Journal of Counselor Preparation and Supervision

Volume 17 | Number 5 Article 3

2023

Telemental Health Training in Counselor Education: A Qualitative Research Study

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Abstract

Telemental health training in counselor education is uncommon, mostly because telemental health delivery of counseling has been limited. However, the COVID-19 pandemic required a sudden pivot to technology in order to continue to provide services to clients. Counselors-in-Training also had to pivot to telemental health field experiences, most without intentional training for such in their master's programs. This grounded theory qualitative study describes the lived experiences of seven students in their Practicum course during this period in a master's-level clinical mental health counseling program. Particular themes that emerged were concerns about lack of training in various areas, including crisis intervention/risk assessment online, and positive perceptions of creativity and accessibility.

Keywords

Telemental health training, COVID-19, counselor education, counselors-in-training, distance counseling

Author's Notes

Acknowledgments This research was supported by grant funding from the INSPIRE Fund through Fairfield University's Office of Scholarly Development.

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Counselors-in-Training (CITs) are at a pivotal point in their educational process during their Practicum course (Ikonomopoulos et al., 2016). Not only is this their first experience applying the lessons of their previous content courses, but it also represents their first foray into providing counseling to clients in a professional mental health setting. The transition to becoming a Practicum student can be overwhelming and anxiety-provoking, even if all goes as planned (Al-Darmaki, 2004). In the Spring of 2020, all did not go as planned for Practicum students in most Counselor Education master's programs. In fact, just as they were beginning to ease into their new CIT role, the in-person delivery of mental health services in outpatient settings largely shut down due to restrictions from the COVID-19 pandemic. CITs at these clinics spent a week or two "in limbo," unsure what the plan would be for continuing their clinical education. As outpatient sites realized the enormity of the issue and the likelihood that the shutdown would continue for quite some time, most transitioned to providing counseling through some kind of technology (Appleton et al., 2021).

Telemental Health

Telemental Health (TMH) delivery has existed since the invention of telephone hotlines in the 1960s (Reese et al., 2006), with more options throughout the years to deliver TMH services via synchronous (e.g., telephone, audio-visual technology) and asynchronous (e.g., chat, messaging, apps) methods of service delivery. TMH delivery by psychologists prior to the COVID-19 pandemic is reported around 21% (Wallis, 2022) indicating that this was a delivery model in existence but not necessarily popular, possibly for concerns about its efficacy (Rees et al., 2005; Simms et al., 2011). In addition, most behavioral health sites were concerned about telemental health and did not have the option for CITs to counsel through technology during their training experience. However, recent research indicates that TMH can be as effective as in-person

counseling for many mental health issues and that the therapeutic working alliance is similar (Bouchard et al., 2020; Novella et al., 2019; Watts et al., 2020). Even larger scale, meta-analytic studies report that no significant difference has been found between teletherapy and in-person therapy, either in treatment outcomes or in attrition rates (Lin et al., 2022).

Telemental Health Training

During the rapid shift to telemental health, many practitioners, as well as trainees, had no training in these delivery systems and were intimidated by the need for some understanding of technology for implementation. Many of these training concerns were related to the HIPAA-security of various technologies, especially when considering the complexity of internet data storage (Lopez et al., 2019). In addition, counselors felt underprepared to assess a suicidal or homicidal client and unsure of the protocol for crisis intervention when online (Lopez et al., 2019). The COVID-19 pandemic did not allow an opportunity for trainees to develop these skills, due to the sudden need for social distancing.

Some counselor education programs offered training in TMH before the COVID-19 pandemic, and others implemented such training due to necessity during the pandemic. Robertson & Lowell (2021) discovered that, when counselor educators were asked to what extent they were satisfied with the training that their students received in distance counseling, "the greatest percentage of respondents [counselor educators] were either 'somewhat dissatisfied' (37%) or 'neither satisfied nor dissatisfied' (33%). Only 16.7% of respondents indicated that they were 'extremely satisfied or satisfied' while another 13% indicated that they were 'extremely dissatisfied'" (p. 19). Interestingly, many faculty members in these programs communicated confidence in teaching TMH with limited formal training in TMH (Robertson & Lowell, 2021). Based on these findings, the consistency and quality of such training is questionable. Despite

research findings that indicate the need for a framework of telebehavioral health competencies to guide counselor training in this area (Suggs et al., 2022) few standards exist for TMH training (Robertson & Lowell, 2021; Perle, 2022).

Although most counselors and clients express interest in continuing some form of telemental health treatment even in the absence of pandemic-related social distancing (Barnett et al, 2021), literature on the TMH training efficacy within the counseling profession is limited compared to psychology and other helping professions (Minton et al., 2018; Robertson & Lowell, 2021). Moving forward without appropriate training of CITs may pose harm to their clients, as indicated by Trepal as far back as 2007 (Trepal et al., 2007).

Therefore, understanding the experiences of CITs who switched to TMH without much instruction is helpful to inform counselor educators and supervisors of the needs of CITs to engage effectively in TMH. These experiences also may indicate best practices for TMH training as well as how to train CITs for future systemic crises in clinical training. This grounded theory study investigated the lived experience of clinical mental health counseling students from a private university in the northeast region who were in their Practicum experience during the initial COVID-19 shutdown in March, 2020.

Method

A qualitative study method was determined as best to understand the lived experience of clinical mental health CITs who switched to TMH delivery of services during their initial clinical training experience. Qualitative research explores these experiences on a deeper level, to inductively arrive at an understanding that is complex, while taking into account the multiple identities of participants (Denzin & Lincoln, 2011). The grounded theory model encourages us to "move beyond description" (Creswell, 2013, p. 83) to explain the process experienced by these

participants.

Researcher Reflexivity

Researcher reflexivity is crucial when conducting qualitative studies, in order to bracket experiences and address bias. The first author identifies as a straight, cisgender female, able-bodied, neurotypical, born in the United States, of Armenian and English/Dutch parents. The experience of the first author with qualitative research is three separate qualitative projects, two are on-going and one from a previous institution resulted in a poster presentation. This author was teaching a Practicum class during the COVID-19 shutdown in March, 2020. The second author identifies as a heterosexual, cisgender male, able-bodied, neurotypical, born in the United States, of Italian and English parents. This is the first qualitative research experience of the second author. The second author was a full-time graduate student in a Clinical Mental Health Counseling program during the COVID-19 shut down in March, 2020, and started a Practicum placement in September, 2021.

The third author identifies as a straight, cis-gender female, able-bodied, neurotypical, born in the United States. This is the first experience of the third author with qualitative research. The author was a full-time student in a Clinical Mental Health Counseling program during the COVID-19 shut down in March, 2020, and started a Practicum placement in September, 2021. The fourth author identifies as a straight, cisgender female, able-bodied, neurotypical, born in the United States, of German and Irish parents. The experience of the fourth author with qualitative research is two separate qualitative projects, one is on-going and one from a previous institution resulted in a poster presentation. This author was enrolled in graduate classes during the COVID-19 shut-down in March, 2020. The last author is a straight, cisgender female, able-bodied, neurotypical, asian immigrant. This author has three qualitative research publications and one unpublished

completed qualitative project. She currently is a counselor educator who has only provided same location counseling services and has only trained students to be same location counselors prior to COVID-19 pandemic. During the COVID-19 pandemic, this author secured training in TMH and became a BC-TMH. The participants were unknown to this author.

Participants and Setting

Seven clinical mental health counseling graduate students who were enrolled in their Practicum course during the Spring 2020 semester volunteered to participate in this study. The participants' ages ranged from 24-39, one identified as male and the remaining identified as female. There were five Caucasian participants, one African-American participant, and one multi-racial participant. The participants were assigned pseudonyms after the interview to protect their identity when presenting the results. Robert (identified as male, Caucasian), Sam (identified as female, mixed race), Debbie (identified as female, African-American), Carla (identified as female, Caucasian), Celeste (identified as female, Caucasian), Christine (identified as female, Caucasian), and Liz (identified as female, Caucasian), Participants were recruited through a flyer distributed by e-mail to eligible students with indication of Institutional Review Board approval for the study. This was a purposive selection process, given that only those students who had experienced the COVID-19 shutdown of in-person delivery of counseling during their practicum experience were appropriate for the study. All participants reviewed the informed consent form with interviewers and signed the form before being interviewed, per IRB requirements.

Procedure

Three clinical mental health counseling students (second, third and fourth authors) who were students in the first author's Research Methodology course participated as researchers voluntarily. These researchers conducted all qualitative interviews with participants. All

researchers felt it was essential for accuracy of qualitative data that faculty researchers (i.e., first and last authors) not be involved in the interviewing process, given the evaluative nature of their role with CITs. Interviewees were trained through distribution of a qualitative research text by Merriam and Tisdell (2016), an article on semi-structured interviews by Whiting (2008), as well as a training workshop on qualitative interviewing with first and fifth authors. During this training, student researchers role-played a qualitative interview and received feedback from faculty researchers to improve their skills. Finally, during their Research Methodology course, these students had conducted a mock qualitative interview with classmates, also receiving feedback from faculty.

All authors collaborated to generate open-ended questions for interviews, and semi-structured interviews were conducted via zoom at scheduled times with participants. Some examples of the questions asked are, "How did you feel about transitioning from in person to online classes/internship/practicum?"; "How did you feel about the TMH training you received in your counselor education program?"; and "What was the most intriguing thing that happened to you when you provided telemental health?" Interviews were recorded through Zoom and transcribed using N-Vivo Software, owned by the first author. Interviewers corrected misspellings and small grammatical errors, and transcripts were sent to participants for member checking. Once this step was completed, all researchers coded for themes.

Coding Procedures

Grounded theory begins with the open coding process, which each researcher completed independently with the transcribed interviews. After this period, researchers came together to review their open codes and to begin to explore a possible "core" phenomenon to move into the axial coding process (Strauss & Corbin, 1998). This core phenomenon was identified as CIT

telemental health self-efficacy. Finally, the selective coding process created more complex descriptions within categories.

Trustworthiness

Lincoln & Guba (1986) developed the idea of trustworthiness as a way of establishing the reliability of qualitative research. With this in mind, all authors kept journals to reflect on their reactions and possible biases to information discussed during qualitative interviews and with the research team. Student researchers reflected on their own experiences as current students who continued to be influenced by the COVID-19 pandemic in clinical settings. Additionally, the faculty researchers reflected on their roles in preparing students for this sudden event and some of the impact of the negative feedback being offered about the process.

Results

The analysis of interview data indicates themes of both challenges and supports experienced by our participants during their transition to TMH. The emerging themes of challenges fall into categories of perceived lack of training in TMH, apprehension related to crisis intervention and risk assessment via TMH, difficulties of assessing safety using physical and medical markers, and logistical barriers of TMH for CITs and clients. The supports which helped ease this transition were supervisor and peers, increased CIT flexibility and creativity in session, preferred modalities of delivery, and site level of flexibility and adaptability to TMH. Below are participants' words using fictitious names provided under the participant information to illustrate the themes that emerged in this study.

Challenges for CITs

Overall, the participants expressed challenges of adapting rapidly to TMH. One of the most common challenges was adjusting to counseling a person through a screen rather than sitting with

them in-person. Sam articulated, "...that relationship building that rapport building was difficult because you're on a screen, right? So there's that, there's this lack of connection." Others were unsure of the impact on the counseling relationship given that they had never engaged in counseling in-person. Liz said, "I mean, I felt like I had good relationships and was able to build rapport through virtual therapy, but I can't say better or worse than none [no counseling] at this moment." Other than general relationship concerns, there were specific themes that were common among our participants.

Perceived Lack of Training in TMH

Most participants discussed their anxiety related to lack of training in TMH. Celeste captured the overall consensus with "I was kind of nervous going in because I was only really fully trained, I guess, to do counseling…in-person, …we never really were taught how to do it online." Debbie also mentioned that, "There was really no training…you know, you're on the screen, you're making sure your lighting is OK. You're worried about their background…Are they who they say they are?" Liz summarized their experience with, "We kind of all felt like we were all lacking, and we were all just like doing it together and figuring it out as we went." As can be surmised, these participants did not feel trained or competent to provide TMH but did their best to meet the needs of their clients and to complete their training requirements.

Apprehension Related to Crisis Intervention and Risk Assessment via TMH

This concern about training was evident in the area of crisis intervention. Sam summed up the overall essence of their fear by expressing,

> There was this element of, God forbid, anything like did happen with the client. Or they told me, … maybe… suicide risk. …They're not with me….. They are over a screen, and there was this feeling of…. what would … I do like, I feel like I

would be alone in this situation…How can I act quickly if like, I don't know where? …[If] I know where they are, but I can't get to them right away.

Similarly Robert shared, “I have a lot of formal training and crisis intervention…[but] crisis intervention over telehealth?” Celeste experienced a similar situation.

> I had a patient basically telling me that they were going to kill themselves, but I had no idea where they were, …We had a good rapport and they won't tell me where they were, but I was like, All right, so I have to check in on you hourly. And then they were like, OK...So I was able to call two one one. They were mad at me, of course, but it took all day to build that trust for them just to tell me, I don't even care, though I was…just I was worried sick about that.

Beyond concerns about crisis and risk assessment, there were other safety and treatment issues.

Challenges with Assessing Safety Using Physical and Medical Markers

Limited Body Language. Carla, Christine, and Rob were concerned about the lack of body language to assess safety and risk of clients. They discussed the lack of visual cues in using the phone for TMH. Carla shared, “I did phone calls, so I didn't even get to physically see them.” Christine shares an error in her perception of a client due to lack of visual cues.

> [We] were on the phone and how I didn't know what they looked like … I just really envision her as being this like, very frail, skinny, unhealthy, like unkempt woman who saw her on the street. … her case manager would go to her house and she … looked so put together. Her hair was so neat… she's so good, like a button down and I'm like, No way. But I was so surprised by that.

Finally, Rob summarized their issues with technology and body language with “you had the

technical issues,... or there's even like those other cues that you don't notice if a client isn't there with you, …You don't really notice a client's body language…being able to like shake a client's hand."

Challenges with Special Population Needs. Some of these participants worked with clients with substance-related and eating disorders which typically would have required them to escort clients to collect urine for analysis, blood draws and/or document weight. Celeste addressed this issues directly with:

> [when using telemental health] you couldn't tell if they were high …that's because of like the [lack of] body language and a lot of it was like dark rooms [can't]..., see it in the eyes, just the way that they spoke to you [so] you need to do a drug screen during [but] …you had to rely on them coming in. You couldn't finish it. You couldn't get the signature.

Carla verifies Celeste's concerns with, "it's also a little difficult to get the medical side of things like bloodwork, vitals. If they're not coming in-person, we can't escort them to our room to take their vitals. If they're in telehealth, we have to strongly encourage them to go to the doctor where they can just not go."

Outside of these treatment concerns mentioned above, the participants also had to negotiate some logistical issues, both for themselves and for their clients.

Logistical Barriers of TMH for CITs

CITs encountered some logistical issues with providing TMH including screen fatigue, lack of connection of peers and supervisors, and finding a work-life balance.

Screen Fatigue. Rob shared his day with,

> I would roll out of bed at 8:45, log in to [software program] at 9:00 and have a session at 9:00. And then I would sit at my desk all day until my supervisor made

me take a lunch break, in which case I would still sit at my computer and write client notes. And I would go until 5:00, and then I would be done for the day, and then I would still be sitting at my desk…my back would hurt. My eyes would just be shy… because I was staring at a screen.

Lack of Connection with Peers and Supervisors. CITs shared their difficulties with lack of access to others and the need for more regular check-ins to understand their new role. Sam expressed, "I was home by myself, like I didn't have … my supervisor right down the hall for me, right? Anything happened. I wouldn't have been able…[to] call my supervisor." Christine shared, "maybe just knowing that you're not alone … just being able to like, talk about it and lean on each other, I think is really helpful."

Work-Life-Technology Issues. Given that CITs were providing counseling from their homes, they had to learn to separate and create boundaries in the home for work-life balance. Christine shared that "telehealth was just like so odd to all of us…[it's not] like going in person and like having this like space away from your life." Sam indicated that "making sure that…my connection was still good or also making sure that like nobody…was allowed at my house. I had to always make sure that I was alone. No one can hear me. No one can hear them…" Debbie noted she would "figure out what space I'm going to be in, depending on where other people are…in my house."

These participants also had some technology issues as they used a home office. Christine had anxiety related to missing phone messages as she shared "[clients] couldn't call me directly, so they had to leave me a message..then I would get kind of anxious…start checking my voicemail more because what if someone called me, and then I suppose it wouldn't ring…would leave me a message." Liz found "the biggest challenge…was wi-fi on either mine or the clients…"

Logistical Barriers of TMH for Clients

These participants were also concerned with environmental challenges for the client in terms of access to reliable Wifi, computer or phone equipment, private spaces within the home/apartment, as well as getting consent forms and signed forms for audio-recordings. Carla shared:

> families…from low SES backgrounds…Wi-Fi was sometimes a problem. Sometimes the younger kiddos would even have to be babysitting their siblings during sessions or…there's a ton of sibling screaming in the background and interrupting and not having a private space to talk. So my kids would be talking in front of their whole families about their…deepest stuff.

Liz also encountered these technical issues as she shared, "obviously the video was better than the phone, but…like the awkward [time] where it would cut out for a minute, and you'd have to say, oh, wait, and you're talking over each other."

> Christine shared some of her client logistical issues related to group sessions. A newcomer: didn't want to turn his camera on…he was kind of like covering it. It definitely affected the group because there was a point during that group where I felt like… all of the the participants were like super close and like had really bonded or even like over the Zoom. But then it's like this new person came in and then they were like, really awkward and weird and like not wanting to share and like it.

Positives for CITs

CITs also identified experiences that were positive and supportive during this period of transition to TMH.

Support from Supervisors and Peers

Most of the participants indicated what Carla shared, that her "supervisor was amazing …helping me with the virtual part of things because she was doing the same thing too." Sam found the "internship meeting … talk[ing] about … our feelings, … like the differences with in-person versus online" helpful. Debbie found her " supervisor was very helpful, [and] knowing that there was always someone that was in the call [or]...right down the hall, … [found it] very helpful when it came to addressing crisis."

Appreciated the Increased Accessibility for Clients

The participants found accessibility for clients as a positive of TMH, and some noticed fewer no-shows of clients during this time. Rob had a client who " could just sit in his bedroom and talk to [him]." Christine said, "I wonder if they show up more because … it's easier access … technology at their house … it's [also] easier to blow … off … don't have to log on." Debbie echoed this thought with "it was really beneficial knowing that there was a virtual setting for them to be able to get counseling." Celeste shared "sometimes I notice that when they were on the phone, my clients, they were more willing to open up…like they felt like I didn't have to face them then and feel any shame. And so some of my best sessions were…over the phone or on telehealth."

Increased CIT Flexibility and Creativity

The participants found themselves thriving with the increased flexibility and creativity. They had to develop new skills. As Carla stated "like you have to get creative to engage people." Sam was creative and " would share [her] screen, go to YouTube and go and pick…a meditation video that she wanted…a nice…landscape picture…and have her just listen to the guided meditation…." Celeste learned to change her "tone of voice to be more exaggerating so that they could understand it more." Rob learned to "embrace the weirdness of it…instead of…viewing it as a hurdle…be creative and find a new way to do something…make it fun." Debbie also had an

experience which may not have occurred in an in-person session. A client chose not to have the camera on for two sessions. “So the third session I was able to see her….I can only imagine how uncomfortable it is for someone just to come in face to face to see you… I think her being at home in her own space, being comfortable….And that was it. She never missed a session.”

Open Communication About Preferences

Each person in the process (client, CIT, and site supervisor) had preferred modalities of delivery and these had to be appreciated and discussed. Carla shared that “not having to put on real pants….can look semi-presentable [on camera] but … felt more comfortable, … and I didn’t have to burn more gas … [to] drive there” was a benefit for her. Sam understood that ” a lot of people preferred in-person…[and she did not] want to do virtual …counseling.” After this experience, Sam believes.”now … a lot of people…do …prefer virtual counseling.”

Site’s Level of Flexibility/Adaptability to TMH

The site's level of flexibility and adaptability to TMH was factored into how supported the participants felt. Celeste’s site provided them a “computer [with a] video camera.” Sam mentioned that [her] internship was having the interns all come to the agency, and they gave… laptops and…a presentation…step-by-step of how to access or to start doing services…for our clients. So that was helpful.” This technology-related help and flexibility was described as having a positive impact on the transition to TMH.

Discussion

This study examined the lived experience of clinical mental health counseling students who were in their Practicum experience during the beginning of the COVID-19 pandemic. The results shed light on some of the factors that aided in their transition to TMH as well as demonstrated the challenges that these participants faced, from lack of training in TMH to uncertainty about their

ability to complete their training in a timely fashion. The participants identified support from supervisors and peers, and accessibility of the online modality for clients as positive experiences of this transition. These participants felt that these positive experiences were dependent on the client, participant (i.e., CIT), site-preferred modalities of delivery, site level of flexibility/adaptability to TMH, as well as the site's ability to be flexible and creative with the transition to TMH. Some participants were able to adapt to online tools to engage clients through screen sharing, playing virtual games with child clients, and using humor to defuse the stress of COVID-19.

Other participants struggled with perceived lack of training in TMH from the counselor education program, indicating the need for TMH training to all CITs during their master's degree. Some areas that were most problematic for the participants were related to lack of TMH training in assessing safety, physical and medical markers, challenges with limited body language availability, logistical concerns for certain disorders such as substance use disorders and eating disorders (where urines screens and weights need to be conducted in-person).

Other logistical concerns included access to reliable Wifi, computer or phone equipment, private spaces within the home/apartment, signing documents, and screen fatigue after consequent counseling sessions. Given that CITs were providing counseling from their personal living space due to social distancing protocols, they had to learn to create boundaries there for themselves and others in the space. All of these areas of concern for our participants have been indicated as needed training for ethical TMH counseling by Callan et al. (2016). In addition, the participants also indicated that the lack of informal connections with co-workers, supervisors, and peer-CITs that are available at same-location on-ground settings made the transition to this stage of their training difficult. Finally, participant self-efficacy may have been moderated by personal resiliency factors

as all participants were prepared in the same program but adapting to TMH experiences is varied.

Implications for Counselor Education

The themes from this study suggest the need for counselor education programs to provide training in TMH in a standardized way. Most of the concerns presented by the participants speak to the need for minimal training standards (i.e., technology logistics, crisis management, navigating supervision) which can be put in place by accrediting bodies. Next, this research suggests that creativity and flexibility related to TMH is essential to being an effective professional counselor. Investigating training methods and increasing creative TMH assignments may support the development of flexible, resilient CITs, prepared for the changing TMH landscape in professional counseling. Finally, given the importance of supportive relationships during the training process, CITs at telemental health sites need to have more intentional connections between themselves, peer trainees, and other counselors at the site through technology or in-person.

Limitations

Although this study adds important information to the growing literature around the impact of COVID-19 on the clinical training of counseling students and what aided in the transition to TMH, there are a few limitations. First, given that this is a qualitative study with seven participants, the results are not generalizable to a larger population. The sample size and qualitative design does not allow extrapolating to training needs related to demographics such as age, ethnicity, technology literacy. In addition, all participants were from one university with a traditional course delivery format in the northeast. The experience of students from online programs or those programs that provide extensive TMH training may be significantly different from student experiences in an in-person program. Second, the researchers who conducted the interviews were students in the same clinical mental health program. They may have a personal relationship outside of this research

project through attending the same university; however, they were at different points in the program. Although strategies were used for bracketing of bias (such as journaling), as well as member checking of data, observer effects could have influenced interpretation of data. Further research of a quantitative nature that could expand on suggestions for standardization of training (timing of training during program, best practices for delivery of training, and trainer's required qualifications) is needed.

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