Journal of Counseling Research and Practice

Volume 7
Issue 2 *Spring 2022*

Article 3

2021

Media and Technology in Counseling: Emerging Practices and Ethical Considerations in Response to COVID-19

Vikram Surya Chiruvolu
Technotherapy

Justin Jacques
Johns Hopkins University

Follow this and additional works at: https://egrove.olemiss.edu/jcrp

 Part of the Counseling Psychology Commons, and the Counselor Education Commons

Recommended Citation

Chiruvolu, Vikram Surya and Jacques, Justin (2021) "Media and Technology in Counseling: Emerging Practices and Ethical Considerations in Response to COVID-19," *Journal of Counseling Research and Practice*: Vol. 7: Iss. 2, Article 3.
Available at: https://egrove.olemiss.edu/jcrp/vol7/iss2/3

This Article is brought to you for free and open access by the Education, School of at eGrove. It has been accepted for inclusion in Journal of Counseling Research and Practice by an authorized editor of eGrove. For more information, please contact egrove@olemiss.edu.

Media and Technology in Counseling: Emerging Practices and Ethical Considerations in Response to COVID-19

The Journal of Counseling Research and Practice (JCRP)
Volume 7, No. 2
(40-62)

Vikram Surya Chiruvolu
Technotherapy
Justin Jacques
Johns Hopkins University

Abstract
COVID-19 has ushered in a new chapter of counseling in the United States and throughout the world. Counselors' responses to the pandemic have been fundamentally reshaped by universal elements of the information age, including high-speed internet, smartphones, and computer-based technologies such as synchronous meeting software and collaboration tools. Now, clinicians can use technology to ally with clients, deliver psychoeducational media, and open new categories of intervention and engagement that alter the size, shape, and availability of the "counseling room" by extending it into a virtual space. The immediate investment in information technology demanded by the pandemic highlights an increasing need to deepen clinicians' awareness of the psychology of cyberspace, the clinical applications of technological capabilities, and the use of synchronous online video counseling, all of which can directly increase quality of care, strengthen the therapeutic bond, and improve clinical outcomes. This manuscript explores the pairing of technology and counseling, outlining an open, integrative approach to counseling with updated practice and ethical competence. Properly conceived and combined, technical innovation and advanced counseling strategies developed in response to the COVID-19 pandemic will lead to updated practices of technology-assisted counseling that offer a new modality of care as fundamental and as potentially impactful as talk therapy was over a century ago.

Even before the COVID-19 pandemic, systemic strains such as diminishing resources (Kataoka et al., 2002; Santiago et al., 2013) and a rise in help-seeking behaviors (Lipson et al., 2019) stretched the capacity of mental health clinicians in the United States (Butryn et al., 2017), including those working in public schools, correction facilities, integrated mental health service agencies, and rehabilitation centers (Butryn et al., 2017). Despite the increased access to mental healthcare brought about by the Patient Protection and Affordable Care Act (PPACA) of 2010, the American healthcare system still lacks enough mental healthcare

Author Note. Justin G. Jacques https://orcid.org/0000-0002-8574-5380
Vikram Chiruvolu is the founder and CEO of Technotherapy.org in Washington, D.C. We have no known conflict of interest to disclose. Correspondence concerning this article should be addressed to Justin Jacques, Johns Hopkins University Student Assistance Program, 550 N. Broadway #403, Baltimore, MD 21205. Email: jjacque3@jhu.edu

providers to meet the tremendous need that has been further exacerbated by the pandemic (Czeisler et al., 2020), especially among the poor (Gamm et al., 2010). The shortage of mental health providers in the U.S. has been shown to exacerbate existing inequalities (Mongelli et al., 2020). For instance, it significantly impacts adolescents because they do not have access to mental health care for due to limited service offerings and long wait times (Radez et al., 2021). As the Children's Defense Fund (2020) has indicated, inadequate access to health coverage, untreated mental and emotional problems, rampant substance abuse, and an overburdened and ineffective juvenile justice system contribute to increased incarceration among those who do not receive assistance. In addition to increased incarceration rates, substance abuse and mental health issues also lead to more disability worldwide than any other factor (Wainberg et al., 2017). Further, research suggests that a growing treatment gap between extant behavioral health needs and available services exacerbates the disparity between rich and poor nations in meeting their mental healthcare needs (Wainberg et al.). Currently, only 30% of those who need mental health services have access to care worldwide (Kohn et al., 2004).

Given the incredible mental health need, both domestic and international, that existed well before COVID-19 (Rehm & Shield, 2019), as well as the tremendous potential of media technology to help meet that need (Figueroa & Aguilera, 2020), the field of mental health will have an important opportunity to respond by expanding the use of effective, empirically-informed counseling theories and techniques that infuse media and technology as part of their practice. Evidence increasingly suggests that empirically-based psychotherapies have resulted in positive outcomes in low-resource communities (Bass et al., 2013). Additionally, literature on the cost-effectiveness of treatment has shown the economic value of preventing and treating mental disorders in such communities (Chisholm et al., 2016). The clear need for additional mental healthcare services in low-resource communities, coupled with the ease of access to such services afforded by media and technology, indicates the imperative to decrease the enormously high percentage (~70%) of the world's population that does not have access to mental health care (Henderson et al., 2017).

To explore the potential for technologically mediated mental health care to respond to these urgent needs, this paper begins with a critical overview that will define new concepts related to media and technology in the field of mental health in support of a broader discussion of the rapidly evolving counseling landscape at present. Additionally, this manuscript discusses how technology relates to service delivery and a shift from the old to new service delivery paradigms. This is followed by a theoretical overview to highlight how three foundational theories can inform technology assisted practice—namely psychodynamic, humanistic, and multicultural. Next, a critical interpretive analysis of emerging ethical considerations

and emerging ethical implications are provided. Finally, practical implications of the shift to the use of media and technology within the field of mental health are discussed.

A Concise Overview of the Recent Shift to Media and Technology in Counseling

The recent and necessary trend of adopting media and technology into counseling practice is an exciting development for the field of mental health. However, this sudden shift is also concerning, as many counselors may be unfamiliar with media and technology (terms and tools) and specifically unprepared to incorporate this new paradigm of service delivery into their standard practice in a professional, data-informed, and therapeutic way.

New Terms for the Electronic Paradigm in Counseling

The transition to predominantly technological mental health care interventions driven by the pandemic has thrust new terms into the practitioner's consciousness, often without sufficient context for easy understanding. The application of electronic media to health is known as "eHealth" (Eysenbach, 2001), and the practice of connecting mobile applications to health interventions is known as "mHealth." Both ideas are subsets of the broader field of Health IT (HIT; Jamal et al., 2009). An "E-intervention" is a specific action or activity that a clinician carries out with a client via media and technology to create positive change in mental, emotional, behavioral, or social patterns (Midgley, 2006). These can include specific activities on a mobile device or web application employed by a clinician to implement or reinforce a recommendation for action to a client, such as scheduled reminders, check-ins, location-based services, text messages, phone calls, recorded audio or video, or a progress dashboard. Much of the growth of eHealth, HIT, and E-interventions over the past five years has been driven by hundreds of government-financed academic research projects (Hollis et al., 2015) and for-profit ventures worldwide (Chen et al., 2013). This has included an explosion of interest in, financing for, and adoption of these solutions within the global medical community (Shadangi et al., 2019). The COVID-19 pandemic has increased the necessity of these interventions (Renn et al., 2021), creating uncertainty and hesitancy among practitioners (Cowan et al., 2019). However, clinicians have had no choice but to utilize these novel and unfamiliar tools in order to meet the ever-increasing mental health needs of their clients.

The Shift in Practice to Media and Technology Use

The rapid adoption of media and technology by counselors in the wake of the pandemic was highlighted by a 2020 study that found only 21% of psychologists had used telepsychology in their clinical practices prior to COVID-19, and 45.70% had never used telepsychology (Pierce et al., 2020). The same study found that in the wake of the pandemic, 96.45% of

psychologists use telepsychology in their practices, and 67.32% report that they have gone completely virtual (Pierce et al, 2020; see Figure 1). During the initial weeks and months of the COVID-19 pandemic, media and technology adoption needed to happen quickly (Mishkind et al., 2021), as online delivery of services had primarily been encouraged by insurance providers who were targeting underserved, rural communities in need of mental health care (Lambert et al., 2016). As the pandemic has lingered, adopting this new online paradigm in professional counseling practice is no longer optional; it is an absolute necessity to continue serving clients (Burgoyne et al., 2020). A recent study purported that the shift to primary teletherapy-based service delivery is here to stay and has clear advantages with respect to client access, continuity of care, and explaining the treatment continuum within the health care system (Burgoyne & Cohn, 2020). However, the same study also reported that the shift to technology in counseling has significant challenges and that clinicians transitioning to this service delivery model are advised to consult their professional organizations, including state organizations, to determine what legal, license-specific, and payor-based rules apply in this new paradigm of mental health service.

The Difference Between Old and New Paradigms

In order to embrace the reality of this new clinical paradigm, counselors accustomed to the traditional face-to-face (F2F) model will need to work to intentionally understand the distinct differences between delivering mental health services in person and counseling virtually utilizing media and technology (Peterson et al., 2019). A recent study found that there is a significant difference between F2F and virtual counseling experiences (Peterson et al., 2019), the latter of which allows for more anonymity and less self-control (Weinberg, 2020). Additionally, virtual counseling participants are often more honest, spontaneous, and open than those engaged in traditional counseling (Weinberg, 2020). These perceived differences may have a significant impact on the counseling relationship (Rees & Stone, 2005). For example, the emerging trend in which counselors use phone apps to augment their treatment and improve therapeutic alliances creates an important need to assess the impact of these newly emerging nontraditional therapeutic relationships (Hensen et al., 2019). Finally, experts assert that there is a distinct psychology of the Internet and an optimal way to engage clients to improve clinical outcomes (Weiberg, 2020). Armed with knowledge of the distinctions between virtual and F2F counseling, counselors must translate their foundational theoretical orientations into practice as they deliver clinical services virtually. A few examples of counseling theory being translated into virtual practice is subsequently explored.

Theoretical Overview

To effectively shift to virtual practice and the use of media and technology in counseling, as necessitated by COVID-19

(see Figure 2), mental health providers should consider how their theoretical orientation(s) can be applied in this new service paradigm. Therefore, three theoretical orientations that are commonly utilized in mainstream therapy practice—namely, psychoanalytic, person centered, and multicultural counseling theory (Jones-Smith, 2019)—are explored as they relate to virtual practice through the use of media and technology.

Psychoanalytic-Informed Counseling Through Media and Technology

Psychoanalytic theory, which includes the core concepts of resistance, transference, and projections, has been foundational to the field of psychotherapy (Jarrett & Vince, 2017) and remains strikingly relevant to the psychology of the internet paradigm because these same seminal ideas from Sigmund Freud, the field's founder, are present in virtual practice (Corbella, 2020; Weinberg, 2020). Resistance according to the psychoanalytic orientation is a defense, anxiety, or opposition to treatment that impedes the counseling process, and that the counselor must overcome (Mcferran & Finlay, 2018). Transference is defined as the client's experience of the counselor through the filter of the client's life history, experience of others, and state of mind (Hersh et al., 2017). Finally, projection is the process whereby individuals transfer their own repressed feelings onto others in an outward deflection of anxious feelings about unacceptable parts of themselves (Pellegrini, 2010).

Research has shown that resistance may be common in the virtual space (Corbella, 2020; Weinberg, 2020); therefore, counselors must recognize these alliance rupture events as they occur, call them out, and subsequently process them with their clients (Safran & Muran, 2000). Resistance and transference, both core constructs of psychoanalytic theory (Jarrett & Vance, 2017), may manifest differently when using virtual platforms. For example, a client who has a substantial digital footprint or online lifestyle including websites, social media, and apps may transfer the way they project their thoughts, feelings, and emotions in those settings with friends to a counseling session with a therapist. This may include intensified forms of transference and passive resistance that the therapist may not recognize or work through because of this new media and technology context of counseling (Ehrlich, 2021; Weinberg, 2020).

In addition to transference and resistance, projection is another fundamental psychoanalytic phenomenon that is much more pronounced in a virtual environment (Ehrlich, 2021; Weinberg, 2020). This dynamic occurs because in F2F sessions, counselors often provide visual feedback through facial expression or body language that will inhibit projections (Weinberg, 2020). In the virtual environment, these cues do not exist as readily, and therefore projections may occur more frequently and intensely (Weinberg, 2020). For example, if the psychotherapist resembled someone with whom the client had a negative experience in their past (e.g., a classmate from their past), it would be much easier for the client

to project their disembodied and unconscious thoughts, feelings, and emotions towards the unsuspecting clinician without constraint. In a Zoom, phone, or synchronous text counseling session, this may catch the clinician by surprise or go unrecognized, resulting in an uncomfortable and caustic interaction or a confusing distance, which can ultimately be defined as a rupture event (Muran & Safran, 2016) or a misattunement between the client and counselor. If not recognized and tended to by the counselor, these events can lead to poor clinical outcomes or a discontinuation of treatment (Flückiger et al., 2018).

Research has also noted that classic psychoanalytic resistances are common in the virtual space; therefore, counselors must recognize them as they occur, call them out, and subsequently process them with their clients (Ehrlich et al., 2021; Weinberg, 2020). One way to do this is through the use of metacognitions (thinking about thinking) when alliance ruptures are identified (Eubanks et al., 2019; Newhill et al., 2003). Clinicians have also discovered that metacognitions are important (Eubanks et al., 2019) because developing a therapeutic bond, negotiating the tasks and goals of counseling (Bordin, 1979; Newhill et al., 2003), and creating intimacy can be particularly difficult in a virtual environment. Researchers have found that in order to bolster the bond, it is important for the therapist to apologize for mistakes or errors that occur in session (Ellis, 2021; Weinberg, 2020), especially when working with clients from marginalized populations (Moster et al., 2017). The therapist's ability to apologize is particularly helpful in a psychodynamic sense because the client can then have a corrective experience related to any fantasies regarding their relationship with their parents, who may never have apologized for their mistakes (Eills, 2021; Weinberg, 2020).

In a virtual counseling environment, the stakes of reflective commentary and metacommunication can be higher even as that communication may be more difficult. In practice, the dynamic-oriented counselor can skillfully and overtly discuss what is taking place in the therapeutic relationship in the here and now, specifically commenting about aspects of the therapeutic alliance through metacommunication (Eubanks et al., 2019). For example, a counselor may notice and then comment on a client giving a minimal response to a question as a way to resist discussing a difficult topic in the course of a therapy session. In a virtual session, with the help of high-resolution video, a therapist may specifically metacommunicate about a single-word, softly worded response where the tone does not match the content, and the body language also feels incongruent with the answer. The counselor might also metacommunicate (process out loud) what they think may be happening based on what they are seeing and hearing through the video interface in order to help the client work through their resistance. To work through a transference issue in a virtual session, the counselor might openly comment about the client's behavior towards them and how it is similar to how they have acted towards a family member or

significant other. These comments are designed to increase client insight and awareness. In the virtual setting, transference-related behavior or verbal patterns might be easier or harder to recognize depending on how the client utilizes the technology (e.g., whether they share their screen, how much of their body they are showing on camera, and whether they show or try to hide their faces). As a result, the clinician may have to work harder at times to identify and work through transference. Finally, to move past a projection in a virtual session, a counselor might discuss how a client is unconsciously taking their unwanted emotions or traits out on the counselor. In a virtual environment, this can be challenging, as a client's projections may be more difficult to identify if the client is consciously or unconsciously limiting the counselor's ability to identify both verbal and nonverbal communication during a televideo session. One intervention that a counselor may employ when they are noticing resistance, transference, and projections is to talk openly (meta-communication) about these core psychodynamic ideas to help disembed from an unhelpful pattern of interactions in the virtual counseling session, which ultimately impedes the treatment process and the client's ability to meet their therapeutic goals.

Person-centered Informed Counseling Through Media and Technology

Person-centered counseling, which draws from the same foundational Freudian ideas as psychoanalytic theory (Sommers-Flanagan, 2018), is another useful lens for exploring this new media and technology paradigm. When practicing from a person-centered or Rogerian orientation, the therapist should demonstrate empathy and a sense of unconditional positive regard with clients (Rogers, 1951). This is often referred to as the therapeutic alliance or a sense of intimacy. When providing counseling virtually, creating a sense of intimacy may look much different than it does in an F2F session. One strategy to create intimacy through media and technology is to help the client feel comfortable with the technology being employed in the online counseling process (Jenkins et al., 2015; King et al., 2009; Weinberg, 2020). Additionally, the counselor can create intimacy by asking the client whether there is anyone in the room where the session is taking place and by showing the client that the counselor is also in a confidential setting. Intimacy can be further increased by recognizing and processing interruptions in technology that occur during counseling and by having a backup plan if the client is unable to keep themselves safe (Glueck et al., 2013; Weinberg, 2020).

Transparency is a secondary Rogerian or person-centered construct that translates easily to the virtual environment and has been shown to be essential when using media and technology to deliver clinical services (Glueck et al., 2013; Weinberg, 2020). Transparency in a virtual setting can be created in a number of ways. First, as previously mentioned, presence can be augmented through the technical skills of the therapist by helping the client through

technology-related challenges they may confront within the chosen virtual platform (Glueck et al., 2013). Presence is also developed by using increased self-disclosure or transparency (Glueck et al., 2013; Weinberg, 2020). Transparency can be created by talking explicitly with clients about difficulties related to the online environment and validating their experiences. It can also be developed by educating clients on how to overcome the physical and emotional barrier created by the screen or app. This can be potentiated by the therapist noticing facial expressions and making immediacy statements. These statements can be as simple as asking the client what is happening for them when the counselor notices a change in verbal or bodily expressions. This intentional strategic intervention brings the focus back to the here and now, helping the client feel seen and heard. Finally, counselors can identify empathic mistakes or ruptures, subsequently apologize, and then take full responsibility for their errors. These moments of misattunement are called empathic failures in the person-centered literature (Rogers, 1977) and can create an opportunity for a corrective relational experience by employing accurate empathy.

Multicultural-informed Counseling Through Media and Technology

A third counseling orientation, multicultural-informed counseling, is an important perspective to consider in the new virtual epitome. The recent political climate, unrest, and protests as a result of police violence during the time of COVID-19 have reminded the counseling profession that there is still work to be done to address structural inequality in in the U.S. Specifically, seminal researchers and authors such as Derald Wing Sue continue to create tools to help counselors combat bias, prejudice, and racism in their work with clients. Because the current political climate is slowly waking the country to structural racism and the impact of racial stress on mental health, it is important to infuse multicultural counseling theory into media and technology practice.

For example, when working with a client of Asian descent using media and technology, a cultural challenge may occur in a counselor's attempts to build intimacy with a client by admitting mistakes in a virtual environment (Wang et al., 2013). According to research, Asian clients or clients from authoritarian cultures may be confused by having an authority figure admit errors, as it can be seen as an admission of weakness regarding the perceived proficiency of the counselor (Wang et al., 2013; Weinberg, 2020). In these circumstances, it is important for the counselor to check in with the client to see how they experienced the intervention (Weinberg, 2020). A second cultural competency consideration when working with Asian clients relates to their comfort with anonymity. In Asian cultures, it is often more acceptable to have an anonymous identity, and this idea may even relate to revealing facial features. Therefore, a client who is meeting a psychotherapist in a virtual environment may be more comfortable keeping intimate parts of their lives

anonymous, not sharing their computer camera, or even not completing the visit when engaging in treatment, which may be anxiety-producing for the clinician (Eberly et al., 2020; Weinberg, 2020). Many other cultural competencies are beyond the scope of this manuscript but should be considered when providing services through media and technology, and it is the therapist's responsibility to continue gaining additional competency in order to provide ethical care.

Critical Interpretive Analysis of Emerging Ethical Considerations

Counselors must also deal with the ethical ramifications of the shift to virtual counseling. This adjustment encompasses both reexamining known ethical considerations and identifying emerging ethical challenges. Understanding media and technology through the lens of ethical challenges will help counselors serve their clients more effectively during this challenging time. In this section, selected ethical codes will be highlighted from the ACA 2014 Code of Ethics (American Counseling Association, 2014) and examined through the lens of media and technology.

Informed Consent and Privacy Considerations

When applying ethical codes A.2.a (informed consent in the counseling relationship) and A.1.b (client welfare related to records and documentation) to virtual practice, a counselor must obtain proper informed consent for the use of technologies with their clients. Informed consent is a continual process in which the client understands the risks and benefits of treatment in a virtual environment and the unique aspects of receiving services virtually rather than F2F. Ongoing informed consent may include a conversation about whether virtual care is appropriate for a given client, as well as what happens in an emergency, given that the counselor and client may not be in the same city or even state. Currently, the need for almost all counselors to meet with clients virtually to keep everyone safe from the virus necessitates multiple informed consent conversations over time, as clients may be in multiple places and states throughout the counseling process.

Codes A.1.b (client welfare as it relates to records and documentation) and B.6 (records and documentation) state that counselors must keep private and confidential records. When practicing technology-mediated counseling, a clinician will need to consider the techniques and locations of storing clinical records, as well as the possibility of maintaining at least two locked doors to ensure HIPPA compliance. Additionally, when providing service either asynchronously through text or synchronously through video, counselors must ensure that they are utilizing HIPPA-compliant software. Finally, counselors must consider how they will transmit clinical information when billing insurance or where they will receive a confidential record from a third party or client. Best practices during this new virtual paradigm include limiting email use, using encrypted email when

necessary, and utilizing an HIPPA-compliant fax or E-fax.

Psychoeducation, Positive Relationships, and Implementation Considerations

Codes A.1.a (primary responsibilities as they relate to client welfare), A.1.c (counseling plans as they relate to client welfare), and A.2.b (informed consent in the counseling relationship as it relates to the type of information needed) require that counselors engage in effective psychoeducation and intervention. It is important that counselors take the time to explain to clients the empirical backing of providing counseling through media and technology as well as its limitations. This conversation could easily be missed, however, because of the rapid switch to media and technology service delivery brought on by the pandemic. Thus, it is particularly important to foreground these conversations throughout the duration of the counseling relationship. It is also essential that counselors use theories and techniques that have been found to be efficacious in their counseling practice when delivered virtually. This includes evidence-based therapy or evidence-based practice that has been further validated in a virtual environment through research.

Code A.1.d (supportive network involvement as it relates to client welfare) may suggest that counselors effectively enroll clients and their supporters in counseling and maintain positive interactions when using media and technology. This possible interpretation of Code A.1.d. is important because recently apps have been used in family counseling to support clients who need additional accountability in mental health or substance use recovery. Furthermore, a trusted coworker or friend may be involved in the treatment team and be encouraged to engage in technology to enhance a client's care. The counselor has an ethical responsibility to make sure that individuals who support clients are enrolled through an appropriate consent process and are adequately trained in the use of the technology. The counselor must also ensure that the relationships with those supports are positive and professional and that the participating parties create healthy boundaries to augment the counseling process. This interpretation of the code is timely and especially important, as the COVID-19 pandemic may increase app use and the recruitment of additional supports.

When translating Code A.9.a (screening as it relates to group work) for media and technology practice, it can be interpreted as a mandate for appropriate screening and implementation of an app when used in a group counseling context. However, this code may also have some implications for individual work. As media and technology are increasingly incorporated into treatment, it is important that counselors are ethical when assessing an individual's digital ability access. Some clients may not own a tablet, smartphone, or laptop because of lack of resources, lack of technological fluency, or personal choice. These limitations can prevent such clients from being active participants in a virtual

group or from benefiting from individual treatment. Counselors need to be able to assess a client's digital lifestyle, which includes access, ability, and willingness to use media and technology in an individual or group setting. This assessment will prevent potential harm to clients by screening out those who would not benefit from virtual treatment. From a social justice perspective, counselors must ensure that by providing services through media and technology they are not discriminating against certain identities of oppression because of a lack of access to these potentially expensive modalities. The current global pandemic exacerbates lack of access to technology for marginalized populations, and counselors will need to work to increase media access through client-specific advocacy efforts.

Scheduling, Confidentiality, Environment, and Risk

There are also ethical considerations related to code A.10 (fees and billing practice) when using technology-mediated platforms to deliver counseling services. A primary example relates to scheduling issues and the "virtual office." Often a link is sent to the client before a virtual session begins through a platform such as Zoom. In some educational institutions, organizations, and private practices, a clinician may be using more than one Zoom link or changing the link for each session to maintain confidentiality. This can cause confusion and frustration for a client and ultimately become a clinical issue because it feels as if the virtual office is essentially a moving target. Additionally, the client may struggle with technological proficiency, in which case the counselor will need to be supportive and empathic and consider whether a technology-based intervention is helpful.

An example of an ethical issue related to billing is automatic billing or invoices that are autogenerated in many of the new billing platforms. These systems, when not properly monitored, can overcharge a client without the client's knowledge and create a potential rupture in the clinical relationship. From a social justice perspective, taking payment only electronically can also prevent vulnerable populations from accessing a much-needed mental health service—for instance, if a client does not have a credit or debit card or a bank account. In the worst-case scenario, confidentiality could be compromised because of scheduling, billing, or technology glitches where information is sent to the wrong email or physical address. In these cases, the use of media and technology can inadvertently introduce a significant clinical issue, and counselors must be aware of the potential for ethical concerns to arise.

Additional relevant codes include codes B.1.c (respecting confidentiality as it pertains to respecting clients' rights) and B.2 (exceptions as they relate to confidentiality and privacy). It is important for a counselor to communicate expectations and availability when using media and technology in counseling. They must be explicit about their space and location requirements for their clients to maintain confidentiality. This includes creating white

noise in nonconfidential environments, having noise canceling headphones if possible, and having the clients let others they live with know they are in a confidential meeting. The pandemic can make this quite challenging, as many more families and friends are sharing spaces. Additionally, counselors should create redundancy in their technology, which means having both a computer and a phone for backup in case one suddenly fails. Furthermore, it is important to test connectivity before the session and to test cameras, speakers, and microphones to ensure they are functioning at an acceptable level. Finally, counselors should be explicit about their availability and let the client know when and how they are available and how long it will take to respond to an urgent message or potential crisis.

One final code combination that is worth noting is code B.6.i (reasonable precautions as they relate to confidentiality) and code B.2 (exceptions as they relate to confidentiality and privacy), which may task counselors with being aware of exceptional situations. When working in a virtual environment, a counselor must be clear that the client and counselor are not in the same physical location, and that therefore the bar is set lower for mandated reporting of safety-related concerns. This can be discussed overtly through the informed consent process, which includes a discussion on confidentiality during the intake process and should be revisited regularly. To further ensure client safety, a best practice is to ask the client to identify their location each time they come to a virtual session and to make sure to obtain an emergency contact and phone number. This information is especially important as the pandemic has caused many clients to utilize various locations to ensure privacy, including home or office. It is also important to know the emergency or crisis resources in the location of the client, which includes the local crisis line, police, and sheriff department's contact information.

Practical Implications

The implications of a newly formed media and technology paradigm during COVID-19 are many. The field of counseling and psychotherapy need unifying terms, concepts, and language to communicate and develop best practices. The field also requires emerging research in virtual counseling services that are being delivered through media and technology. This includes obtaining research funding from government sources to advance best practices with the aim of improving eHealth outcomes. Additionally, because of the strong likelihood of future pandemics and the social justice rationale for expanding the availability of treatment, utilizing media and technology is required to meet the ever-growing demand for clinical services. Furthermore, counselors will need to continually identify and be aware of emerging ethical issues related to virtual counseling to meet the increasing petition for clinical services. Identifying these emerging ethical issues is also important because of the increased speed of innovation, which has been intensified by

the pandemic and may ultimately impact the safety of the client.

Implications of Using Phone Applications in Clinical Practice

As the COVID-19 pandemic has required counselors to deliver mental health care through media and technology, clinicians are commonly using phone applications to enhance their service delivery. There are several best practices to consider in order to enhance service delivery through application use. First, counselors should encourage clients to use self-directed apps and to share their results in concert with their F2F work in counseling sessions. Second, counselors should consider finding researchers attempting to innovate in the area of clinician-focused apps and, when appropriate, attempt to join IRB-approved research protocols and projects. Third, counselors must consult technology specialists who are also experts in mental health about specific apps they are recommending to their clients. Fourth, counselors can write to professional organizations—including American Counseling Association, American Mental Health Counseling Association, or American Psychological Association—and participate in ethical standards development around app use while keeping abreast of the latest developments in the media, technology, and mental health space through reading current publications. Finally, it is important that counselors contact insurers and local officials to advocate for creating billing standards and financing for technology-enabled therapeutic approaches such as phone application use, as not all services are covered by all insurance companies. The use of applications has the potential to significantly bolster clinical practice as new tools are developed, validated, and employed.

Conclusion

Because of the imperative the global pandemic has caused, the use of media and technology in the counseling field needs to be formalized across the helping professions to unite the various disciplines (psychiatrists, psychologists, advanced practice nurse practitioners, social workers, licensed paraprofessional counselors, marriage and family therapists, and addiction counselors) that provide mental health services. The pandemic and the current state of mental health have caused an ever-increasing demand and a unique opportunity to embrace innovation. In response, numerous grants have been made available through the National Institute of Health and other government entities to complete eHealth research. Catalyzed by COVID-19-related mental health issues, it is vital that the mental health field take on the responsibility of pivoting into the virtual age. This includes updating theory and developing and deploying empirically validated best practices. This manuscript formalized this process by presenting foundational definitions and concepts under the umbrella of media and technology as they relate to counseling. The paper also attempted to update counseling theory as it applies to virtual practice and provided a rationale for the importance of assessing

ethical codes in a media and technology context to ensure safe and ethical practice. Finally, counselors must ultimately face their online fears and use their imagination to employ media- and technology-based clinical services in a new reality where mental health is increasingly accepted as an essential aspect of life.

References

American Counseling Association (2014). ACA code of ethics. Author.

Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., Wachter, K., Murray, L., & Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine*, *368*(23), 2182–2191. https://psycnet.apa.org/doi/10.1056/NEJMx140025

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://psycnet.apa.org/doi/10.1037/h0085885

Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process*, *59*(3), 974–988. https://doi.org/10.1111/famp.12589

Butryn, T., Bryant, L., Marchionni, C., & Sholevar, F. (2017). The shortage of psychiatrists and other mental health providers: Causes, current state, and potential solutions. *International Journal of Academic Medicine*, *3*(1), 5–9. https://doi.org/10.4103/IJAM.IJAM_49_17

Chen, S., Cheng, A., & Mehta, K. (2013). A review of telemedicine business models. *Telemedicine and e-Health*, *19*(4), 287–297. https://doi.org/10.1089/tmj.2012.0172

Children's Defense Fund (2020, January 1). *The State of America's Children*. https://www.chn.org/voices/2021-state-of-americas-children-our-children-are-not-immune/

Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., & Saxena, S. (2016). Scaling-up treatment of depression and anxiety: A global return on investment analysis. *The Lancet Psychiatry*, *3*(5), 415–424. https://doi.org/10.1016/s2215-0366(16)30024-4

Corbella, V. (2020). From the couch to the screen: Psychoanalysis in times of virtuality. In F. Irtelli, B. Marchesi, & F. Durbano (Ed.), *Psychoanalysis* (pp. 83–93). IntechOpen. https://10.5772/intechopen.95092

Cowan, K. E., McKean, A. J., Gentry, M. T., & Hilty, D. M. (2019). Barriers to use of telepsychiatry: Clinicians as gatekeepers. *Mayo Clinic Proceedings*, *94*(12), 2510–2523. https://doi.org/10.1016/j.mayocp.2019.04.018

Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M., Robbins, R., Facer-Childs, E., Barger, L., Czeisler, C., Howard, M., & Rajaratnam, S. M. W. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic-United States, June 24-30, 2020. *MMWR: Morbidity and Mortality Weekly Report*, *69*(32), 1049–1057. https://doi.org/10.15585/mmwr.mm6932a1

Eberly, L. A., Kallan, M. J., Julien, H., Haynes, N., Khatana, S., Nathan, A., Snider, C. Chokshi, N., Eneanya, N., Takvorian, S., Anastos-Wallen, R., Chaiyachati, K., Ambrose, M., Quinn, R., Seigerman, M., Goldberg, L., Leri, D., Choi, K., Gitelman, Y., … & Adusumalli, S. (2020). Patient characteristics associated with telemedicine access for primary and specialty ambulatory care during the COVID-19 pandemic. *JAMA Network Open.* http://10.1001/jamanetworkopen.2020.31640

Ehrlich, L. T. (2021, July). Our sudden switch to teleanalysis during a pandemic: Finding our psychoanalytic footing. *International Forum of Psychoanalysis, 30*(3), 167-175. https://doi.org/10.1080/0803706X.2021.1939419

Ellis, H. (2021). *The relationship between alliance rupture and repair and the provision of corrective emotional experiences* (Publication No. 28768397) [Doctoral dissertation, The Chicago School of Professional Psychology]. ProQuest Dissertations and Theses Global.

Eysenbach G. (2001). What is e-health? *Journal of Medical Internet Research*, *3*(2), E20. https://doi.org/10.2196/jmir.3.2.e20

Figueroa, C. A., & Aguilera, A. (2020). The need for a mental health technology revolution in the COVID-19 pandemic. *Frontiers in Psychiatry*, *11*, 523. https://doi.org/10.3389/fpsyt.2020.00523

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316–340. https://doi.org/10.5167/uzh-157613

Gamm, L., Stone, S., & Pittman, S. (2010). Mental health and mental disorders—A rural challenge: A literature review. *Rural healthy people*, *2*(1), 97–114. https://openelearning.ca/trauma/pdf/I4.pdf

Glueck, D. (2013). Establishing therapeutic rapport in telemental health. In K. Myers & C. L. Turvey (Eds.), *Telemental health: Clinical, technical, and administrative foundations for evidence-based practice* (pp. 29–46). Elsevier. https://doi.org/10.1016/B978-0-12-416048-4.00003-8

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health*, *103*(5), 777–780. https://doi.org/10.2105/AJPH.2012.301056

Hersh, R. G., Caligor, E., & Yeomans, F. E. (2017). *Fundamentals of transference-focused psychotherapy: Applications in psychiatric and medical settings*. Springer.

Hollis, C., Morriss, R., Martin, J., Amani, S., Cotton, R., Denis, M., & Lewis, S. (2015). Technological innovations in mental healthcare: harnessing the digital revolution. *The British Journal of Psychiatry*, *206*(4), 263–265. https://doi.org/10.1192/bjp.bp.113.142612

Jamal, A., McKenzie, K., & Clark, M. (2009). The impact of health information technology on the quality of medical and health care: A systematic review. *Health Information Management Journal*, *38*(3), 26–37. https://doi.org/10.1177%2F183335830903800305

Jenkins-Guarnieri, M. A., Pruitt, L. D., Luxton, D. D., & Johnson, K. (2015). Patient perceptions of telemental health: Systematic review of direct comparisons to in-person psychotherapeutic treatments. *Telemedicine and e-Health*, *21*(8), 652–660. https://doi.org/10.1089/tmj.2014.0165

Jones-Smith, E. (2019). *Theories of counseling and psychotherapy: An integrative approach*. Sage Publications.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among US children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*(9), 1548–1555. https://doi.org/10.1176/appi.ajp.159.9.1548

King, V. L., Stoller, K. B., Kidorf, M., Kindbom, K., Hursh, S., Brady, T.,

& Brooner, R. K. (2009). Assessing the effectiveness of an Internet-based videoconferencing platform for delivering intensified substance abuse counseling. *Journal of Substance Abuse Treatment*, *36*(3), 331–338. https://doi.org/10.1016/j.jsat.2008.06.011

Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental health care. *Bulletin of the World health Organization*, *82*(11), 858–866. https://doi.org/10.1111/j.1525-1314.2005.00584.x

Lambert, D., Gale, J., Hartley, D., Croll, Z., & Hansen, A. (2016). Understanding the business case for telemental health in rural communities. *The Journal of Behavioral Health Services & Research*, *43*(3), 366–379. https://doi.org/10.1007/s11414-015-9490-7

Lipson, S. K., Lattie, E. G., & Eisenberg, D. (2019). Increased rates of mental health service utilization by US college students: 10-year population-level trends (2007–2017). *Psychiatric Services, 70*(1), 60–63. https://doi.org/10.1176/appi.ps.201800332

McFerran, K. S., & Finlay, L. (2018). Resistance as a 'dance' between client and therapist. *Body, Movement and Dance in Psychotherapy, 13*(2), 114–127. https://doi.org/10.1080/17432979.2018.1448302

Midgley, G. (2006). Systemic intervention for public health. *American Journal of Public Health*, *96*(3), 466–472. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2005.067660

Mishkind, M. C., Shore, J. H., Bishop, K., D'Amato, K., Brame, A., Thomas, M., & Schneck, C. D. (2021). Rapid conversion to telemental health services in response to COVID-19: Experiences of two outpatient mental health clinics. *Telemedicine and e-Health*, *27*(7), 778–784. https://doi.org/10.1089/tmj.2020.0304

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus*, *18*(1), 16–24. https://doi.org/10.1176/appi.focus.20190028

Mosher, D. K., Hook, J. N., Captari, L. E., Davis, D. E., DeBlaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse clients. *Practice Innovations*, *2*(4), 221–233. https://doi.org/10.1037/pri0000055

Muran, J. C., & Safran, J. D. (2016). Therapeutic alliance ruptures. In A.

E. Wenzel (Ed.), *Sage encyclopedia of abnormal and clinical psychology* (pp. 3,511–3,514). Sage.

Newhill, C. E., Safran, J. D., & Muran, J. C. (2003). *Negotiating the therapeutic alliance: A relational treatment guide*. Guilford Press.

Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

Pellegrini, D. W. (2010). Splitting and projection: Drawing on psychodynamics in educational psychology practice. *Educational Psychology in Practice, 26*(3), 251–260. https://doi.org/10.1080/02667363.2010.495209

Petersen, D., Salazar, B., & Kertz, S. J. (2020). Therapist and treatment-seeking students' perceptions of telemental health. *Journal of Technology in Behavioral Science*, *5*(2), 113–120. https://doi.org/10.1007/s41347-019-00116-8

Pierce, B. S., Perrin, P. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2021). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in US mental health care delivery. *American Psychologist*, *76*(1), 14–25. https://psycnet.apa.org/doi/10.1037/amp0000722

Radez, J., Reardon, T., Creswell, C., Orchard, F., & Waite, P. (2021). Adolescents' perceived barriers and facilitators to seeking and accessing professional help for anxiety and depressive disorders: A qualitative interview study. *European Child & Adolescent Psychiatry*, 1–17. https://doi.org/10.1007/s00787-020-01707-0

Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus video conferenced psychotherapy. *Professional Psychology: Research and Practice, 36*(6), 649–653. https://doi.org/10.1037/0735-7028.36.6.649

Rehm, J., & Shield, K. D. (2019). Global burden of disease and the impact of mental and addictive disorders. *Current Psychiatry Reports, 21*(2), 1–7. https://doi.org/10.1007/s11920-019-0997-0

Renn, B. N., Chu, F., & Zaslavsky, O. (2021). Telemental health after COVID-19: Understanding effectiveness and implementation across patient populations while building provider acceptance are the next steps. *The Journal of Clinical Psychiatry, 82*(5), 36030. https://doi.org/10.4088/JCP.21lr14037

Rogers, C. R. (1951). *Client-centered therapy: Its current practice,*

implications and theory. Houghton Mifflin.

Rogers, C. R. (1977). *Carl Rogers on personal power*. Delacorte.

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology*, *56*(2), 233–243. https://doi.org/10.1002/(SICI)1097-4679(200002)56:2%3C233::AID-JCLP9%3E3.0.CO;2-3

Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology*, *69*(2), 115–126. https://doi.org/10.1002/jclp.21951

Shadangi, P. Y., Dash, M., & Kar, S. (2019). Why physician's keep coming back to telemedicine: Predicting using unsupervised learning. *Indian Journal of Public Health Research & Development, 10*(1), 216–221. http://dx.doi.org/10.5958/0976-5506.2019.00044.5

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2018). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques*. John Wiley & Sons.

Wang, J. H., Adams, I. F., Pasick, R. J., Gomez, S. L., Allen, L., Ma, G. X., Lee, M. X., & Huang, E. (2013). Perceptions, expectations, and attitudes about communication with physicians among Chinese American and non-Hispanic white women with early stage breast cancer. *Supportive Care in Cancer: Official Journal of the Multinational Association of Supportive Care in Cancer*, *21*(12), 3315–3325. https://doi.org/10.1007/s00520-013-1902-8

Weinberg, H., & Rolnick, A. (2020). *Theory and practice of online therapy*. Routledge. https://doi.org/10.4324/9781315545530

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: A research-to-practice perspective. *Current Psychiatry Reports*, *19*(5), 28–38. https://doi.org/10.1007/s11920-017-0780-z

Figure 1

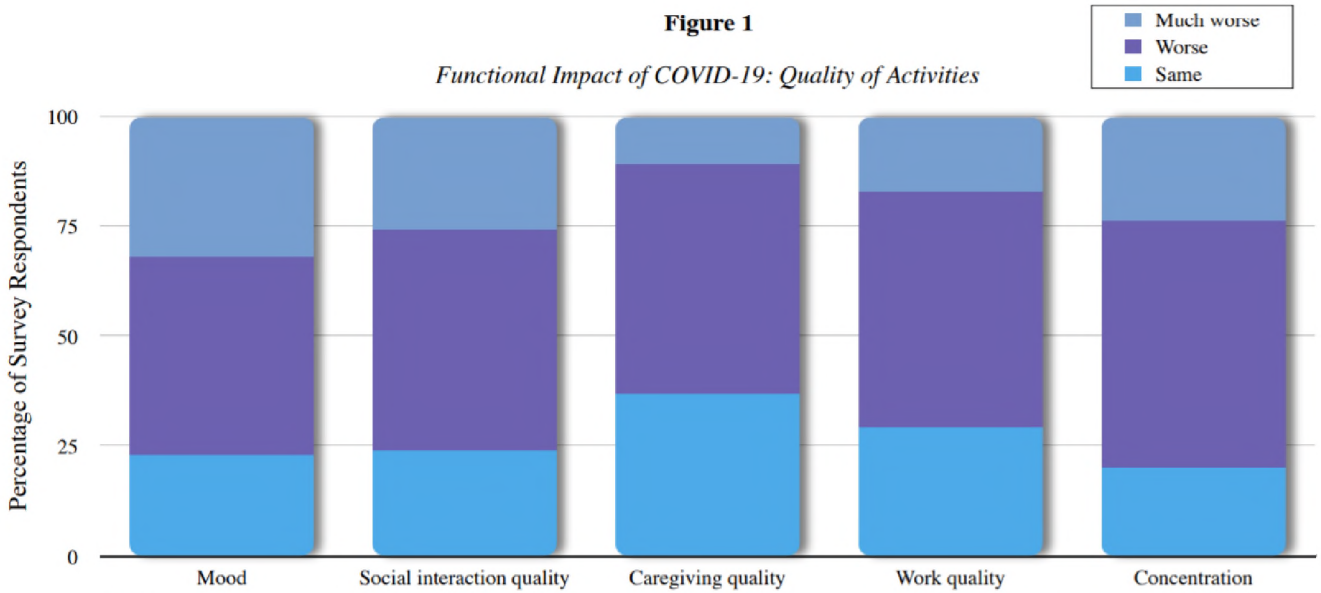
Use of Telepsychology Before and During the COVID 19 Pandemic

	Before the COVID 19 Pandemic	**During COVID 19 Pandemic**
Psychologists' use of Telepsychology	21%	96.45%
Psychologists that had not used Telepsychology	45.70%	No data available
Psychologists that have gone completely virtual	No data available	67.32%

Note. Data from Pierce et al. (2020).

Figure 2

Functional Impact of COVID-19: Quality of Activities



Note. Figure summarizes data from survey results reported by Park, A., Velez, C. V., Kannan, K., & Chorpita, B. F. (2020). *Stress, functioning, and coping during the COVID-19 pandemic: Results from an online convenience sample*.

Figure 3

Considerations for ACA Ethical Codes in Virtual Practice

ACA 2014 Code	Content of Code	Ethical Consideration for Virtual Practice
A.2.a. *Informed Consent*	Clients have the freedom of chose when entering into a counseling relationship and need information about the counseling process and the counselor.	Ensuring there are proper protocols in place to ensure that clients can have informed consent and continue to consent to treatment in a virtual environment.
A.1.b. *Records and Documentation*	Counselors create, safeguard, and maintain documentation.	Ensuring that client records and documentation are kept confidential in a myriad of virtual environments
B.6. *Records and Documentation*	Counselors create, safeguard, and maintain appropriate records and documentation.	Maintaining confidential records and proper documentation in a virtual environment.
A.1.a. *Primary Responsibility*	The primary responsibility of counselors is to respect the dignity and promote the welfare of clients.	Providing the client with psychoeducation regarding the efficacy and limitations of interventions when delivered virtually.
A.1.c. *Counseling Plans*	Counselors and their clients work together to create plans that offer reasonable promise of success and are appropriate to the client.	Collaborate with the client regarding the development of a treatment plan that is reasonably efficacious in virtual contexts.
A.2.b. *Types of Information Needed*	Types of Information Needed Counselors explicitly explain to clients the nature of all services provided.	Providing clients with an explanation of the nature of the online services provided and data that supports the evidence-based counseling practice.
A.1.d. *Support Network Involvement*	Counselors recognize that support networks hold various meanings for clients and consider enlisting others as positive resources.	Ensuring client supports are educated and understand the advantages and limitations of utilizing media and technology in the context of the treatment context.
A.9.a. *Screening*	Counselors screen prospective group counseling participants. Counselors select members whose needs and goals are compatible the group	Screening potential clients to ensure they are appropriate to receive treatment in a virtual environment.
A.10. *Fees and Business Practice*	Section heading which includes self-referral, unacceptable business practices, and establishing fees.	Clarity regarding business practices. This includes how fees will be collected, if late cancellations with be billed, and how their financial information will be stored.

B.1.c. *Respect for confidentiality*	Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent.	Respecting and protecting confidential information in a virtual environment and handling authorized disclosure in ethical manner.
B.2. *Exceptions*	Section heading which includes Serious and Foreseeable Harm and Legal Requirements, Confidentiality Regarding End-of-Life Decisions.	Clearly explaining how limits to confidentiality will be handled in the virtual environments. This includes threat to self and others.

Note. Figure summarizes the American Counseling Association's (2014) ACA Code of Ethics.