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The Self-Efficacy of Counselors Providing Telemental Health Services During the COVID-19 Pandemic

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This is to certify that the doctoral dissertation by

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Abstract

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by

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MS, Northeastern State University, 2016

BS, University of Oklahoma, 2011

Dissertation Submitted in Partial Fulfillment

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Abstract

Since the onset of the COVID-19 pandemic, counselors have had to adapt and evolve to meet the needs of clients and the growing need for mental health services. In addition to a lack of experience providing telemental health (TMH) services, many counselors had received little or no TMH training or continuing education prior to the onset of the COVID-19 pandemic. Counselor self-efficacy (CSE) may be an important factor in determining how counselors have been impacted by the increase in provision of TMH services, and the areas where they are needing more support. The purpose of this quantitative study was to explore how the amount TMH training and continuing education received, the amount of time spent providing TMH services, and the amount of time spent providing counseling services predict CSE. Participants (n=84) completed an online survey containing items from the *Counseling Self-Estimate Inventory* (*COSE*). Results of a bivariate regression and one-way ANOVA indicated that TMH training and continuing education did not predict CSE; however, differences between groups revealed an interesting phenomenon which prompted further discussion. Results also showed that both the amount of time spent providing TMH services and the amount of time spent providing counseling services predicted CSE. Counselors and counselor educators can use results from this study to advocate for more resources and support for counseling students and counselors who are providing TMH services. Furthermore, results from this study indicate a need for more research on CSE and TMH to improve counselor education and support.

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Dedication

To Grayson and Millie. You two are my greatest inspiration and my reason for pursuing my hopes and dreams. You are both going to do incredible things in your lives, and I want you to know that you can achieve anything you pursue wholeheartedly. I will always be right alongside you both, cheering you on in every adventure. No matter what I accomplish, being your momma will always be what I am most proud of. I love you both more than all the words, in all the books, in all the world.

To my husband, Ben, thank you for your support and the many sacrifices you have made that have allowed me to pursue my goals. Your confidence in me is what keeps me grounded through all the challenges I face, and your love for me and our children is a constant reminder of what matters most. You have inspired me to be the best version of myself, and I'm so thankful that I get to share this accomplishment with you. I love you!

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To my committee chair, Dr. Victoria Sepulveda, thank you for believing in me and this study and for helping me to see my full potential. Your kindness, knowledge, and humility are just a few of the qualities that I hope to model in my own work as a counselor educator. I look forward to more opportunities to learn from you and alongside you.

To my committee member, Dr. Rebecca Cowan, you have played such an important role in this process, and I have learned so much from you. Your feedback, thoughts, and suggestions helped me to grow as a researcher and writer and I'm excited to conduct future research studies because of the confidence you inspired in me. Thank you for sharing your knowledge and wisdom, and for being an incredible role model for me as I move forward in my career in counselor education and supervision.

Table of Contents

List of Tables v

Chapter 1: Introduction to the Study 1

Background 3

Problem Statement 5

Purpose of the Study 7

Research Questions and Hypotheses 7

Theoretical Framework 9

Nature of the Study 10

Definitions 11

Assumptions 12

Scope and Delimitations 12

Limitations 13

Significance 14

Summary 15

Chapter 2: Literature Review 16

Literature Search Strategy 17

Theoretical Framework 18

Self-Efficacy Theory 18

Literature Review 20

Telemental Health 20
Counselors and Continuing Education 27
Counselor Self-Efficacy 30
Summary and Conclusions 32
Chapter 3: Research Method 34
Research Design and Rationale 34
Population 35
Sampling and Sampling Procedures 36
Procedures for Recruitment and Participation 36
Data Collection 36
Instrumentation 37
Demographic Questionnaire 37
Counseling Self-Estimate Inventory 38
Operationalization of Constructs 39
Approximate Hours of TMH Training or Continuing Education Completed 40
Experience Providing TMH Services 40
Experience Providing Counseling Services 41
Counselor Self-Efficacy When Providing Telemental Health Services 41
Data Analysis Plan 42
Testing Hypotheses 42

Descriptive Statistics 44
Analysis of Variance (ANOVA) 45
Bivariate Linear Regression 45
Pearson Product-Moment Correlation 46
Threats to Validity 47
Ethical Procedures 48
Summary 49
Chapter 4: Results 51
Data Collection 53
Results 57
Descriptive Statistics 58
Hours of TMH Training or TMH Continuing Education Received (Independent Variable 1) 58
Time Providing TMH Services (Independent Variable 2) 59
Time Providing Counseling Services (Independent Variable 3) 60
Counseling Self-Estimate Inventory (Dependent Variable) 61
Research Question 1 63
Research Question 2 70
Research Question 3 75
Summary 80

Chapter 5: Discussion, Conclusions, and Recommendations 82
Interpretation of the Findings 83
Research Question 1 83
Research Question 2 87
Research Question 3 88
Limitations 89
Recommendations 92
Implications 94
Conclusions 96
References 98
Appendix: Demographic Questionnaire 113

List of Tables

Table 1. Frequency Distribution of Respondents by Gender 55

Table 2. Frequency Distribution of Respondents by Race and Ethnicity 56

Table 3. Frequency Distribution of Respondents by Age 59

Table 4. Frequency Distribution of Respondents by Hours of TMH Training or TMH Continuing Education Received 59

Table 5. Frequency Distribution of Respondents by Time Providing TMH Services 59

Table 6. Frequency Distribution of Respondents by Time Providing Counseling Services 60

Table 7. Descriptive Statistics COSE Total Score and Subscale Scores 62

Table 8. COSE Total Score 62

Table 9. COSE Distribution 62

Table 10. Model Summary COSE: Hours of TMH Training and COSE Overall 64

Table 11. Hours of TMH Training or Continuing Education Bivariate Regression 65

Table 12. Pearson Product Correlation: Hours of TMH training and COSE Overall 69

Table 13. Hours of TMH Training or TMH Continuing Education and COSE Descriptive Statistics 72

Table 14. Hours of TMH Training or TMH Continuing Education and COSE one-way ANOVA 69

Table 15. Tukey Multiple Comparisons Post Hoc Tests: Hours of TMH training 69

Table 16. Model Summary COSE: Time Spent Providing TMH Services and COSE Overall..... 71

Table 17. ANOVA: Time Spent Providing TMH Services and COSE Overall 71

Table 18. Pearson Product Correlation: Time Spent Providing TMH Services and COSE Overall..... 72

Table 19. Time (in years) Providing TMH Services and COSE Descriptive Statistics.... 73

Table 20. Time (in years) Providing TMH Services and COSE one-way ANOVA 74

Table 21. Model Summary COSE: Time Spent Providing Counseling Services and COSE Overall..... 81

Table 22. Time (in years) Spent Providing Counseling Services and COSE Linear Regression..... 81

Table 23. Pearson Product Correlation: Time Spent Providing Counseling Services and COSE Overall 77

Table 24. Time (in years) Spent Providing Counseling Services and COSE Descriptive Statistics 79

Table 25. Time (in years) Spent Providing Counseling Services and COSE One-Way ANOVA 80

Chapter 1: Introduction to the Study

According to the National Institute of Mental Health (NIMH; 2020), nearly 52.9 million adults in the United States live with a mental illness, though only 24.3 million reported that they received mental health services in the same year (NSDUH, 2020). The number of substance abuse, behavioral disorder, and mental health counselors is significantly disproportionate to the growing need, with only 327,500 counselors identified as part of the profession and nearly 41,000 job openings in the counseling field occurring every year due to counselors leaving the field for various reasons, including transfers to different occupations and retirement (U.S. Bureau for Labor Statistics, 2020). Though reports of mental illness in the United States is consistently rising, the counseling field has been met with a continuous shortage of providers which has posed a significant treatment barrier for many individuals seeking counseling services. In addition to a shortage of counselors, individuals have also faced numerous other treatment barriers including a lack of transportation, living in a rural area with limited resources for mental health, and financial difficulties (Ostrowski, 2016). One way to address some of these barriers has been for counselors to provide Telemental health (TMH) services, which the NIMH defines as, "the use of telecommunications or videoconferencing technology to provide mental health services. It is sometimes referred to as telepsychiatry or telepsychology." TMH has been available for several years, though the uptake of TMH practices has been slow up until the onset of the coronavirus disease 2019 (COVID-19; Abraham et al., 2021).

Since the onset of the COVID-19 pandemic, many counselors have been forced to modify the setting in which they conduct therapy, often moving back and forth between in-person sessions to TMH sessions (Callahan, 2020; Madigan et al., 2020). Many counselors have chosen to forego in-person sessions altogether in favor of TMH so that therapeutic services do not have to be disrupted due to illness or other related factors (Callahan, 2020). The shift from in-person sessions to TMH may be seamless for the few counselors that are familiar with this platform; however, for the counselors who have little to no experience with TMH, this transition can be challenging (Berger, 2017; Goldstein & Glueck, 2016; Madigan et al., 2020). Currently there are several continuing education courses and certification programs, such as the Board Certified Telemental Health (BC-TMH) program, designed to support counselors in gaining knowledge about ethical and legal practice, treatment, assessment, and multicultural competencies when providing TMH. Nonetheless, there is a gap in research regarding the effectiveness of these types of programs and their impact on counselor self-efficacy (CSE) when providing TMH services (Cosh et al., 2021; Tolou-Shams et al., 2021). To clearly define the population being focused on for this study, the term "counselor" will be used to describe any licensed or license-eligible mental health service provider with a master's degree who treats mental, behavioral, and emotional problems and disorders in a therapeutic setting.

In this chapter, I begin by outlining the background that helped consolidate my topic of interest. I then break down the problem and purpose of this study while reporting

my research questions and hypotheses. I describe my selected theoretical framework, the nature of the study, definition of key terms, assumptions, scope and delimitations, and limitations. I culminate this chapter by discussing the significance and possible implications for social change as an outcome of this study.

Background

As a counselor and educator who transitioned to providing TMH services for the first time during the COVID-19 pandemic, I watched many of my colleagues, as well as myself, face unique obstacles and challenges in trying to acclimate to providing counseling services virtually. When I observed that TMH training and education is not specifically mentioned within the curriculum requirements outlined by the Council for Accreditation of Counselors and Related Education Programs (CACREP; 2016), I was prompted to search the available literature for information surrounding TMH and counselor training. In my initial search, I was able to find a growing number of research surrounding TMH to help lay the foundation for my study. With the limited access to mental healthcare in rural areas, TMH provision can enable practitioners to better serve their surrounding communities and contribute to positive social change in areas that were previously inaccessible (McDougal et al., 2022). Furthermore, TMH allows people to access mental health services that they may otherwise be unable to during times of crisis (Barnett & Kolmes, 2017). Though the rapid increase in need and demand for TMH services that followed the onset of the COVID-19 pandemic was an isolated event, the need and demand for TMH remains steady (Lipschitz et al., 2022). Despite the continued

uptake of TMH services, there has yet to be any research conducted surrounding how TMH training and continuing education impacts CSE, which has been shown to correlate with counselor burnout, counselor retention, and perceived level of professional competence (Goreczny et al., 2015; Lent et al., 2006; Li et al., 2021).

The knowledge and skills acquisition of counselors has been the focus of many research studies since the advent of counseling (Dumos & Zuwaylif, 1963; Fyffe & Oei, 1979; Lent et al., 2003; Ritenour et al., 1983). This has led to more meaningful discussions and research surrounding the qualities held by counselors who perceive themselves and are perceived by others as being effective practitioners. Albert Bandura was at the forefront of the movement to explore what leads some people to have a strong belief in their ability to effectively accomplish their goals, and through his research was able to construct self-efficacy theory and to identify key factors in the development of CSE (Bandura, 1977, 1982, 1993, 1994, 1997b). Although many factors that have been shown to impact CSE, including observation of counseling skills, performance of counseling skills, and professional support, the research surrounding how a rapid transition to providing TMH services may impact CSE does not exist (Bandura, 1993; Goreczny et al., 2015). Furthermore, research on TMH training and continuing education is limited (Baird et al., 2018; Gifford et al., 2012; Glueckauf et al., 2018; Kozlowski & Holmes, 2017; Robertson & Lowell, 2021) and does not provide insight into how or if these types of trainings impact counselor CSE. Although some research does exist about the personal experiences of counselors when providing TMH services, it is not yet known

how a practitioner's length of experience in providing TMH services and length of experience providing counseling services impacts CSE when providing these types of services.

The development of CSE when learning multidimensional skills, such as the provision of TMH services, can be complex due counselors having varying strengths and struggles regarding skills acquisition and application and level of flexibility and quickness to adapt (Douglas & Morris, 2015). Though these complexities exist among counselors, one way in which CSE can be influenced regardless of individual differences is through training and continuing education. In alignment with Bandura's (1993) assertions about the development of self-efficacy, counselor's ability to apply knowledge and practice skills is essential to the development of CSE; therefore, it could be hypothesized that practitioner experience providing TMH services may predict CSE when providing TMH services. Lastly, the available research surrounding CSE indicates that there is a correlation between practitioners' years of experience providing counseling services and CSE, which may also predict CSE when learning and utilizing new information and skills (Li et al., 2005; Morrison & Lent, 2018; Ooi et al., 2018; Suh et al., 2018).

Problem Statement

The onset of the COVID-19 pandemic not only threatened the physical health of our world, but it also contributed to a significant upswing of mental health issues as well (Serafini et al., 2020). For example, the general population has reported an increase in

anxiety, depression, phobias, compulsive behavior, and insomnia following the onset of the COVID-19 pandemic (Lorenzo et al., 2022). More specifically, women and young adults appear to report the highest increase in mental health issues following the onset of the COVID-19 pandemic (Lorenzo et al., 2022). These growing mental health concerns have been further exacerbated by major historical events surrounding racial/ethnic inequities, which have resulted in social and racial unrest (La Roche, 2020). Although counselors are professionally and ethically responsible for developing and promoting the cultural competence of themselves and others, the ever-changing social climate combined with the increase in personal and professional mental health load brought forth by the COVID-19 pandemic has created many new and complex challenges for many people in the counseling field (Aafjes-van Doorn, 2021; La Roche, 2020). Though some counselors with increased experience providing TMH services prior to the onset of the COVID-19 pandemic reported less anxiety and self-doubt providing TMH services while navigating unprecedented challenges, other counselors with less experience and training providing TMH services expressed higher levels of anxiety and self-doubt (Aafjes-van Doorn, 2021). Regardless of training or experience, many counselors have also indicated that they are unsure if they plan to provide TMH services in the future. It is reasonable to believe that this may be partly due to poor self-efficacy (Aafjes-van Doorn, 2021).

I sought to determine if a lack of formal training or continuing education about TMH is a significant contributing factor to the struggles that professional counselors face in providing TMH services, as this may lead to poor self-efficacy. Also, the therapeutic

limitations and difficulties with assessment and diagnosis while practicing TMH may also contribute to poor self-efficacy (Cosh et al., 2021; Racine et al., 2020). Self-efficacy can be a strong predictor of treatment outcomes as professional counselors are more likely to use strategies with their clients that they feel confident in implementing (Goreczny et al., 2015). At this time, research focusing on the self-efficacy of counselors when providing TMH services is limited; however, the existing research surrounding the implications and importance of CSE supports the necessity for such a study. Also, the lack of research surrounding TMH practice and efficacy highlights the need for more exploration on TMH and its impact on practitioners and consumers.

Purpose of the Study

The purpose of this quantitative study was to identify and explore the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic. Additionally, this study was designed to determine if there was an observable difference in the self-efficacy of counselors providing TMH services who have completed TMH training or continuing education courses and counselors providing TMH services who have not. Self-efficacy was measured using the *Counseling Self-Estimate Inventory (COSE*; Larson et al., 1992).

Research Questions and Hypotheses

The research questions and hypotheses for this study were as follows:

Research Question 1: How does TMH training and continuing education predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH during the COVID-19 pandemic?

$H_0$1: Based on responses provided by counseling professionals, TMH training and continuing education does not appear to predict the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic.

H_A1: Based on responses provided by counseling professionals, TMH training and continuing education appears to predict the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic.

Questions regarding individual predictors are as follows:

Research Question 2: When controlling for other predictors, does prior experience providing TMH services predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

$H_0$2: When controlling for other predictors, prior experience providing TMH services does not predict the level of self-efficacy held by counselors when treating clients via TMH.

H_A2: When controlling for other predictors, prior experience providing TMH services does predict the level of self-efficacy held by counselors when treating clients via TMH.

Research Question 3: When controlling for other predictors, does prior experience as a practitioner predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

$H_0$3: When controlling for other predictors, prior experience as a practitioner does not predict the level of self-efficacy held by counselors when treating clients via TMH.

H_A3: When controlling for other predictors, prior experience as a practitioner does predict the level of self-efficacy held by counselors when treating clients via TMH.

Theoretical Framework

Albert Bandura (1977) asserted that people regularly engage in mentally strenuous activities, and these activities contribute to the level and strength of self-efficacy in many different areas. Based upon this assumption, Bandura then postulated that a person's self-efficacy is responsible for when and if coping behavior is used in any given situation that is challenging or threatening. Out of this hypothesis, Bandura began testing his self-efficacy theory, which proposed that continuous exposure to challenging or threatening activities that are safe, leads to an increase in self-efficacy.

Regarding CSE specifically, the scientific foundation for Counselor Self-Efficacy Theory was established by Bandura (1986) and is widely accepted by counselor educators and supervisors as being a necessary precursor to competent practice (Kozina et al., 2010). CSE encompasses the beliefs and attitudes held by counseling professionals or

trainees, which impacts their ability to effectively deliver counseling services (Kozina et al., 2010; Larsen & Daniels, 1998).

The aim of this research study was to explore the self-efficacy of counselors providing TMH services during the COVID-19 pandemic. Bandura's (1977; 1986) theory surrounding self-efficacy is compelling and supported by years of research performed by numerous scholars; additionally, there are several assessments that have been created to measure self-efficacy, and many of them have been tested and used many times. Based upon alignment with my research questions and goals and the existing research, Bandura's theory appeared to be the best fit for my dissertation topic.

Nature of the Study

To address the research questions in this quantitative study I used a correlational, one-shot survey research design to identify and explore the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic. I studied the correlation between the independent variable (IV), which is the number of TMH training and continuing education courses completed, and the dependent variable (DV), which is the level of self-efficacy as measured by the *Counseling Self-Estimate Inventory (COSE)*. I used a cross-sectional data collection method and collected data at one point in time through surveys. Data analysis included descriptive analyses to provide information about the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic and to provide information about differences between

participants, such as, post-graduate training, years of experience in the field, and years of providing services via a TMH platform.

Definitions

Coronavirus disease 2019 (COVID-19): COVID-19 is a novel disease caused by a virus named SARS-CoV-2 that was discovered in Wuhan, China in December 2019 (Centers for Disease Control and Prevention [CDC], 2021). This disease spread quickly and worldwide, resulting in a global pandemic that has been ongoing. Several variants COVID-19 have been identified since its onset in 2019, making it difficult to treat and eradicate.

Counselor self-efficacy: Counselor self-efficacy is a counseling professional's belief in their ability to apply and utilize their knowledge, skills, and abilities to effectively work with clients and to appropriately navigate clinical situations (Larson & Daniels, 1998; Lent et al., 2003).

Professional experience: Professional experience is the amount of time that has been spent by a professional in training and individual sessions (Ben-Porat & Itzhaky, 2015).

Professional training: Professional training refers to the amount or number of CEUs previously completed by a professional (Tsoi et al., 2016)

Self-efficacy: Self-efficacy is the belief that one has in their ability to reach their goals effectively (Bandura, 1986).

Telemental health (TMH): TMH refers to "The provision of mental health services such as psychotherapy, medication management, and assessment via real-time videoconferencing or phone" (Lipschitz et al., 2022, p. 1).

Assumptions

One of my assumptions of this study was that counselors experienced an uptake in their provision of TMH services following the onset of the COVID-19 pandemic based upon the available research and data gathered surrounding TMH usage across the United States (Karimi et al., 2022; Lipschitz et al., 2022). Another assumption of this study was that counselors' responses may be impacted by current social, cultural, and political issues, a lack of real or perceived administrative support when transitioning to TMH, and vicarious and direct experiences of trauma because of the COVID-19 pandemic. I also assumed that participants would respond honestly to the survey questions and not inflate their responses.

Scope and Delimitations

In this study, the focus was on one outcome variable and three predictor variables. The overall predictor variable that was focused on was TMH training and continuing education. Secondary predictor variables included prior experience providing TMH services and prior experience as a practitioner. The predictor variables were selected due to the gap in research surrounding the impact of TMH training and the extent to which this predicts CSE in comparison to other factors like prior experience providing TMH services and prior experience as a practitioner. The eligibility criteria for participating in

this study was that the individual is currently practicing as a licensed or license-eligible counselor and is currently providing TMH services to their clients. Due to the ongoing challenges presented by the COVID-19 pandemic, I thought that recruiting participants who were currently providing TMH services would ensure that the data being collected was based upon in vivo experiences.

Limitations

One limitation that may have impacted the results of my research study would be the issue of self-report bias. Due to the nature of what was being measured (i.e., self-efficacy), participant self-report is necessary and therefore increased the potential for participants to struggle with memory of what they were asked to report on, issues understanding the questions that were being asked of them, and social desirability bias (Fisher, 1993). One way to compensate for social desirability bias and struggles with memory is to do a projective technique such as indirect questioning; however, this approach also has limitations as well (Fisher, 1993). Another potential limitation of my research study was the use of convenience sampling which can limit the generalizability of results (Salkind, 2012). Nonetheless, convenience sampling is often accepted in social sciences as it increases access to research participants (Salkind, 2012). Lastly, another limitation of my research study is that the participants were limited to those who are familiar with the use of technology, the internet, and social media and can follow instructions for an online survey. Therefore, these factors may have limited the generalization of results.

Significance

Counselors are faced with the ethical responsibility of ensuring that they are informed on best practices and remain up to date on their professional development which takes considerable time, effort, and money. These demands are not new; however, due to the rapid changes brought forth by the COVID-19 pandemic, many counselors did not have the ideal amount of time, knowledge, or support prior to transitioning to TMH (Tolou-Shams et al., 2021). With the growing demand and need for TMH services brought forth by the COVID-19 pandemic, having a better understanding of how TMH services impact counselors has never been more critical to ensuring effective and ethical practice in the counseling field (Madigan et al., 2020). By conducting this research study, I addressed this need by creating a foundation for future research surrounding TMH and the experiences of counselors. Additionally, results from this study provided information about how CSE is impacted by a lack of formal training regarding TMH practice, which will allow counselor educators and supervisors to advocate for TMH training and education to be incorporated into existing curriculum. Regarding social change, the results from this study can aid and encourage counselor education programs and counselor supervisors to provide more opportunities for the development of TMH skills and knowledge. Furthermore, the results from this study can contribute to counselors receiving more support and training surrounding TMH services, thus impacting the quality and effectiveness of counseling services provided via TMH.

Summary

In Chapter 1, I discussed the growing demand and need for the provision of TMH services due to factors that existed prior to the onset of the COVID-19 pandemic, which were then exacerbated by the mental health crisis that occurred following the onset of the COVID-19 pandemic. Furthermore, the necessity for more training and support for counselors who are providing TMH services was discussed, along with the potential impact that a lack of training may have upon CSE. This research study is a response to a need for more information about the impact that certain factors have had upon CSE as counselors have transitioned to providing TMH services or increased their provision of TMH services because of the COVID-19 pandemic. I discussed Bandura's (1977) theory of self-efficacy and examined CSE as an important component of counselor performance, competence, beliefs, and attitudes. Chapter 2 provides an exhaustive review of the available literature surrounding key components of this research study.

Chapter 2: Literature Review

Prior to the onset of the COVID-19 pandemic, there was limited focus on the impact that TMH has had upon MHPs. Following the onset of the COVID-19 pandemic, researchers began to study the experiences held by those in the mental health field more rigorously as MHPs were forced into providing TMH services and the increase in the demand for such services has been rapid and steady (Maurya et al., 2020). Although various topics surrounding TMH have been studied, such as counselor perception and attitude (Appleton et al., 2021; Johnson & Rehfuss, 2020; Lin et al., 2021; Maurya et al., 2020), research on CSE when providing TMH had not been done prior to this study. Furthermore, data regarding TMH training and CE outcomes is narrow and the impact that TMH training and CE have upon CSE when providing TMH services had not been examined prior to this study (Robertson & Lowell, 2021).

An exhaustive search and examination of applicable literature was conducted in support of the purpose of this study which aimed to identify and explore the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic. In the following literature review, I will discuss the literature research strategy used to gather information regarding the topics applicable to this research study. Following the literature search strategy, a discussion of an identified theoretical framework will be outlined and explored regarding its applicability to this research study. To support the necessity and importance of this study, the current research surrounding

TMH practices, counselors and continuing education, and CSE was considered and broken down into relevant and applicable topics.

Literature Search Strategy

To identify literature that was pertinent to my dissertation topic, I conducted searches using the Walden libraries and was intentional in my selection of pieces from respected journals, books, and dissertations. While engaging in the literature review process, I accessed the following databases: PsycINFO, SAGE Journals, SocINDEX with Full Text, Taylor and Francis Online, ERIC, CINAHL & MEDLINE Combined Search, ProQuest Central and Google Scholar. Keywords and phrases used to search these databases included: *Continuing Education, Continuing Professional Development, Continuing Education, COSE, CASES, Self-Efficacy, Self-Concept, Self-Perception, Self-Confidence, Telemental Health, Teletherapy, Telepsychology, Telepsychiatry, Telehealth, Distance Counseling, Counselor, Psychologist, Psychiatrist, Counselor Self-Efficacy, Counseling Self-Efficacy, Counselor Perception, COVID-19 and mental health,* and *COVID-19 and Telemental Health*. The years that were searched initially were 2012 through the present; however, due to the limited amount of literature in the areas of TMH, CSE, and counselor continuing education, the search was expanded to previous years (2000 to present), and older resources were appraised for their contribution to the theoretical framework of this research study.

Theoretical Framework

Theoretical frameworks enable researchers to create a map for how they will explore meaningful topics and provides a foundation for understanding what is being studied (Grant & Onsanloo, 2014; Lynch et al., 2020). A theoretical framework helps researchers to maintain focus on the goal(s) of their study and identify the connections between pre-existing research and the research questions being explored (Grant & Onsanloo, 2014; Lynch et al., 2020). In this section, I illustrate how I used self-efficacy theory (Bandura, 1977, 1982, 1993, 1994, 1997b) as a framework for my study.

Self-Efficacy Theory

Bandura developed the term "self-efficacy" to describe an individual's belief in their ability to behave in a way that will allow them to reach a desired outcome (Bandura, 1977, 1982, 1993, 1994, 1997b). Bandura (1977) asserted that people engage in mentally strenuous activities regularly, and these activities contribute to the level and strength of self-efficacy in many different areas. Based upon this assumption, Bandura then postulated that a person's self-efficacy is responsible for when and if coping behavior is used in any given situation that is challenging or threatening. Out of this hypothesis, Bandura began testing his self-efficacy theory, which proposed that continuous exposure to challenging or threatening activities that are safe, leads to an increase in self-efficacy.

In his later works, Bandura (1997a) identified four ways in which self-efficacy can be cultivated, which includes "experience of success or mastery in overcoming obstacles" (p. 4), "social modeling" (p. 4), "social persuasion" (p. 4), and "reducing stress

and depression, building physical strength, and learning how to interpret physical sensations" (p. 4). Experience of success or mastery in overcoming obstacles refers to person's experience with persevering despite adverse and challenging situations (Bandura, 1997a). Social modeling occurs when a person can observe the successes of others and therefore is inspired to believe that they are also capable of success (Bandura, 1997a). Social persuasion occurs when a person is persuaded by another to believe in their ability to achieve certain goal(s) (Bandura, 1997a). Lastly, reducing stress and depression, building physical strength, and learning how to interpret physical sensations are identified as key factors in cultivating self-efficacy due to the influence that physical and emotional states have upon a person's perception of what they are capable of (Bandura, 1997a).

Regarding CSE specifically, the scientific foundation for CSE theory was established by Bandura (1986) and is widely accepted by counselor educators and supervisors as being a necessary precursor to competent practice (Kozina et al., 2010). CSE encompasses the beliefs and attitudes held by counseling professionals or trainees which impacts their ability to effectively deliver counseling services (Bakioglu & Turkum, 2020; Kozina et al., 2010; Larsen & Daniels, 1998).

Applicability of Self-Efficacy Theory to This Research Study

A continuously growing body of research suggests counselors' training, clinical, and supervision experiences impact the development of their self-efficacy and thereby have a significant impact on counselor competence, burnout, resilience, and treatment

outcomes (Bakioglu & Turkum, 2020; Goreczny et al., 2015; Jaafar et al., 2009; Kozina et al., 2010, Lent et al., 2009; Mattews et al., 2018; Mullen et al., 2015). Although formal education has been shown to increase self-efficacy among mental health counselors (Merrick et al., 2016; Oordt et al., 2009), the research is limited regarding how continuing education impacts the self-efficacy of counselors that are currently practicing. Prior to this study, the impact of TMH continuing education courses on CSE when providing TMH services had yet to be examined despite the significant increase in TMH practices since the onset of the COVID-19 pandemic (Abraham et al., 2021). Self-efficacy theory is foundational to my research study, as CSE needs to be explored as it relates to current TMH practice, especially as one considers (a) the significant impact CSE has upon both counselors and their clients and (b) the increased need for the provision of TMH services over the last several years.

Literature Review

Telemental Health

TMH is defined as a type of health service where services are delivered at-a-distance, rather than in-person, using various telecommunication technologies, such as videoconferencing, telephone, email, or text messaging (American Psychological Association, 2017; World Health Organization, 2009). TMH may also fall under the umbrella of the broader term of "Telehealth," which refers to the provision of any long-distance clinical health care service (Karimi et al., 2022). Prior to the onset of the

COVID-19 pandemic, the usage of TMH services was limited, and therefore many practitioners provided TMH services sparingly or in some cases not at all.

Although some graduate training programs and continuing education courses provide counselors and counseling students with instruction on TMH practices, the accessibility of these resources to certain individuals may be limited. For example, to become a BC-TMH provider, counselors must hold a qualifying license or National Certified Counselor status, must pay fees to complete an approved TMH training course, must have a passing score on the Telemental Health Examination, and must pay a $150 application fee (Center for Credentialing & Education [CCE], 2022). For newly graduated counselors who are still under supervision and who have yet to achieve a passing score on the National Counselor Examination (NCE) or the National Clinical Mental Health Counseling Examinations, becoming a BC-TMH provider is not possible. Therefore, in addition to financial barriers that may prevent counselors from receiving TMH training, the inability to access or to fully benefit professionally from such training may also be discouraging for some counselors, particularly those that are new to the field. Though it can be assumed that TMH training and continuing education opportunities can increase knowledge and understanding of TMH practices, research surrounding the amount of training counselors receive and how this impacts their counseling self-efficacy was not conducted prior to this study.

Telemental Health Practices During the COVID-19 Pandemic

According to the *American Community Survey Reports* data collected by the U.S. Census Bureau, in 2018 it was reported that at least 92% of households in the United States had at least one computer, and 85% of households in the United States had an internet subscription (Martin, 2021). Additionally, this survey also reported that smartphones were present in at least 84% of households (Martin, 2021). With the increase in access to the internet and streaming devices in the years prior to the onset of the COVID-19 pandemic, telehealth use was slowly trending up; however, the restrictions brought forth by an increase in COVID-19 cases caused telehealth use to increase dramatically (Karimi et al., 2022).

A review of literature on TMH usage during the COVID-19 pandemic conducted by Abraham et al. (2021) also appeared to support the assertion that there has been a significant uptake in TMH practices since the beginning of the COVID-19 pandemic. Abraham et al. also reported that the overall perceptions of TMH appeared to be neutral-to-positive. Despite the growing information surrounding TMH usage, Abraham et al. noted that more research surrounding TMH is necessary to fully understand the implications of the available research; moreover, they suggested that there is a lack of research and resources surrounding TMH.

Case reports following the onset of the COVID-19 pandemic found that the usage of telehealth services went from being less than 1% (FAIR Health, 2020, as cited in Weiner et al., 2021) to as much as 80% (March to April 2020) in areas that experienced higher

numbers of COVID-19 cases (Drees, 2021, as cited in Weiner et al., 2021). A more recent study also indicated that the average usage of telehealth services from April to October 2021 was around 23% across all respondents, with those with Medicaid and Medicare averaging the highest usage of telehealth services (Karimi et al., 2022).

In their discussion of COVID-19 and TMH practices, Madigan et al. (2020) asserted that the need for physical distancing to reduce transmission of the virus in addition to government mandates, has made telehealth both a necessary and preferential choice for many clients and practitioners. Madigan et al. also noted that TMH increases accessibility to people who may not have previously had access to mental health services. In terms of considerations, Madigan et al. mentioned the lack of adequate internet connections and privacy within dwellings as potential challenges and limitations when providing TMH. The future considerations made by Madigan et al. support the argument that additional attention and training is needed for TMH practitioners to provide ethical and effective services. In another article, Racine et al. (2020) discussed the benefits and limitations of providing TMH services for child maltreatment and child trauma treatment and the lack of research surrounding the efficacy of practicing therapeutic approaches that are commonly used and empirically supported when working with child trauma via a TMH platform. Despite the lack of research, however, Racine et al. asserted that TMH services provide access to treatment that may not be available otherwise, thus highlighting the potential benefit of and the necessity for the provision of TMH services.

Impact of the Rapid Transition to Providing Telemental Health Services

Though reports of mental illness and substance abuse have increased following the onset of the COVID-19 pandemic and the usage of telehealth has increased, mental health providers have experienced many challenges while making the transition to providing TMH services (CDC, 2021; Sammons et al., 2020; Slone et al., 2021). Despite the growing research which asserts that TMH can be used ethically and effectively to establish a therapeutic relationship, some mental health providers continue to have reservations about TMH practice which has led to low uptake in some areas (Cost et al., 2021). Several mental health providers have also reported changes in employment or that they have stopped practicing altogether following the onset of the COVID-19 pandemic (Slone et al., 2021). Additionally, some counselors have reported a decline in their caseload since the onset of the COVID-19 pandemic (Sammons et al., 2020; Slone et al., 2021). Though the reasons for reluctance to utilize telehealth, changes in employment, termination of practice, and caseload decline among mental health providers could be attributed to many different factors, the current research illuminates some of the possibilities.

In a study conducted by Tolou-Shams et al. (2021), the impact that rapidly transitioning to TMH services during the COVID-19 pandemic has had upon clients and counselors was explored. The counselors in this study provided trauma-informed mental health services to a population of predominantly Latinx, Black, and Asian youth and their families. One important factor which may have impacted the outcome of this study is that

regardless of discipline, the counselors who participated in this study completed the American Psychological Association's Telepsychology Best Practices 101 Series (2021) (8 hours total) in the first 2 weeks of transitioning to providing TMH services when the shelter-in-place order was implemented. The results from the survey data gathered by Tolou-Shame et al. (2021) indicated that most clinicians were satisfied or somewhat satisfied with the clinical aspects of their sessions (i.e., rapport, client engagement, therapeutic, intervention, treatment planning); however, as much as 25% of clinicians identified as being neutral or dissatisfied. Although the total amount of TMH continuing education that participants received is unknown as is the amount of time that participants had spent prior to the onset of the COVID-19 pandemic providing TMH services, the results from Tolou-Sham et al.'s study appear to indicate that there may be a positive correlation between TMH continuing education and the experiences of TMH providers.

In another study conducted by Slone et al. (2021), it was found that among the 500 mental health providers that were surveyed, those that depended upon private insurance or out-of-pocket payments rather than insurances like Medicare or Medicaid were more likely to report a decrease in caseload and were less likely to practice following the onset of the COVID-19 pandemic. This could be related to obstacles associated with acquiring and maintaining insurance contracts and a lack of knowledge or training related to business practices. Some mental health providers have also reported concerns over a lack of training around TMH modalities, such as those surrounding ethical issues (Knott et al., 2020; Perle et al., 2013). This lack of training surrounding

TMH practice may negatively impact professional competence and lead to a reluctance to utilize TMH (Cosh et al., 2021; Slone et al., 2021).

Lastly, Lin et al. (2021) discussed the various challenges faced by mental health providers when transitioning to TMH services during the COVID-19 pandemic. These challenges include "ethical and legal issues, privacy/confidentiality, referral sources, management of client safety and crises, and reimbursement policies" (Lin et al., 2021, p. 450). A few specific ethical concerns faced by counselors are due to a lack of technological competence which could result in breaches of privacy and confidentiality (Gamble et al., as cited in Lin et al., 2021). A lack of control over the environmental privacy of clients is another ethical concern as counselors may be unaware of another individual listening to sensitive conversations between the counselor and their client (Gamble et al., as cited in Lin et al., 2021). Some mental health practitioners have also expressed concerns about a lack of knowledge surrounding ethical and legal practices for teletherapy which could have negative implications for both counselors and their clients (Glueckauf et al., as cited in Lin et al., 2021). Regarding therapeutic practice, in the study conducted by Lin et al. (2021) where 440 mental health providers were asked to provide their perceptions of how well they displayed common therapeutic skills/abilities when providing therapeutic services in-person and again when they provided services via a teletherapy platform, results indicated that mental health providers rated themselves as being significantly less skilled when providing TMH services than they did when providing in-person services. Though the results from Lin et al.'s (2021) study are

indicative of the self-perceptions of mental health providers rather than based upon unbiased performance evaluation, self-perception has been shown to impact self-efficacy which could contribute to some mental health providers' struggle to provide TMH services (Goreczny et al., 2015).

Counselors and Continuing Education

According to the American Counseling Association (ACA; 2014), counselors are expected to seek opportunities for continuing education so that they maintain awareness of current information within their field and so that they maintain and gain competencies that will allow them to work ethically and effectively with diverse populations (C.2.f.). Though most states require counselors to complete a certain number of continuing education credits every year to maintain their licensure, the research surrounding how continuing education affects the work of counselors is limited (Lyons et al., 2015). Research surrounding the outcomes of continuing education courses is essential to exploring the impact of such trainings on clinical competence, as this is the expected outcome (Owen-Pugh & Javson, 2015).

Although the idea that completing continuing education is essential to ensuring that ethical and effective practice takes place in the mental health field, counselors are given little guidance regarding which trainings will have the most impact on them as individuals (Fender, 2018). Additionally, counselors are often responsible for funding their continuing education endeavors, which can make it difficult for them to afford beneficial trainings and impacts the types of trainings that they may have access to

(Owen-Pugh & Javson, 2015). While many counselors recognize that there is a significant amount of learning that is achieved through experience, a lack of opportunities for continuing education and consultation with peers and supervisors makes it difficult for many to build clinical competence and self-efficacy (Fender, 2018; Merrick et al., 2016; Owen-Pugh & Javson, 2015).

Continuing Education and Telemental Health Practices

Following the onset of the COVID-19 pandemic the ever-evolving landscape of mental health care became even more complex with the increase and shift in the needs of consumers (Johnson & Rehfuss, 2021). To ensure continuity in care for their clients, many counselors made the decision to provide TMH services despite having little to no training or practice providing these types of services (Abraham et al., 2021; Appleton et al., 2021; Cosh et al., 2021; Racine et al., 2020; Tolou-Shams et al., 2021). Callan et al. (2017) discussed the growing need for TMH training, specifically in the areas of "TMH therapy, case conceptualization and mechanisms of change, cognitive neurosciences ethics and professional guidelines, governing laws and rules pertinent to behavioral health practice, and professional communication and record keeping" (p. 63).

Although the Council for Accreditation of Counselors and Related Education Programs (CACREP; 2016) outlines the roles and settings of counselors are to be included in the training of master's level counseling students enrolled in CACREP accredited programs, this contextual dimension does not specify the inclusion of TMH training (Section 5.2.a). Furthermore, not all counseling programs have sought or

established CACREP accreditation, which means that unless an institution provides education surrounding TMH practice to their students, the counselors entering the field upon graduation are limited in their knowledge about how to ethically and effectively provide TMH services. Without having TMH training in their master's degree program, counselors are responsible for identifying and paying for TMH training, which can be challenging for many reasons, including a lack of available finances and a lack of awareness surrounding what trainings would be a good fit for individual needs (Owen-Pugh & Javson, 2015).

In their qualitative research involving counselor trainees, Johnson and Rehfuss (2017) discussed how telehealth training and education is critical in advocating for appropriate utilization of new technology. Johnson and Rehfuss (2017) recruited participants from eight health-related educational programs, including masters level counseling students, to spend three weeks in a telehealth training course which required them to not only learn about telehealth practices but to also apply this knowledge to standardized patients. Following this training, participants were then interviewed about their experiences and from those interviews, researchers identified common themes (Johnson & Rehfuss, 2017). Several participants in this study expressed more awareness about the benefits of telehealth and the need for more counselor telehealth training opportunities (Johnson & Rehfuss, 2017). Participants in this study also identified some concerns and challenges that they had when utilizing telehealth, such as building rapport with clients, technological issues, and ethical dilemmas (Johnson & Rehfuss, 2017).

Despite the reported challenges and concerns, several participants in Johnson and Rehfuss' (2017) study commented on the overall benefit of the training and how it increased their confidence and willingness to utilize telehealth in their practice.

Counselor Self-Efficacy

While self-efficacy can be defined as a person's belief that they are able to solve any task or problem that they are confronted with (Bandura, 2001), CSE specifically refers to a counselor's belief and appraisal of their ability to effectively counsel clients in the present and future (Larson & Daniels, 1998). Though much of the available research surrounding CSE supports Bandura's (1977, 1982, 1993, 1994, 1997b) findings on self-efficacy and continues to highlight the importance of CSE in the mental health profession, research on CSE is limited and much of the focus has been on the experiences of counselor trainees or novice counselors. Nonetheless, the available research surrounding CSE serves to validate the need for counselors of all experience levels to receive adequate training and support as this is an essential component in positive treatment outcomes and the overall professional well-being of counselors.

In one study regarding the development of CSE, Goreczny et al. (2015) studied the self-efficacy and anxiety among psychology trainees that were at various stages of training. Participants were asked to complete several questionnaires, including the Counselor Activity Self-Efficacy Scale (CASES; Lent et al., 2003) and the Counselor Self-Estimate Inventory (*COSE*; Larson et al., 1992; Goreczny et al., 2015). The results from this study indicated that CSE was higher in advanced-level graduate students

compared to students earlier in their training (Goreczny et al., 2015). Even more interestingly, the undergraduate students reported higher levels of CSE than beginning-level graduate students (Goreczny et al., 2015). Though several possible explanations for these results were discussed, it is worth noting that Goreczny et al. (2015) asserted that perhaps the CSE of beginning-level graduate students was impacted by their increased awareness that there were many things that they needed to learn to build their counselor competency. The implications from Goreczny et al.'s (2015) study further supports the importance of helping counselor trainees develop CSE, and that CSE is increased by the practice of learned counseling skills and receiving feedback about performance. Finally, Goreczny et al. (2015) discussed the need for evaluation of training program outcomes, as the available research indicates that training programs can have a significant impact on the development of CSE among counselor trainees.

Counselor Self-Efficacy When Practicing Telemental Health

Though there is a significant amount of research surrounding CSE and TMH, the self-efficacy held by counselors when practicing TMH has yet to be explored. The research surrounding counselor perception of TMH and counselor experiences while providing TMH, however, is steadily growing. The available research suggests that a correlation may exist between counselor perception and CSE, specifically regarding skill performance, role comfort, and session quality (Larson et al., 1992; Lent, Hill, & Hoffman, 2003; Lent et al., 2006).

In their study of counselors' perception of distance counseling (DC), Maurya et al. (2020) found that counselors with more experience expressed a higher comfortability with providing TMH than those with less experience. Similar findings were also reported by Adams et al. (2022) in a study which examined counselors' concerns with delivering TMH to autistic individuals during the COVID-19 pandemic. Adams et al. (2022) recruited participants with at least one or more years of clinical experience, with the majority reporting high technological competence and professional experience in working with individuals diagnosed with autism spectrum disorder (ASD) suggesting that these factors may positively impact counselor perception of TMH. These research findings support the need for further exploration into CSE when practicing TMH as it is reasonable to hypothesize that counselor perception when practicing TMH is correlated with CSE.

Summary and Conclusions

This review of literature provided a foundation for my research study by highlighting the key components of Bandura's theory of self-efficacy (Bandura, 1986) and the impact that CSE has upon counselor competence, burnout, resilience, and treatment outcomes. The significant changes that have occurred in the mental health field due to the onset of the COVID-19 pandemic are astounding (Cosh et al., 2021; Hyde et al., 2022; Wilczewski et al., 2022) and prior to this study, failed to address the relationship between the increase in provision of TMH services and counselor self-efficacy (Wilczewski et al., 2022). Additionally, research surrounding the TMH training

and CE needs of counselors is limited, though the importance of such training is often highlighted (Callan et al., 2017). In Chapter 3, I will introduce the major components of my research study which will explore the current gap in research on counselor self-efficacy and how the rapid increase in provision of TMH services due to the COVID-19 pandemic has impacted mental health providers.

Chapter 3: Research Method

This research study yielded information about how TMH training and continuing education has impacted the CSE of counselors who have experienced a rapid transition or increase in providing TMH services because of the COVID-19 pandemic. The motivation of this study was to observe predictors of CSE, specifically when providing TMH services, which is based upon Bandura's (1977) theory of self-efficacy. TMH training and continuing education, prior experience providing TMH services, and prior experience providing counseling services were investigated as predictors of CSE among counselors who have been providing TMH services since the onset of the COVID-19 pandemic. In this chapter, I discuss and delineate my research methodology within the following sections: research design and rationale; population; sampling and sampling procedures; procedures for recruitment and participation; data collection; instrumentation; data analysis plan; threats to validity; and ethical procedures.

Research Design and Rationale

I used a nonexperimental, cross-sectional, survey research design to identify and explore background and number of TMH continuing education courses as predictors of self-reported CSE. Using a correlational regression method allowed me to test a prediction model that examines the impact that TMH continuing education has upon CSE; however, it did not allow me to measure cause and effect. Furthermore, unlike longitudinal designs where measurements are taken more than once over a period, a cross-sectional design only provided observation of the population of interest at one point

in time. This impacted my ability to draw conclusions about observations made over time, though cross-sectional research designs reduce the likelihood of attrition and missing data. Finally, I utilized an online survey design to broaden the accessibility to individuals in diverse locations and allow more flexibility in time for participants to complete the survey.

Population

The population for this study was counselors who have been providing counseling services before the onset of the COVID-19 to present day. The members of this community were licensed, or under supervision for licensure, mental health counselors. For example, this population may include the following licensed or license-eligible counseling professionals: licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, or the equivalent licensure of which the designation may vary by state. Members were required to have provided TMH services to their clients at some point in time before or during the COVID-19 pandemic. Although the total number of counselors currently providing TMH services in the United States is unknown, a report published by the U.S. Bureau of Labor Statistics estimated that in 2021 there were 327,500 counseling jobs available to serve the over 300 million people that currently reside in the United States. With the rapid increase in usage of TMH services, it is reasonable to believe that a significant portion of practicing counselors offer TMH services to their clients; therefore, the population available for this study was considerable.

Sampling and Sampling Procedures

I employed a nonprobability, self-selecting sampling among counselors who met the inclusion criteria for this study. To calculate the required sample size for this study I used version 3.1 of G*Power (Faul et al., 2009). I set the α level for my study, or probability of making a Type I error, at .05 (5%), which indicated a five percent chance of detecting an effect when there was none (Frankfort-Nachmias & Leon-Guerrero, 2018). I set the power level (1-β), or likelihood of detecting an effect, at .80 (80%) and selected .15 for the effect size, and this led to an estimate of 84 as the recommended sample size for this study. Assuming that the response rate to the study survey could be around 20% (Sauermann & Roach, 2013), I estimated that sending at least 420 or more surveys would provide sufficient data to complete the study.

Procedures for Recruitment and Participation

Since there are many methods that could be utilized to connect with counselors, I employed different approaches to recruit participants. I posted the survey on social media, the *ACA Connect* online discussion forum, CESNET-L listserv online discussion forum, and any other applicable public forums accessed by counselors. An email list was also be compiled through referrals from local universities, businesses, and agencies.

Data Collection

I used SurveyMonkey to deliver the surveys for this research study. SurveyMonkey is frequently used by researchers to conduct web-based surveys as it has an internally hosted system and multiple security features to ensure that any data

collected are confidentially and securely stored (SurveyMonkey, 2022). SurveyMonkey provides users with the option to have a Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant account and stores data in SOC2 accredited data centers which are internally owned by SurveyMonkey. Finally, SurveyMonkey uses Secure Sockets Layer (SSL) protocol, which is used to authenticate and encrypt links between networked computers and ensures secure connections from web servers to browsers (SurveyMonkey, 2022). To align with the Institutional Review Board (IRB) guidelines outlined by my university, I stored all data downloaded from SurveyMonkey on a password-protected computer and password-protected file to maintain confidentiality and security (Walden University, 2020). The stored data were viewed only by me for the purpose of this study and have been saved for a minimum of 5 years following the completion date of this study per my university's guidelines. Once the 5 years have elapsed, I will ensure the data have been permanently erased from my computer.

Instrumentation

Demographic Questionnaire

A demographic questionnaire was included in the survey to gather information which would describe the sample and to provide information related to the identified predictor variables. For example, participants were asked to identify how many hours of TMH training and continuing education they have had, how long they have been providing TMH services, and how long they have been providing counseling services. Along with the demographic questionnaire, the *COSE* was used to measure the IV of

CSE. In the demographic questionnaire, I included questions to collect data surrounding participant's age, race/ethnicity, gender identity, sexual identity, approximate hours of TMH training or continuing education completed, years of experience providing TMH services, years of experience providing counseling services, age groups to whom they provide counseling services, and age group which makes up the majority of the clients to whom they provide counseling services.

Counseling Self-Estimate Inventory

The *COSE* is an assessment that was developed by Larson et al. (1992) and based upon Bandura's self-efficacy theory (Bandura, 1977, 1982, 1993, 1994, 1997b). The *COSE* consists of 37 items which are used to examine five factors: Microskills (12 items), Process (10 items), Difficult Client Behaviors (7 items), Cultural Competence (4 items), and Awareness of Values (4 items). Items are rated by participants using a Likert-type scale; therefore, higher scores indicate greater self-efficacy. For example, participants are asked to respond based upon the degree to which they 1 = strongly disagree to 6 = strongly agree with each statement to reflect their current self-estimate of their performance in counseling sessions. Regarding internal consistencies, the following was reported for the *COSE* total score and each of the five factors: *COSE* total = .93, microskills = .88, process = .87, difficult client behaviors = .80, cultural competence = .78, and awareness of values =.62. Estimates of internal validity indicated the instrument was (a) positively related to counselor performance, self-concept, problem-solving appraisal, performance expectations, and class satisfaction; (b) negatively related to state

and trait anxiety; (c) minimally related to aptitude, achievement, personality type, and defensiveness; and (d) sensitive to change over the course of master's practicum and across different levels of counselors. Sample questions from the measure include: (a) When using responses like reflection of feeling, active listening, clarification and probing I am confident I will be concise and to the point (Microskills); (b) I am unsure how I will lead my client towards the development and selection of concrete goals to work towards (Process); (c) I do not feel I possess a large enough repertoire of techniques to deal with the different problems my client may present (Difficult Client Behaviors); (d) When working with persons who identify as non-white, I am confident that I will be able to bridge cultural differences in the counseling process (Cultural Competence); and (e) I feel that I will not be able to respond to the client in a non-judgmental way with respect to the client's values, beliefs (Awareness of Values). Studies performed by Jaafar et al. (2009), Karairmak (2018), and Kozina et al. (2010) all support the reliability and validity of the *COSE* for measuring CSE. Permission to utilize the *COSE* in this study was not necessary as it is available in the public domain.

Operationalization of Constructs

I selected predictor variables for this study that may have influenced the CSE of counselors providing TMH services based upon findings in the available research (Baird et al., 2018; Gifford et al., 2012; Glueckauf et al., 2018; Kozlowski & Holmes, 2017; Li et al., 2005; Morrison & Lent, 2018; Ooi et al., 2018; Robertson & Lowell, 2021; Suh et

al., 2018). Each variable was coded as they are identified in each section. Variables outlined were applied to all participants.

Approximate Hours of TMH Training or Continuing Education Completed

The first predictor variable in which I gathered information to complete this study were the approximate hours of TMH training or continuing education that had been completed by respondents. This information was gathered as part of the demographic questionnaire. Respondents were asked to provide a self-report on the approximate hours of TMH training or continuing education that they have received by selecting one of the following options: (a) Less than 1, (b) 2 to 3 hours, (c) 4 to 5 hours, (d) 6 to 7 hours, (e) over 8 hours. These choices were constructed based upon the number of continuing education hours required to apply for the BC-TMH credential, which at this time is 9 hours (CCE, 2022).

Experience Providing TMH Services

The second predictor variable in which I gathered information to complete this study was the approximate amount of time respondents have been providing TMH services. This information was gathered as part of the demographic questionnaire. Respondents were asked to provide a self-report on the approximate period of time they have been providing TMH services by selecting one of the following options: (a) 1 to 2 years, (b) 3 to 4 years, (c) 5 to 6 years, (d) 7 to 8 years, and (e) over 9 years. These choices were selected based upon the approximate timeline for the onset of the COVID-

19 pandemic which was discovered in 2019 and began to rapidly spread in the United States in early 2020 (CDC, 2021).

Experience Providing Counseling Services

The third predictor variable in which I gathered information to complete this study was the approximate amount of time respondent have been providing counseling services. This information was gathered as part of the demographic questionnaire. Respondents were asked to provide a self-report on the approximate period they have been providing counseling services by selecting one of the following options: (a) 2 to 3 years, (b) 4 to 5 years, (c) 6 to 7 years, (d) 8 to 9 years, and (e) over 10 years. These choices were selected based upon the inclusion criteria outlined for this study, specifying that participants must have been providing counseling services prior to the onset of the COVID-19 pandemic. The COVID-19 pandemic was discovered in 2019 and began to rapidly spread in the United States in early 2020, meaning participants had been providing counseling services for at least 2 to 3 years, making them eligible to participate in this study (CDC, 2021).

Counselor Self-Efficacy When Providing Telemental Health Services

CSE when providing TMH services was the outcome variable being focused on in this study. I used the *COSE* to measure the self-efficacy held by respondents when providing TMH services (Larson et al., 1992).

Data Analysis Plan

After downloading the data that was collected from surveys, I then utilized International Business Machines (IBM) Statistical Package for the Social Science (SPSS; Version 27) software to analyze the data. The analysis initially focused on filtering out participants who did not meet the eligibility requirements to participate in this study. I sorted and delineated characteristics within the data file in SPSS; then, I cleaned and screened the data. Data analyses was then performed to test for assumptions and to test research hypotheses. These results will be presented in Chapter 4.

To clean the data, I first audited the data for any data entry errors and corrected any observed errors. I did not end the data collection process until the data gathered for each question met the appropriate sample size. Due to the data being uploaded into SPSS and digitally sorted, the data cleaning process did not present any unforeseen issues.

After inspecting the demographic questionnaires, I then tallied the responses. Frequencies and percentages of respondents were noted for each identified category (i.e., number of TMH trainings and continuing education completed, approximate time spent providing TMH services, and approximate time spent providing counseling services). Categorical responses were then sorted by reporting the number of participants who fell into each category.

Testing Hypotheses

A bivariate linear regression was the primary analysis used to evaluate each of the research questions (RQ) in the proposed study. To determine the statistical significance

of the linear relationship identified by the bivariate linear regression analyses, I ran a Pearson product-moment correlation or a Tukey Post Hoc Analysis.

The following research questions were investigated in this study:

Research Question 1: How does TMH training and continuing education predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH during the COVID-19 pandemic?

$H_0$1: Based on responses provided by counseling professionals, TMH training and continuing education does not appear to predict the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic.

H_A1: Based on responses provided by counseling professionals, TMH training and continuing education appears to predict the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic.

Questions regarding individual predictors are as follows:

Research Question 2: When controlling for other predictors, does prior experience providing TMH services predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

$H_0$2: When controlling for other predictors, prior experience providing TMH services does not predict the level of self-efficacy held by counselors when treating clients via TMH.

H_A2: When controlling for other predictors, prior experience providing TMH services does predict the level of self-efficacy held by counselors when treating clients via TMH.

Research Question 3: When controlling for other predictors, does prior experience as a practitioner predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

$H_0 3$: When controlling for other predictors, prior experience as a practitioner does not predict the level of self-efficacy held by counselors when treating clients via TMH.

$H_A 3$: When controlling for other predictors, prior experience as a practitioner does predict the level of self-efficacy held by counselors when treating clients via TMH.

Descriptive Statistics

Descriptive statistics allow researchers to organize and describe data gathered from a sample or a population (Frankfort-Nachmias & Leon-Guerrero, 2018). Upon reviewing the descriptive statistics for this study, I observed the measures of central tendency and variability to develop a more thorough description of the data. I then determined if the statistical tests' assumptions were met by visually observing data charts.

Analysis of Variance (ANOVA)

An ANOVA statistical analysis was employed to identify and observe any differences between the subgroups of the independent variables and the dependent variable (Frankfort-Nachmias & Leon-Guerrero, 2018; Warner, 2013). To conduct an ANOVA statistical analysis, the following assumptions are necessary: (a) observations are made on random and independent samples from the population, (b) dependent variables are continuous and measured at the interval or ratio level, (c) outcome variables are normally distributed, and (d) there are equal variances between treatments, or homogeneity of variances (Frankfort-Nachmias & Leon-Guerrero, 2018; Warner, 2013). To meet criteria for running an ANOVA statistical analysis first created categorical variables using the subgroups within the independent variables. These categorical variables were delineated from multiple-choice questions provided to respondents in the survey for this study. Second, I ensured that observations were randomly and independently sampled by using a cross-sectional research design. Third, after the data was collected, I selected the appropriate test in SPSS to ascertain if the outcome variables are normally distributed. Lastly, I identified and ran the appropriate test in SPSS to determine if there is a homogeneity of variances.

Bivariate Linear Regression

A bivariate linear regression model allows researchers to observe how one independent variable impacts or predicts the values of a dependent variable (Frankfort-Nachmias & Leon-Guerrero, 2018). A linear relationship (i.e., observing data displayed

on a scatter diagram with a straight line) gives researchers the ability to approximate results (Frankfort-Nachmias & Leon-Guerrero, 2018). I first conducted a bivariate linear regression to observe how the amount of TMH training and continuing education predicted the level of CSE, as measured by the *COSE*, held by counselors when providing TMH services. I then conducted a bivariate linear regression to observe how prior experience providing TMH services predicts the level of CSE, as measured by the *COSE*, held by counselors when providing TMH services. Lastly, I ran a bivariate linear regression to observe how prior experience providing counseling services predicts the level of CSE, as measured by the *COSE*, held by counselors when providing TMH services.

Prior to running a bivariate linear regression model, I determined if the data met the assumptions for a bivariate regression. The necessary assumptions for a bivariate regression are as follows: (a) a linear relationship exists between the independent and dependent variable, (b) multivariate normality is observed, (c) there is little or no multicollinearity, (d) there is no autocorrelation, and (e) homoscedasticity is observed. (Frankfort-Nachmias & Leon-Guerrero, 2018). These assumptions were tested prior to running bivariate regression analyses.

Pearson Product-Moment Correlation

A Pearson product-moment correlation model allows researchers to examine the strength of a linear relationship between two variables, such as the predictor variables and dependent variable identified in this research study (Frankfort-Nachmias & Leon-

Guerrero, 2018). After conducting a bivariate regression analysis for each RQ in this study, I then conducted a Pearson product-moment correlation model to identify the degree of linearity between each of the three predictor or independent variables and the dependent variable. The necessary assumptions for a Pearson product-model correlation are as follows: (a) variables are measured at the interval or ratio level and are continuous, (b) a linear relationship between the two variables is observed, (c) outliers are absent, and (d) each observation contains a pair of values (Frankfort-Nachmias & Leon-Guerrero, 2018).

Threats to Validity

In quantitative research, validity refers to the degree to which a test measures what it is designed to measure (Frankfort-Nachmias & Leon-Guerrero, 2018; Salkind, 2012). Validity is not black or white, but rather it is measured on a continuum from low validity to high validity (Salkind, 2012). In a non-experimental research design, threats to validity are factors that raise questions about a researcher's ability to conclude that the independent variable being measured is what affects the dependent variable instead of a separate unidentified variable (Creswell & Creswell, 2018). Internal validity threats are important to identify when using a non-experimental, cross-sectional survey research design. However, some threats can be eliminated due to the nature of such a study (Creswell & Creswell, 2018). Though participants for this study were not recruited randomly, participants were self-selected; therefore, reducing threats related to selection and regression.

External validity threats occur whenever researchers incorrectly assume that the sample data collected applies to other populations, settings, or situations (Creswell & Creswell, 2018). Three potential threats to external validity are as follows: (a) interaction of selection and treatment, (b) interaction of setting and treatment, and (c) interaction of history and treatment (Creswell & Creswell, 2018). The participant inclusion criteria for this study were fairly limited with respect to the research topic; therefore, the interaction of selection of treatment should be low due to the ability to generalize results to a significant portion of the population of counselors. Also, since participants were completing a survey that can be accessed online, the setting in which they completed this survey varied, thus minimizing the interaction of setting and treatment. Although I was unable to observe any changes in participants' CSE when providing TMH services over time since this study is a cross-sectional survey research design, the results from this study can be generalized to the identified population when controlling for descriptive statistics.

Ethical Procedures

Before conducting this research study, I engaged in the Institutional Review Board (IRB) Approval Process sanctioned by Walden University, which ensures that this research study followed the university's ethical standards (Walden University, 2020). I provided participants with documentation of meeting ethical guidelines, which included seeking approvals and permissions for conducting this study (Walden University, 2020).

Conducting surveys on the internet has provided researchers with more opportunities to study topics which would otherwise be difficult or impossible; however, online research poses unique ethical concerns that must be considered (Groves et al., 2009). In collecting data for this survey research, I was selective of the website which I used to gather survey responses to ensure that data was secure and encrypted (Groves et al., 2009). I included a comprehensible informed consent for participants to review prior to the study which outlined the purpose of the study, inclusion criteria, duration of participation, procedures, and confidentiality (Groves et al., 2009). I also provided options where the participant could agree to participate in the study, elect to not participate in the study, or request more information prior to agreeing to participate in the study. Finally, I provided my contact information and invited participants to contact me directly should they have any questions or concerns.

Summary

This study used a nonexperimental, cross-sectional, survey research design to investigate several factors which may predict the CSE held by counselors providing TMH services during the COVID-19 pandemic. I ran an ANOVA, a bivariate linear regression, and a Pearson product-moment correlation to analyze the predictive nature of TMH training and continuing education courses completed, prior experience providing TMH services, and prior experience providing counseling services. To complete this study I needed a sample size of at least 84 with a margin of error of 5% and the desired power level of .80 to promote statistical significance. In Chapter 3, I have discussed the research

method, analyses, and design that was developed for this research study. Methods for sampling, recruiting, survey procedures, and instruments that were used in this study were also discussed. I will provide information regarding the data collection process along with the results gathered regarding each hypothesis in Chapter 4.

Chapter 4: Results

Despite the continued uptake of TMH services, there has yet to be any research conducted surrounding how TMH training and continuing education impacts CSE. The purpose of this study was to identify and explore the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic. Additionally, the aim of this study was to determine if there is an observable difference in the self-efficacy of counselors providing TMH services who have completed TMH training or continuing education courses and counselors providing TMH services who have not. The three research questions and hypotheses for the study were as follows:

Research Question 1: How does TMH training and continuing education predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH during the COVID-19 pandemic?

$H_0$1: Based on responses provided by counseling professionals, TMH training and continuing education does not appear to predict the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic.

H_A1: Based on responses provided by counseling professionals, TMH training and continuing education appears to predict the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic.

Questions regarding individual predictors are as follows:

Research Question 2: When controlling for other predictors, does prior experience providing TMH services predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

$H_0$2: When controlling for other predictors, prior experience providing TMH services does not predict the level of self-efficacy held by counselors when treating clients via TMH.

H_A2: When controlling for other predictors, prior experience providing TMH services does predict the level of self-efficacy held by counselors when treating clients via TMH.

Research Question 3: When controlling for other predictors, does prior experience as a practitioner predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

$H_0$3: When controlling for other predictors, prior experience as a practitioner does not predict the level of self-efficacy held by counselors when treating clients via TMH.

H_A3: When controlling for other predictors, prior experience as a practitioner does predict the level of self-efficacy held by counselors when treating clients via TMH.

In this chapter, I discuss the data collection process, the general demographics of the sample population, my method for data analysis, including descriptive statistics,

ANOVA, bivariate linear regression, and correlation analysis. Data interpretation will also be discussed for each research question.

Data Collection

I was notified by Walden University that I received IRB approval on September 12th, 2022 (approval # 09-13-22-0989297) and began recruiting study participants using the approved methods. Upon receiving IRB approval, my university posted a call for participants for my research study on their Participant Pool Website. I distributed my survey link via multiple online platforms to recruit participants. All postings to online platforms included a brief overview of the study that had been preapproved by the IRB. This overview described the voluntary nature of the study, the problem and purpose of the study, and the inclusion criteria for each participant. I disseminated postings on LinkedIn, Instagram, and Facebook directly and on the main feeds of professional pages on Facebook. These professional pages included various therapist and counseling-related groups, along with counselor education and supervision groups. Additionally, I posted on the *ACA Connect Call for Study Participants* discussion board and the CESNET-L listserv.

I initially posted a call for participants to *ACA Connect* on September 26th, 2022, followed by another post on December 15th, 2022. At the time of posting there were 407 subscribers to the *ACA Connect Call for Study Participants* group, which is comprised of ACA members. Once I was approved to post on CESNET-L listserv, I posted a call for participants on October 19th, 2022, followed by three more posts, one in November 2022

and two in December 2022. The CESNET-L listserv is an unmoderated listserv for counselor educators and supervisors that had 6,651 subscribers at the time of my last posting. On November 12th, 2022, I posted on The Boulder Psychotherapy Institute (BPI) Networking List, which at the time of posting was reported to reach over 1,000 subscribers. My call for participants requests included a short summary of the purpose of the study, details about the study, a summary of inclusion criteria, and a link to the survey hosted on the SurveyMonkey online data collection platform. The survey was created to be accessible via mobile and desktop platforms. Upon clicking on the link to the survey, prospective research study participants were taken to a page which outlined the informed consent document for the study and were required to acknowledge and provide consent prior to answering any survey questions. The IRB approval number, along with my contact information, was provided on the informed consent page.

The first month was slower regarding the number of responses received. After each post to the CESNET-L listserv, I observed the greatest increase in responses. The CESNET-L listserv was the most effective resource for achieving the minimal sample size of 84 participants. On December 16th, 2022, I closed the survey with 98 total responses and 85 completed responses for an 87% completion rate. I was able to identify two discrepancies which occurred in the data collection process. First, I discovered that the option of "35-44 years old" was unintentionally omitted from the demographic question, "Which age group makes up the majority of the clients you provide counseling services to." The results from this question were not necessary to complete the data

analysis for this study. Second, I discovered that the last four questions of the *COSE* were not added to the survey that was completed by participants. Respondents completed 89% of the *COSE* and answered most items in the Micro-skills, Cultural Competence, and Awareness of Values subscales, and answered all items in. the Counseling Process and Dealing with Difficult Client Behaviors subscales.

I fulfilled the necessary sample size of at least 84 participants needed for an alpha of .05 and the optimal power level of .95 for statistical significance, which was discussed in Chapter 3. This study was completed with a total of 85 participants, the majority of whom were female (n = 67, 78.8%). One of the goals of this study was to gather data from a representative sample, and a majority response from female participants aligns with the current data, which indicates that women outnumber men in the counseling field (U.S. United Census Bureau, 2019). Table 1 provides an outline of the descriptive data collected from participants regarding gender.

Table 1

Frequency Distribution of Respondents by Gender

		n	%
Valid	Male	13	15.3
	Female	67	78.8
	Gender Non-Conforming	4	4.7
	Non-Binary	1	1.2
	Total	85	100.0

Additional demographic data was collected for descriptive analysis, including race and ethnicity, age, and ages of clients served. White or Caucasian (*n* = 58, 68.2%) participants were the most represented in the sample, followed by Black or African American participants (*n* = 10, 11.8%). See Table 2 for an outline of the descriptive data collected from participants regarding race and ethnicity.

Table 2

Frequency Distribution of Respondents by Race and Ethnicity

		n	%
Valid	American Indian or Alaska Native	5	5.9
	Black or African American	10	11.8
	Native Hawaiian or Other Pacific Islander	0	0
	White or Caucasian	58	68.2
	Hispanic or Latino	3	3.5
	Asian or Asian American	3	3.5
	Multiracial	6	7
	Total	85	100.0

For effective data analysis, I created subgroups for participant ages with ranges. Participants were more evenly dispersed across age groups than anticipated, with the 35-44 age range representing the highest number of respondents (*n* = 32, 37.6%), followed closely by the 25-34 age range (*n* =23, 27%) and the 45-54 age range (*n* = 20, 23.5%).

See Table 3 for an outline of the descriptive data collected from participants regarding age.

Table 3

Frequency Distribution of Respondents by Age

		n	%
Valid	18-24	0	0
	25-34	23	27
	35-44	32	37.6
	45-54	20	23.5
	55-64	10	11.8
	65+	0	0
	Total	85	100.0

Results

The purpose of this quantitative study was to identify and explore the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic. This study also aimed to determine if there is an observable difference in the self-efficacy of counselors providing TMH services who have completed TMH training or continuing education courses and counselors providing TMH services who have not. This study consisted of three IVs, which were hours of TMH training or TMH continuing education received, time providing TMH services, and time providing counseling services. This study had one identified DV, which was CSE as measured by the *COSE*.

Descriptive Statistics

I utilized IBM SPSS (Version 27) software to analyze data and began by computing descriptive statistics for each variable in this study. I ran a frequency distribution of respondents for each IV and the DV for this study, and the total score and mean scores on the survey data collected on the *COSE.* I took the survey data for the *COSE* directly from the completed questionnaires and completed the data calculations based upon the scoring information published for the instrument. The descriptive statistics for each variable are outlined in the sections below.

Hours of TMH Training or TMH Continuing Education Received (Independent Variable 1)

The survey for this study included a demographics questionnaire, questions regarding hours of TMH training or TMH continuing education received, time providing TMH services, and time providing counseling services, and the *COSE.* When asked about the hours of TMH training or TMH continuing education that they had received, participants were given the option of reporting Less than 1 hour, 1 to 2 hours, 3 to 4 hours, 5 to 6 hours, 7 to 8 hours, or Over 8 hours. The responses to this question were coded as follows: 1.00 = Less than 1 hour, 2.00 = 1 to 2 hours, 3.00 = 3 to 4 hours, 4.00 = 5 to 6 hours, 6.00 = 7 to 8 hours, 7.00 = Over 8 hours. The data collected showed that most participants had received 1 to 2 hours of TMH training or TMH continuing education (n = 24, 28.2%), followed closely by 3 to 4 hours of TMH training or TMH continuing education (n = 18, 21.2%) (See Table 4).

Table 4

Frequency Distribution of Respondents by Hours of TMH Training or TMH Continuing Education Received

		n	%
Valid	Less than 1 hour	15	17.6
	1 to 2 hours	24	28.2
	3 to 4 hours	18	21.2
	5 to 6 hours	10	11.8
	7 to 8 hours	3	3.5
	Over 8 hours	15	17.6
	Total	85	100.0

Time Providing TMH Services (Independent Variable 2)

When asked about the amount of time they have spent providing TMH services, participants were given the option of reporting 1 to 2 years, 3 to 4 years, 5 to 6 years, 7 to 8 years, or Over 9 years. The responses to this question were coded as follows: 1.00 = 1 to 2 years, 2.00 = 3 to 4 years, 3.00 = 5 to 6 years, 4.00 = 7 to 8 years, 6.00 = Over 9 years. The data collected showed that most participants had spent 1 to 2 years providing TMH services (*n* = 43, 50.6%), followed closely by 3 to 4 years of providing TMH services (*n* = 34, 40%; See Table 5).

Table 5

Frequency Distribution of Respondents by Time Providing TMH Services

		n	%
Valid	1 to 2 years	43	50.6

3 to 4 years	34	40
5 to 6 years	6	7.1
7 to 8 years	1	1.2
Over 9 years	1	1.2
Total	85	100.0

Time Providing Counseling Services (Independent Variable 3)

When collecting data surrounding the amount of time spent providing counseling services, participants were given the option of reporting 2 to 3 years, 4 to 5 years, 6 to 7 years, 8 to 9 years, or Over 10 years. The responses to this question were coded as follows: 1.00 = 2 to 3 years, 2.00 = 4 to 5 years, 3.00 = 6 to 7 years, 4.00 = 8 to 9 years, 6.00 = Over 10 years. The data collected showed that most participants had spent over 10 years providing counseling services (*n* = 35, 41.2%; See Table 6).

Table 6. *Frequency Distribution of Respondents by Time Providing Counseling Services*

		n	%
Valid	2 to 3 years	11	12.9
	4 to 5 years	10	11.8
	6 to 7 years	19	22.4
	8 to 9 years	10	11.8
	Over 10 years	35	41.2
	Total	85	100.0

Counseling Self-Estimate Inventory (Dependent Variable)

The *COSE* consists of 37 items which are used to assess counselor self-efficacy. The questions examine five factors: Micro-skills (12 items), Process (10 items), Difficult Client Behaviors (7 items), Cultural Competence (4 items), and Awareness of Values (4 items). Items are rated by participants using a Likert-type scale; therefore, higher scores indicate greater self-efficacy. On a Likert Scale of 1 to 6, participants are asked to respond based upon the degree to which they 1 = strongly disagree to 6 = strongly agree with each statement to reflect their current self-estimate of their performance in counseling sessions. The *COSE* total score is calculated by taking the sum of responses and dividing it by the number of items in the scale. The subscale scores are similarly determined by taking the sum of responses to the items related to each subscale and dividing them by the total number of items within that subscale. The *COSE* Total Score for respondents was 3.8 with a standard deviation of .2 with scores ranging from 3.10 to 4.17. See Tables 7, 8, and 9 for more information. Upon completion of the data collection process, I observed that 4 of the items on the *COSE* were unintentionally omitted from the survey. Of the questions that were omitted, one of the questions was included the Micro-skills subscale, two of the questions were included in the Cultural Competence subscale, and one of the questions was included in the Awareness of values subscales. The Counseling Process and Dealing with Difficult Client Behaviors subscales were not impacted. The focus of this study was on CSE as measured by the total *COSE* score and research efforts were not focused on exploring the specific subscales of the *COSE*. Each

subscale in the *COSE* was represented in the survey provided to participants, making the omission of 4 items moot.

Table 7. *Descriptive Statistics COSE Total Score and Subscale Scores*

		Mean	Std. Deviation
	COSE Total Score	3.77	.19327
	Micro-Skills Score	5.11	.58646
	Counseling Process Score	3.88	.73498
	Dealing with Difficult Client Behaviors Score	4.20	.73498
	Cultural Competence Score	5.06	.81936
	Awareness of Values Score	4.82	.51281

Table 8. *COSE Total Score*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3.01-3.5	5	5.9	5.9	5.9
	3.51-4	70	82.4	82.4	88.2
	4.01-4.5	10	11.8	11.8	100.0

Table 9. *COSE Distribution*

N	Valid	85
	Missing	0
Std. Deviation		.19327

Variance	.037
Skewness	-.506
Std. Error of Skewness	.261
Kurtosis	1.345
Std. Error of Kurtosis	.517
Range	1.07
Minimum	3.10
Maximum	4.17

Research Question 1

The first RQ examined whether the amount of TMH training and TMH continuing education (IV) received by counselors predicts CSE (as measured by the *COSE*; DV) when treating clients via TMH during the COVID-19 pandemic. I used a bivariate linear regression model to explore this RQ. Before running a bivariate linear regression model in SPSS, I took the necessary steps to determine if the assumptions were met. First, I used dummy coding to transform the IV from a categorical variable to a continuous variable to satisfy the assumption that both variables being studied were continuous. I then created a scatterplot to observe if a linear relationship between the IV and the DV existed, and the results from this appeared to indicate a linear relationship. I then tested for independence of residuals, and it appeared that this assumption was confirmed, as evidenced by a Durbin-Watson statistic of 1.994 (See Table 10). I then checked for homoscedasticity, and this appeared to be confirmed as assessed by visual inspection of a plot of standardized residuals versus standardized predicted values. Residuals were then

determined to be normally distributed as assessed by visual inspection of a normal probability plot.

The model summary results indicated that hours of TMH training and TMH continuing education accounted for 2.9% of the variation in CSE with adjusted $\boldsymbol{R}^2$ = 1.8%, which is a small size effect according to Cohen (1988). This indicates that 97.1% of the variation cannot be explained by hours of TMH training and TMH continuing education alone and that hours of TMH training and TMH continuing education did not statistically significantly predict CSE, therefore I rejected the alternative hypothesis and retained the null hypothesis $F(1, 83) = 2.5$, $\boldsymbol{p} = .117$. (See Table 11).

I also conducted a Pearson product-moment correlation to assess the strength and direction of the relationship between hours of TMH training and TMH continuing education and CSE. Preliminary analyses showed that normality was violated as two of the six *p*-values were statistically significant, as assessed by the Shapiro-Wilk test ($\boldsymbol{p} > .05$), and there was one outlier. I ran a data analysis with and without the outlier and observed no appreciable difference in the results, therefore, I opted to keep the outlier in my report. The hours of TMH training and TMH continuing education received by counselors was not shown to statistically significantly predict CSE, $\boldsymbol{r}(83) = .171$, $\boldsymbol{p} = .117$ (See Table 12).

Table 10. *Model Summary COSE: Hours of TMH Training and COSE Overall*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.171[a]	.029	.018	.19157	1.994

a. Predictors: (Constant), Approximate hours of telemental health training or telemental health continuing education received:
b. Dependent Variable: *COSE* Overall

Table 11. *Hours of TMH Training or Continuing Education Bivariate Regression*

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.092	1	.092	2.502	.117
	Residual	3.046	83	.037		
	Total	3.138	84			

a. Dependent Variable: *COSE* Overall

b. Predictors: (Constant), Approximate hours of telemental health training or telemental health continuing education received:

Table 12. *Pearson Product Correlation: Hours of TMH training and COSE Overall*

		COSE Total	Hours TMH Training
COSE Overall	Pearson Correlation	1	.171
	Sig. (2-tailed)		.117
	Sum of Squares and Cross-products	3.138	5.881
	Covariance	.037	.070
	N	85	85
Hours TMH Training	Pearson Correlation	.171	1
	Sig. (2-tailed)	.117	
	Sum of Squares and Cross-products	5.881	376.588
	Covariance	.070	4.483
	N	85	85

In addition to a bivariate regression model, I used a one-way ANOVA to expand upon RQ 1 and measure if CSE while providing TMH services increased with the hours of TMH training or TMH continuing education received. A one-way ANOVA statistical model was selected to investigate this research question as the independent variable consisted of six subgroups of time ranges. I took the appropriate steps to ensure that the necessary assumptions for a one-way ANOVA statistical model were met. Assumptions for a one-way ANOVA consist of having a continuous dependent variable, a categorical independent variable with at least two or more independent groups, and independence of

observations. Once I verified that these assumptions were met, I moved forward with determining if other required assumptions were met.

Absence of outliers in the groups of independent variables in terms of the dependent variable is another assumption of a one-way ANOVA. To determine whether there were outliers in the data being measured, I created and inspected a boxplot of each group within the variable. Upon inspecting the boxplots, I observed that there was one outlier in the data. Outliers are commonly present in social science research, and since this instance was isolated and appeared to be a genuinely unusual data point, I chose to keep the outlier in the data analysis (Frankfort-Nachmias & Leon-Guerrero, 2018). Continuing my test of assumptions, I moved forward to determine if my data for this research question achieved normal distribution. I utilized the Shapiro-Wilk test of normality which was violated as two of the six *p*-values were statistically significant ($p < .05$). I elected to review skewness and kurtosis along with Q-Q plots to ascertain the normal distribution of data and chose to continue moving forward. There was homogeneity of variances, as assessed by Levene's test for equality of variances (***p*** = .473), therefore, I used a one-way ANOVA to complete my data analysis.

I ran a one-way ANOVA to ascertain if CSE while providing TMH services increases with the hours of TMH training or TMH continuing education received. I reviewed the means and standard deviations for each subgroup (See Table 13). The CSE when providing TMH services was statistically significantly different for the number of hours of TMH training or TMH continuing education received, $F(5,79) = 2.92$, $p = .018$

(See Table 14). Since the results from my one-way ANOVA were statistically significant, I conducted a Tukey post hoc test to determine where the differences were located (See Table 15). There was an increase in CSE scores from the participants who reported having less than 1 hour of TMH training or TMH continuing education (*M* = 3.**7**, *SD* = .2) to the participants who reported having over 8 hours of TMH training or TMH continuing education (*M* = 3.**9**, *SD* = .16) which was statistically significant (.**2**, 95% CI [.0023, .3929], *p* = .046). Additionally, there was an increase in CSE scores from the participants who reported having 5 to 6 hours of TMH training or TMH continuing education (*M* = 3.**7**, *SD* = .**3**) to the participants who reported having over 8 hours of TMH training or TMH continuing education (*M* = 3.**9**, *SD* = .**2**) which was statistically significant (.2, 95% CI [.0004, .4371], *p* = .049). No other statistically significant differences were observed among subgroups.

Table 13. *Hours of TMH Training or TMH Continuing Education and COSE Descriptive Statistics*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean Lower Bound	95% Confidence Interval for Mean Upper Bound	Minimum	Maximum
Less than 1	15	3.6763	.19935	.05147	3.5659	3.7867	3.10	3.94
1 to 2 hours	24	3.8184	.16285	.03324	3.7496	3.8871	3.51	4.17
3 to 4 hours	18	3.7555	.16155	.03808	3.6752	3.8359	3.47	4.02

5 to 6 hours	10	3.6551	.25607	.08098	3.4719	3.8383	3.22	4.04
7 to 8 hours	3	3.8031	.22553	.13021	3.2429	4.3634	3.65	4.06
Over 8 hours	15	3.8738	.15748	.04066	3.7866	3.9611	3.69	4.17
Total	85	3.7700	.19327	.02096	3.7283	3.8117	3.10	4.17

Table 14. *Hours of TMH Training or TMH Continuing Education and COSE one-way ANOVA*

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.489	5	.098	2.915	.018
Within Groups	2.649	79	.034		
Total	3.138	84			

Table 15. *Tukey Multiple Comparisons Post Hoc Tests: Hours of TMH training*

(I) Approximate hours of telemental health training or telemental health continuing education received:	(J) Approximate hours of telemental health training or telemental health continuing education received:	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Over 8 hours	Less than 1	.19757*	.06687	.046	.0023	.3929

	1 to 2 hours	.05548	.06027	.940	-.1206	.2315
	3 to 4 hours	.11831	.06402	.442	-.0687	.3053
	5 to 6 hours	.21875*	.07476	.049	.0004	.4371
	7 to 8 hours	.07070	.11581	.990	-.2676	.4090

*. The mean difference is significant at the 0.05 level.

Research Question 2

The second RQ examined whether the length of time providing TMH services (IV) predicts the CSE (as measured by the *COSE*; DV) when treating clients via TMH during the COVID-19 pandemic. Before running a bivariate linear regression model in SPSS, I took the necessary steps to determine if the assumptions were met. First, I used dummy coding to transform the IV from a categorical variable to a continuous variable to satisfy the assumption that both variables being studied were continuous. I then created a scatterplot to observe if a linear relationship between the IV and the DV existed, and the results from this appeared to indicate a linear relationship. I then tested for independence of residuals, and it appeared that this assumption was confirmed as evidenced by a Durbin-Watson statistic of 1.646 (See Table 16). I then checked for homoscedasticity, and this appeared to be confirmed as assessed by visual inspection of a plot of standardized residuals versus standardized predicted values. Residuals were then determined to be normally distributed as assessed by visual inspection of a normal probability plot.

The model summary results indicated that the length of time providing TMH services accounted for 6.1% of the variation in CSE with adjusted $\boldsymbol{R}^2 = 5.0\%$, which is a very small size effect according to Cohen (1988). This indicated that the length of time

providing TMH services statistically significantly predicted CSE, therefore, I can reject the null hypothesis and accept the alternative hypothesis, $F(1, 83) = 5.38$, $\boldsymbol{p} = .023$. (See Table 17).

I also conducted a Pearson product-moment correlation to assess the strength and direction of the relationship between the length of time providing TMH services and CSE. Preliminary analyses showed that normality was violated as one of the three *p*-values were statistically significant, as assessed by the Shapiro-Wilk test ($\boldsymbol{p} > .05$), and there were four outliers. I ran a data analysis with and without the outliers and observed no appreciable difference in the results, therefore I opted to keep the outliers in my report. There was a statistically significant, small positive correlation between the length of time providing TMH services and CSE, $\boldsymbol{r}(83) = .25$, $\boldsymbol{p} < .05$, with length of time providing TMH services explaining 6% of the variation in CSE (See Table 18).

Table 16. *Model Summary COSE: Time Spent Providing TMH Services and COSE Overall*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.247[a]	.061	.050	.18842	1.646

a. Predictors: (Constant), Time (in years) spent providing TMH services
b. Dependent Variable: *COSE* Overall

Table 17. *ANOVA: Time Spent Providing TMH Services and COSE Overall*

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.191	1	.191	5.384	.023

	Residual	2.947	83	.036		
	Total	3.138	84			

a. Dependent Variable: *COSE* Overall

Table 18. *Pearson Product Correlation: Time Spent Providing TMH Services and COSE Overall*

		COSE Overall	Time spent providing TMH services
COSE Overall	Pearson Correlation	1	.247*
	Sig. (2-tailed)		.023
	Sum of Squares and Cross-products	3.138	3.090
	Covariance	.037	.037
	N	85	85
Time spent providing TMH services	Pearson Correlation	.247*	1
	Sig. (2-tailed)	.023	
	Sum of Squares and Cross-products	3.090	49.953
	Covariance	.037	.595
	N	85	85

*. Correlation is significant at the 0.05 level (2-tailed).
b. Predictors: (Constant), Time (in years) spent providing TMH services

I then ran a one-way ANOVA to determine if CSE when treating clients via TMH increased with experience providing TMH services. I took the appropriate steps to ensure that the necessary assumptions for a one-way ANOVA statistical model were met.

Participants were classified into five groups: 1 to 2 years (*n* = 43), 3 to 4 years (*n* = 34), 5 to 6 years (*n* = 6), 7 to 8 years (*n* = 1), and Over 9 years (*n* = 1) (See Table 19). Only three of the five groups within the IV were included in the data analysis, as two of the groups were automatically omitted due to their limited number of cases (*n* =1). Upon inspecting the boxplots, I observed that there were four outliers in the data. I chose to keep the outliers and compare the result of the one-way ANOVA with and without the outliers. Moving forward with keeping the outliers, I conducted the Shapiro-Wilk test of normality which was violated as one of the three *p*-values were statistically significant ($p < .05$). I elected to review skewness and kurtosis along with Q-Q plots to ascertain the normal distribution of data and chose to continue moving forward. There was homogeneity of variances, as assessed by Levene's test for equality of variances (***p*** = .878), therefore, I used a one-way ANOVA to complete my data analysis. Data are presented as mean ± standard deviation. *COSE* score increased from 1 to 2 years (3.7 ± .2), to 3 to 4 years (3.8 ± .2), to 5 to 6 years (3.8 ± .2) of experience providing TMH services, in that order, but the differences between groups was not statistically significant, $F(4, 80) = 1.4\mathbf{2}$, $p = .237$ (See Table 20).

Table 19. *Time (in years) Providing TMH Services and COSE Descriptive Statistics*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean Lower Bound	95% Confidence Interval for Mean Upper Bound	Minimum	Maximum
1 to 2 years	43	3.7308	.19826	.03023	3.6698	3.7919	3.10	4.17

3 to 4 years	34	3.7991	.18099	.03104	3.7360	3.8623	3.33	4.17
5 to 6 years	6	3.8129	.19930	.08136	3.6038	4.0221	3.51	4.00
7 to 8 years	1	3.9375	.	.	.	.	3.94	3.94
Over 9 years	1	4.0408	.	.	.	.	4.04	4.04
Total	85	3.7700	.19327	.02096	3.7283	3.8117	3.10	4.17

Table 20. *Time (in years) Providing TMH Services and COSE one-way ANOVA*

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.207	4	.052	1.415	.237
Within Groups	2.931	80	.037		
Total	3.138	84			

After removing the outliers, I then conducted another Shapiro-Wilk test of normality which revealed that the variables were normally distributed ($p > .05$). There was homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .076$), therefore, I used a one-way ANOVA to complete my data analysis. Data were presented as mean ± standard deviation. *COSE* score increased from 1 to 2 years (3.7 ± 0.13), to 3 to 4 years (3.8 ± .18), to 5 to 6 years (3.8 ± .2) of experience providing TMH services, in that order, but the differences between groups was not statistically significant, $F(4, 76) = 1. 75$, $p = .149$.

Research Question 3

The third RQ examined whether the length of time spent providing counseling services (IV) predicts CSE (as measured by the *COSE*; DV) when treating clients via TMH during the COVID-19 pandemic. Before running a bivariate linear regression model in SPSS, I took the necessary steps to determine if the assumptions were met. First, I used dummy codes to transform the IV from a categorical variable to a continuous variable to satisfy the assumption that both variables being studied were continuous. I then created a scatterplot to observe if a linear relationship between the IV and the DV existed, and the results from this appeared to indicate a linear relationship. I then tested for independence of residuals, and it appeared that this assumption was confirmed, as evidenced by a Durbin-Watson statistic of 1.64 (See Table 21). I then checked for homoscedasticity, and this appeared to be confirmed as assessed by visual inspection of a plot of standardized residuals versus standardized predicted values. Residuals were then determined to be normally distributed as assessed by visual inspection of a normal probability plot.

The model summary results indicated that the length of time spent providing counseling services accounted for 5.7% of the variation in CSE with adjusted R2 = 4.6%, which is a small size effect according to Cohen (1988). This indicated that the length of time spent providing counseling services statistically significantly predicted CSE, therefore, I can reject the null hypothesis and accept the alternative hypothesis, $F(1, 83) = 5.02$, $p = .028$. (See Table 22).

I also conducted a Pearson product-moment correlation to assess the strength and direction of the relationship between the length of time spent providing counseling services and CSE. Preliminary analyses showed that normality was violated as one of the five *p*-values were statistically significant, as assessed by the Shapiro-Wilk test (***p*** > .05), and there was one outlier. I ran a data analysis with and without the outlier and observed no appreciable difference in the results, therefore I opted to keep the outlier in my report. There was a statistically significant, small positive correlation between the length of time spent providing counseling services and CSE, ***r***(83) = .24, ***p*** = .028, with length of time providing counseling services explaining 6% of the variation in CSE (See Table 23).

Table 21. *Model Summary COSE: Time Spent Providing Counseling Services and COSE Overall*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.239[a]	.057	.046	.18881	1.641

a. Predictors: (Constant), Time (in years) spent providing counseling services
b. Dependent Variable: *COSE* Overall

Table 22. *Time (in years) Spent Providing Counseling Services and COSE Linear Regression*

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	.179	1	.179	5.023	.028

	Residual	2.959	83	.036		
	Total	3.138	84			

a. Dependent Variable: *COSE* Overall

b. Predictors: (Constant), Time (in years) spent providing counseling services

Table 23. *Pearson Product Correlation: Time Spent Providing Counseling Services and COSE Overall*

		COSE Overall	Time spent providing counseling services
COSE Overall	Pearson Correlation	1	.239*
	Sig. (2-tailed)		.028
	Sum of Squares and Cross-products	3.138	5.628
	Covariance	.037	.067
	N	85	85
Time spent providing counseling services	Pearson Correlation	.239*	1
	Sig. (2-tailed)	.028	
	Sum of Squares and Cross-products	5.628	176.894
	Covariance	.067	2.106
	N	85	85

*. Correlation is significant at the 0.05 level (2-tailed).

I ran a one-way ANOVA to determine if CSE when treating clients via TMH increased with experience providing counseling services. I took the appropriate steps to ensure that the necessary assumptions for a one-way ANOVA statistical model were met. Assumptions for a one-way ANOVA consist of having a continuous dependent variable, a categorical independent variable with at least two or more independent groups, and independence of observations. Once I verified that these assumptions were met, I moved forward with determining if other required assumptions were met.

Participants were classified into five groups: 2 to 3 years (n = 11), 4 to 5 years (n = 10), 6 to 7 years (n = 19), 8 to 9 years (n = 10) and Over 10 years (n = 35) (See Table 24). Upon inspecting the boxplots, I observed that there was one outlier in the data, which I chose to keep in my data analysis. I conducted the Shapiro-Wilk test of normality which was violated as one of the five p-values were statistically significant ($p < .05$). I elected to review skewness and kurtosis along with Q-Q plots to ascertain the normal distribution of data and chose to continue moving forward. There was homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .220$), therefore, I used a one-way ANOVA to complete my data analysis. Data are presented as mean ± standard deviation. *COSE* score increased from 2 to 3 years (3.6 ± 0.2), to 4 to 5 years (3.7 ± .25), to 6 to 7 years (3.8 ± .12), to 8 to 9 years (3.9 ± 0.22) of experience providing counseling services, in that order, and the differences between groups were shown to be statistically significant, $F(4, 80) = 3.01$, $p = .023$ (See Table 25).

Since the results from my one-way ANOVA were statistically significant, I conducted a Tukey post hoc test to determine where the differences were located. In conflict with the results from the one-way ANOVA, the Tukey post hoc test did not show any statistically significant differences among subgroups. Differences in distributions between the one-way ANOVA and the Tukey post hoc test can result in a one-way ANOVA that renders statistically significant findings and a Tukey post hoc test that does not, and this is not an uncommon occurrence (Laerd, 2015). The conservative nature of the Tukey post hoc test may have contributed to the discrepancy in finding, as well as the differences in distributions used in the one-way ANOVA and the Tukey post hoc test (Hsu, 2016; Laerd, 2015).

Table 24. *Time (in years) Spent Providing Counseling Services and COSE Descriptive Statistics*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
2 to 3 years	11	3.6391	.19628	.05918	3.5073	3.7710	3.22	3.94
4 to 5 years	10	3.6754	.25225	.07977	3.4950	3.8559	3.10	4.06
6 to 7 years	19	3.8271	.12289	.02819	3.7679	3.8864	3.59	4.04
8 to 9 years	10	3.8500	.21610	.06834	3.6954	4.0046	3.63	4.17
Over 10 years	35	3.7844	.17795	.03008	3.7232	3.8455	3.33	4.17
Total	85	3.7700	.19327	.02096	3.7283	3.8117	3.10	4.17

Table 25. *Time (in years) Spent Providing Counseling Services and COSE One-Way ANOVA*

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.411	4	.103	3.016	.023
Within Groups	2.727	80	.034		
Total	3.138	84			

Summary

In this chapter, I outlined the statistical analysis used for each research question and provided interpretation of those results. Three research questions were examined in this study, and two returned results that partially supported the hypothesis and one retained the null hypothesis. To summarize, Research Question 1: How does TMH training and continuing education predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH during the COVID-19 pandemic? The results indicated that TMH training and continuing education did not statistically significantly predict CSE. However, results did show an effect for TMH training and continuing education on CSE in some subgroups of hours, though these

differences were not statistically significant. Overall, the alternative hypothesis for Research Question 1 was not supported.

Research Question 2: When controlling for other predictors, does prior experience providing TMH services predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH? The results indicated that prior experience providing TMH slightly predicted CSE and were statistically significant. There was also a statistically significant effect found for experience providing TMH services on CSE in some subgroups of years. Overall, the alternative hypothesis for Research Question 2 was mildly supported.

Research Question 3: When controlling for other predictors, does prior experience as a practitioner predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH? The results indicated that prior experience providing counseling services slightly predicted CSE and were statistically significant. There was also a statistically significant effect found for experience providing TMH services on CSE in some subgroups of years. Overall, the alternative hypothesis for Research Question 3 was mildly supported.

In Chapter 5, I interpret the findings, discuss the limitations of the study, and outline recommendations for future research. Furthermore, I report the implications for positive social change due to this study. Lastly, I provide recommendations for professional practice based upon my research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to identify and explore the level of self-efficacy held by counselors when treating clients via TMH during the COVID-19 pandemic. This study also aimed to determine if there is an observable difference in the self-efficacy of counselors providing TMH services who have completed TMH training or continuing education courses and counselors providing TMH services who have not. This study consisted of three IVs, which were hours of TMH training or TMH continuing education received, time providing TMH services, and time providing counseling services. This study had one identified DV, which was CSE as measured by the *COSE*. The *COSE* is an assessment that was developed by Larson et al. (1992) and consists of 37 items which are used to examine five factors: Micro-skills, Process, Difficult Client Behaviors, Cultural Competence, and Awareness of Values.

Based upon the data analysis conducted for the three RQs examined in this study, I concluded that the null hypothesis should be rejected for RQ2 and RQ3 as the data analysis for these questions provided statistically significant results. The results showed there was a statistically significant, small positive correlation between the length of time providing TMH services and CSE. Although *COSE* scores were shown to increase with length of time providing TMH services, results did not indicate the difference between groups was significant. The results showed there was a statistically significant, small positive correlation between the length of time spent providing counseling services and

CSE. *COSE* scores were shown to increase with length of time providing counseling services, and results did indicate the difference between groups was significant.

Results indicated the length of time providing TMH services was not shown to statistically significantly predict CSE; therefore, the null hypothesis for RQ 1 could not be rejected. Nonetheless, statistically significant differences between groups were observed when examining the length of time providing TMH services and CSE. In the following sections, I provide a more extensive interpretation of findings discuss the limitations of the study, provide recommendations, and consider the implications of the findings. Then, I provide a conclusion to the study with my final thoughts.

Interpretation of the Findings

There were 85 counselors who participated in this study by completing a demographic questionnaire and the *COSE*. In total there were 98 respondents, and 13 of these did not fully complete the survey; therefore, they were not included in my final analysis. All participants indicated that they met the criteria for the study as outlined in Chapter 3.

Research Question 1

RQ1: How does TMH training and continuing education predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH during the COVID-19 pandemic?

I chose to focus this study on CSE based upon the growing body of research that suggests that CSE has a significant impact on counselor competence, burnout, resilience,

and treatment outcomes (Bakioglu & Turkum, 2020; Goreczny et al., 2015; Jaafar et al., 2009; Kozina et al., 2010, Lent et al., 2009; Mattews et al., 2018; Mullen et al., 2015). Although there is research surrounding how formal education has been shown to increase CSE (Merrick et al., 2016; Oordt et al., 2009), I noticed there is a lack of research regarding how continuing education courses impacts CSE. Furthermore, how TMH continuing education courses impacts CSE when providing TMH services had yet to be explored prior to this study.

I hypothesized that as TMH training and continuing education hours increased, the level of CSE when providing TMH services would also increase. After completing data analysis for RQ1, I observed there was not a statistically significant positive correlation between the amount of TMH continuing education and training received and CSE. Further data analyses revealed, however, there was a statistically significant difference between subgroups.

The average score on the *COSE* was shown to be higher among participants who reported having over 8 hours of TMH training or TMH continuing education than participants who reported having less than 1 hour and participants who reported having 5 to 6 hours of TMH training or TMH continuing education. These results prompted me to identify research or literature which might explain why CSE would increase as participants reported having more TMH training or TMH continuing education only to significantly decrease for those who reported 5 to 6 hours of TMH training or continuing education. One theory that could explain this observed phenomenon is that participants

were either overconfident in their skills, abilities, and competencies and this impacted how they responded to items in the *COSE* (Ehrlinger et al, 2016).

Ehrlinger et al. (2016) conducted studies that examined the relationship between theories of intelligence and overconfidence, and the differences in how people allocate attention to different aspects of a task and how this impacts overconfidence. Participants who had an entity (fixed) theory of intelligence appeared to display significantly more overconfidence than participants that had a more incremental (malleable) theory of intelligence (Ehrlinger et al., 2016). Also, participants that held an entity theory of intelligence allocated less attention to difficult problems than participants that held an incremental theory of intelligence (Ehrlinger et al., 2016). Lastly, overconfidence was shown to decrease in participants who held an entity theory of intelligence whenever their attention was directed to focusing on difficult aspects of a task (Ehrlinger et al., 2016). Based on the results from these studies, it appears overconfidence is significantly impacted by how they view intelligence and that those that believe intelligence is fixed pay less attention to difficult problems or tasks and display more overconfidence than those who believe intelligence is malleable (Ehrlinger et al., 2016).

The results from Ehrlinger et al.'s (2016) studies provide insight into a possible explanation for the responses gathered for RQ1. It could be hypothesized that having 4 hours or less of TMH training or continuing education was not enough time for counselors to direct their attention on challenges that could arise when providing TMH services. This lack of attention to difficult issues that could arise in TMH practice then

led counselors with a more entity theory of intelligence to be overconfident in their skills, abilities, and competencies related to providing TMH services. It could then be asserted that the counselors that reported 5 to 6 hours of TMH training and continuing education, had enough training to recognize the difficulties and limitations they could face providing TMH services, and that this is what then reduced their overconfidence and led to lower scores on the *COSE*.

Another theory which may provide an explanation for the unanticipated results of this research question, is that counselor burnout influenced participants' responses to items on the *COSE*. Studies on burnout, and specifically counselor burnout, have revealed that factors such as stress, compassion fatigue, and vicarious trauma contribute an increase in burnout (Szilagyi, 2021). Maslach and Leiter (1997) discussed burnout occurring on a continuum and asserted that efficacy vs. ineffectiveness was one of three ways that people can either be fully engaged or burned out. With this concept in mind, it could be hypothesized that the CSE of participants who reported having 5 to 6 hours of TMH training or continuing education was impacted by a heightened sense of ineffectiveness as a counselor. The origin of this sense of ineffectiveness as a counselor could have been brought on by their awareness of challenges and difficulties faced when providing TMH services, along with other factors that contribute to counselor burnout.

Research Question 2

RQ2: When controlling for other predictors, does prior experience providing TMH services predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

In my research on self-efficacy and the implications that CSE has for counselors and their performance, I became familiar with the four ways to cultivate self-efficacy as outlined by Bandura (1997b). One way to cultivate self-efficacy is by experiencing success or mastery in overcoming obstacles (Bandura, 1997b). With the rapid onset of the COVID-19 pandemic, counselors were forced into providing TMH services, and many counselors had limited or no prior experience providing TMH services at that time (Aafjes-van Doorn, 2021). Lack of experience providing TMH services would seemingly indicate a limited opportunity for experiencing success or mastery in overcoming obstacles while conducting TMH services.

I hypothesized that as the amount of time providing TMH services increased, the level of CSE when providing TMH services would also increase. The data analysis I performed for RQ2 indicated that there was a statistically significant positive correlation between the amount of time providing TMH services and the level of CSE when providing TMH services, leading me to reject the null hypothesis and accept the alternative hypothesis. Furthermore, I observed that *COSE* scores increased from participants who reported 1 to 2 years of experience providing TMH services, to 3 to 4 years of experience providing TMH services, to 5 to 6 years of experience providing

TMH services, in that order. Although differences between groups did not appear to be statistically significant, it is worth mentioning a positive linear relationship was observed.

Research Question 3

RQ3: When controlling for other predictors, does prior experience as a practitioner predict the level of self-efficacy (as measured by the *COSE*) held by counselors when treating clients via TMH?

Although providing TMH services comes with challenges that face-to-face counseling services does not, the foundational knowledge needed to be an effective counselor remains constant regardless of therapeutic setting. The available research indicates that education and mastery experiences positively impact self-efficacy, therefore it stands to reason that counselors who have spent more time providing counseling services would have more opportunities to cultivate knowledge, have many experiences of success and mastery, and overcome obstacles in the counseling setting, which would then lead to their development of a strong CSE (Bandura, 1997b; Bakioglu & Turkum, 2020; Kozina et al., 2010; Larsen & Daniels, 1998).

I hypothesized that as experience providing counseling services increased, the level of CSE held by counselors when providing TMH services would also increase. The results from the data analysis I performed for RQ3 indicated that there was a statistically significant positive correlation between experience providing counseling services and CSE when providing TMH services. This led me to reject the null hypothesis and accept the alternative hypothesis. In addition to this finding, I observed that *COSE* score

increased from 2 to 3 years of experience providing counseling services, to 6 to 7 years of experience providing counseling services to 8 to 9 years of experience providing counseling services, in that order, and the differences between groups were shown to be statistically significant.

Limitations

As I was preparing to conduct this study, I was aware of various limitations that could occur. I first considered the potential for social desirability bias due to the nature of the topic being studied (Larson & Bradshaw, 2017). I asked participants to divulge information about themselves professionally that could require some vulnerability and a higher level of self-awareness, such as, information related to their cultural competency and dealing with difficult client behaviors. To increase the likelihood for truthful responses and decrease the chances of response bias, I ensured that participants were made aware of the anonymity of their responses more than once. In addition to informing participants about the confidential nature of this study in each call for participants, I also included this information in the consent form they read prior to participating in this study. During the data cleaning process and data analysis, I was able to observe any outliers and perform a visual inspection of data normality and central tendency, all of which indicated that response bias did not occur.

Another limitation that I considered was the use of convenience sampling in this study. Although participants were self-selected and were not given any incentives to participate in this study, they were solicited through various networks that I had access to

and, therefore, not randomly selected. Due to this limitation, most participants reported having over 10 years of experience providing counseling services, with other identified groups of participants with less experience displaying a more even distribution of the remaining sample. Despite the concern over this limitation, I observed that the demographic information gathered from participants, such as age, gender, ethnicity, and race, are generalizable to the population of mental health counselors (U.S. Census Bureau, 2019). Additionally, the larger sample size for this study helped to increase the generalizability and probability of the results, which would have been more difficult to achieve with a smaller sample size produced using random sampling methods. Based upon this information, I have confidence my sample fairly reflects the representative population of mental health counselors.

Despite my efforts to recruit participants using several different methods, I observed recruitment was a potential limitation for this study. Due to the anonymity of study participants, I am unable to confirm where many responses for this study came from; however, I did notice during the data collection process that I received a large increase in responses each time I posted on CESNET-L. It can be assumed that participants recruited via CESNET-L may have a higher average of years providing counseling services than the general mental health counselor population based upon their self-identification as being a counselor educator or supervisor. Data collected from participants regarding time providing counseling services seemed to support this assumption, as 41% of participants reported having 10 or more years of counseling

experience. Nonetheless, I was able to receive enough responses from participants who reported having spent less time providing counseling services that I believe my sample was an appropriate reflection of the overall mental health counselor population. Moreover, when reporting time spent providing TMH services, participant responses indicated that most of them had less than 4 years of experience. This appeared to confirm that regardless of how much previous experience participants had providing counseling services, most had limited experience providing TMH services when the COVID-19 pandemic began.

An unexpected limitation for this study was participants not completing the survey due to an accidental omission of four items on the *COSE*. The *COSE* consists of 37 items which are used to assess counselor self-efficacy. The questions examine five factors: Micro-skills (12 items), Process (10 items), Difficult Client Behaviors (7 items), Cultural Competence (4 items), and Awareness of Values (4 items). Of the questions that were omitted, one of the questions was included the Micro-skills subscale, two of the questions were included in the Cultural Competence subscale, and one of the questions was included in the Awareness of values subscales. The Counseling Process and Dealing with Difficult Client Behaviors subscales were not impacted. Despite the omission of four items, respondents were able to complete 89% of the *COSE* in total. Since the focus of this study was on CSE as measured by the total *COSE* score and research efforts were not focused on exploring the specific subscales of the *COSE*, I do not believe that this

limitation was significant. Furthermore, each subscale in the *COSE* was represented in this study making this limitation moot.

Recommendations

The primary takeaway from this study is that both time providing TMH services and time providing counseling services were shown to predict CSE (as measured by the *COSE*). As the amount of time providing TMH services or the amount of time providing counseling services increased, CSE was also shown to increase among participants. An interesting takeaway from this study is that although hours of TMH training and continuing education received was not shown to be predictive of CSE, statistically significant differences were observed among subgroups. Results showed that participants who reported having over 8 hours of TMH training had a significantly higher *COSE* score when compared to participants who reported having less than 1 hour of TMH training and continuing education and participants who reported having 5 to 6 hours of TMH training and continuing education.

With the results from this study in mind, counselor training programs could better support counseling students by providing students with more education about TMH services along with more opportunities for students to practice providing TMH services. Currently CACREP standards do not require universities to provide counseling students with TMH training or education, which means that many counseling students enter their counseling practice at a disadvantage (CACREP; 2016). With the need and demand for TMH services holding study, it is imperative that students are appropriately trained to

provide these types of services. One way that counseling programs could support students in develop CSE when providing TMH services is by identifying ways that TMH can be incorporated into practicum and internship experiences.

Since this study was the first of its kind in that it examined CSE as it specifically relates to the provision of TMH services, I believe that there are several meaningful ways that this research could be expanded upon. For example, an experimental study where participants were given a pre-test and a post-test measuring CSE before and after receiving TMH training would provide greater insight into the impact that TMH training has upon CSE. Future research might also consider a qualitative research design in which counselors are interviewed about their experiences providing TMH services and the tools, resources, and strategies that have helped them to develop CSE when providing TMH services. This information could then be utilized in developing and expanding upon the TMH education and resources provided to both counseling students and practicing counselors.

Other studies related to TMH, CSE, and overconfidence could provide significant information and insight into counselor training and education. For instance, a mixed methods study using a larger sample size which explores the relationship between CSE and overconfidence, and then also examines how overconfidence impacts CSE when providing TMH services. Identifying and understanding the different factors which contribute to overconfidence when providing TMH services would allow counselor

educators to develop training resources which work to manage these influences appropriately.

Finally, additional studies surrounding counselor burnout, CSE, and TMH could give additional insight into the issues contributing to counselor burnout and how this relates to CSE and TMH. One proposed explanation for the unexpected results from RQ1 is that a factor, such as, counselor burnout influenced participant responses. Due to the numerous challenges encountered by counselors following the onset of the COVID-19 pandemic, which included the increase in provision of TMH services, more research surrounding how factors like burnout have impacted counselors both personally and in their practice is necessary to providing sufficient support and resources. Furthermore, more research surrounding how counselor burnout has impacted the counseling field is needed to understand what resources and support is needed to recruit and retain counselors.

Implications

Counselors have faced unique challenges since the onset of the COVID-19 pandemic, and, as such, have had to adjust their provision of counseling services to better meet the needs of their clients and community. Although TMH has been utilized for several years, many counselors did not provide TMH services until they were put in a position where they had no alternative option. Of the participants in this study, over 90% reported having less than 4 years of experience providing TMH services, which supports previous research surrounding the major uptake in TMH services following the onset of

the COVID-19 pandemic (Li et al., 2021). Now that the usage of TMH has become a commonplace practice, it is imperative that more research is done to determine how best to support counselors in developing self-efficacy and competence when providing services virtually.

Findings from this study can contribute to social change and help counselors and counselor educators to develop programs and disseminate resources that will help counselors build their self-efficacy and competence in providing TMH services. The purpose of this study was to determine how TMH training and continuing education predicts CSE when counselors are providing TMH services, and although a predictive relationship could not be observed, the difference between groups did prove to be significant and meaningful. CSE was shown to increase with the amount of TMH training or continuing education, except for the group of respondents who reported having 5 to 6 hours of TMH training or continuing education. The respondents who reported having 5 to 6 hours of TMH training or continuing education reported a lower average of CSE than the group of respondents who reported having less than 1 hour of TMH training or continuing education. More research is needed to explore this phenomenon and to determine what resources or information may be needed to support counselors who are overconfident in their ability to provide ethical and effective TMH services.

Results from this study could also contribute to positive social change by eliciting insight into how experience providing TMH services is an essential component to helping counselors develop self-efficacy and how counselor education programs can help

students develop self-efficacy when providing TMH services prior to graduation. Results from this study showed that as the number of hours providing TMH services increased, so did the level of CSE reported by respondents. Research which could help us better understand what areas of mastery or competency contribute to an increase in CSE when providing TMH services would allow us to develop curriculum that is specifically aimed at providing the education, resources, and support needed for counselors to develop in those areas.

Conclusions

The COVID-19 pandemic has had a significant impact on mental health at the personal, professional, and institutional level. Counselors have been experiencing higher levels of stress and burnout due to the increase in demand for mental health services, the increased intensity of mental health concerns reported by clients, various changes, and challenges in providing counseling services, and personal struggles with navigating a world that has been permanently altered by a global pandemic (Aafjes-van Doorn, 2021; La Roche, 2020). Recruiting and retaining counselors in the mental health field should be of utmost priority, and more research efforts are needed to identify ways to provide the necessary support and resources that counselors.

This study sought to explore a topic that is essential to understanding how counselors are experiencing one of the big shifts in counseling practice following the onset of COVID-19, which is the widespread increase in providing TMH services. The results of this study demonstrated that TMH training and continuing education does

influence different groups of counselors, and that there may be factors which are leading to under confidence or overconfidence in how some counselors view their skills, abilities, and competencies in providing TMH services. More research is needed to understand what aspects of TMH training and continuing education are influencing the development of CSE. Additionally, due to the unexpected differences observed between groups of counselors, more research is needed regarding how personal and professional characteristics of counselors may influence their report of CSE when providing TMH services.

The results of this study showed that both the amount of time providing TMH services and the amount of time providing counseling services slightly predicted CSE. Counselors with the most TMH training and continuing education (more than eight hours) reported the highest average CSE scores. Also, counselors with the most counseling experience (more than 10 years) reported the highest average CSE scores. Although these results were anticipated, more research is needed to explore how CSE is developed and what resources and support counseling students and counselors need to increase their CSE in all therapeutic settings. Furthermore, more knowledge and understanding surrounding how to develop CSE when providing TMH services will allow counselor educators to develop the appropriate training and resources to support counselors as they work tirelessly to help people and communities that might not be reached without the availability of TMH services.

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Appendix: Demographic Questionnaire

1. What is your current age (in years)? _____
2. Please select one or more of the following categories that best describe your race or ethnicity:

   ☐ American Indian or Alaska Native

   ☐ Black or African American

   ☐ Native Hawaiian or other Pacific Islander

   ☐ White or Caucasian

   ☐ Hispanic or Latino

   ☐ Asian or Asian American

3. Gender: How do you identify?

   ☐ Male

   ☐ Female

   ☐ Transgender

   ☐ Gender Non-Conforming

   Self-Identify: _____

4. What is your sexual orientation?

   ☐ Asexual

   ☐ Bisexual

   ☐ Gay

   ☐ Heterosexual or straight

- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ None of the above, please specify: _____

5. Approximate hours of telemental health training or telemental health continuing education received:
   - ☐ Less than 1
   - ☐ 1 to 2 hours
   - ☐ 3 to 4 hours
   - ☐ 5 to 6 hours
   - ☐ 7 to 8 hours
   - ☐ Over 8 hours
6. Approximate period of time that you have been providing telemental health services:
   - ☐ 1 to 2 years
   - ☐ 3 to 4 years
   - ☐ 5 to 6 years
   - ☐ 7 to 8 years
   - ☐ Over 9 years
7. Approximate period of time that you have been providing counseling services:
   - ☐ 2 to 3 years

- ☐ 4 to 5 years
- ☐ 6 to 7 years
- ☐ 8 to 9 years
- ☐ Over 10 years

8. Which of the following groups do you providing counseling services to? (Select all that apply)
   - ☐ 0-5 years old
   - ☐ 6-12 years old
   - ☐ 13-17 years old
   - ☐ 18-24 years old
   - ☐ 25-34 years old
   - ☐ 35-44 years old
   - ☐ 45+
9. Which age group makes up the majority of the clients you provide counseling services to?
   - ☐ 0-5 years old
   - ☐ 6-12 years old
   - ☐ 13-17 years old
   - ☐ 18-24 years old
   - ☐ 25-34 years old
   - ☐ 35-44 years old

☐ 45+