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Counselor Experience With Outcomes of Telehealth and Substance Use Disorder

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Walden University
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Abstract

Counselor Experience With Outcomes of Telehealth and Substance Use Disorder Therapy

by

Shamarah Hutchins

MA, Capella University, 2016

BS, Wilberforce University, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Prior to 2020, telehealth, the remote delivery of health care via digital information and communication technologies, was rarely used in substance use disorder (SUD) treatment facilities. The onset of COVID-19 quickly created a shift to telehealth services for the safety and health of providers and patients. Researchers have explored many aspects of telehealth, including the client and counselor/client experience, but have not studied the counselor experience separately. The purpose of this qualitative study was to better understand counselors' lived experiences pertaining to telehealth use; perceptions of how it impacts clinical performance, self-efficacy, and training; and beliefs about its effectiveness when working with clients with SUD. Bandura's self-efficacy theory was the theoretical framework for the investigation, which featured interpretative phenomenological analysis. Twelve counselors who worked at SUD treatment facilities participated in semistructured interviews. Thematic analysis of the interview data occurred by manually coding the data to identify themes, categories, and subcategories. The findings showed that telehealth had benefits for both the client and the counselor, including flexibility, counselor availability, safety from COVID, and the ability to communicate with clients despite the lack of in-person counseling. The findings also revealed a need for more training on developing counseling skills through telehealth services. The positive social change implications of the study include providing a better understanding of the use of telehealth to assist community members and the need for flexible support systems for counselors. Such systems may improve clinical performance and counselor efficacy in delivering telehealth services to patients with SUD.

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Dedication

To my daughters, Gabrielle and Madison Hutchins: I want you to know you can do whatever you put your mind to and never give up on your dreams. To my pastor, Elder Dr. Larry D. Tatum, for always being the father figure I needed. To my grandmother, Elsie Thomas: Your strength and encouragement over the years are unmatched. To my mother, Paula Thomas: Your life story helped me make this journey possible. To my siblings (Vincent, Little Paula, and Shayla) for holding me accountable to lead the way. To my Uncle Jimmie, whose wavering love I miss dearly. Lastly, my besties (Chaunnecy, Jazmen, and Angel): Life with you all has been amazing. Thanks for always being there. We did it!

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Substance use treatment has evolved from Alcoholics Anonymous as the sole type of treatment to evidence-based practice therapy (Lin et al., 2019). Amid increasing numbers of deaths from substance use in the 21st century, telehealth interventions have emerged to connect counselors and facilities with clients (Eibl et al., 2017; World Health Organization [WHO], 2020). However, despite advocacy to increase the use of telehealth services, the modality is still underutilized in substance use treatment and rehabilitation centers (Molfenter et al., 2018). In response to the need to increase use of telehealth, scholars (e.g., Eibl et al., 2017; Lin et al., 2019; Molfenter et al., 2015, 2018; Thomas et al., 2020) have suggested further research on its practices and benefits.

In March 2020, the WHO identified the novel coronavirus (COVID-19) as a global pandemic, leading to prompt quarantines in the United States and other countries. As a result, many health care providers, including substance use disorder (SUD) organizations, switched to remote services (i.e., telehealth) to slow the virus's spread (WHO, 2020). However, there remained a need to review the services' effectiveness and the counselors' experiences with remote delivery (Botaitis & Southern, 2020).

Prior to 2020, telehealth was underutilized in private and government-owned SUD agencies in the United States (Molfenter et al., 2018). Molfenter et al. (2018) found that telehealth was used in less than 1% of substance use treatment, an extremely low percentage compared to other recovery care fields and indicating a gap in individuals' interest and clinicians' use of various telehealth techniques. Thomas et al. (2020) identified an increase of telehealth in health care and SUD organizations. However, they

identified a gap in the literature specific to counselors' use of and comfort with telehealth, often due to service dynamics or lack of technology access. A thorough literature review (see Chapter 2) shows how counselors' use of telehealth has impacted clinical performance, self-efficacy, training, and beliefs regarding telehealth's success in the SUD field. The social implications of addressing the gap in the literature include providing SUD organizations and counselors with a better understanding of using telehealth to assist community members. The information could be useful for building flexible support systems for counselors, impacting clinical performance and counselor efficacy in delivering telehealth services to patients with SUD.

In Chapter 1, I provide an overview of the study. The chapter begins with the background of the problem, followed by the purpose of the study, research question, theoretical framework, nature of the study, and definitions. In the chapter, I also discuss the assumptions, scope and delimitations, and limitations of the study. This chapter will conclude with the significance of the research and its potential implications for social change.

Background

Researchers have studied telehealth in response to the increasing need to provide therapy in nontraditional ways (Brusoski & Rosen, 2015; Eibl et al., 2017; Lin et al., 2019). Lin et al. (2019) explored nontraditional treatment methods to improve therapeutic outcomes for counselors and clients. Individuals have cited stigma and inaccessibility as reasons for not pursuing or continuing SUD treatment, indicating the need for more convenient options (Centers for Disease Control and Prevention [CDC], 2018). However,

clients are not the only ones seeking expanded treatment access, as counselors have called for new methods to increase their interventions and interactions serving the SUD population (Beitel et al., 2018).

Researchers of telehealth and treatment have approached patients and counselors separately (Eibl et al., 2017). Some (e.g., Oser et al., 2013)have exclusively studied counselors' ability to engage and provide services for individuals with SUD. Although some research has been specific to telehealth outcomes, most has focused on substance use treatment and rehabilitation centers (e.g., Molfenter et al., 2018). Thus, there is a need for further exploration of alternate service methods, including ways to reduce barriers to treatment and increase counselor interventions and interaction with SUD populations (Botaitis & Southern, 2020). Eibl et al. (2017) and Oser et al. (2013), among others, deemed telehealth an avenue worthy of further investigation in SUD treatment.

In a quantitative survey of psychological distress and burnout among SUD counselors, Baldwin-White (2016) measured counselors' attitudes and confidence in therapeutic success through interventions that did not involve face-to-face communication. Prior to Baldwin-White, Oser et al. (2013) discussed nontraditional ways of service delivery and measured counselors' attitudes and confidence in therapeutic success through interventions in SUD populations. Baldwin-White and Oser et al. found insufficient literature to gauge telehealth services. Both sets of scholars indicated the need for further research on telehealth, with Baldwin-White suggesting an exploration of other factors relevant to SUD counselors and retention. In turn, Oser et al. discussed the production and benefits of telehealth services.

More recently, Botaitis and Southern (2020) and Thomas et al. (2020) examined the dynamics of using telehealth services in the counseling field, finding knowledge gaps regarding counselors' perceptions of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. Botaitis and Southern concluded that telehealth services increased the demand for counseling services, particularly in underserved populations. Thomas et al. concluded the service dynamics or lack of technology access is the reason necessity for telehealth services to be sought out. Telehealth will continue to grow in response to need and outcomes; as such, additional research is needed to understand the benefits and challenges of conducting psychotherapy through technology.

Problem Statement

Research on telehealth's effectiveness shows telemedicine interventions to be promising, especially when face-to-face treatment is not available (Lin et al., 2019). However, there has been a lack of inquiry to understand the psychological, societal, or economic factors that could drive improved treatment retention in outpatient settings, including the use and effectiveness of telemedicine in SUD treatment programs (Eibl et al., 2017). This research focus is important because it pertains to counselors' ability to perform their jobs successfully when treating individuals with SUD (Baldwin-White, 2016). Telehealth has changed counseling dynamics and treatment access, but there is still little information on its effectiveness in health services delivery and counselor clinical interventions, counselor self-efficacy, and counselor retention (Cristofalo, 2021). The present study begins to address the gap in the literature on the dynamics of telehealth

services in SUD programs and counselors' perspectives (see Bandawar et al., 2018; Eibl et al., 2017; Kazemi et al., 2017; Lin et al., 2019).

Purpose of the Study

The purpose of this qualitative study was to better understand the lived experiences of counselors as they described their use of telehealth and how it impacts clinical performance, self-efficacy, training, and beliefs about its effectiveness when working with clients with SUD. In conducting the study, I sought a better understanding of counselors' perceived effectiveness of clinical interventions, self-efficacy, retention, and telehealth perceptions.

Research Question

The overarching research question for this study was, How do SUD counselors perceive how the use of telehealth has impacted clinical performance, counselor self-efficacy, counselor training, and counselor beliefs? To answer this question, I conducted semistructured interviews with participants. The open-ended interview questions were

1. What has been your experience with telehealth?
2. What was your overall experience with the navigation of telehealth with peers?
3. What training was provided for you to navigate telehealth platforms and implement therapy services via telehealth?
4. How has providing services through telehealth affected you or your mental health?

Theoretical Framework

The theoretical framework for this study was Bandura's (1977) self-efficacy theory. Self-efficacy theory represents people's beliefs and judgments about their ability to effectively perform work-related activities. Bandura's theory provides an appropriate foundation for looking at individuals' beliefs regarding their ability to accomplish professional goals; thus, it is a commonly used framework in the counseling literature (Bandura, 1977)). Self-efficacy theory is useful for counselor selection and training because of the construct's stability and reliability, making it an appropriate framework to assess the development of counselor competence in four areas, as identified by Betz (2004): performance accomplishments, vicarious experience, social persuasion, and physiological and emotional states. I explored these areas to gain a better understanding of counselors' perceptions of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs about the effectiveness of telehealth in the SUD field. Self-efficacy theory receives a more detailed discussion in Chapter 2.

Nature of the Study

I used a qualitative approach for the present study due to the nature of the data required to answer the research question. Qualitative methodology is useful when focusing on individuals' experiences and perceptions (Creswell, 2014). I collected data by conducting semistructured interviews with counselors to uncover their thoughts, understandings, and perceptions about telehealth. An interpretative phenomenological analysis (IPA) design was appropriate to determine how participating counselors made sense of their experiences specific to meaning and processes, not the events and their

causes (see Harper & Thompson, 2011). The IPA approach facilitated an understanding of the role of telehealth in SUD services delivery and its effectiveness specific to counselors' perceptions of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs (see Hilty et al., 2013). Data interpretation was via thematic analysis; this involved a search for relationships among participant responses and examination of how these relationships were related to the topic of study (see Nowell et al., 2017). Chapter 3 includes a more in-depth description of the research method for this study.

Definitions

Burnout: A state of physical or emotional exhaustion involving a sense of reduced accomplishment and loss of personal identity (Lee et al., 2020). Counselors and other individuals, particularly those in helping professions, are at risk of burnout (Lee et al., 2020).

Counselor belief: An individual's understanding, learning dynamics, decision-making, and experiences working in the counseling field (see Bandura, 1977).

Counselor performance: Counselors' ability to provide effective therapy as it relates to the return for services for treatment (Joshi et al., 2021).

Counselor training: Instruction on appropriate counseling techniques for encouraging growth within the services provided (Joshi et al., 2021).

Interpretative phenomenological analysis (*IPA*): A qualitative research approach to exploring individuals' lived experiences related to a phenomenon of interest (Harper & Thompson, 2011).

Performance accomplishments: The ability to learn information, which determines whether someone truly understands and can succeed within the work environment (Bandura, 1977).

Physiological and emotional states: Individuals' well-being, which can influence how they feel about their abilities in a particular situation or work environment (Bandura, 1977).

Self-efficacy: The ability to carry out behaviors to achieve performance goals by controlling one's motivation, behavior, and social environment (Bandura, 1977).

Social persuasion: The provision of positive verbal feedback and fostering of individuals' belief that they have the skills and capabilities to (Bandura, 1977).

Telehealth (also called *telemedicine*): Health care services that use digital information and communication technologies, such as computers and mobile devices, to deliver care remotely (Lin et al., 2019).

Vicarious experience: Learning by observing others and having a positive role model to encourage positive self-beliefs (Bandura, 1977).

Assumptions

In conducting the study, I had three identified assumptions. The first assumption was that qualitative methodology with an IPA design would be appropriate to collect the data needed to answer the guiding research question. Another assumption was that participating counselors would voluntarily engage in semistructured interviews to share their perspectives in response to open-ended questions. A final assumption was that the participants would respond to the interview questions (see Appendix A) truthfully and to

the best of their ability. These assumptions were necessary to present the collected data as trustworthy, valid, and reliable. In Chapter 3, I will provide an in-depth discussion of the trustworthiness, credibility, and dependability measures taken for the study.

Scope and Delimitations

The aim of this study was to gather information about the use of telehealth and understanding, clinical performance, counselor self-efficacy, counselor training, and counselor beliefs in providing services for SUD. Participating counselors shared their perspectives on counselor performance, counselor self-efficacy, counselor training, and counselor beliefs. The findings could inform the strategies use by treatment facility leaders to address counselor self-efficacy and increase counselors' morale, engagement, and retention. As noted by Johnston et al. (2019), if treatment facilities focused on engaging in nontraditional ways, treatment success rates would increase and counselor burnout would decrease, thus improving retention and self-belief. The study was bound by the sample population of counselors working in community-based facilities specializing in SUD treatment. Most previous researchers have presented the client's perspective (e.g., Kazemi et al., 2017; Oser et al., 2013; Rodda et al., 2015); therefore, this study focused on counselors rather than clients.

The procedures used in this study may be transferrable to other populations and samples, and the information gathered could be helpful in related situations. Although the results may vary slightly in different communities and with different programs, the findings may provide a better understanding of counselors' use of telehealth.

Limitations

Limitations are inherent in any research. The participants in this study came from rural and urban counseling facilities. The first limitation was that the sample was from a specific area and thus not representative of SUD counselors nationwide. This limitation was necessary due to the impracticality of traveling great distances to collect data. Another limitation was time constraints on data collection due to participant recruitment, counselors' work schedules, and COVID-19 social distancing guidelines (see National Institute on Drug Abuse [NIDA], 2020). Working around participating counselors' hours meant having less time to obtain the information needed for the research. Despite these limitations, the findings might be transferable to other regions and populations. Conducting the study through social media outlets to gather data from a broader range of counselors could enhance the validity and reliability of the findings (Phillips, 2018).

Researcher bias is another potential limitation of the research. A researcher's approach and processes can introduce bias in qualitative data collection (Creswell, 2014). Researchers' and participants' facial expressions, tone of voice, dress, and reactions to answers can contribute to unintentional bias. I remained as neutral as possible during the study, from recruitment to data analysis and findings presentation. To prevent bias during interviews, I had a qualitative methodologist review all questions to ensure proper wording and alignment. Conducting the interviews through the videoconferencing platform Zoom minimized impact of expressions, body language, and reactions.

Last, bias could have also affected reporting the findings. Because researchers must continually focus on the data, they could struggle to remain impartial when

analyzing participants' responses (Creswell, 2014). To reduce the likelihood of its occurrence, I sought to be aware of the potential for bias. Having a peer reviewer look at the analysis and findings also helped eliminate bias. Further, I took breaks in data collection and analysis, which allowed me to return to the data with an open mind.

Significance

Individuals in the United States have encountered growing barriers to accessing SUD treatment due to COVID-19 (NIDA, 2020). The transition from face-to-face to remote health care services due to the pandemic posed problems for many organizations without experience in telehealth treatment (Thomas et al., 2020). Gaps in treatment structure and behavioral health workforce shortages have challenged treatment delivery, as well (Phillips, 2018). Phillips (2018) attributed the health care workforce shortage to the increasing number of unmet service needs. Research has shown telemedicine to be a beneficial service with positive SUD treatment outcomes (Kazemi et al., 2017). Despite evidence of telehealth's benefits, little research exists specific to its use from the counselor's perspective.

This study focused on counselors' challenges and how telehealth use has impacted clinical interventions, counselor self-efficacy, counselor retention, and counselor beliefs about helping clients with SUD behavior change. I conducted the study to respond to the literature gap noted by McHugh et al. (2013) and Martinsen et al. (2021). Both sets of researchers identified the need to clarify risks and protective factors to guide interventions and retention efforts for counselors.

I used a qualitative approach to understand the application of telehealth from the counselor's perspective. The intention was to learn from counselors' perceptions of telehealth's effectiveness regarding clinical interventions, counselor self-efficacy, counselor retention, and counselor beliefs. The findings could bring about social change based on the knowledge gained from counselors' perceptions. In addition, the study could contribute knowledge that stakeholders can use to develop flexibility and support systems for SUD organizations.

Summary

In this chapter, I presented the research topic of counselors' use of telehealth and its impacts on clinical interventions, counselor self-efficacy, counselor retention, and counselor beliefs about how remote care helps clients with SUD. Chapter 1 included the problem statement and background information, including the gap in research this study addressed, followed by discussion of the study's implications for positive social change. Next, the chapter included a brief overview of the scope of the study, methods used, assumptions and limitations, as well as the study's significance. In Chapter 2, I will review relevant literature, which further indicates the need for the study.

Chapter 2: Literature Review

Researchers have begun to examine the effectiveness and promise of telemedicine interventions for SUD services, especially when face-to-face treatments are not available (Lin et al., 2019). However, scholarship is limited regarding understanding the use of telehealth and how it impacts SUD treatment settings and telemedicine from the counselors' perspective (Eibl et al., 2017). Following WHO's identification of COVID-19 as a worldwide pandemic, health care providers, including those treating clients with SUD, had to reevaluate their approaches to treatment. Unable to meet face-to-face, many facilities began to offer telehealth services (Thomas et al., 2020).

However, there has been little research on telehealth experiences through the SUD counselor lens, specifically in regard to how remote health care affects clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. This is important information, as previous research has shown low effectiveness in SUD treatment in general given by counselors yet without measuring the counselors' satisfaction (Perle & Nierenberg, 2013). The COVID-19 experience led to an increased awareness of telehealth among health service providers, SUD counselors, and therapists. The use of telehealth increased within many U.S. organizations as a result of the pandemic (Thomas et al., 2020).

The goal of this research was to build upon the literature to understand how SUD counselors' use of telehealth has impacted clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. The goal of this qualitative study was to understand the application of telehealth for SUDs from the counselor's perspective. The

objective was to describe counselors' perceived effectiveness of telehealth on clinical performance, counselor self-efficacy, counselor training, and counselor beliefs about telehealth.

In this chapter, I review literature pertaining to the study topic. The chapter begins with overviews of the literature search strategy and the study's conceptual framework. The literature review that follows indicates the need to obtain counselors' perceptions of the effectiveness of telehealth specific to clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. I also discuss the expansion of SUD services through telehealth and the subsequent client and counselor outcomes. The chapter shows the gap in the literature regarding SUD counselors' experiences using telehealth.

Literature Search Strategy

To obtain background information on the study topic, I searched counseling, psychology, and human services databases, such as EBSCOhost, ProQuest, PsycArticles, PsycINFO, SAGE Journals, and Thoreau Multi-Database Search, which I accessed from Walden University Library. Keywords used to focus the search were *substance use disorder*, *substance use*, *counselor*, *therapist*, *psychologist*, *experience*, *burnout*, *self-efficacy*, *counselor burnout*, *telehealth*, *e-health*, *qualitative method*, *substance*, *treatment modality*, *telemedicine*, *treatment outcomes*, *telehealth AND COVID-19*, *telehealth AND counselor retention*, *counselor belief AND telehealth AND substance use disorder*, and *m-health.* To access the most current research, I searched for literature that was published from 2013 through 2021.

I used various methods to retrieve related articles. The review began with a general keyword search through Google Scholar and the Walden University Library. This search returned 36 articles focused on engagement, counselor burnout, counselor perceptions, and counselor engagement with clients. I input these articles into an article review template to examine the research methods, purposes, and research gaps. After completing the general search, I conducted an advanced search using only peer-reviewed articles. I input the keywords with Boolean operators *and*, *or*, and *not*, which helped return results specific to the research topic. I conducted the same general searches in all databases with specific variations depending on the returned results, using different combinations of terms and Boolean operators and changing the order of the terms. During the literature search, it became evident that many results were not current, and there had been minimal research on this topic. To combat these problems, I used the advanced search function, putting more words together, such as *teletherapy AND counselor perception*. I located additional literature by reviewing relevant articles' references lists.

Theoretical Framework

The theoretical framework for this study was self-efficacy theory (Bandura, 1977), which represents people's beliefs and judgments about their capabilities to perform related activities effectively. Self-efficacy affects every area of human endeavor, influencing people's power to face challenges competently and the choices they are most likely to make (Bandura, 1977). According to Bandura (1977)These effects are particularly apparent and compelling in behaviors related to education, employment, and personal life which leads to self-efficacy. Self-efficacy is an appropriate concept to assess

the development of counselor competence in four areas: performance accomplishments, vicarious experience, social persuasion, and physiological and emotional states (Betz, 2004).

The present qualitative study was a means to gain an understanding of organizations or groups. Qualitative research is appropriate to provide a clear interpretation of the structure, order, and broad patterns found among a group of participants (Saldaña, 2016). The literature review showed the need to explore counselor perspectives and outcomes regarding the use of telehealth in treating clients with SUD. This chapter addresses how self-efficacy theory applied to the study regarding the perceived effectiveness of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. In the following sections, I discuss how performance accomplishments, vicarious experiences, social persuasion, and physiological and emotional states concern the research gap.

Performance Accomplishments

Determining performance accomplishments entails interpreting someone's previous performance or experience with a phenomenon—in this case, providing telehealth counseling services within the SUD field. One source of self-efficacy is mastery experiences. Expanding services into a new mode of delivery may contribute to counselors' mastery experiences, which they gain by successfully assuming new challenges. Bandura (1977) stated that mastery experiences provide reliable information on whether someone truly understands and can succeed.

According to Cooper et al. (2019), the counseling field has been behind in developing the educational and supervised experiences required to achieve competency in using telehealth. Performance accomplishments from self-efficacy and the concept of mastery experiences were essential to this study to determine counselors' self-efficacy and competence development.

Vicarious Experience

The second source of self-efficacy is vicarious experience, which occurs when individuals learn by observing others. People with positive role models are likely to display some of the models' behavior, resulting in positive self-beliefs. Bandura (1977) asserted that people who believe in themselves are successful and able to master activities. However, social workers with little or no training struggle to deliver effective telehealth while navigating the legal and ethical complexities of having positive role models (Cristofalo, 2021). Cristofalo (2021) explored the strengths and weaknesses of using telehealth during and before the COVID-19 pandemic, providing insight into counselors' perceptions of using telehealth for therapy in general and SUD treatment in particular. Cristofalo examined the vicarious experiences of other counselors and the effectiveness of clinical performance to understand counselors' self-efficacy, showing how remote care has helped clients with SUD and the understanding of self-efficacy theory. The findings are essential as they align with the present study's goals of understanding how counselors' use of telehealth has impacted clinical performance, counselor self-efficacy, counselor training, and counselor beliefs.

Social Persuasion

The third aspect of self-efficacy is social persuasion, which entails giving positive verbal feedback and persuading individuals to believe they have the skills and capabilities to succeed (Bandura, 1977). The earlier individuals receive social persuasion, the more likely they are to build self-efficacy. Molfenter et al. (2015) peripherally explored social persuasion in a case study of telemedicine trends in SUD treatment. In their study, the use of telemedicine in SUD treatment and recovery services was limited; thus, the researchers could not gauge the self-efficacy of those using the technology due to the modality's ready availability. Molfenter et al. suggested future research on tracking technology implementation for longer periods, thus providing more information for practicing communities to understand the need for and use of telemedicine and technology.

Since 2020, there has been tremendous growth in telehealth services worldwide due to the modality's rapid uptake based on the need for social distancing and limited face-to-face interaction (Thomas et al., 2020). Thomas et al. (2020) discussed developing skills, empowering providers to use telehealth, and integrating telehealth into future care plans. The researchers' findings also indicated the need to understand self-efficacy and persuasion.

Emotional Psychological States

Self-efficacy comprises individuals' emotional, physical, and psychological well-being, all of which influences how they feel about their abilities in a particular situation or work environment (Bandura, 1977). Bandura (1977) asserted that how people perceive and interpret information is more important than their emotional and physical reactions.

Therapists' confidence increases the likelihood of their providing effective therapy (Nissen-Lie et al., 2020). Nissen-Lie et al. (2020) and showed a relationship between the therapists' emotional response and the individual served when therapists fully understood their jobs. In contrast, therapists unsure about the dynamics of their overall work relationship exhibited a more negative response and were thus not motivated to change or develop within the environment. Conversely, when individuals are motivated to change, the therapists experience more positive feelings, such as confidence. Although Nissen-Lie et al. provided useful information on how individuals feel about their abilities in a particular situation or work environment, the findings were not specific to telehealth, as is the focus of this study. In the following sections, I further discuss performance accomplishments, vicarious experience, social persuasion, and physiological and emotional states and how they relate to the research gap.

Literature Review Related to Key Concepts

Three primary topics were relevant to this study: (a) history of substance use, (b) evolution of SUD treatment in relation to using telehealth, and (c) benefits and barriers of telehealth. This section begins with a review of the history of substance use dependence and various aspects of treatment. Next, I discuss telehealth and its evolution with a review of studies related to the present study. Then, I examine key studies on counselor burnout pertaining to the use of telehealth, SUD and telehealth, therapist retention, and counselors' beliefs about telehealth. This section will end with an exploration of the literature gap regarding the experiences of SUD counselors and the use of telehealth.

History of Substance Use Disorder Treatment

Drug use, now known as SUD, is not a new concern. People have used drugs since the discovery of mind-altering substances; the use of such substances has often led to SUD. Eventually, society began to view drug use as a mental health problem and developed rehabilitation programs (Henninger & Sung, 2014). In this section, I discuss the history, benefits, and stigma of SUD treatment (Simha et al., 2021)

SUD treatment began in the United States in the early 1800s with the determination that the average person's alcohol consumption was four and a half gallons per year (Henninger & Sung, 2014). Alcohol grew in popularity, becoming easily accessible and affordable for all members of society, leading to decreased family interaction and job performance (Henninger & Sung, 2014). Dr. Benjamin Rush, a physician and activist, identified alcoholism as a disease that should be treated as such (White, 2002). Dr. Rush's assertions that alcohol use was a significant public health problem inspired the temperance movement.

SUD treatment in the United States began with alcohol and spread to other drugs (Henninger & Sung, 2014). Dr. Rush advocated for abstinence, distributing pamphlets about the harmful effects of alcohol. Early treatments included cold baths, vomiting, and aversion therapy, allowing people to bleed, blister, and sweat (White, 2002). Soon, other physicians began to contribute to understanding the key physical consequences of alcohol and other substance use (Henninger & Sung, 2014). Alcohol addiction became a disorder in response to chronic alcohol use, leading to the founding of the American Association for the Cure of Inebriation (AACI). AACI was the first organization to provide treatment

for alcoholism, arguing for treatment over criminal offenses (White, 2002). AACI addiction facilities provided short- and long-term detoxification and inpatient treatment. The temperance movement shifted from isolated approaches to sobriety to a common recovery process.

Moving into the 20th century, substance use increased due to the popularity of drugs such as marijuana, cocaine, and LSD (White, 2002). The modern alcoholism movement suggested that alcoholism was a curable public health disease (Henninger & Sung, 2014). SUD research by medical professionals and psychologists increased, and treatment options disappeared.

In 1935, Bill Wilson and Dr. Robert Smith created the self-help recovery group Alcoholics Anonymous (AA) to fill the gaps in treatment (Henninger & Sung, 2014). AA enabled addicts to provide support to one another in quitting and abstaining from alcohol. In 1939, Wilson and Smith produced *The Big Book*, outlining AA principles and the 12 steps of recovery. AA is one way to fill the void within community treatment, serving as an extension of services.

The 1950s brought the Minnesota model of addiction treatment, a new approach to alcoholism intended to reach more people in need. With AA as a guide, the model provided 2- to 4-week residential treatment for men with alcohol addiction (White, 2002). The Minnesota model uses a multidisciplinary and holistic approach, teaching people to treat each other with respect. Doctors and nurses provide medical treatment, with counseling by psychologists, social workers, and clergy.

Next, community-based treatment facilities opened, with social workers providing outpatient care to individuals who had completed inpatient services. This approach had successes and failures. Patients would frequently miss follow-up appointments, and care was often the responsibility of physicians without training in addiction medicine (Henninger & Sung, 2014).

After community-based treatment facilities, the next evolution was therapeutic communities, created by Charles Dederich in 1958 (Henninger & Sung, 2014). The treatment had two phases. Phase 1 was a residential treatment program to rehabilitate addicts with the help of doctors and social workers. Phase 2 was a form of community integration, with a patient's families and friends supplementing the health care team. In Phase 2, people learned to develop alternative lifestyles to promote societal changes.

In the early decades of the 21st century, prescription opioid use has become a national epidemic. In response, there are now thousands of drug rehabilitation programs worldwide (CDC, 2018), ranging from traditional, evidence-based approaches to more holistic services (Ham et al., 2013). As substance use and abuse increased, legislators introduced policies and reforms, and providers sought new technology to increase access to counseling. One such technological advancement, telehealth has changed the dynamics of counseling and treatment access, allowing providers to reach people in need where they are (Shigekawa et al., 2018).

Evolution of Telehealth for Substance Use Disorder

Telehealth in the United States began in 1993 with the founding of the American Telemedicine Association. At the time, the internet was growing in popularity, and health

care providers were exploring new communication tools (Gogia, 2020). During the Great Recession, the federal government boosted the economy by funding the American Healthcare System, designating over $25 billion to health information technology and digital delivery, including telemedicine. Due to the amount of money allocated, health care providers needed to use telehealth in the field the best way they knew how. In 2016, the Health Resources and Services Administration received funding to expand telehealth use in rural areas. Since then, studies have shown that individuals in rural communities benefit the most from telehealth; however, researchers have primarily focused on client outcomes, not therapist perceptions.

Supporters of telehealth deem it a cost-effective way to access and deliver high-quality health care, including SUD treatment (Botaitis & Southern, 2020). Botaitis and Southern (2020) found that counseling through telehealth was as effective as in-person visits for a variety of behavioral problems, including substance use. Telehealth has the beneficial outcomes of responding to a need within the community, effectively providing therapy for longer periods, and reducing organizations' operational costs (Shigekawa et al., 2018). In a meta-analysis, Shigekawa et al. (2018) accessed telehealth services articles published between January 2004 and May 2018. The focus was specific to the delivery of telehealth compared to in-person visits and if the use of telehealth affected other services. The findings showed that telehealth services for mental health and SUD treatment had the same results as in-person care in most cases. However, it was unclear whether telehealth reduced the use of other services, led to duplicated services, or improved access to care. Shigekawa et al. found that when telehealth was available,

mental health hospital visits decreased. Despite telehealth's benefits, additional research is needed to identify the best counselor interventions and the benefits and challenges concerning the impact on the counselor overall.

With benefits come barriers. One of the main challenges found by Gajarawala and Pelkowski (2021) was the need for general intervention and specialized training to accommodate techniques for different characteristics, settings, and circumstances. The present study addressed the literature gap by providing counselors' perceptions of the effectiveness of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs specific to the use of telehealth.

SUD treatment depends on counselors' ability to navigate avenues of providing effective therapy. In 2017, approximately 47,000 Americans died from overdoses related to drugs and alcohol, indicating the need for more treatment availability (CDC, 2018). Increasing accessibility required implementing nontraditional service methods to improve therapeutic outcomes (NIDA, 2018). As telehealth evolved, private and government-owned SUD agencies adopted the use of video conference therapy, promoting the new technology to provide better counseling service in rural areas, where fewer therapists were available (Frankfort-Nachmias & Leon-Guerrero, 2018). In addition to reaching more clients, telehealth was a means to decrease therapists' stress from missed appointments.

Despite advocacy within private and government-owned SUD agencies, telehealth remained underutilized in substance use treatment and rehabilitation centers (Molfenter et al., 2018). This changed in 2020 when the COVID pandemic occurred and many

organizations had to shift to telehealth services to stay in operation (Botaitis & Southern, 2020). Molfenter et al. (2018) found telehealth used in less than 1% of substance use treatment, an extremely low percentage compared to other recovery care fields, such as hospitals, with 20% utilization. In surveying 363 treatment facilities in eight states, Molfenter et al. examined 11 telehealth technology approaches for individuals interested in receiving the services. Data collected were participants' reported experience with computerized screening and assessment tools, texting appointment reminders and motivational messages, video- and telephone-based therapy, support chats, and other helpful treatments and tools. The findings showed a significantly higher percentage of clients interested in telehealth treatment than the percentage of facilities currently using the technology, indicating a gap in individuals' interest and clinicians' use. Although the gap focused on individuals wanting to use telehealth, the study also showed that facilities and counselors used telehealth less often because of their discomfort or lack of access to technology.

The literature indicated that telehealth is underused in the SUD service field; however, individuals' interest is increasing. Eibl et al. (2017) compared treatment outcomes for in-person versus telemedicine treatment using opioid agonist therapy. The research was a nonrandomized cohort comparison study with 3,733 opiate use disorder patients. The findings showed that individuals treated through telemedicine remained in therapy longer than those treated in person; thus, a nontraditional treatment method can improve the length of stay in clinic settings. There is a need for further research to understand the psychological, societal, or economic factors driving improved treatment

retention in outpatient and telemedicine settings. Eibl et al.'s findings aligned with Molfenter et al. (2018), providing an understanding of telehealth and its benefit to counselor-client treatment services.

Bandawar et al. (2018) focused on advancements in SUD and mental health treatment and how they have affected the continuum of care. The researchers explored therapy and interventions in rural areas for clients diagnosed with SUD. Bandawar et al. used a human-supported, therapeutic, web-based intervention of a guided, self-paced approach to treatment to achieve behavioral change, asking a counselor to provide support, contact, or feedback. Another intervention was the therapeutic education system, which dealt with psychosocial skill training intervention and behavior change. Here, counselors would provide modules and discuss them over telehealth to increase self-direction and understanding of therapeutic processes. However, these interventions provided the clients' perceptions of telehealth outcomes, not the counselors', thus indicating a need to explore counselors' understanding of and beliefs about telehealth interventions in SUD settings. Bandawar et al. recommended further exploration of interventions used with time of treatment, indicating the need to revisit counselors' interventions and how they fulfill counselors' output for treatment needs.

Despite evidence of telehealth's effectiveness and use, there is little research specific to its use from the counselor's perspective. This study builds on the literature, providing insight into telehealth from the counselor's point of view.

Counselors and Substance Use Disorder Telehealth Treatment

In-person treatment has been counselors' primary approach to therapy, including substance use treatment. Counselors face challenges in providing face-to-face treatment, including (a) patients needing to schedule appointments while they are in the office, (b) the conflict of having another appointment with another agency but still needing access to a SUD counselor, and (c) crisis situations and counselors not always available face-to-face (Dewar et al., 2016). Stigma is a significant contributor to the tremendous gap in SUD treatment services (Simha et al., 2021).

These barriers indicate the need for telehealth, which extends the providers' availability and offers individuals an immediate resource. Oser et al. (2013) found that face-to-face therapy led to extremely high counselor burnout due to clients trying to choose their counselors and counselors changing jobs frequently. Counselors often moved to different positions within the same or a different organization because of an overly stressful workload, a lack of standardized training, and unreasonable expectations of billable hours. The research showed burnout was universal across rural and urban counseling settings, leading to poor-quality clinical care based on reduced effectiveness of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. Oser et al. suggested further research investigating the differences between rural and urban counselors and intervention approaches to decrease counselor burnout. Their suggestion was important to this study because of the theoretical concept of self-efficacy and beliefs and judgments about oneself performing or completing a task. Self-efficacy affects every area of human endeavor and will assist with exploring the perceived

effectiveness of clinical interventions, self-efficacy, and counselor retention (Bandura, 1977).

Baldwin-White (2016) found that substance counselors are at higher risk of burnout than other counseling professionals because their clients can be more demanding and need more attention. Burnout consisted of emotional exhaustion, depersonalization, a lack of confidence in therapeutic success, and negative attitudes toward substance-abusing clients. When asked about burnout, counselors discussed seeing individuals face-to-face and not having time to explore the necessary avenues of treatment. Baldwin-White suggested further research in measuring attitudes toward clients and confidence in therapeutic success through interventions outside of face-to-face. The researcher also recommended exploring other factors relevant to substance use counselors and their experience of burnout.

Burnout places a heavy burden on substance use counselors based on the demands of providing necessary services for SUD clients. The dropout rate of substance use counselors is 50% (Sherman et al., 2013). McHugh et al. (2013) discovered that dropout is common in SUD treatment settings, leading to poorer outcomes and lower treatment completion rates. Poor treatment outcomes can make counselors perceive their therapeutic approach as ineffective, increasing the likelihood of burnout. Additional research is necessary to clarify risk and protective factors and guide intervention and retention efforts. McHugh et al. recommended studying the relationship between distress intolerance and coping motives with treatment entry, retention, and outcome.

Telehealth is a promising approach to diversifying treatment, providing options for engagement and retention to ensure the well-being and recovery of counselors and clients. This study is necessary to learn from counselors' perceptions of the effectiveness of telehealth clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. The findings could bring about social change, better enabling counselors to assist communities through telehealth services and building flexibility and support systems for behavioral health organizations.

Summary

The literature review was an investigation of research on SUD counseling and telehealth. The topics explored included counselor burnout, perceptions, and client engagement. There was little literature available on telehealth experiences from the counselor's perspective and the effect of telehealth on clinical performance, counselor self-efficacy, counselor training, and counselor beliefs (Perle & Nierenberg, 2013). Among the research reviewed were studies using the theoretical framework of self-efficacy theory, which provides useful information on how individuals feel about their abilities in a particular situation or work environment (Bandura, 1977). In addition, Chapter 2 presented the history of SUD and counseling for the disorder, how telehealth treatment emerged, the barriers and benefits of telehealth, and counselors and telehealth services. Throughout the literature, researchers indicated the need for further inquiry (Baldwin-White, 2016; McHugh et al., 2013; Oser et al., 2013).

The present study provides insight into counselors' perceptions of the effectiveness of clinical performance, counselor self-efficacy, counselor training, and

counselor beliefs. Chapter 3 will present the research methodology, including the processes for data collection and analysis. Considerations of validity and research ethics will also appear.

Chapter 3: Research Method

The aim of this study was to gather information from SUD counselors who are providing telehealth services within community settings. The goal was to understand how SUD counselors' use of telehealth has impacted clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. I used self-efficacy theory (Bandura, 1977) in focusing on performance accomplishments, vicarious experience, social persuasion, and physiological and emotional states.

In this chapter, I review the study's methodology, including the research design, role of the researcher, and ethical procedures used to safeguard participants. I discuss the sampling strategy, instrumentation, data collection and analysis plans, and issues of trustworthiness. The chapter concludes with a summary and a brief introduction to Chapter 4.

Research Design and Rationale

The overarching research question for this study was, How do SUD counselors perceive how the use of telehealth has impacted clinical performance, counselor self-efficacy, counselor training, and counselor beliefs? The open-ended interview questions were

1. What has been your experience with telehealth?
2. What was your overall experience with navigation of telehealth with peers?
3. What training was provided for you to navigate telehealth platforms and implement therapy services via telehealth?

4. How has providing services through telehealth affected you or your mental health?

A qualitative IPA approach is appropriate to evaluate a person's lived experience (Harper & Thompson, 2011). The design facilitates understanding how people feel about their experiences and phenomena and is a useful approach to investigating complex topics that evoke emotion (Harper & Thompson, 2011). Use of the IPA design is beneficial for three reasons. First, phenomenology is apt to uncover accounts of people's lived experiences on their own terms (Smith & Osborn, 2015). Second, IPA recognizes that people are sense-making individuals, and the design allows researchers to make sense of what is happening within a person's emotions. Last, IPA is idiographic, with scholars committed to viewing the detailed experience of each case separately and then exploring it generally (Harper & Thompson, 2011).

The qualitative IPA design was appropriate for the present study because substance use treatment is a complex phenomenon. Qualitative research enabled a deeper understanding of telehealth from the counselor's perspective instead of a surface explanation of a large sample, as from a quantitative approach (see Creswell, 2014). Qualitative methodology is a means to answer "how" and "why" questions, providing detailed insight and understanding of counselors and telehealth services. The goal of this study was to describe counselors' perceived effectiveness of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs about telehealth. A qualitative approach was appropriate to fulfill these objectives.

Role of the Researcher

The role of the researcher was that of investigator, interacting with counselors to gather the necessary information for analysis. My duty as the researcher was to make participating counselors feel comfortable answering questions. Building a rapport showed my interest in understanding the phenomenon of telehealth for substance use treatment and patient outcomes. Because I have worked at several of the substance use treatment facilities where the participants are employed, I could have known some of the counselors in the sample population. I avoided potential conflicts by not interviewing any counselors I have supervised within the past year.

Methodology (STOP)

Participant Selection Logic

The population was adult counselors employed by a substance use treatment organization having five more licensed clinicians in the SUD field. Participant selection was via ResearchAndMe (https://researchandme.com) a data driven recruiting service platform that helps manage finishing a research study. Researcher used snowball sampling and ask participants for help in identifying other potential subjects (Levine, 2014). Participant criteria were as follows: (a) working in telehealth services for SUD for a minimum of 3 months, (b) having no relationship between counselor and researcher within the last year, and (c) education level with certificates or degrees in the following: chemical dependency counselor assistant (CDCA), Licensed Chemical Dependency Counselor II or III, or independent chemical dependency counselor. Counselors could also be licensed as Licensed Social Worker (LSW), Licensed Independent Social

Worker(LISW), Licensed Professional Counselor (LPC), Licensed Professional Clinical Counselor (LPCC), or clinical psychologists if they work with the SUD population.

IPA studies can have as few as two or as many as 25 participants (Noon, 2018). The anticipated sample size for this study was 12; however, if data saturation had occurred before completing 12 interviews, recruitment and data collection would have stopped. Data saturation occurs when interviewing additional participants produces no new information, with no gaps in information or unexplained data collection (Creswell, 2014). Collected demographic information included age and history of employment within the SUD field (see Appendix B). I noted the race and gender of the counselors but did not use this information as inclusion or exclusion criteria for participation. All participants (ten female, two male) worked for SUD treatment organizations.

Counselors were ineligible to participate if they had a supervisory relationship with me within the past year. If no relationship existed, they were eligible for selection if they met the other criteria. Individuals without licensure of CDCA, Licensed Chemical Dependency Counselor II or III or independent, LSW, LISW, LPC, LPCC, or clinical psychologist could not participate.

I engaged in passive and active recruitment to identify participants. Passive recruitment entailed posting informational flyers to encourage interested individuals to get in touch for more information (Gelinas et al., 2017). Active recruitment entailed directly approaching and interacting with counselors to solicit their engagement in the study. Each potential participant received a letter detailing the purpose, procedures, and eligibility criteria. I contacted interested individuals to review the study and their

eligibility. The discussion included confidentiality, the scope of the study, use of the information obtained, and the voluntary nature of participation, with an opportunity for them to ask questions. Upon receipt of their informed consent form, I scheduled the interviews, I conducted the interviews. During the interviews, I asked open-ended interview questions and recorded the participants' responses with their consent. At the end of the meeting, I asked participants if they knew any counselors who might also be willing to take part in the study.

Instrumentation

The primary data collection tool was a semistructured interview protocol with open-ended questions. Interview and qualifying questions pertained to demographic information; services provided; education level and licensure; and reflections on telehealth with clinical interventions, counselor self-efficacy, counselor retention, and counselor beliefs. Analyzing the answers to the interview questions and reviewing participants' comments provided sufficient information to answer the research question.

I developed the interview questions after performing a literature review to identify the gap in research, subsequently testing and refining the open-ended questions in a pilot study. The interview protocol was the instrument used to gather participants' perceptions of telehealth on clinical performance, counselor self-efficacy, counselor training, and counselor beliefs. Semistructured interviews allowed for one-on-one conversations with participants.

The interview questions were relevant to the topics of interest, making them valid for collecting data to answer the guiding research question. The participants needed to

have a working knowledge of SUD treatment services; thus, they must have worked in SUD organizations and held licensure to provide SUD services. All other questions asked elicited personal and demographic information. The instrument included questions that allowed me to gather efficient data.

Semistructured interviews were sufficient to collect the necessary data to fulfill the study's purpose. The participants could provide as much or as little information as they were comfortable sharing. A prepared interview protocol ensured that the collected data provided the information needed to answer the research question.

The primary data collection tool was the researcher-developed interview protocol. I began each semistructured interview by acknowledging the approved consent form and collecting demographic information. Next, I asked predeveloped open-ended questions to gather participants' perceptions of telehealth on clinical performance, counselor self-efficacy, counselor training, and counselor beliefs.

Procedures for Pilot Study

I conducted a pilot study before the main study. The pilot study participants were two counselors employed at SUD treatment organizations and purposively chosen via snowball sampling. Criteria for pilot study participation were the same as the actual study: (a) working in telehealth services for SUD for a minimum of 3 months; (b) no relationship between counselor and researcher within the last year; and (c) education level, holding certificates or degrees in CDCA, Licensed Chemical Dependency Counselor II or III or independent chemical dependency counselor. Participants could also hold licensure as LSW, LISW, LPC, LPCC, or clinical psychologists if they worked

with the SUD population. The purpose of a pilot study is to determine the feasibility of a study and practice the interview questions to ensure participant understanding (Malmqvist et al., 2019). The Walden University Institutional Review Board (IRB) approval number for the pilot study was 03-14-22-0343729. I discuss the findings from the pilot study in Chapter 4.

Procedures for Recruitment, Participation, and Data Collection

Participant interviews took place via Zoom in a virtual meeting format, with scheduling options meant to ensure participant comfort and flexibility. The meeting format was compliant with the Health Insurance Portability and Accountability Act of 1996. Data collection from each participant occurred in one sitting, with the interviews recorded via Zoom cloud-based recording. Each interview lasted 1 hour or less. I took notes during the interviews to capture thoughts, expressions, body language, and tone of voice. The goal was to collect all necessary data in 4 weeks.

A debrief at the end of the interview allowed participants to ask questions and provide additional information or opinions. I transcribed the interview recordings within 3 days, sending participants their transcripts to review for accuracy. Verifying the answers with participants is a good way to establish the reliability of the information gathered for a study (Malmqvist et al., 2019). Finally, I encouraged participants to contact me if they had any questions or concerns about participating or wanted to learn the study's findings. No, participants reached out about any questions or concerns about the study.

Data Analysis Plan

I initiated data analysis by examining participants' answers to each interview question. The primary source of data collection was semistructured interviews with open-ended questions conducted with counselors employed by SUD organizations. I audio-recorded and transcribed the interviews to ensure the accurate capture of participants' words. Qualitative data analysis begins with coding and finding concepts and relationships between passages (Creswell, 2014).

I used thematic analysis when conducting manual coding. Thematic analysis is a recommended approach to learn about people's views, opinions, knowledge, experiences, or values from a set of qualitative data (Nowell et al., 2017). I closely examined data to identify common themes, recurring ideas, and patterns of meanings. The themes that emerged from the data were sufficient to answer the research question, which was, How do SUD counselors perceive how the use of telehealth has impacted clinical performance, counselor self-efficacy, counselor training, and counselor beliefs? Next, I compared the data to the literature to assess the accuracy of my findings. Data analysis followed a six-step process of familiarization, coding, and generating, reviewing, defining, naming, and writing the findings (Malmqvist et al., 2019). I noted no discrepant cases as I was coding.

Issues of Trustworthiness

Credibility

A researcher takes steps to ensure credibility by providing multiple checks for validity before, during, and following the interview process. Conducting a pilot study is one way to increase credibility. During the interviews, I rephrased questions when needed

to ensure that participants could respond accurately, truthfully, and consistently. I recorded the interviews and transcribed the participants' responses, giving each counselor the opportunity to review the transcript for accuracy. Transcript checking increased the internal validity of the research (see Birt et al., 2016). As another way to ensure overall study credibility, participants were also able to ask questions during or after the interview for clarity. Member checking, reflexivity, and peer review were part of the analysis process. Data collection continued until saturation occurred (see Birt et al., 2016).

Transferability

One way to improve the transferability of a study's findings is using thick description. Thick description entails providing each participant with documentation of study procedures, including the research method and design, participant selection, and data collection and analysis, as well as coding and identifying emerging themes (Mills et al., 2010). This way, the participants can make their own determinations about transferability. The data collection tool—the interview protocol—underwent committee review and refinement based on the pilot study. A way to increase external validity is to use psychological realism, allowing participants to experience the study as a real event by telling them the background of the research and the goal of the study (Neubauer et al., 2019).

Dependability

A study must have dependability if it is to be reliable. The first step to ensuring dependability is to describe all procedures in detail for another researcher to follow and replicate. A pilot study also boosts dependability, uncovering any inappropriate questions

that could negatively impact the research findings (Malmqvist et al., 2019). Another way to increase dependability is to have qualified experts (in this case, my dissertation committee and two other professors) review the study information. Last, I used thematic data analysis to ensure that the codes and themes were accurate and appropriate to answer the research question. All of these strategies helped increase the dependability of the study.

Confirmability

I established confirmability by providing a thorough description of the procedures used, the data collected, and the means of data analysis. Other individuals reviewed the research process and findings to ensure accuracy. During the study, I created checkpoints to ensure reliability, validity, and accuracy. Confirmability in research means a reader can repeat the study's steps from beginning to end (Antoniou & Antoniou, 2020).

Intra- and Intercoder Reliability

Intracoder reliability is the degree to which a researcher gathers, rates, and analyzes data in the same manner for each participant. To establish intracoder reliability, I developed a rating schema before evaluating the participants' transcripts. The color-coded schema was based on similarities among answers (see Noon, 2018). Research studies must have validity and reliability to provide generalizable, replicable, and accurate information. I maintained documentation during all phases of research, making the study transparent and replicable. I shared the information gathered with those involved in the research as well as outside sources to ensure the study was consistent and the data were valid and accurate.

Ethical Procedures

Researchers must follow proper ethical procedures to ensure study integrity and participant safety. Before sampling participants, I completed and submitted research and accountability forms to the proper individuals for review. The IRB provided approval to conduct the study (approval no. 03-14-22-0343729). No participants were minors, so there was no parental consent or special consideration required beyond the participants' signed informed consent. All participants knew that their participation was voluntary and they could withdraw at any point. Recruitment occurred through purposive and snowball sampling. Because there were no organization names used, there was no informed consent required from facilities.

Walden University requires that all student and faculty research receive IRB approval to ensure the study will occur ethically and align with state and federal regulations. The IRB reviewed the proposal, including the informed consent form participants would receive and sign, before granting approval to conduct the study. This process ensured adherence to ethical procedures. Walden University also requires new researchers to take a National Institutes of Health course regarding the processes involved in ethical research. I submitted the certificate of completion (see Appendix C) with my IRB application.

To help with confidentiality, I ensured that there was no identifying information attached to any of the collected data. Data analysis occurred in a consistent and predetermined manner to preserve the integrity of the data. Data storage was such that passwords were necessary for access; thus, only approved individuals could access the

raw data. Confidentiality is one of the ethical standards for licensure as a counselor (Ellis & Freeman, 2020); this expectation carried over to this study. I managed bias by not including counselors currently or recently (within the past year) under my supervision. Whether positive or negative, an established relationship could make it challenging to eliminate biases from the supervisor-counselor dynamic.

Another ethical consideration was the potential for dual roles. Although I took measures to avoid this situation, I could have interacted with counselors who were former clients. One way to address ethical concerns is bracketing, in which researchers examine their beliefs, biases, assumptions, theories, or previous experiences to see and describe the essence of a specific phenomenon (Ellis & Freeman, 2020).

To address possible ethical considerations, I obtained appropriate written consent addressing the why, who, where, and when of data collection before selecting participants. The pilot study assisted with minimizing bias and rehearsing the interview questions before the actual study. The consent process included communicating the steps taken to keep the data anonymous and confidential. Data storage was cloud-based through Zoom and retained on a computer for 5 years, after which time I will delete the files (Gray et al., 2020).

Summary

Chapter 3 provided information regarding the research design and rationale of the study, the researcher's role, and the methodology and approach. There were descriptions of participant selection and data analysis. I also discussed the processes used to ensure the study's credibility and integrity and the participants' safety, including obtaining IRB

approval and participants' informed consent. Chapter 4 will present the information garnered from interviews, documents, and any other material deemed relevant to the study. Chapter 5 includes a discussion of the findings, conclusions drawn from the data and the findings, and recommendations for practice and future research.

Chapter 4: Results

The purpose of this qualitative study was to better understand the lived experiences of counselors as they described their use of telehealth and how it impacts clinical performance, self-efficacy, training, and beliefs about its effectiveness when working with clients with SUD. The study provides a better understanding of counselors' perceived effectiveness. I asked the following interview questions:

1. What has been your experience with telehealth?
2. What was your overall experience with navigation of telehealth with peers?
3. What training was provided for you to navigate telehealth platforms and implement therapy services via telehealth?
4. How has providing services through telehealth affected you or your mental health?

Chapter 4 includes information on the data collection and analysis procedures and the findings. The demographic data appear first, followed by a discussion of the interview data. Next, I discuss evidence of trustworthiness, including credibility, transferability, dependability, confirmability, and intra- and intercoder reliability. I also present the study findings with supporting evidence for the research question and describe any discrepant data.

Pilot Study

I conducted a pilot study prior to data collection. The pilot study participants were two counselors employed at SUD treatment organizations who met the same criteria as the actual study: (a) working in telehealth services for SUD for a minimum of 3 months;

(b) no relationship between counselor and researcher within the last year; and (c) education level, holding certificates or degrees in CDCA, Licensed Chemical Dependency Counselor II or III, or independent chemical dependency counselor. Counselors could also hold licensure as LSW, LISW, LPC, LPCC, or clinical psychologists if they worked with SUD populations. The pilot study took place through Zoom, and both participants read and indicated that they understood the interview questions. Based on the findings, I did not change the pilot study instrumentation and data analysis strategies from those presented in Chapter 3. The purpose of a pilot study is to determine the feasibility of the study and practice the interview questions to ensure participant understanding (Malmqvist et al., 2019).

Setting

The study participants resided in the United States and worked in the counseling field as licensed counselors. I selected participants based on their responses on the site Research and Me (https://researchandme.com) to prescreening questions about their work experience and licensure. Participants engaged in Zoom interviews from a comfortable place of their choosing. Table 1 provides a summary of participant demographics.

Table 1

Participant Demographics

Variable	No. of participants
Gender	
Female	10
Male	2
License	
Psychologist	1
LPCC-S	2
LPC	1

LSW	1
CDCA	2
LICDC	1
Multiple licenses	4

Note. LPCC-S = licensed professional clinical counselor with supervision designation; LPC = licensed professional counselor; LSW = licensed social worker; CDCA = chemical dependency counselor assistant; LICDC = licensed independent chemical dependency counselor.

Eighteen individuals expressed interest in the study; however, only 14 passed the prescreening phase. Of those, 12 individuals took part in interviews; two did not reply to schedule the interview. The 10 female and two male participants held counseling licenses of CDCA, Licensed Chemical Dependency Counselor II or III, or independent chemical dependency counselor. Participants could also hold licensure as LSW, LISW, LPC, LPCC, or clinical psychologists. All participants met the criteria of residing in the United States, working with a SUD organization, and providing telehealth services for a minimum of 3 months.

Data Collection

I collected data from the 12 participants via Zoom interviews. Each participant underwent screening through Research And Me, received and agreed to consent forms, and scheduled interviews; two participants opted to receive an update on the dissertation and summary outcomes. Zoom enabled the recording and transcription of interviews, providing a Word document as output. I replayed the audio and compared the transcribed document with the audio for accuracy, saving all data to password-protected computer files. The interviews lasted from March 21, 2022, to April 7, 2022. Upon transcript confirmation, I imported the files into a Microsoft Excel spreadsheet for analysis. All

data remained password-protected at all stages of the process, and there were no identifying indicators associated with the data; instead, I assigned numeric identifiers (e.g., Participant 1 and Participant 2). Data collection was via semistructured interviews with open-ended questions. I used manual coding to identify themes regarding views, opinions, knowledge, experiences, or values expressed in the qualitative data. After conducting 12 interviews, I noticed clear patterns emerging and participants' answers becoming repetitive, indicating I had reached data saturation. After confirming this with my committee, I determined that there were enough data to discontinue collection.

Data Analysis

Before conducting the interviews, I opted to manually code the data. After collecting all data, I determined that the manual process was still the best option compred to automatic software. I divided participants' responses into polar data (e.g., yes/no, positive/negative), which became the information identified while analyzing the data. For example, Interview Question 1 was, "What is the overall performance of telehealth in your opinion?" The participants' responses fell into the categories of poor, good, and excellent, allowing me to determine the pole. In coding the data, I underlined all positive responses in purple, all middle-ground responses in green, and all negative responses in red. Many of the responses had several parts, necessitating color-coding the longer responses. Using pens of various colors to underline similar elements made it easy to identify the commonalities among the answers.

Next, I grouped participant quotes by color and analyzed each group to determine what most of the respondents thought. The main categories investigated in the study

included intervention, training, belief, performance, peer interaction, and mental health. Among the subcategories created in response to the emerging themes were group therapy, individual therapy, eye movement desensitization and reprocessing (EMDR), family group, and accessibility. These categories are some of the more critical and immediately accessible for the purposes of this study and aligned with self-efficacy theory (Bandura, 1977).

Evidence of Trustworthiness

Credibility

Ensuring credibility entailed performing multiple checks for validity before, during, and after the interview process. I conducted a pilot study to increase credibility. During the interviews, I rephrased questions when needed so that participants could respond accurately, truthfully, and consistently. I recorded and transcribed the interviews and allowed each participant to review the transcript for accuracy, increasing the internal validity of the research. Participants could ask for clarification during and after the interview as another way to ensure overall study credibility.

Transferability

To assist with the transferability of the study, I provided each participant with a consent form and documentation of the study procedures. The audio interviews took place via Zoom to eliminate body language cues and make participants comfortable enough to answer honestly. Doing so aids in the transferability of the study.

Dependability

The strategies for dependability were as discussed in Chapter 3. I described all procedures in detail for another researcher to follow and replicate. A pilot study is another means to boost dependability by uncovering any questions that could negatively impact the research findings (Malmqvist et al., 2019). My committee members were available to review the questions. In addition, I adopted a thematic data analysis approach to ensure that the codes and themes were accurate and appropriate to answer the research question. All of these strategies helped increase the dependability of the study.

Confirmability

To establish confirmability, I provided a detailed description of the study procedures, including the data sought, collected, and analyzed. I asked my dissertation committee members to review the study processes and results for anything that might have skewed the results. I reflected on the process, data collection, and potential bias throughout the study and analyzed those notes to draw conclusions, making any necessary changes to keep the study as reliable, valid, and accurate as possible.

Intra- and Intercoder Reliability

To establish intracoder reliability, I developed a color-coded rating schema based on similarities among answers (see Noon, 2018) before evaluating the transcripts. I documented all phases of research, making the study transparent and replicable. Intercoder reliability entailed sharing my initial findings with the participants and qualified others to ensure that the study was consistent and the data were valid and accurate.

Results

The interview data were sufficient to answer the research question. In this section, I analyze the data from participants' responses.

Interview Question 1

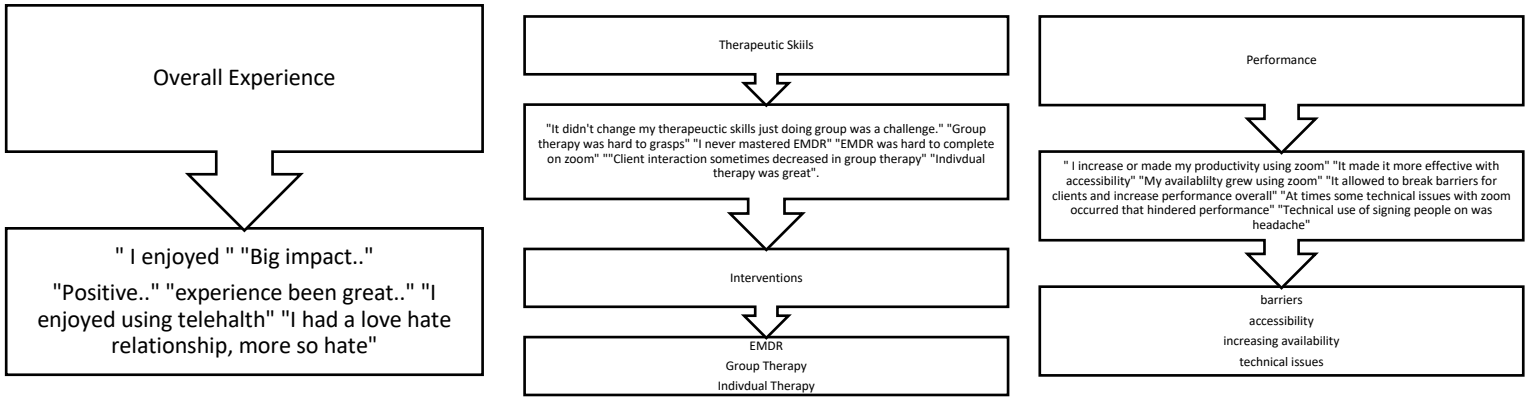
Interview Question 1 was, What has been your experience with telehealth? The responses to this question indicated that the majority of the participants had a positive experience with telehealth services in providing services to SUD clients. Some of the responses supporting this perception were

- "I enjoyed it. I believe that it made it more accessible for people who normally couldn't like it helped with the barriers."
- "I think it's had a really big impact on increasing the availability for services."
- "Positives are that we can continue to communicate with each other [and] have interaction."
- "It made it more accessible not only for the clients but for the therapist as well."
- "I'm a fan of telehealth. [I've] seen more clients, reached more people."
- "My experience has been great. I was able to provide services to my clients even though we weren't able to meet face-to-face and keep their services consistent."

Figure 1 presents the questions and coding breakdown.

Figure 1

Codes and Categories for Interview Question 1



Other respondents reported having a negative experience with telehealth pertaining to the technical function. They struggled to provide group, EMDR, and rational reality therapy interventions, all of which were designed as face-to-face services. Several of the respondents identified downfalls of using telehealth services:

- "Transition over from face-to-face to virtual, and sometimes there was [*sic*] technical issues, you know, getting people to sign on." (Participant 5)
- "It has been a challenge at times to provide EMDR." (Participant 3)
- "One way that made things more difficult [was] because it was harder, like in a group setting, to keep people focused and on task." (Participant 2)
- "Never achieved a comfort level of doing EMDR by Zoom. The other thing that can be challenging is doing group." (Participant 1)
- "Having some clients on Zoom, and then some are in person. This is very difficult because you must alter your subject matter to each group, even if you had documents to pass out and things like that." (Participant 10)

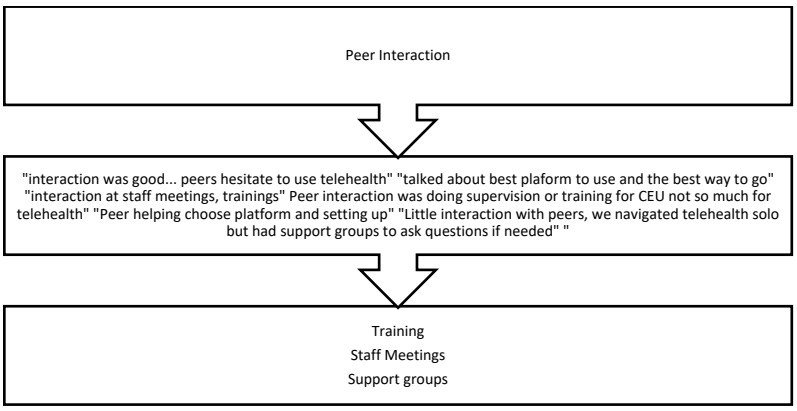
Analysis of participants' responses indicated that telehealth was an overall positive platform that provided access to SUD clients and the ability to communicate with clients throughout treatment. This information aligns with research showing that increasing accessibility requires implementing nontraditional service methods to improve therapeutic outcomes (NIDA, 2018). People have cited stigma and inaccessibility as reasons for not accessing SUD treatment, indicating the need for more convenient options (CDC, 2018). The analysis of this study's data showed positive perceptions of accessibility, communication, and overcoming barriers to access.

Interview Question 2

Interview Question 2 was, What was your overall experience with the navigation of telehealth with peers? Determining the participating counselors' perceptions of telehealth regarding their peers required first asking if they had any peer interaction through telehealth. Although many of the participants did not interact with their peers for counseling within the telehealth platform, they did interact for suggestions, trainings, support groups, and staff meetings. Figure 2 shows the codes and categories for Interview Question 2.

Figure 2

Codes and Categories for Interview Question 2



Participant 7 stated

> Peer interaction was good. Many of [my] peers hesitated to use telehealth for therapy. My experience has been whether you think you can or think you can't, you're always right. I think that has been across the board with my peers, is that the people who are like, "Yeah, telehealth. I just got to adapt some stuff and have, like, a positive attitude"—those people had a good experience. The people who

> are like, “I can’t do this. How do you do this? How’s it going to work?” Those are the people who have struggled the most and want to go back [to] face-to-face.

Participant 8 offered “figuring out what were the best platforms for telehealth to use and talked about which one that we like best.” In describing their overall experience, Participant 4 shared

> I think a lot of it depends on what the organizational goals were. However, it wasn’t until 2020 when I think most of my other peers really did telehealth therapy, and then a lot of them didn’t want to do it. They were just forced into it.

A level of self-efficacy was evident in Participant 6’s characterization of their overall experience: “I asked my peers, but I researched the platforms, and then I started just testing out different platforms to see what works best for me and my organization.” Previous experience with telehealth was also an asset, as Participant 11 noted: “Peer interaction was during supervision or trainings. I came from previous experience with using telehealth services, so everything came naturally. The Zoom platform is user-friendly.”

Participant 9 relied on her peers throughout the conversion to telehealth service for therapy. She reported that, without them, she probably would not have made the transition:

> They’re the ones that helped me get prepared because I didn’t even have a computer or any products. I started off with FaceTime with my clients because prior to this, getting onto Zoom and any of the other health care platforms was a

challenge because there were a lot of glitches, audiovisual glitches. So me talking to my colleagues was very helpful and supportive.

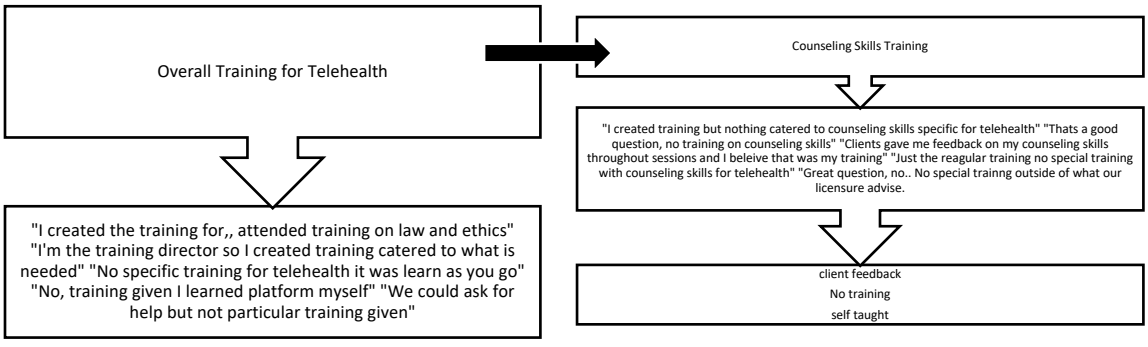
Another participant had trained each person providing services through telehealth. The participant's overall experience navigating telehealth was positive as they navigated the provision of education. In Cristofalo's (2021) study, social workers did not have training in navigating telehealth and lacked positive role models. The social workers struggled to deliver effective services. However, in the present study, some participants reported positive peer interaction in navigating telehealth services.

Interview Question 3

Interview Question 3 was, What training was provided for you to navigate telehealth platforms and implement therapy services via telehealth? Each participant said this was a great question. The responses ranged from no training provided for therapy skills through telehealth to training catered to telehealth counseling skills. Figure 3 shows the codes and categories for Interview Question 3.

Figure 3

Codes and Categories for Interview Question 3



Participant 9 stated, “I created training over the time due to us having to shut down during COVID. I attended APA training for telehealth to learn about ethics and laws, but that was about it.” In response to providing service through telehealth, most of the participants discussed the clients’ receipt of services:

- “Client would say how well the assessment went through Zoom and it did not feel awkward.” (Participant 10)
- “I had a few new counselors shadow groups, and they would tell me I had great interaction with the clients.” (Participant 1)
- “Feedback usually came from clients after they’ve had a couple sessions. I would ask them how the services were, and they will give a reply of, ‘I’m enjoying it, and you’re very engaging.’” (Participant 12)
- “Kind of just observation-type training, never really any formal training.” (Participant 2)

Participant 7 is a trainer and a counselor for her organization. She had completed or taught training on engaging people in likeability and how to use screen sharing and other tools within the therapy setting. Participant 11 is a supervisor who used Relias, an online training program for health care organizations. The participant reported that all clinicians attend orientation and receive 1 hour of virtual telehealth training; however, she was unsure if any trainings specifically catered to telehealth counseling skills.

The earlier individuals experience social persuasion, the more likely they are to build self-efficacy (Bandura, 1977). Each participant’s interaction with training and building skills varied; most of the feedback outcomes came from client interactions,

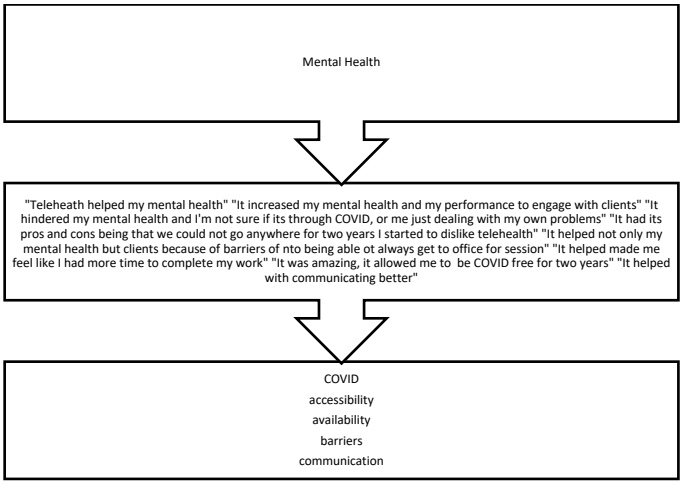
which were mainly positive. These interactions allowed counselors to build upon and acknowledge that social persuasion contributes to building self-efficacy.

Interview Question 4

Interview Question 4 was, How has providing services through telehealth affected you or your mental health? Figure 4 shows the codes and categories for Interview Question 4.

Figure 4

Codes and Categories for Interview Question 4



Most participating counselors found this question difficult to answer. The difficulty resulted from coming off a pandemic after providing telehealth services strictly for 2 years. In March 2020, the WHO identified the novel coronavirus (COVID-19) as a global pandemic, leading to quick quarantine in the United States and worldwide. As a result, many health care providers, including SUD organizations, switched to remote services (i.e., telehealth) to slow the virus's spread (WHO, 2020). Data analysis of

participants' interviews showed an even representation of telehealth as helpful or a struggle. For helpful outcomes, participants reported

Participant 2 stated

> Telehealth relieved a lot of my anxiety with making productivity when productivity was something I had to produce. However, it also affected my mental health negatively because I just needed to get out of the house. So, for a while, it was hard not being able to leave the house due to the pandemic.

Participant 4 stated

> I love telehealth. I would be so happy to only do telehealth for the rest of my career. I think that this is something that we need to integrate long term. …We need to make sure that everybody has access to mental health care through telehealth. As for me, it allowed me to have more flexibility.

Participant 10 stated

> Telehealth has been helpful. Up until the last week, I was able to stay clear of COVID. So, I love that aspect of being safe from the pandemic. Also, it has economical savings for me on gas, things like that, because I could just work from home, and I didn't have to travel anywhere.

Participant 9 stated

> It was helpful because it gave me much more flexibility to be able to help my patients without being in the challenge of you having to come to the office between 10 a.m. and 6 p.m. That eased my mental health.

Participant 7 stated

It's been increasingly helpful because when I do have no-shows or when I do have days where I have a special schedule that's not as full as, you know, it can be sometimes. You have that day where maybe you only have a couple clients that are scheduled.

Participant 11 stated

I like telehealth. [It] feels more efficient to me and not feel exhausted from seeing so many clients face-to-face. It's been helpful on my mental health.

Other participants reported telehealth being a struggle for their mental health:

Participant 5 stated

It's been a struggle. It's so overwhelming. I know what I prefer, and me making the best out of it from being at home, and I'm starting to have some of the lag where, you know, being able to go somewhere, see people. [With face-to-face] interaction, you get out of the house. I became a little less motivated to work.

Participant 8 stated

I think it's been a struggle, because most of us went to telehealth because of COVID, and COVID took us out of a lot of our routine. The structure of just the idea that I get up and go to work and perform my service, like getting out of that routine, kind of has caused me to lose momentum for myself.

Participant 6 stated

Mental health needs have exploded, and I struggled with my own anxiety and depression through the pandemic when it was solely telehealth. Whether that was

because of telehealth, I'm not sure how to pinpoint that. It just was like, you know, all kinds of things going on.

Figure 5 is a word clould of the most common words that participants used in their interviews.

Figure 5

Most Commonly Used Words by the Participants

Telehealth access and use increased due to community shutdowns, forcing many organizations and counselors to provide services in a different way. Shigekawa et al. (2018) looked at telehealth compared to in-person visits and whether the use of telehealth affected other services. The findings showed that, in most cases, telehealth services for mental health and SUD treatment had the same results as in-person care. Telehealth was beneficial to some, decreasing the stress of meeting productivity, helping them stay clear

of COVID and being sick, and giving everyone access to services. Although telehealth may have affected others' mental health due to the inability to leave their homes while dealing with anxiety and depression, having remote access gave counselors a different way of providing services to individuals with SUD diagnoses.

Summary

Much of the information gleaned from this study contributed to filling the research gap in understanding telehealth services in the SUD field. Molfenter et al. (2015) suggested additional research on tracking technology implementation to understand the need for and use of telemedicine and technology. Thomas et al. (2020) discussed developing skills and empowering providers to use telehealth to understand self-efficacy and persuasion. Researchers have indicated the need for more information about telehealth services and their impact on the health care field. This study's findings showed that telehealth had benefits for both the client and the counselor, including flexibility, counselor availability, safety from COVID, and the ability to communicate with clients despite the lack of in-person counseling. The most surprising finding was the lack of training for counseling skills through telehealth services. Thus, there is a need for more training on developing counseling skills through telehealth services. Chapter 5 presents the conclusion and potential implications of the findings.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative study was to better understand the lived experiences of counselors as they described their use of telehealth and how it impacts clinical performance, self-efficacy, training, and beliefs about its effectiveness when working with clients with SUD. The theoretical framework was Bandura's (1977) self-efficacy theory. Self-efficacy represents people's beliefs and judgments about their ability to effectively perform work-related activities (Bandura, 1977). Bandura's theory is an appropriate foundation for exploring individuals' beliefs regarding their ability to accomplish professional goals; thus, it is a commonly used framework in counseling research (see Bandura, 1977). Self-efficacy theory addresses a counselor's competence in four areas: performance accomplishments, vicarious experience, social persuasion, and physiological and emotional states (Betz, 2004). Drawing on the purpose and dynamics of the theoretical framework provided a better understanding of participating counselors' perceived experiences of clinical performance, counselor self-efficacy, counselor training, and counselor beliefs about the effectiveness of telehealth in the SUD field.

Interpretation of the Findings

There were several key findings in this study. According to Bandura (1977), performance accomplishments require having experience first and understanding the product or services provided. Perle and Nierenberg (2013) showed the need to measure counselors' satisfaction with telehealth services. In this study, 10 of the 12 participants had a positive experience with telehealth services, even with most facing the new challenge of rapidly switching to telehealth due to the pandemic. Many of the participants

had technical issues when using telehealth services but were able to master the medium through continuous use of the software until the technical issues subsided. Measuring counselors' satisfaction with telehealth services aligned with Perle and Nierenberg (2013) call for additional research. In line with the framework of self-efficacy theory (Bandura, 1977), significant increases in effort, persistence, and overcoming failure helped counselors improve their performance with telehealth services use, self-efficacy, and performance accomplishments. Even with technical issues, participants' self-efficacy resulted in positive telehealth experiences and improved clinical performance in making services accessible for clients with SUD.

Through vicarious experience, individuals learn from observing a positive role model and displaying some of the models' behavior, resulting in positive self-beliefs (Bandura, 1977). Cristofalo (2021) explored the use of telehealth during and before the COVID-19 pandemic and provided insight into counselors' perceptions of using telehealth by examining vicarious experiences. Cristofalo showed how remote care had helped clients with SUD and the understanding of self-efficacy theory. Most participants in the present study did not physically observe peers completing the task of providing telehealth services. However, the majority of them had positive interactions with their peers, encouraging them to provide services to the community.

One participant said she would have never thought about changing to telehealth services until her peers helped and guided her through navigating the software. Participant 10 allowed a few counselors to shadow her on appointments to make their transition to telehealth a little smoother. The participant received positive and

encouraging responses, which let her know she helped them feel comfortable providing telehealth services. Another participant provided training on telehealth services, assisting new and veteran employees in navigating the software and providing helpful hints on using it with clients. This finding aligned with Bandura's (1977) self-efficacy theory, which suggests that people who believe in themselves are successful and able to master activities. The participants in this study had some input into the decision to provide telehealth services and believed they could complete the task.

The third aspect of self-efficacy is social persuasion, which encompasses giving positive feedback and persuading individuals to believe they have the skills and capabilities to succeed (Bandura, 1977). Many of the participants had not received training in providing services with telehealth. However, they often received positive feedback from their telehealth clients, including that they were doing a great job counseling individuals (Participants 2, 5, and 10), they were keeping the sessions engaging and fun (Participant 10), and they felt confident with the information provided (Participant 1). All participants receiving positive feedback had positive experiences with telehealth and enjoyed providing the services. This finding also supports self-efficacy theory specific to individuals' beliefs about their capabilities to perform a task.

Self-efficacy is a psychological state of people's emotional, physical, and psychological well-being, which influences how they feel about their abilities in a particular situation or work environment (Bandura, 1977). In 2020, COVID-19 necessitated the move to telehealth services, with many counselors who had never provided virtual counseling having to do so quickly. Participant 5 reported starting her

new job on a Friday; on Monday, the office shut down, requiring everyone to work from home and provide telehealth services to clients. The participant had no choice but to change her work dynamics despite her beliefs because she needed to care for her family. She reported feeling frustrated with her inability to navigate the software without training. Although clients' initial perceptions of the software were negative, Participant 5 took time to figure out the software on her own, making for a smoother session.

One participant provided telehealth and face-to-face counseling for a couple of years before COVID happened and believed that "if it's working for the client, I will continue to do it." Participant 12 said their mental health suffered when providing services for clients when they did not feel they were doing a great job. However, the client's encouragement and knowing they were making a change in the client's life allowed them to achieve emotional well-being and provide effective services through telehealth. The findings enabled a better understanding of how SUD counselors' use of telehealth through the self-efficacy of performance accomplishments, vicarious experience, social persuasion, and physiological and emotional states impacted their clinical performance, self-efficacy, training, and beliefs.

Limitations of the Study

The limitations encountered did not differ from the limitations presented in Chapter 1. The first limitation was that the sample represented a specific service area and not the general counseling population. The next limitation was time constraints on data collection based on participant recruitment, counselors' work schedules, and COVID-19 social distancing guidelines. Working around participating counselors' hours meant

having less time to obtain the information needed for the research. In responding to questions verbally, participants could have given less in-depth and candid answers than they would have by answering in writing. The data provided were a voluntary form of self-assessment, and I assumed that the data were accurate, valid, and reliable.

Recommendations

Further research could provide additional understanding of the interventions and necessary changes to provide telehealth services. Topics to explore include navigating telehealth after a pandemic and the resultant changes to counseling, reimbursement changes with the switch to telehealth services, and any trainings created specifically for counseling skills through telehealth. A longitudinal study could reveal how counselors' experiences changed as the pandemic progressed and telehealth services expanded or contracted. Such studies could provide valuable information to expand options for SUD treatment. It would also be valuable to examine the use of telehealth services in other aspects of mental health therapy, not just SUD.

Implications

This study's findings could contribute to improving access to telehealth services. Many of the participants' complaints about telehealth involved the lack of training and guidance on navigating the services in the abrupt shift due to COVID-19. I conducted this qualitative study to understand counselors' beliefs, thoughts, and feelings about telehealth services, as a majority of the research addressed how clients felt about the services and outcomes (Kazemi et al., 2017). The knowledge gained from counselors' perspectives

could bring about social change by encouraging flexibility and the development of support systems for SUD organizations' future use of telehealth services.

Conclusion

This study stemmed from a desire to help those who might not know how to advocate for themselves. Many people hold negative opinions of individuals who use substances. As a result, SUD counselors often feel they have no support when navigating different avenues to provide counseling for their clients (Cristofalo, 2021). As the pandemic has demonstrated, there are many ways other than face-to-face to reach a client. Making counselors aware and accepting of evolving modes of delivery could prevent them from feeling overwhelmed and frustrated by clients not showing up to appointments. Counselors' thoughts, perceptions, and ideas are valid, and there is a need to hear what they need to address the situation. As indicated by Bandura (1977), self-efficacy affects every area of human endeavor, influencing people's power to face challenges competently and the choices they are likely to make. These effects are particularly apparent and compelling in behaviors related to education, employment, and personal life. Understanding counselors' clinical performance, self-efficacy, training, and beliefs could improve SUD organizations' client and service outcomes.

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Appendix A: Interview Questions

The overarching RQ for this study is: How do substance use disorder treatment counselors perceive how the use of telehealth has impacted clinical interventions, counselor self-efficacy, counselor retention, and counselor beliefs? The open-ended interview questions will be as follows:

1. What has your experience been with telehealth?
    - How has telehealth impacted your implementation of your therapeutic skills or evidence-based practices?
    - Did you see a difference over the last 3 months from using telehealth with your performance with providing therapy?
        - If so in what way?
2. What was your overall experience with navigation of telehealth with peers?
    - Is there anyone you leaned on to assist you in learning telehealth software?
        - What was your experience with learning the software from your trainer?
3. What training was provided for you to navigate telehealth platforms and implementing therapy services via telehealth?
    - Did you have specific training catered to telehealth counseling skills?
        - What did the training focus on?
        - What training did you receive related to implementing counseling skills through telehealth?
        - What training did you receive related to using the software platform?

    - Was the training you received helpful to you?
    - Was feedback given to you as to how you were doing with telehealth services?

4. How has providing services through telehealth affected you or your mental health?
    - Has it been helpful?
        - If so, how?
    - Has it been a struggle?
        - If so, how?

Appendix B: Demographic/Inclusion Questionnaire

Name: _____ Age: _____

1. What gender do you identify as?
    a. Male
    b. Female
    c. Trans-gender
    d. Non-binary
    e. Prefer not to answer
    f. Other____
2. Please specify your ethnicity, or what is your ethnicity?
    a. Caucasian
    b. African American
    c. Latino or Hispanic
    d. Asian
    e. Unknown
    f. Prefer not to say
    g. Other
3. Current place of employment: _____
4. Are there 5 or more counselors working with the organization you work for?

    _____
5. Does the organization provide SUD services? _____
    a. How long have you worked for the organization? _____

6. Do you provide SUD services? _____
7. Do you provide telehealth services? _____
    a. How long have you provided SUD and telehealth services?

        _____
8. Have you had a relationship with the researcher (me) in the last 12 months pertaining to the work environment? _____
9. What certification or license do you hold?
    a. Chemical Dependency Counselor Assistant (CDCA)
    b. Licensed Chemical Dependency Counselor II, III or independent Chemical Dependency Counselor
    c. LSW, LISW
    d. LPC, LPCC
    e. Clinical Psychologist

Appendix C: CITI Program Completion Certificate

CITI PROGRAM

Completion Date 04-Jan-2022
Expiration Date N/A
Record ID 46496034

This is to certify that:

Shamarah Thomas-Hutchins

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Student's
(Curriculum Group)
Doctoral Student Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w392bef31-2887-45f6-a1de-1cfb0929e290-46496034