (33.3)	7 (22.6)
Vocational/educational disruptions & changes	'Being able to adapt to a work from home routine, and to do my job effectively from home.'	21 (22.3)	1 (6.7)	1 (12.5)	7 (25.0)	3 (25.0)	9 (29.0)
Ecological and Systemic							
Displacement/living elsewhere	'I have temporarily relocated from [city] and don't know when I'll be going back.'	6 (6.4)	1 (6.7)	1 (12.5)	1 (3.6)	2 (16.7)	1 (3.2)
Going out as difficult or threatening	'I find myself dreading going out to stores, and when I do, it's really stressful if people aren't wearing masks or maintaining social distance.'	9 (9.6)	5 (33.3)	0 (0.0)	1 (3.6)	0 (0.0)	3 (9.7)
Home as constricting	'I don't have my personal space. The bedroom is where I work and sleep and it sucks.'	10 (10.6)	3 (20.0)	3 (37.5)	1 (3.6)	2 (16.7)	1 (3.2)
Inability to travel	'Losing the option of travel has felt limiting.'	4 (4.3)	2 (13.3)	1 (12.5)	0 (0.0)	0 (0.0)	1 (3.2)
Emotional							
Empathy & awareness of others' suffering	'I am painfully aware of the awesome challenges that billions of people are facing.'	7 (7.4)	2 (13.3)	0 (0.0)	2 (7.1)	0 (0.0)	3 (9.7)
Fear, anxiety, & worry	'General anxiety about social situations and errands. Immediate concerns of health, safety, and survival.'	21 (22.3)	6 (40.0)	0 (0.0)	6 (21.4)	4 (33.3)	5 (16.1)
Sadness & grief	'I also have been grieving the loss of things that have needed to be cancelled.'	5 (5.3)	0 (0.0)	0 (0.0)	1 (3.6)	2 (16.7)	2 (6.5)
Stressed & frustrated	'The ever changing information/unknowns surrounding COVID have been particularly stressful.'	10 (10.6)	2 (13.3)	1 (12.5)	4 (14.3)	1 (8.3)	2 (6.5)
Physical							
Health vulnerabilities	'As a person with asthma, I've avoided leaving home and going grocery shopping, etc.'	5 (5.3)	2 (13.3)	0 (0.0)	0 (0.0)	0 (0.0)	3 (9.7)
Less access to healthcare services	'Tele-health instead of in-person doctor visits; putting off medical procedures.'	5 (5.3)	2 (13.3)	0 (0.0)	1 (3.6)	0 (0.0)	2 (6.5)
Negative health impacts	'I've had a lot more trouble staying asleep at night and have vivid dreams and nightmares almost every night.'	8 (8.5)	1 (6.7)	1 (12.5)	4 (14.3)	0 (0.0)	2 (6.5)

TABLE 4 (Continued)

Challenges	Sample quote	Sample (N = 94), %	Class 1 (n = 15), %	Class 2 (n = 8), %	Class 3 (n = 28), %	Class 4 (n = 12), %	Class 5 (n = 31), %
Psychological							
Added mental toll & burden	'I also feel a lot of decision fatigue in trying to figure out the best way to do things - to work, to visit family, to shop, etc.'	10 (10.6)	2 (13.3)	2 (25.0)	3 (10.7)	0 (0.0)	3 (9.7)
Disorienting uncertainties	'Uncertainty about how long this situation will last.'	8 (8.5)	2 (13.3)	1 (12.5)	3 (10.7)	1 (8.3)	1 (3.2)
Relational							
Cannot physically be together	'Digitally mediated communication (Zoom) has become ubiquitous, much of human interaction is lost or dampened.'	28 (29.8)	2 (13.3)	1 (12.5)	8 (28.6)	1 (8.3)	12 (38.7)
Isolation & loneliness	'Increased daily social isolation can be overwhelming.'	15 (16.0)	4 (26.7)	5 (62.5)	3 (10.7)	2 (16.7)	1 (3.2)
Relational strain	'My relationship has suffered as we've both been exposed to each other's strong personalities and both have mental illness.'	5 (5.3)	1 (6.7)	0 (0.0)	0 (0.0)	3 (25.0)	1 (3.2)

disadvantaged. While the challenge of not being able to gather emerged elsewhere, 62.5% of *Languishing* clients described this challenge in terms of loneliness and isolation, and they endorsed few relational benefits (e.g. connecting through technology) overall. One client named this as '*the feeling of being isolated in a totally different way than self-isolating or medically isolating*'. The frequency of clients in this subgroup reporting home as constricting (37.5%) was also higher than in other subgroups, suggesting a unique challenge related to living arrangements. They also reported increased mental toll and burden (25%). Interestingly, despite reporting the most severe symptoms, this subgroup did not write about emotional challenges related to the pandemic, and their responses about self-learning were insightful. Fifty per cent indicated they had learned about or confronted personal vulnerabilities, though they framed these insights in noticeably self-critical ways (e.g. '*Wow. I'm a trash person*'). Their primary benefits were a slower pace and simpler routine (37.5%), time and opportunity for self-reflection (25%), and positive changes in physical health (25%; e.g. '*quit drinking*'). However, 25% reported the pandemic offered no benefits at all.

3.2.3 | Class 3: Flourishing (n = 28)

The *Flourishing* subgroup reported the lowest symptoms and highest well-being. Yet, their functioning is not explained by the absence of adversity, as they named several pandemic-related challenges, including the inability to gather physically (28.6%), vocational/educational disruptions (25%), loss of normal coping and routines (21.4%) and feelings of fear, anxiety and worry (21.4%). However, this subgroup seemed well-positioned to adapt meaningfully to new and challenging circumstances. They were supported relationally with access to and time for friends and family, mostly benefiting from time and stronger bonds with their quarantine 'pods' (32.1%). One client wrote, '*I spend more time with my family, I talk with my friends by phone more*'. They also enjoyed a slower pace and simpler routine (28.6%), time for activities, projects and learning (21.4%), and expressed more gratitude and hope (21.4%). In contrast to the *Languishing* subgroup's new awareness about personal vulnerabilities, the *Flourishing* subgroup's learning primarily centred on awareness of personal strengths (35.7%, e.g. '*I'm resilient, thoughtful, and determined*' and '*I'm capable of working through difficult situations and supporting others, but at the same time, maintaining boundaries to keep myself healthy*'). Markedly, only one client here described home as constricting or negative economic impacts, suggesting that this subgroup may be more well-resourced.

3.2.4 | Class 4: Fortitudinous (n = 12)

Fortitudinous clients reported high symptoms comparable to the *Languishing* subgroup but significantly higher, albeit mid-range, well-being. They seemed to experience difficult emotions, namely fear, anxiety and worry (33.3%) without access to previously-available

TABLE 5 Benefits reported by mental health clients during the pandemic

Benefits	Sample quote	Sample (N = 94), %	Class 1 (n = 15), %	Class 2 (n = 8), %	Class 3 (n = 28), %	Class 4 (n = 12), %	Class 5 (n = 31), %
Behavioural and Lifestyle	Activities, projects, & learning	17 (18.1)	2 (13.3)	0 (0.0)	6 (21.4)	3 (25.0)	8 (25.8)
	'I have also been able to cook, bake, and craft more, which I find to be relaxing activities.'						
	Economic benefits	8 (8.5)	0 (0.0)	0 (0.0)	4 (14.3)	1 (8.3)	3 (9.7)
	'I also really reduced my spending, and that has been an important gift of this time.'						
	Slower pace, simpler routine	18 (19.1)	3 (20.0)	3 (37.5)	8 (28.6)	1 (8.3)	3 (9.7)
	'I was fortunate enough that some things could slow down during this time. I gained some really critical down time. I feel like I have free time in some ways I have not in years.'						
	Vocational & working from home	12 (12.8)	2 (13.3)	1 (12.5)	4 (14.3)	3 (25.0)	2 (6.5)
	'Being able to work full time from home has been hugely positive.'						
Ecological and Systemic	Connection with nature	7 (7.4)	3 (20.0)	0 (0.0)	1 (3.6)	1 (8.3)	2 (6.5)
	Home as a safe haven	7 (7.4)	0 (0.0)	0 (0.0)	1 (3.6)	1 (8.3)	5 (16.1)
	'I feel content being at home, taking care of home-based duties.'						
Emotional	Less stress, anxiety, & guilt	9 (9.6)	2 (13.3)	0 (0.0)	5 (17.9)	0 (0.0)	2 (6.5)
	'Not having people constantly in my space has helped me feel less anxious and more in control of my time and energetic resources.'						
	More gratitude & hope	12 (12.8)	2 (13.3)	0 (0.0)	6 (21.4)	1 (8.3)	3 (9.7)
	'I have an immense amount of gratitude to have my health and job.'						
Physical	Physical benefits	5 (5.3)	1 (6.7)	2 (25.0)	2 (7.1)	0 (0.0)	0 (0.0)
	'I've been caught up on sleep for the first time in a decade.'						
Psychological	Clarifying values & goals	6 (6.4)	0 (0.0)	0 (0.0)	3 (10.7)	0 (0.0)	3 (9.7)
	'A dramatic recalibration of values, foci, ambition, priority.'						
	Envisioning societal change	8 (8.5)	2 (13.3)	1 (12.5)	3 (10.7)	1 (8.3)	1 (3.2)
	'Observing how the free people of the world have come to realize that much destruction and evil exists in some societies.'						
	Time & opportunity for self-reflection	9 (9.6)	2 (13.3)	2 (25.0)	2 (7.1)	0 (0.0)	3 (9.7)
	'I've had time to be in therapy and really consider where I'm at and process a major loss.'						
	Nothing	8 (8.5)	4 (26.7)	2 (25.0)	0 (0.0)	0 (0.0)	2 (6.5)
	'I am finding it difficult to see any positives of the situation at the moment.'						

TABLE 5 (Continued)

Benefits	Sample quote	Sample (N = 94), %	Class 1 (n = 15), %	Class 2 (n = 8), %	Class 3 (n = 28), %	Class 4 (n = 12), %	Class 5 (n = 31), %
Relational							
Creatively connecting through technology	'I like steps people are taking to keep community alive, such as featuring social events online. It's not the same, but it speaks positively to people's sense of community.'	15 (16.0)	3 (20.0)	1 (12.5)	3 (10.7)	0 (0.0)	8 (25.8)
More independence & alone time	'I've also benefited from being able to stay at home without feeling any guilt or pressure about it, as I have in the past when I've declined or canceled invitations to get together with people or do things due to days when I feel tired and/or depressed.'	10 (10.6)	4 (26.7)	1 (12.5)	2 (7.1)	0 (0.0)	3 (9.7)
Relational connections & supports	'My family has been incredibly supportive from afar, and we grow ever closer.'	11 (11.7)	1 (6.7)	0 (0.0)	2 (7.1)	1 (8.3)	7 (22.6)
Time & stronger bonds with quarantine 'pod'	'I have spent lots of time with my children.'	25 (26.6)	5 (13.3)	0 (0.0)	9 (32.1)	3 (25.0)	8 (25.8)
Time with pets	'I often get to be with my cat while I am working. She is an older cat (almost 17) so I value every moment.'	6 (6.4)	0 (0.0)	1 (12.5)	1 (3.6)	2 (16.7)	2 (6.5)

coping resources and routines (33.3%). They also reported vocational/educational disruptions and challenges (25%) and had a newfound appreciation for structure and routine (25%), which were lost in the shift to working from home. Notably, this subgroup uniquely reported relational strain resulting from the pandemic (25%). As an example, one client wrote, 'I am stuck at home with a boyfriend whose depression at times turned verbally abusive to me', and another indicated that the pandemic 'was somewhat a cause of my relationship ending'. Further, their self-learning suggests they were contending with some difficult realities: increased awareness of personal vulnerabilities (33.3%), changing values, beliefs and identity (33.3%), and processing difficult emotions (33.3%). Nevertheless, this subgroup presented as fortitudinous in their ability to acquire or sustain moderate levels of well-being in the face of such hardship. They described benefiting from engaging with activities, projects and learning (25%), vocational/educational changes or working from home (25%), and appreciating time with their quarantine 'pod' (25%).

3.2.5 | Class 5: Mobilized (n = 31)

Mobilized clients reported low symptoms equitable to the *Stagnant* subgroup but significantly higher, mid-range well-being. This subgroup endorsed the challenges of inability to gather physically (38.7%), vocational/educational disruptions (29%), loss of normal coping and routine (22.6%) and feelings of fear, anxiety and worry (16.1%). Their most endorsed benefits were relational, possibly suggesting stronger relational support systems overall which may have contributed to their well-being. Specifically, this subgroup benefited from creatively connecting with others through technology (25.8%), developing stronger bonds with their quarantine 'pods' (25.8%), and experiencing relational connections and support (22.6%). One client wrote that the pandemic had helped 'deepen [my] relationship with [my] children & wife'. Their self-learning was also primarily relational, specifically in their increased awareness about needs for and value of relationships (16.1%) or appreciating introversion and alone time (16.1%). In addition to relational benefits and learning, *Mobilized* clients benefited from time for activities, projects and learning (25.8%), which was noticeably different from the *Stagnant* subgroup. For example, one client wrote about 'finding time to read, cook, clean, plant a small garden, and communicate with friends and family. It feels as if much of the "fluff" of city life has cleared'. These clients seemed to be more intentionally adapting to the pandemic than passively experiencing its effects, perhaps contributing to higher levels of well-being.

4 | DISCUSSION

This study employed a mixed-methods, concurrent triangulation design (Hanson et al., 2005) with clients from a community mental health clinic during the early months of the COVID-19 pandemic. A latent profile analysis yielded five distinct client subgroups based

TABLE 6 Learning reported by mental health clients during the pandemic

Learning	Sample Quote	Sample (N = 94), %	Class 1 (n = 15), %	Class 2 (n = 8), %	Class 3 (n = 28), %	Class 4 (n = 12), %	Class 5 (n = 31), %
Behavioural and Lifestyle	Appreciation for structure & routine	7 (7.4)	0 (0.0)	1 (12.5)	0 (0.0)	3 (25.0)	3 (9.7)
	Life wasn't great before, making changes	7 (7.4)	1 (6.7)	1 (12.5)	4 (14.3)	0 (0.0)	1 (3.2)
	Self-care & learning new skills	7 (7.4)	1 (6.7)	0 (0.0)	4 (14.3)	0 (0.0)	2 (6.5)
Ecological and Systemic	Appreciation for being at home	3 (3.2)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (9.7)
	Facing & processing difficult emotions	14 (14.9)	3 (20.0)	1 (12.5)	3 (10.7)	3 (25.0)	4 (12.9)
	Gratitude	3 (3.2)	0 (0.0)	0 (0.0)	2 (7.1)	0 (0.0)	1 (3.2)
Physical	Peace, calm, & self-forgiveness	4 (4.3)	0 (0.0)	0 (0.0)	1 (3.6)	1 (8.3)	2 (6.5)
	New health awareness	2 (2.1)	1 (6.7)	0 (0.0)	1 (3.6)	0 (0.0)	0 (0.0)
	Changing values, beliefs, & identity	7 (7.4)	1 (6.7)	0 (0.0)	1 (3.6)	4 (33.3)	1 (3.2)
Psychological	Awareness of personal strengths	19 (20.2)	3 (20.0)	1 (12.5)	10 (35.7)	2 (16.7)	3 (9.7)
	Awareness of personal vulnerabilities	14 (14.9)	2 (13.3)	4 (50.0)	3 (10.7)	4 (33.3)	1 (3.2)
	Reframing & adapting	11 (11.7)	4 (26.7)	0 (0.0)	2 (7.1)	1 (8.3)	4 (12.9)
Nothing or unsure		4 (4.3)	1 (6.7)	1 (12.5)	0 (0.0)	0 (0.0)	2 (6.5)

TABLE 6 (Continued)

Learning	Sample Quote	Sample (N = 94), %	Class 1 (n = 15), %	Class 2 (n = 8), %	Class 3 (n = 28), %	Class 4 (n = 12), %	Class 5 (n = 31), %
Relational		13 (13.8)	3 (20.0)	0 (0.0)	3 (10.7)	2 (16.7)	5 (16.1)
Appreciating introversion & alone time	'I am surprised that I enjoy not feeling obligated to be socially available all the time. I used to feel obligated to be out of the house a lot (work, exercise, socialization), so it's really nice just being at home.'						
Need for & value of relationships	'Human contact is very important and that I miss not having it.'	17 (18.1)	4 (26.7)	1 (12.5)	5 (17.9)	2 (16.7)	5 (16.1)
Awareness of relational challenges	'That when I get depressed that I want a divorce.'	1 (1.1)	1 (6.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Balancing closeness & autonomy	'I need alone time and I need meaningful interactions with others to feel happy and healthy.'	5 (5.3)	0 (0.0)	1 (12.5)	2 (7.1)	1 (8.3)	1 (3.2)

on indicators of symptoms and well-being, while responses to open-ended questions about pandemic-related challenges, benefits and self-learning shed light on unique patterns of experience and adaptation within and across these client subgroups. This study's clinical sample, person-centred quantitative analyses and targeted questions about the pandemic's specific effects make novel contributions to the emerging pandemic literature.

Unsurprisingly, we identified two subgroups, the *Languishing* and *Flourishing*, representing a predictable, inverse relationship between symptoms and well-being. Our identification of three additional subgroups advances literature differentiating symptoms from well-being and documents the various ways these constructs can constellate within individuals and their lived experience (Keyes, 2005; Lamers et al., 2011; O'Connor et al., 2012, 2015). Specifically, we identified subgroups reporting mid-range symptoms and well-being (*Stagnant*), high symptoms and mid-range well-being (*Fortitudinous*), and mid-range symptoms and high well-being (*Mobilized*).

These distinct profiles challenge conceptualisations of (a) clinical formulation that conflate symptoms and well-being, and (b) understandings of symptoms and well-being as only inversely related. Instead, our findings point to the importance of considering well-being in addition to symptom reduction in psychotherapy, though research on these effects in clinical settings is limited (Jankowski et al., 2020). Attention to eudaimonic dimensions, such as psychological and social well-being (e.g. meaning in life and connection with others), may be especially protective in times of heightened, prolonged stress like the COVID-19 pandemic. In fact, evidence suggests that, relative to emotional well-being, psychological well-being is more stable over time and less sensitive to changing circumstances (Joshano, 2019). While researchers have reported the pandemic's alarming mental health effects (Pfefferbaum & North, 2020), attention to eudaimonic forms of well-being may help explain why some psychotherapy clients, a vulnerable group as a whole (Esterwood & Saeed, 2020; Yao et al., 2020), appear less at risk than others. It may be that the pandemic's challenges are less turbulent for clients with higher levels of psychological and social well-being, as they likely have more resources to employ and may appraise self and other resources more favourably during prolonged adversity.

Our covariate analyses identified additional factors that might influence subgroup membership, and these analyses suggest a privilege effect among those with the most optimal functioning. Relative to the *Flourishing* subgroup, clients were less likely to be White in the *Languishing* and *Stagnant* subgroups, and they were less likely to be heterosexual in the *Mobilized* and *Languishing* subgroups. These findings are consistent with research documenting the disproportionate effects of disasters on persons with minoritised identities (Martin-Howard & Farmbry, 2020), including pandemic-specific literature on the health and well-being consequences for sexual minorities (Fish et al., 2021) and higher levels of pandemic-related threat, discrimination, negative beliefs and economic impacts among racial and ethnic minorities (Trammell et al., 2021). Unsurprisingly, the covariate analyses also revealed that, relative to the *Flourishing* subgroup, clients in the *Languishing*

subgroup were more likely to rate the pandemic's effects as negative. Clients belonging to marginalised groups have likely faced additional systemic challenges in adapting to the pandemic's effects. Indeed, a variety of risk and protective factors influence how people fare in the face of crises (Bonanno, 2005; Mancini, 2020), and future research should continue monitoring and attending to disparities among those who hold less social privilege.

In considering our findings, it is important to clarify that clients' reported functioning, as measured by indicators of symptoms and well-being, might be antecedent to the pandemic. Study participants were in mental health treatment for reasons unrelated to and predating the pandemic's onset. Further, cross-sectional data do not allow for long-term estimation of the pandemic's effects, the influence of pre-pandemic functioning on capacities for adaptation, or coping resources and processes that may have influenced mental health or well-being. Nevertheless, clients' pandemic experiences as depicted in their qualitative responses provide meaningful context for interpreting their functioning and suggest additional factors that may have influenced functioning in the early months of the pandemic.

4.1 | COVID-19 pandemic experiences

To our knowledge, this is the first empirical investigation of psychotherapy clients' accounts of the COVID-19 pandemic's specific effects. This study helps fill that gap by reporting what clients endorsed as personally challenging, beneficial and insightful. There were noticeable trends in how the subgroups responded to the open-ended questions about the pandemic's effects, suggesting the importance of various coping and resilience capacities and processes, as well as the potential influence of contextual factors on functioning.

4.1.1 | Coping and adaptation

Distinct coping processes seemed to be represented across the subgroups, which may partially account for differences in functioning. One relevant area may be the extent to which clients engaged in active versus passive coping. There were significant differences in well-being between the *Stagnant* and *Mobilized* subgroups, despite reporting equitable mid-range symptoms. One of the most noticeable descriptive differences in their qualitative responses was *Stagnant* clients' inactive, passive relationship with the pandemic's effects and their infrequent endorsement of activities, hobbies and new learning. Previous research has documented a relationship between psychological well-being and the use of active coping strategies (Lin, 2016), that is, intentional attempts to respond to a stressor rather than passive coping involving avoidance of a stressor and its effects (Choi et al., 2012). This led us to wonder if engaging with meaningful and/or enjoyable activities might partially account for higher well-being in *Mobilized* clients.

A similar pattern follows in the *Languishing* and *Fortitudinous* subgroups, who had similarly high symptoms, with significant differences in well-being and greater endorsement of active coping in the *Fortitudinous* subgroup, such as using newfound time for old hobbies. Of course, those who seemed to employ active coping strategies may have also benefitted from more time to do so, and circumstances for those in the *Languishing* and *Stagnant* groups may have limited time and energy for active coping. Further, the precise nature of the relationship between coping and well-being in our sample is unclear. Clients with greater psychological strength may be more inclined towards adaptive coping, or their coping strategies may have enhanced their sense of well-being. Despite this, clients who feel little control over their pandemic circumstances might benefit from therapeutic interventions that foster a sense of agency and promote adaptation, especially if stress arousal is low. Despite reporting the most severe symptoms, *Languishing* clients' qualitative responses were largely void of emotional challenges, which could be explained by processes of minimisation to limit the risk of feeling overwhelmed. These clients' clinical presentation might be characterised more by apathy than arousal, which could potentially inhibit the agentic capacities necessary for positive adaptation.

Meaning-based coping and the ability to find benefits in stressful and traumatic situations (Folkman & Moskowitz, 2007) also appear relevant for these clients' functioning. In reflecting on what they had learned about themselves during the pandemic, *Flourishing* clients acquired heightened awareness of personal strengths, whereas *Languishing* clients were tuned in to their vulnerabilities. Clients in the *Flourishing*, *Fortitudinous* and *Mobilized* subgroups were able to identify a variety of pandemic benefits, but about one quarter of the *Languishing* and *Stagnant* clients struggled to identify any benefits at all. This is especially noteworthy in the *Fortitudinous* subgroup, who reported high symptoms similar to the *Languishing* subgroup and were contending with some difficult challenges and insights. The subgroups identifying benefits (i.e. *Flourishing*, *Fortitudinous*, and *Mobilized*) also reported moderate to high levels of psychological well-being, which might suggest they have greater fortitude (Van Tongeren et al., 2019) or finding meaning and benefits in their hardship has contributed to psychological strength. Clients may benefit from exploration of (a) how they are making meaning of themselves and their circumstances amidst ongoing difficulties and (b) what personal and culturally embedded strengths can help promote adaptation.

4.1.2 | Resource availability

We would be remiss to ignore the possibility that access to and appraisal of available resources might influence clients' functioning. Some notable trends emerged suggesting differences in resources across subgroups. Researchers have long documented the protective function of social support amidst stress (e.g. Turner, 1999), and some subgroups in our sample seemed relationally advantaged. *Flourishing*

clients frequently described benefiting from time and stronger bonds with their quarantine 'pods', while the *Languishing* subgroup wrote about feelings of loneliness and isolation. *Mobilized* clients' experiences seemed especially oriented towards relationships; despite being challenged by the inability to gather, they sustained connections through technology and benefited from more time with their 'pods'. These findings are consistent with emerging literature on the importance of social support in minimising mental health symptoms during the pandemic. Grey et al. (2020) found that social support was associated with markedly lower rates of depression and better sleep quality relative to those who felt isolated. Researchers have raised alarm about the potential for lasting, post-pandemic effects stemming from prolonged isolation (Saltzman et al., 2020), suggesting that some may struggle to rebound even as restrictions ease. Clients who have lived alone or experienced a long-term void of relational support may be particularly vulnerable to longer-term effects and could benefit from interventions that promote social well-being.

Researchers have also documented the vulnerability of persons who are economically disadvantaged (Martin-Howard & Farmbry, 2020), and indicators of economic privilege emerged in the qualitative responses that might point to a similar effect among participants. For example, the percentage of *Languishing* clients who wrote about home as constricting was higher than any other subgroup, citing small residences or feeling confined to a room in shared living spaces. In contrast, only one of 31 *Flourishing* clients wrote about home as constricting. Considering the resources needed to acquire independent and spacious living arrangements, these observations might suggest greater affluence among clients with more positive mental health.

4.2 | Strengths, limitations and future directions

This study has several strengths. Our use of latent profile analysis contributes to the growing literature identifying heterogeneous psychotherapy client profiles along symptom and well-being dimensions (Fosha & Thoma, 2020; Jankowski et al., 2021; Trompetter et al., 2017), which are essential to consider for differential treatment planning. A practice-based design lends to more focused attention on pandemic functioning in clinical populations, and the community mental health setting represents realistic treatment conditions for many psychotherapy clients. Lastly, the triangulation and complementarity of data using a mixed-methods design illuminates aspects of clients' experiences that a singular methodological approach might miss (Hanson et al., 2005). However, this study is not without limitations. We used a relatively small ($N = 94$), homogenous sample from an urban community in the northeast United States. Clinical samples in other regions or with more diversity across race, gender, and sexual orientation may be distinct and afford greater ability to detect demographic differences across subgroups. Further, the time of data collection was one of widespread and unprecedented disruption. Thus, our sample may disproportionately represent clients who had capacity to participate in research amidst the initial upheaval of

the pandemic, which could lead to underestimating the psychological distress and compromised well-being of clinical populations during this time. These data are also cross-sectional, limiting our ability to estimate more parsimoniously the pandemic's effects and the influence of pre-pandemic functioning and capacities for resilience on how clients fared as the pandemic wore on. Finally, we did not explicitly ask about coping resources and strategies, but rather drew inferences from clients' descriptions of pandemic-related challenges, benefits, and learning. Thus, clients may describe their coping somewhat differently if this area was directly explored.

Several ideas for further investigation are worth noting. First, the current public health crisis has been a significant global event, and the extent of its effects will likely unfold well beyond its declared end. Given the ongoing, dynamic nature of the pandemic, as well as its divergent impacts in various regions, it will be imperative to monitor trajectories of symptoms, well-being, and experiences over time. Second, researchers and clinicians should inquire about specific coping behaviours and resilience capacities, as well as unique stressors (e.g. home space constraints) and resources (e.g. active social support), to estimate their relationships with client functioning. The pandemic presents a unique opportunity to add to the limited literature on coping with the spread of infectious disease. Third, research could investigate the effects of psychotherapy in promoting or sustaining positive mental health, especially with the novelty of abrupt and prolonged transitions to teletherapy and therapists' simultaneous pandemic experiences.

5 | CONCLUSION

This investigation contributes to the COVID-19 literature by documenting the various ways mental health and well-being are related, in particular, among psychotherapy clients at a time of widespread disorientation and change. Clients' reports of pandemic-related challenges, benefits, and new self-learning lend insight into coping and adaptation processes in clinical populations, which are relevant for research and clinical practice in the ongoing context of the COVID-19 pandemic. While this study makes important contributions, ongoing research is needed to follow the pandemic's effects and to more parsimoniously estimate the relationships among mental health, well-being, stressors, resources and coping.

CONFLICT OF INTEREST

The authors have no conflict of interest to report.

ETHICAL APPROVAL

This study was approved by Boston University's Institutional Review Board under protocol #4450E.

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