Mental Health Therapy Efficacy Differences as a Function of the Delivery Method of Telehealth or In-person

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Abstract

This quantitative causal-comparative study examined whether perceived therapeutic efficacy differs between in-person and telehealth delivery of outpatient mental health counseling. The research addressed the lack of clarity about how the rapid expansion of telehealth during the COVID-19 pandemic may have influenced clients' perceptions of treatment effectiveness. Grounded in social psychology theory, the study explored how relational processes and perceived interpersonal quality shape clients' experiences of therapy across modalities.

A purposive sample of 70 adults receiving services at a Utah outpatient clinic participated, with 35 completing in-person counseling and 35 using telehealth. Therapeutic efficacy was measured with the Session Rating Scale (SRS), and an independent samples t-test compared mean scores across groups. Results showed no statistically significant differences between modalities, indicating that clients perceived therapy to be equally effective whether delivered in person or remotely. These findings support existing research showing comparable outcomes across modalities and extend the literature by providing post-pandemic data from a general outpatient population. Implications highlight the need for clinicians to develop hybrid-competence skills and routinely incorporate alliance-based feedback tools into telehealth sessions. Future research should examine mechanisms—such as therapeutic alliance, psychological presence, and relational attunement—that may explain why efficacy remains stable across delivery methods, as well as explore how different client subgroups experience modality in a permanently hybrid mental health landscape.

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Chapter 1: Introduction

The COVID-19 pandemic increased the need for more mental health services, as more than 50% of Americans reported increased stress, worry, and anxiety which has negatively impacted their mental health (Johnson, 2021). According to Czeisler et al. (2021), more than 2 in every 5 Americans faced adverse mental health symptoms since June of 2020. It was also noted there are not enough mental health services or funding to help those in need (Kopelovich, 2021). According to Johnson (2021) prior to the COVID-19 global pandemic there were about 1 in every 5 adults who reported struggling with mental health issues. Since the pandemic the number of adults struggling with mental health issues has increased to about 1 in every 3 adults who reported having some symptoms of anxiety and depression (Johnson, 20201).

Due to the uncertainty about how long COVID-19 and its variants will last, and the negative economic impact on communities all over the world, researchers noted a dramatic increase in psychological distress (Sumner et al., 2021). Sumner et al. (2021) noted that many individuals experienced symptoms consistent with posttraumatic stress disorder (PTSD) during the pandemic, alongside increased substance use disorders, a pattern that has been similarly documented across multiple studies examining pandemic-related psychological distress (Czeisler et al., 2021; Tucker & Czapla, 2021). While the health concerns have been the primary focus of the pandemic, healthcare professionals also identified the need for increased mental health services and treatment (Sumner et al., 2021). Researchers also reported a significant positive correlation between psychological distress and physical illnesses such as heart disease, stroke, diabetes, and dementia (Sumner et al., 2021).

One way healthcare providers must reach those people during the pandemic has been through the expansion, or for some clinicians, the development of telehealth services. Mochari-

Greenberger and Pande (2021) noted that due to the tripling of levels of depression and anxiety nationally surrounding those fearing getting the disease and those stuck quarantining at home, many have turned to telehealth services as in-person treatment options were not available for most people. Despite the increase in mental health symptoms, many individuals delayed or avoided seeking care during the pandemic due to fears associated with leaving their homes for mental and physical health treatment, further widening the gap between need and service access (Czeisler, 2021). Indeed, Greenberger and Pande reported 42.6% of adults in the United States who had a behavioral health condition were unable to receive any treatment during the year 2020.

Receiving treatment that was high quality was also another challenge during the pandemic, which is why clinics and other professional healthcare facilities developed protocols and policies to allow telehealth services for their clients to have easy access to services (Mochari-Greenberger & Pande, 2021). Almost overnight mental health professionals had to adjust from providing in-person services to adapting to using telehealth services and setting up home offices where they had none in the past. While these services had been used and researched in the past, many people still utilized in-person services. (Czeisler, 20201).

According to Czeisler (2021) studies done in Wuhan, China noted that those who had the most increase in adverse mental health effects from COVID-19 were healthcare providers themselves. Czeisler (2021) noted that as of June 2020, 5,412 adults in the United States reported having increased depression, anxiety, and trauma due to the aftereffects of the pandemic. Research is needed to extend what was done by Varker et al. (2019), where they looked at the efficacy of telepsychology to look at the efficacy during COVID-19 pandemic. Johnson (2021)

also noted that the number of deaths attributed to opioid overdoses increased in 40 states due to the shortage of services and many in-person clinics being shut down due to COVID restrictions.

It is important to examine the shift toward telehealth as a mandated or default practice within outpatient organizations and to consider whether the effectiveness of services differs across age groups (Waller et al., 2020). Emerging research suggests that while many clients benefit from telehealth delivery, access to and comfort with technology may vary by age, potentially creating barriers for certain populations (Lin et al., 2022; Pierce et al., 2021). Waller et al. (2020) examined the delivery of cognitive behavioral therapy via telehealth and found that clinicians perceived treatment effectiveness to be influenced not only by the client's environment but also by the physical location from which therapists provided services. Similarly, other researchers noted that differences in treatment setting, privacy, and environmental control may influence therapeutic engagement and perceived efficacy in remote care (Kopelovich et al., 2020; Kneeland et al., 2021). Taken together, these findings highlight the need for further research to assess whether client perceptions of therapeutic efficacy are affected by the physical locations of both the client and therapist, as well as by demographic factors such as age and technological access (Lin et al., 2022; Waller et al., 2020).

Statement of the Problem

The problem prompting the study was a lack of understanding about perceived differences in efficacy between in-person and telehealth counseling (Mochari-Greenberger, 2021). Researchers called for information about the efficacy of delivering mental health services through virtual modalities (Bush et al., 2019; Mochari-Greenberger, 2021; Kopelovich, 2021). Specifically, research was needed about mental health services efficacy comparisons between in-person and virtual treatments (Mochari-Greenberger & Pande. 2021; Burhani & Naqvi, 2020).

This information is needed to determine how to respond to the increased need for mental health services during this pandemic (Soklaridis, 2020).

Purpose of the Study

The purpose of this quantitative method and causal-comparative design study was to determine if there is a difference in the efficacy of mental health therapy between telehealth or in-person methods of the delivery of therapy. The study population was adults engaging in outpatient mental health services. The sample consisted of 70 adults receiving outpatient mental health services at a clinic in Utah, with 35 participants engaged in in-person therapy and 35 participants receiving services via telehealth. Participants were recruited from active clients of the clinic who met inclusion criteria and were currently receiving individual outpatient treatment. The independent variable was the treatment delivery method (in-person or telehealth), and the dependent variable was perceived treatment efficacy, as measured by the Session Rating Scale (SRS; Duncan et al., 2003). Data for both groups was collected using a self-report survey received by email with instructions to complete the survey about their last therapy session. Participants receiving in-person and telehealth services completed the SRS survey electronically and returned the survey to the researcher via email. Collected data was analyzed using an independent samples t-test with IBM SPSS Statistics Version 24 to examine differences in perceived efficacy between the two treatment modalities.

Introduction to Framework

Research was needed to extend the social psychology theory that was developed by Kurt Lewin in 1935 (Cherry, 2020). Cherry (2020) also noted that Lewin's theory of social psychology was formed on the basis that people need social interaction to develop a sense of

who they are. It affects not only a person's perception of themselves but also how they feel and their overall mood (Bockler, 2019).

According to Miles et al. (2021), the current pandemic led to decreased contact between most people and their support system. This has included long periods of intermittent quarantining in which people are required to stay at home and have no contact with friends, family, and health care providers. Due to this, there has been a need for more distance healthcare services through telehealth. The social psychology theory is based on the fact that people need to have opportunities for connections with others to promote their well-being and mental health (Miles et al, 2021). This study examined whether the reduced in-person contact associated with the COVID-19 pandemic affected the perceived efficacy of mental health treatment or whether telehealth delivery adequately supported the therapeutic process despite physical separation. Findings indicated that treatment efficacy did not differ significantly between in-person and telehealth modalities, suggesting that video-based interaction was sufficient to support effective therapeutic engagement. These results extend social psychology theory by demonstrating that psychological presence and relational connection can be maintained through telehealth platforms, even in the absence of physical co-location, and support continued investigation into the mechanisms through which therapeutic relationships are sustained across delivery formats.

Introduction to Research Methodology and Design

A quantitative causal-comparative research design was used to examine differences in perceived treatment efficacy between in-person and telehealth delivery of outpatient mental health therapy. Causal-comparative designs are appropriate when the independent variable cannot be manipulated, and existing groups are compared on an outcome of interest (Schenker & Rumrill, 2004). In this study, the independent variable, treatment delivery modality,was not

manipulated, as participants were already receiving services either in person or via telehealth at the time of data collection.

Data was collected using a self-report survey administered to adult clients receiving outpatient mental health (in-person or telehealth) services at a clinic in Utah with multiple locations across the state. Participants represented a range of ages and socioeconomic backgrounds. The survey assessed participants' perceptions of therapeutic efficacy based on their current treatment modality. Clients receiving in-person and telehealth services received the survey electronically via email about the last therapy session they completed. This design allowed for comparison of perceived efficacy between delivery modalities within a naturalistic outpatient treatment setting.

Research Question

RQ1

Is there a statistically significant difference in treatment efficacy scores between telehealth and in-person delivery?

Hypothesis

H10

There is no statistically significant difference in treatment efficacy scores between telehealth and in-person delivery.

H1A

There is a statistically significant difference in treatment efficacy scores between telehealth and in-person delivery.

Significance of the Study

This study is significant due to the ongoing need for telehealth services as there is no current end to the COVID-19 pandemic. Kneeland et al. (2021) noted that being able to identify if delivering effective telehealth services by using a cognitive behavioral therapy technique will help clinicians in the future to be able to provide more efficient therapeutic services. It may also help guide them in methods and techniques that can use to improve efficiency to be able to create an in-person feel while online. Kneeland et al. (2021) and Waller et al. (2020) also noted that there is an increased need for therapeutic services and in some areas a requirement for mental health providers to change the modality of providing services to telehealth there is a need for continued study of the efficacy of telehealth delivery.

Definitions of Key Terms

Cognitive Behavioral Therapy (CBT): According to the National Health Service (2014), cognitive behavioral therapy was first developed by Albert Ellis and presented to the American Psychological Association in 1957. CBT is a therapeutic approach designed to help clients identify and challenge maladaptive beliefs, thoughts, emotions, and behaviors in order to improve problem-solving skills and promote behavioral change.

Efficacy of Treatment: According to the American Psychological Association, efficacy of treatment refers to the effectiveness of an intervention and its ability to produce the intended therapeutic outcomes.

In-Person Therapy: For the purpose of this study, in-person therapy is defined as clients meeting face-to-face with their therapist or clinician at the provider's place of business.

Telehealth: According to the Health Resources and Services Administration (2017), telehealth is defined as the delivery of healthcare services through telecommunication

technologies and electronic platforms, allowing patients to receive care remotely. Telehealth services are commonly delivered via video conferencing platforms such as Zoom, WebEx, Google Meet, Microsoft Teams, and similar technologies.

Summary

This chapter introduced the background and rationale for the present study examining differences in perceived treatment efficacy between telehealth and in-person delivery of outpatient mental health therapy. The general societal problem addressed in this study was the increased demand for mental health services during the COVID-19 pandemic, which contributed to the rapid expansion of telehealth services as an alternative method for delivering mental health treatment. Although telehealth services were widely implemented to address barriers to care during the pandemic (Czeisler, 2021; Mochari-Greenberger, 2021), uncertainty remained regarding whether clients perceived telehealth therapy to be as effective as traditional in-person therapy (Bush et al., 2019; Mochari-Greenberger, 2021; Kopelovich, 2021). The specific problem addressed in this study was the need for research examining potential differences in perceived therapeutic efficacy between telehealth and in-person counseling modalities in outpatient mental health settings (Kneeland et al., 2021; Kopelovich et al., 2020).

The purpose of this quantitative causal-comparative study was to determine whether a statistically significant difference existed in perceived treatment efficacy between telehealth and in-person delivery of mental health therapy. The study population consisted of adults receiving outpatient mental health services at a clinic in Utah. The sample included 70 participants, with 35 individuals receiving therapy through telehealth services and 35 individuals receiving therapy through in-person sessions. The independent variable was the delivery modality of therapy (telehealth or in-person), and the dependent variable was perceived treatment efficacy as

measured by the Session Rating Scale (SRS). Data were collected through a self-report questionnaire that was emailed to participants by the researcher to complete and email back to the researcher. Data were analyzed using an independent samples t-test using IBM SPSS Statistics Version 24.

This study findings contribute to the existing literature by examining whether delivery modality influenced clients' perceptions of therapeutic efficacy in outpatient mental health treatment. As telehealth continues to be integrated into behavioral health services beyond the COVID-19 pandemic, understanding whether perceived treatment effectiveness differs across delivery modalities may help inform clinical practice, service delivery decisions, and the continued development of telehealth within mental health care systems.

Chapter 2: Literature Review

The general societal problem is the COVID-19 pandemic has increased the need for more mental health services, as more than 50% of Americans reported increased stress, worry, and anxiety which has negatively impacted their mental health (Johnson, 2021). The problem with the current literature is that it looks at the efficacy of telehealth pre-covid times, and not since the onset of the pandemic. Specifically, research is needed on mental health services efficacy comparisons between in-person and virtual treatments (Mochari-Greenberger & Pande. 2021; Burhani & Naqvi, 2020). This information is needed to determine how to respond to the increased need for mental health services during this pandemic (Soklaridis, 2020).

This chapter reviews the literature relevant to the present study. The chapter begins with the theoretical framework of social psychology theory. It then examines the prevalence of mental health problems during the COVID-19 pandemic, followed by mental health statistics nationally and within the state of Utah. Next, the chapter reviews changes in mental health service delivery during the pandemic, including outpatient and inpatient treatment trends. The literature on telehealth emergence and utilization is then presented, followed by a review of telehealth efficacy prior to COVID-19 and comparative research examining in-person versus telehealth psychotherapy outcomes. The chapter concludes with a discussion of gaps in the literature and the need for further research.

Documentation

The databases used to locate research for this review included EBSCOhost Roadrunner Search through the National University online library. Keywords used to research the topic were telehealth, mental health, and COVID, in-person therapy, telehealth mental health therapy, efficacy, and telehealth. The following topics are addressed in this chapter: the theoretical

framework of social psychology theory, the prevalence of mental health treatment needs in the COVID-19 pandemic, treatment options for mental health during COVID-19, efficacy of telehealth prior to COVID-19, and efficacy of in-person mental health treatment prior to COVID-19. Discussion about research needed to extend the literature will appear in most sections and the literature review will conclude with a summary.

Search terms were combined using Boolean operators to increase precision and breadth (e.g., telehealth AND psychotherapy AND efficacy; videoconferencing AND therapeutic alliance; COVID-19 AND outpatient mental health AND access). Priority was given to peer-reviewed studies and meta-analyses that (a) directly compared telehealth and in-person psychotherapy, (b) evaluated outpatient populations, or (c) addressed relational mechanisms relevant to efficacy, including therapeutic alliance, engagement, and client-perceived benefit. Because the pandemic produced rapid, policy-driven changes in behavioral health delivery, the literature review also distinguishes between findings obtained during emergency adoption periods and findings more likely to reflect stabilized, routine telehealth conditions. This distinction supports clearer interpretation of what current evidence can—and cannot—conclude regarding comparative efficacy across modalities.

Framework

Social psychology theory provides the conceptual foundation for understanding how individuals interpret interpersonal experiences and evaluate relational interactions. Broadly, social psychology examines how thoughts, emotions, and behaviors are shaped by social context, perceived norms, and interpersonal processes (Cherry, 2020; McLeod, 2007). Within psychotherapy, treatment outcomes are influenced not only by technical intervention strategies but also by clients' perceptions of empathy, responsiveness, collaboration, and relational safety.

Because telehealth alters the physical context of therapeutic interaction, social psychology theory offers a useful framework for examining whether mediated communication changes how clients perceive therapeutic effectiveness. The following sections review core principles of social psychology and their relevance to psychotherapy delivery modality.

The guiding theoretical framework for this study is social psychology theory. Cherry (2020) reported that social psychology is based on the fact that the way people see themselves is greatly influenced by society, and how they perceive themselves in relation to others. This extends to their beliefs, choices, and behaviors. McLeod (2007) stated that two of the assumptions made by social psychology theorists are that first people's emotions, thoughts, and behavior are influenced by the society they create, and second that behaviors occur in a social context no matter whether other people are physically present.

Social psychology theory emphasizes that human behavior and self-perception are fundamentally shaped through interpersonal interaction. Rather than functioning in isolation, individuals interpret their experiences through ongoing relational exchanges that influence motivation, self-concept, and social judgment (Cherry, 2020). The core concepts of social psychology—goal-directed social behavior, situational influence, self-concept formation through social comparison, expectation confirmation, and correspondent inference—collectively illustrate that meaning is constructed within relational contexts. Individuals engage in social behavior to meet needs for belonging, status, protection, and understanding, and they adapt their responses depending on situational cues and perceived social norms. At the same time, they evaluate themselves through reflected appraisal and social comparison processes while forming judgments about others based on observable behavior, often attributing actions to stable personality traits rather than contextual variables (Cherry, 2020).

Synthesized together, these principles suggest that psychological experiences are shaped not merely by objective events, but by how individuals interpret relational signals within specific contexts. In psychotherapy, this implies that treatment outcomes may be influenced by how clients perceive therapist responsiveness, emotional availability, and collaborative engagement within the therapeutic interaction. Therefore, changes in delivery modality—such as shifting from in-person sessions to telehealth—may alter situational cues and contextual features that shape these relational interpretations, even if core therapeutic techniques remain consistent.

Collectively, these core concepts emphasize that human behavior and self-evaluation are shaped through social interpretation processes that occur within context. Applied to psychotherapy delivery, this suggests that client perceptions of benefit are likely influenced by (a) expectations about what therapy should look like, (b) the situational conditions in which therapy occurs (in-office versus remote), and (c) the client's interpretation of the therapist's intentions and responsiveness. The framework therefore supports examining whether telehealth can sustain the same relational evaluation processes that underlie perceived efficacy in in-person therapy.

The origins of social psychology can be traced to early philosophical foundations, with Aristotle's observation that humans are inherently social beings forming the conceptual basis of the field. This foundational idea was later formalized in the early 20th century when McDougall published the first book explicitly focused on social psychology, helping to define discipline as a distinct area of study. The field was further advanced by Allport in 1924, who emphasized the role of social interaction in shaping individual behavior and psychological functioning, a principle that continues to underpin modern social psychology theory (McLeod, 2023).

Relevance of Social Psychology Mechanisms to Psychotherapy Delivery Modality

Social psychology theory is particularly relevant to psychotherapy because treatment efficacy is influenced not only by intervention techniques but also by interpersonal processes embedded within social interaction (Cherry, 2020; McLeod, 2007). A robust body of psychotherapy research has demonstrated that relational factors—including therapeutic alliance, empathy, collaboration, and perceived responsiveness—are consistently associated with positive treatment outcomes across modalities (Horvath et al., 2011; Norcross & Lambert, 2019; Wampold & Imel, 2015). Social psychological constructs such as social perception, attribution theory, role expectations, and relational reciprocity provide a theoretical framework for understanding how clients interpret therapist behaviors and evaluate session quality (Heider, 1958; Kelley, 1973; Fiske & Taylor, 2013). Within psychotherapy, these processes are operationalized through the client's subjective experience of being understood, validated, and collaboratively engaged dimensions commonly measured through alliance scales and session evaluation instruments (Horvath et al., 2011; Flückiger et al., 2018).

From a social psychology perspective, the central analytic question in comparing in-person and telehealth delivery is not whether telehealth replicates the physical environment of face-to-face therapy, but whether it sustains sufficient relational exchange to support psychological presence, emotional attunement, and perceived responsiveness (Lombard & Ditton, 1997; Wampold & Imel, 2015). If clients' social-cognitive evaluation processes remain intact across modalities, then perceived therapeutic efficacy should remain comparable, even when communication is technologically mediated.

Psychological Presence Versus Physical Co-Location

Social psychology and communication theory suggest that meaningful interpersonal influence does not require physical co-location but rather depends on perceived social presence

and relational engagement (Lombard & Ditton, 1997; Short et al., 1976). Individuals routinely form impressions, attribute intentions, and experience emotional resonance through mediated communication formats such as video conferencing, telephone interaction, and digital messaging, although the range and salience of social cues may vary across platforms (Fiske & Taylor, 2013; Walther, 1992). Social information processing theory further posits that relational depth can develop through mediated channels when sufficient communicative exchange occurs, even if nonverbal cues are reduced (Walther, 1992).

In psychotherapy, this distinction is clinically significant because core therapeutic processes—including validation, empathic reflection, collaborative goal setting, and rupture repair—are grounded in clients' perceptions of responsiveness and attunement rather than the mere sharing of physical space (Horvath et al., 2011; Wampold & Imel, 2015; Norcross & Lambert, 2019). Research on telepsychology has similarly indicated that alliance ratings in video-delivered therapy are often comparable to those observed in face-to-face treatment (Backhaus et al., 2012; Norwood et al., 2018). Accordingly, delivery modality becomes clinically relevant not because it changes physical proximity, but because it may alter how relational cues are transmitted and interpreted. If mediated communication sustains sufficient psychological presence and perceived emotional availability, then therapeutic processes central to efficacy may remain intact across modalities.

Implications for Measuring Efficacy in a Modality Comparison

When comparing psychotherapy delivery modalities, interpretation of efficacy depends on the outcome constructs selected for analysis. A substantial body of research indicates that client-reported measures of session quality, alliance, and perceived helpfulness are robust predictors of treatment outcomes across therapeutic approaches (Horvath et al., 2011; Flückiger et al., 2018;

Norcross & Lambert, 2019). Within common factors theory, perceived relational quality—including collaboration, empathy, and emotional attunement—accounts for a meaningful portion of therapeutic change beyond specific intervention techniques (Wampold & Imel, 2015). In the present study, perceived efficacy is operationalized through session-level client ratings that reflect relational quality and collaborative fit, constructs that align with established alliance and session evaluation measures (Horvath et al., 2011; Flückiger et al., 2018).

From a social psychology perspective, client-reported efficacy represents a social-cognitive evaluation of the therapeutic interaction. Clients interpret therapist behaviors, attribute intent, and assess relational responsiveness through processes consistent with attribution theory and social perception frameworks (Heider, 1958; Fiske & Taylor, 2013). Therefore, if perceived efficacy remains stable across in-person and telehealth conditions, it suggests that the interpersonal evaluation mechanisms underlying therapeutic alliance remain functionally intact despite differences in physical context. This theoretical framing supports the use of client perceptions as a meaningful outcome variable in modality comparisons, as such perceptions reflect the client's integrated interpretation of relational engagement rather than solely symptom change.

Recent scholarship demonstrates that social psychology consistently adapts to major societal disruptions, reflecting shifts in collective behavior and relational norms. Tam et al. (2021) argue that the field's research priorities often mirror prevailing global conditions, such as the focus on aggression and obedience during World War II or the emphasis on social identity and intergroup processes during periods of civil rights movements. In the context of the COVID-19 pandemic, social psychology research has increasingly examined self-regulation, prosocial behavior, social adaptation, and the psychological effects of disrupted interpersonal contact (Tam et al., 2021).

This shift underscores the discipline's attention to how individuals adjust their relational expectations and behaviors when typical forms of social interaction are altered.

Synthesized within the present study, this trend suggests that changes in socialization patterns during the pandemic—including reliance on mediated communication and reduced physical co-presence—may shape how individuals interpret relational engagement. If social psychological processes adapt to contextual changes in interaction norms, then clients' expectations and evaluations of psychotherapy may likewise shift in response to telehealth normalization. Therefore, examining psychotherapy delivery modality within a post-pandemic context aligns with broader social psychology inquiries into how altered social environments influence interpersonal perception and behavioral evaluation.

Kashima (2021) noted that during this time the role of institutions, meaning health departments and the World Health Organization, greatly affected socialization and behavioral responses to their mandates. Jetten et al. (2021) noted that some positive shifts during the COVID-19 pandemic included more focus on human behavior becoming more reliant on the collaborative effort of researchers and each other and working together at a collective level to have greater real-world effects in change to keep themselves and others safe.

During the COVID-19 pandemic, researchers documented significant increases in anxiety, depression, and loneliness associated with prolonged social isolation and disruption of typical interpersonal routines (Albarracin & Jung, 2021). Albarracin and Jung (2021) further suggested that widespread loss—whether economic, relational, or structural—may have impaired individuals' capacity for self-regulation and prosocial engagement. These findings align with broader social psychological models indicating that reduced social contact can influence both emotional well-being and empathy-related processes.

Similarly, Meier et al. (2021) emphasized that the pandemic created a natural context for examining how social behavior adapts when traditional forms of in-person interaction are restricted. They noted increased reliance on digital communication platforms, which simultaneously facilitated connection and introduced new risks, including increased reports of cyberbullying alongside prosocial online engagement. Taken together, this literature highlights two central themes that emerged during the pandemic: the restructuring of social relations and the interplay between social behavior and health-related decision-making (Albarracin & Jung, 2021; Meier et al., 2021). These themes underscore the importance of examining how altered interaction patterns may influence relational perception processes, including those occurring within psychotherapy.

Kashima (2021) conceptualizes human development as embedded within socially constructed "niches," wherein individuals shape and are shaped by the relational, political, and economic environments they inhabit. From a social psychological perspective, identity formation and behavioral norms emerge through reciprocal interaction between individuals and their social contexts. Communities provide interpretive frameworks that influence how individuals understand themselves, their roles, and their place within collective structures. During the COVID-19 pandemic, disruptions to typical patterns of in-person interaction required individuals to reconstruct these social niches under altered conditions characterized by physical distancing, digital communication, and shifting social expectations (Kashima, 2021).

Synthesized within the present study, this theoretical lens suggests that changes in relational environments—such as the transition from in-person psychotherapy to telehealth—may alter the contextual cues through which individuals interpret social roles and relational engagement. If therapeutic interaction constitutes a micro-social niche, then delivery modality may influence

how clients situate themselves within that relational space. Examining modality differences through this framework allows for investigation of whether reconstructed interaction environments meaningfully affect clients' perceptions of therapeutic effectiveness.

Albarracin and Jung (2021) reported that during the pandemic some people became more prosocial and began helping those who were struggling in a similar way to them due to the theory of prosocial behavior, which in turn increased their ability to have more personal resilience. Ward (2020) noted that people in small communities came together to help neighbors out of jobs and with limited income to be able to afford things like COVID tests faster than bigger charities could. Ward (2020) noted that the pandemic and its challenges brought communities closer together despite them having to quarantine and social distance, as people supported local businesses and neighbors more during this time. Kashima (2021) reported that the pandemic brought about threats to humanity's ability to adapt and function day to day as humanity is very reliant on people traveling and trading goods and information. With cultural tightening in different areas of the world, it forced social psychologists to question if humans can still thrive when resources and socialization as they knew it is now altered (Kashima, 2021).This framework relates to the problem statement because the social psychology theory is based on the fact that people need to have opportunities for connections with others in order to promote their well-being and mental health (Miles et al, 2021). Albarracin and Jung (2021) noted that a big struggle for people needing to find connection with others was primarily through social media platforms, which leads to a whole series of questions about how people not socializing in person affects their mental health and perceptions of what societal norms are. Kashima (2021) reported that the pandemic brought about threats to humanity's ability to adapt and function day to day as humanity is very reliant on people traveling and trading goods and information. With cultural

tightening in different areas of the world, it forced social psychologists to question if humans can still thrive when resources and socialization as they knew it are now altered.

Telehealth, social connection, and relational cue transmission.

During the COVID-19 pandemic, reductions in in-person contact significantly altered how individuals maintained relationships, sought social support, and interpreted interpersonal cues (Albarracin & Jung, 2021; Meier et al., 2021). Social psychological research suggests that relational meaning is constructed through interpretation of verbal and nonverbal signals, contextual cues, and perceived responsiveness (Fiske & Taylor, 2013; Heider, 1958). Within psychotherapy, these mechanisms are central to alliance formation and treatment engagement (Horvath et al., 2011; Flückiger et al., 2018).

The rapid transition to telehealth raised questions regarding how relational cues function when interaction is technologically mediated rather than physically co-located. Communication research indicates that video-mediated platforms preserve several core social signals, including facial expression, vocal tone, and conversational turn-taking, though they may attenuate certain contextual or embodied cues (Lombard & Ditton, 1997; Walther, 1992). Empirical studies of telepsychology have generally reported comparable alliance ratings between video-delivered and in-person therapy, suggesting that key relational processes can be maintained despite differences in physical setting (Backhaus et al., 2012; Norwood et al., 2018; Lin et al., 2022).

From a social psychology perspective, therapeutic effectiveness is shaped by clients' interpretations of therapist engagement, emotional availability, and collaborative intent rather than physical proximity alone (Wampold & Imel, 2015; Norcross & Lambert, 2019). Because alliance processes consistently predict treatment outcomes across modalities (Flückiger et al., 2018), comparative research conducted after telehealth normalization is theoretically meaningful.

Such research evaluates whether mediated interaction sustains the interpersonal evaluation mechanisms clients use to assess session quality in traditional in-person contexts.

This theoretical framework is related to the research question because the phenomenon of the COVID-19 pandemic and limited in-person contact leaves the question as to if it has had an impact on the efficacy of a person's treatment due to not being able to see providers in person. Part of the social psychology and importance of this study and the overall patient experience is establishing a therapeutic alliance. Traditionally this was done in an in-person office-type setting, but can the same alliance be achieved through telehealth platforms. Kneeland et al. (2021) noted in their study with men in a residential treatment setting that this was initially a huge challenge for them. They found that to humanize the therapist and build rapport which would allow the client to feel more comfortable the therapist had to engage in some minor self-disclosure which in an in-person setting was not always necessary (Kneeland et al., 2021).

Prevalence of Mental Health Problems in the COVID-19 Pandemic

The COVID-19 pandemic produced widespread disruption to daily routines, employment, social interaction, and healthcare access. Public health crises are historically associated with increases in psychological distress, including anxiety, depression, trauma-related symptoms, and substance use (Czeisler et al., 2021; Sumner et al., 2021). Early pandemic data indicated sharp increases in mental health symptom reporting across demographic groups both within the United States and internationally (Johnson, 2021; Wang et al., 2022). Understanding the scope and severity of these increases is critical for contextualizing the demand for mental health services and the subsequent shift in service delivery modalities. The following sections examine diagnoses observed during the pandemic and national mental health statistics.

Mental Health Diagnoses Seen During the Pandemic

Many of the diagnoses seen during the pandemic are similar to those seen prior to the pandemic, but on a more acute level. Bajaj et al. (2021) conducted a data analysis using data collected from Reddit by first identifying users on Reddit that were suffering from a mental health diagnosis. Secondly, they collected 99,334 posts by others and 147,034 posts that used the keywords of covid, coronavirus, and pandemic and eliminated those users who did not post before than pandemic to get to their study base of 32,000 users, They then used Artificial Intelligence (AI) and machine learning to weed through the posts to take out the data about those users that posted about mental health during the pandemic. Bajaj et al. (2021) found some of the trending diagnoses and searches that were conducted through the popular information website Reddit included: anxiety, autism, PTSD, suicide, depression, and stress along with common searches about the pandemic and COVID. Mochari-Greenberger and Pande (2021) looked at one specific company that provided telehealth services during the pandemic called AbleTo. From their research of what mental health symptoms/diagnoses that they were treating included anxiety, depression, substance use, and suicidality. They also reported that there was an increase seen mainly among females under age 40. They also noted that during the pandemic not only did Americans experience more depression, anxiety, and stress but there was a higher level of severity of symptoms and a lot of burnout among healthcare employees and other work environments that were considered essential (Mochari-Greenberger & Pande, 2021).

Pal and Danda (2023) noted that not only did Americans experience an increase in mental health symptoms, but those adults in India who experienced lockdown during the pandemic also reported an increase in anxiety, stress, and depression. Pal and Danda used a semi-structured 42-question self-report questionnaire using google forms and recruited 284 participants in India to

respond to it. Of those 284 56% were male and 44% were female. The study found that their reported mental health symptoms of anxiety, sleep difficulties, and depression were due to fear about the pandemic as well as stress over losing business and professional identity because they could not work or keep their business afloat throughout periods of lockdown. Similarly, Wang et al. (2022) did a study using data from the PROTECT online survey in the United Kingdom for people ages 50 and over. They were able to capture data from the report of 11,188 observations that 3,462 participants were. They collected data for two separate time frames within the pandemic. The first set of data was collected in June of 2020 during lockdown and with a 2-meter social distancing rule in effect. The second set of data was collected in September of 2020 when some restrictions were lifted, and citizens were allowed to leave home for work with a 10 pm curfew. Wang et al. (2022) used the PHQ-9 to assess symptoms of depression and the GAD-7 to assess symptoms of anxiety. The findings showed that among older adults in England, there was a marked deterioration of mental health including an increase in depression and anxiety starting as early as March of 2020 and continuing through the end of November 2020 when the study closed. Arpino et al. (2021) did a study in April 2020 in adults in France, Spain, and Italy which were the first three European countries that were affected severely by the COVID-19 virus. They found that 50% of the participants sampled reported feeling more depressed than usual, and had feelings of loneliness, anxiety, and suicidal ideations.

Some limitations that were mentioned by the above studies were that each study looked at only a small percentage of their populations studied. Bajaj et al. (2021) used an online forum and commentary and posts from members, rather than doing an actual study with participants and getting confidential data, so there are some questions as to the validity of the information that was gathered as it is very subjective material. Mochari-Greenberger and Pande (2021) got data

from an online mental health provider that gave services to a small number of people compared to those affected during the pandemic. While representative of a more middle-class population, those who could not afford services or part of the more severely affected population would have been missed by their research. The Pal and Danda (2023) research was conducted in India, and while they included a large number of participants it was not fully representative of their total population. Wang et al. (2022) conducted a more comprehensive study using previously peer-reviewed tools and only included those age 50 and above in their study. Arpino et al. (2021) explored a very broad area covering participants in 3 European countries but still reported the need for further research to look at a broader population and the longer-term effects and impact of COVID-19 on mental health.

Mental Health Statistics From the Start of the COVID-19 Pandemic

Many researchers agree that during the COVID-19 pandemic mental health issues began to increase. Johnson (2021) did a cumulative report on data collected by several organizations including the Health Enhancement Research Organization, Mental Health First Aid, AbleTo, Talkspace, and the Action Alliance's Mental Health and Suicide Prevention National Response program. From the collective data, Johnson (2021) found that 1 in 3 adults identified having symptoms of anxiety and/or depression. Johnson (2021) also noted that in as many as 40 of the states in the United States, there was a significant increase in drug overdoses during the year 2020. Czeisler et al (2021) did a meta-analysis of research and data collected by various organizations during the pandemic. It was reported that in a study conducted by the US Centers for Disease Control, 5,412 adults were surveyed with the four-question PHQ-4 and the six-question Impact of Event Scale and 30.9% of people reported symptoms of anxiety and depression and 26.3% reported experiencing symptoms of trauma or stress-related disorders

(Czeisler et al., 2021). Another study that Czeisler et al. (2021) referenced in their metanalysis looked at 124 patients in the United Kingdom who were infected by COVID-19. Nearly one-third of them reported altered mental status and some of those went on to fit clinical definitions of new-onset psychosis, and 20.3% left the hospital meeting criteria for PTSD. Czeisler et al. also reported that in a study that they did during 2020 with adults, those ages 18-24 experienced more adverse mental and behavioral health symptoms at 25.5% of those in the 18-24 age range reported serious suicidal ideation, compared to those in the 65 and over age group whom only 2% of participants in the study reported having suicidal ideation. They went further and broke down the study by race/ethnicity and in June of 2020 participants reporting serious suicidal ideation were 18.6% of US Adults who were Hispanic, 15.1% were African American, and 7.9% were White. This suggested that there was more to be looked at in terms of discrimination and racism during the pandemic. Additionally, Sumner et al. (2021) investigated at the impact of the COVID-19 pandemic on trauma and physical health and noted that those exposed to the COVID-19 virus reported symptoms of trauma including increased depression, anxiety, and drug use. From their analysis of data given from seven different studies, Sumner et al. offered three suggestions for further research. The first suggestion was to stop treating physical health and mental health separately as they are more intertwined than they are treated. Secondly, Sumner et al. reported that there needs to be more research on whether reducing psychological distress helps to improve a person's physical health. The third suggestion was for more communication about how important it is to be psychologically healthy to help motivate the integration of physical and mental healthcare into routine treatment (Sumner et al., 2021).

Mochari-Greenberger and Pande (2021) reported on trends in mental healthcare since the start of the pandemic and compiled statistics from virtually delivered behavioral healthcare.

noted that there was a tripling in levels of anxiety and depression symptoms reported related to the precautions put in place to protect against the virus. It was also noted that even though mental health issues were prevalent before the pandemic the rate of people reporting mental health diagnoses increased during 2020 from 1 in every 5 people to 2 in every 5 people. Tucker and Czapla (2021) noted in their study that a greater number of people reported post-COVID-19 stress disorder with symptoms similar to post-traumatic stress disorder. In their study, they noted that 35.1% of their participants endorsed symptoms of anxiety, 20% depression, and 18.2 % sleep difficulties. Mental health effects of COVID-19 noted by Miles et al. (2021) include anxiety, depression, and sleep difficulties in China, America, Canada, and Dutch countries. Vahratian et al. (2021) reported that another survey was done by the CDC using the Household Pulse Survey and they found that there was an increase between the months of August 2020 and February 2021 of reported depression and anxiety from 36.4% of adults taking the survey to 41.5%. Czeisler et al. (2021) reported that during the pandemic anxiety disorders increased from 8.1% to 25.5%, depressive disorders increased from 6.5% to 24.3% and those who reported suicidal ideation increased from 4.3% to 10.7% from those reporting mental illness in the last half of 2019. Mochari-Greenberger and Pande (2021) reported that before the pandemic mental health diagnoses affected 1 in 5 Americans or around 20.6% of the population.

In the area of addiction crisis, Mendell (2021) looked at an organization called Shatterproof which was created to aid in helping those with addiction get the treatment needed. They reported that Americans struggling with drug and alcohol addiction increased by 42% during the pandemic and just following compared to 2019. Tucker and Czapla (2021) reported that 40.9% of the 5,000 adults in their study endorsed adverse mental health symptoms, and 13.3% of them endorsed using substances to cope with their symptoms.

Meier et al. (2021) reported that there was a significant increase in fear related to the threat of being exposed to the COVID-19 virus. This fear led people to activate their self-protective motivational system and escape or hide in their homes. According to Schaller and Park (2011), people develop negative relationships or social responses to those who present with a fear of infection including those with symptoms such as coughing, sneezing, visible rashes, and unpleasant smells, in public settings. Some people even developed xenophobia and those who identify as Asian American became targets of discrimination (Meier et al., 2021). Albarracin and Jung (2021) also reported that a big concern during and after the pandemic is people's ability to self-regulate. Those who were isolated and alone for most of the time reported more fear and increased depression than those who had social networks to rely on.

In summary, according to most research conducted during and shortly following the main outbreak of the pandemic, researchers showed that there was a significant increase in the emergence of and increase in symptoms of those struggling with mental health and substance use addiction issues. Johnson (2021), Czeisler et al. (2021), Sumner et al. (2021), Mochari-Greenberger and Pande (2021), Tucker and Czapla (2021), Miles et al. (2021), and Vahratian et al. (2021) all noted that there was a significant increase in anxiety, depression, and suicidal ideation during and following the pandemic. Mendell (2021) and Tucker and Czapla (2021) both noted the increase in substance use in order to cope with their symptoms during the pandemic. With the majority of outpatient clinics shut down as noted by the above researchers, there was and still is a need to deliver services to those in need using methods such as telehealth for those unable to access services in person.

Mental Health Statistics in the State of Utah

Because this study will take place in the state of Utah it is important to compare the need to that noted by researchers around the United States and those in Countries most affected by the pandemic. Summers et al. (2019) reported that 1 in 5 Utah adults reported poor mental health and between the years of 2015-2017, 15% of males and 28.5% of females between the ages of 15-17 had serious thoughts of suicide. On the more sobering side of mental health for the State of Utah, suicide is the leading cause of death for people ages 10-24, and 13% of all suicides in the state of Utah were Veterans, and 60% of youth ages 12-17 who were diagnosed with depression did not receive any treatment for it, and over half of the adults in Utah with mental health diagnoses did not receive any treatment or counseling for their mental illness. There are over 100,000 adults in Utah that are diagnosed with a serious mental illness. These statistics were all pre-COVID-19 pandemic. No research studies could be found that indicated the mental health statistics in the State of Utah during the pandemic and that follow as of the start of this study.

Changes in Mental Health During the Pandemic

Albarracin and Jung (2021) noted that in the United States, the COVID-19 pandemic caused around 22 million Americans to lose their jobs. One positive change noted is that people, despite struggling with their own mental health and financial difficulties, have become more prosocial in helping each other. Albarracin and Jung (2021) noted that people supported local businesses more rather than global ones, got to know their neighbors more, and helped each other when supplies were low by sharing with those who needed things they did not have or could not get. Probably the biggest change in mental health during the pandemic was noted by Skolaridis et al. (2020) who did a comprehensive review of research presented by electronic databases Medline, Embase, APA Psych info, and the Cumulative Index to Nursing and Allied

Health Literature. Skolaridis et al. found through a review of 2404 studies and eliminating down to 21 different studies that fit their criteria of interventions during pandemics over the past several years that major changes in mental health aside from the above-mentioned symptoms were the training, guidelines, and protocols for how interventions took place. Some of the interventions included using apps on mobile devices for therapeutic interventions including music therapy, telehealth visits, and art programs. Cole et al. (2020) noted that something that was added during the Ebola and COVID-19 pandemics was programs that were focused on training the trainer or those staff that were involved in treating patients who were ill with diseases in which they had to quarantine and therefore had an increase in mental health symptoms. Albarracin and Jung (2021), Skolaridis et al. (2020), and Cole et al. (2020) pointed out changes that were noted through looking at a metanalysis of other studies done. They did note that due to not only studies done during the COVID-19 pandemic, but also the Ebola outbreak, MERS, SARS, and influenza pandemics there is a similar response among those affected by the disease and those who treat them. A more thorough approach could be used to study the changes and effects that pandemics bring on and the changes that must be made by both healthcare organizations and those in the public who are affected.

Treatment Options for Mental Health During the COVID-19 Pandemic

As mental health needs increased during the COVID-19 pandemic, traditional service delivery systems faced significant disruption. Outpatient clinics reduced in-person visits, inpatient facilities modified admission practices, and regulatory bodies temporarily adjusted telehealth restrictions to maintain continuity of care (Kopelovich et al., 2020; Pierce et al., 2021). These systemic changes accelerated the expansion of telehealth services and transformed how psychotherapy was delivered. Reviewing treatment delivery adaptations during this period

provides necessary context for evaluating comparative efficacy across modalities. The following subsections examine outpatient service trends, telehealth emergence, and inpatient utilization patterns.

Outpatient Clinics

HealthLeaders (2022) found research done by Office Ally, which is one of the commercial payors for Medicare and Medicaid, that of the 101.7 million outpatient mental health visits that were billed between 2016 and 2020 that a quarter of those visits occurred from March to December of 2020. HealthLeaders (2022) data also showed following stay-at-home orders during the pandemic there was a 21.9% decrease in mental health in-person office visits in March of 2020 and by May of 2020 that increased to 55.9% compared to the number of in-person visits in the same month a year prior. Once the country went to remote services and lockdown agencies had to scramble to find technology and equipment to get up and running in each provider's home to continue to serve those most in need (Kopelovich et al 2020). While after lockdowns were lifted, and some in-person sessions were more accessible to clients there was still a great fear for people leaving their homes of being exposed to COVID-19 and this drove people to seek treatment through telehealth services when possible and telehealth visits increased to 27.5% for those with fear and anxiety based issues compared to 25.5% that went in-person (HealthLeaders, 2022). While both studies note that there was an increase in telehealth services during and following the pandemic there are no studies that show if those who were getting treatment via telehealth received comparable treatment as those who received in-person therapy services.

Telehealth Emergence

According to Miles et al. (2021), the current pandemic led to decreased contact between most people and their support system. This has included long periods of intermittent quarantining in which people are required to stay at home and have no contact with friends, family, and health care providers. Due to this, there has been a need for more distance healthcare services through telehealth. Kashima (2021) noted that one big change in people's interactions during the COVID-19 pandemic was a huge increase in the use of social media. Government agencies would use social media and mass text messaging to be able to reach people and warn them of exposure risks and mandates for socializing.

Technology Access and Differential Feasibility Across Considered Populations

Although telehealth has been shown to reduce structural barriers such as transportation burden, geographic distance, and scheduling constraints (Backhaus et al., 2012; Hilty et al., 2013), emerging research has also identified feasibility limitations associated with technology access, privacy, and digital literacy. Studies conducted during and following the COVID-19 pandemic have noted that unstable internet connectivity, limited access to confidential space, and reduced familiarity with videoconferencing platforms can affect client engagement and comfort in remote sessions (Kopelovich et al., 2020; Pierce et al., 2021; Lin et al., 2022).

Barriers related to digital access have been associated with disparities in telehealth utilization, particularly among older adults and individuals with limited technological resources (Chiauzzi et al., 2020; Lin et al., 2022). These contextual constraints may influence session participation, disclosure patterns, and perceived therapeutic alliance, all of which are linked to treatment outcomes (Flückiger et al., 2018; Norcross & Lambert, 2019). Consequently, several scholars have suggested that telehealth efficacy may vary depending on client-level and

environmental moderators rather than functioning as a uniformly equivalent modality across populations (Pierce et al., 2021; Lin et al., 2022).

Within the broader literature, these findings underscore the importance of examining modality comparisons in general outpatient samples while accounting for demographic and access-related variables that may influence perceived benefit. Evaluating these contextual factors allows for more precise interpretation of whether observed equivalence reflects modality stability or differential feasibility across subgroups.

Bulkes (2022) reported that during the COVID-19 pandemic healthcare organizations had to find a way to meet the increased need for mental health services around the world. The challenge they reported was the need to find a way to deliver services that were equivalent to the therapy service that was provided in person. Prior research by Hall and McGraw (2014) showed that the use of telepsychiatry via video conferencing and phone calls was an acceptable and feasible way to reach patients both with serious mental illnesses as well as those with less serious mental illnesses.

In research conducted by Whaibeh et al. (2020), it was noted that telehealth became a way for those stuck in lockdown situations to have some human connections when seeing providers and acquaintances in person was not possible. Another benefit noted by Price-Haywood et al. (2020) of telehealth care was that those in minority groups were able to receive services without having to travel distances and risk exposure to the COVID-19 virus and incur the cost of traveling a long distance to receive services in their preferred language. Further, it was mentioned that for a first-time appointment, it may be difficult for providers to get a complete and thorough evaluation done, but on the positive side, it allows them to be able to see the environment the client is in and offers the ability for the provider to help the client adjust and

change their environment to improve their mental health (Kopelovich et al., 2020). Similarly, Kneeland et al. (2021) conducted a study in an inpatient residential treatment setting, though a less acute setting, it was still a means of treatment during and following the pandemic. Kneeland et al. found patients who were housed in a residential setting reported that there were struggles with providers that could not come into the residential facility, even though clients were there. The biggest disparity they reported was that when they used video conferencing for individual, group, and family therapy sessions there were some challenges that they faced in establishing a therapeutic alliance, replacing non-verbal communication, and keeping participants engaged in treatment due to the need for a hybrid inpatient system (Kneeland et al., 2021).In order to meet the emerging mental health crisis during the COVID-19 pandemic the Office for Civil Rights made accommodations and waived penalties for providers in regard to the Health Insurance Portability and Accountability Act to allow them to be able to use any type of device or service to be able to reach their clients in need more quickly until a more secure type of communication was available (Kopelovich et al., 2020). Connolly et al. (2020) studied the utilization of telebehavioral health during the pandemic among Veterans in the Veteran's Affairs Hospital system and they had an increase of 556% in one month alone of use compared to the same time frame a year earlier. According to Johnson (2021) from the months of February to May 2020, the demand for online therapy with the company Talkspace increased by 65% due to the increased need for services.

Markowitz et al. (2021) reported that early in 2020 due to the COVID-19 pandemic there was a rapid change from in-person to telehealth, and telehealth became standard practice in the industry. There was reported an 85.53% increase in telehealth services in 2020, and those rates are estimated to remain high following the pandemic (Pierce et al., 2021). In studies done by

Pierce et al. (2021) and Wootton (2016), they reported that new research is needed on the efficacy of teletherapy due to the uptick in the usage of it from the COVID-19 pandemic. They also noted that prior studies primarily looked at a single diagnosis or therapeutic methodology rather than if there was a difference between in-person or telehealth delivery methods and that remains largely unstudied.

Inpatient Treatment

Rameriz et al. (2022) reported that the first person to look at the effects of a pandemic was Dr. Karl Menninger in 1919 when he studied the effects on mental health that the H1N1 virus had on those who contracted the virus and increased psychosis leading to inpatient hospitalization. Similarly, during many past viral outbreaks, there is an uptick in people reporting mental health symptoms such as depression, anxiety, substance use, psychological distress, and sleep problems leading to a greater need for inpatient hospitalization (Cenat et al., 2020). Rameriz et al. (2022) studied 470 adults between the ages of 18 and 79 who were admitted to an inpatient psychiatric hospital in Houston, Texas, of which 235 of them were admitted right before the pandemic and 235 were admitted after the pandemic. They found that those that were admitted before the pandemic while still meeting medical necessity for inpatient admission reported less severe symptoms than those who were admitted after March of 2020. Of those admitted during the pandemic, 156 had a diagnosis of major depressive disorder, 74 had been diagnosed with general anxiety disorder, 27 had been diagnosed with bipolar disorder and 60 presented with posttraumatic stress disorder. Hamlin et al. (2022) also did a study on inpatient service utilization during the pandemic. Hamlin et al (2022) looked at admission rates for one specific inpatient psychiatric hospital in Gothenburg, Sweden in two different waves of the pandemic from March to June of 2020 and then from October 2020 to March 2021. They

reported that the rates of inpatient admission for psychiatric hospitalization either remained similar to the time before the pandemic or decreased slightly. It was also reported in their study that those with schizophrenia, other psychotic disorders, and those considered severely mentally ill had an increase in admission rates as the availability of services in-person were not available to them. Those who were younger than 70 and reported struggling with less severe mental health had a decreased rate of inpatient admissions due to their access to telehealth psychiatric services and easy access to seeing a doctor from their homes (Hamlin et al., 2022).

Although the information about the utilization of inpatient services is helpful, it is also very limited. Rameriz et al. (2022) only looked at one facility in Houston, Texas, and Hamlin et al. (2022) did research at a facility in Sweden, so the information gathered was not fully representative of the population of people affected by the COVID-19 pandemic. Cenat et al. (2020) looked primarily at diagnoses that increased during the pandemic in those seeking inpatient services and while mentioning increased suicide rates, increased anxiety and depression, and the effects that the pandemic had on those seeking inpatient it was again not fully representative of the population due to the limited nature of the study. It is important to next look at the effects on the population that not having access to in-person treatment had on the general population due to lockdown and risk.

Impact of Lack of Services During COVID-19

Service disruptions during the early stages of the pandemic raised concerns regarding continuity of care, particularly for individuals with serious mental illness and those reliant on community-based supports (Kopelovich et al., 2020). Reduced in-person availability, technology disparities, and rapid transitions to remote platforms introduced new barriers to engagement (Waller et al., 2020). Evaluating the impact of these disruptions is essential for interpreting

telehealth outcomes during crisis conditions and distinguishing emergency implementation effects from modality-specific effects.

Miles et al. (2021) noted that shortly into the pandemic the need for trained mental health professionals was great and the supply was short. Also, due to most of the country being in quarantine a new way of delivering rapid and effective solutions was greatly needed. Kopelovich et al. (2020) reported that those with serious mental illness who were receiving care through public/community mental health centers had the greatest impact due to the lack of services available for in-person treatment. A big barrier that has come up during this time is that while many people may have the ability to use telehealth services there remains a number of people with serious mental illness who do not have access to the technology required to be able to participate in treatment other than in-person (Kopelovich et al., 2020). Waller et al (2020) did a study in which they surveyed 70 clinicians working in the field on their ability to deliver effective cognitive behavioral therapy for their clients who were diagnosed with eating disorders. Waller et al. had 22 clinicians report that using telehealth services made it difficult for them to deliver therapy due to many technical issues, the platform used to deliver services, changes in the environment for the client and the clinician, and overall delivery of previous in-person techniques like weigh-ins, eating, and getting a personal approach to therapy services without seeing them in person.

The lasting effects of these changes noted by the above researchers would still need to be studied and followed up on. While they mentioned some things in their studies that affected treatment during the pandemic, it has yet to be seen the lasting effect it has now that we are coming out of the pandemic and if these populations of people were affected by having to switch to telehealth services. While the above studies noted some challenges that had to be overcome

during the pandemic telehealth services were not a new platform and had been shown to be effective in the past.

Efficacy of Telehealth Prior to COVID-19

Telehealth was not a novel intervention introduced during the pandemic; rather, it had been studied for decades as a means of expanding access to care. Prior research demonstrated that telebehavioral health services could reduce barriers related to geography, transportation, and stigma while maintaining comparable clinical outcomes across various diagnoses (Backhaus et al., 2012; Hilty et al., 2013). However, much of this literature focused on specific populations or treatment modalities, limiting generalizability to broader outpatient contexts (Kane & Gillis, 2018; Wootton, 2016). A review of pre-pandemic telehealth efficacy research is necessary to establish the baseline evidence prior to widespread emergency implementation.

Prior Research Done on Telehealth

A study done by Backhaus et al. (2012) showed that telehealth is effective in a broad range of uses and can be equivalent to the results from face-to-face therapy. Before the pandemic, there was a gradual shift towards tele-behavioral health due to the need to be able to accommodate more people, get rid of the stigma of leaving work to go to therapy appointments, and decrease long wait times associated with in-person treatment (Mochari-Greenberger & Pande, 2021). Kane and Gillis (2018) reported that those primarily using the telehealth platform prior to the COVID-19 pandemic consisted of those in rural areas, veterans receiving services through the Veterans Affairs Hospital System, and those in correctional facilities. Use by those in urban areas and those who would be considered the general civilian population had not had much need for these services before the pandemic. It is important to note that prior to the pandemic only 1% of mental health services were being completed on telehealth platforms, despite many studies

that were completed to show that results were similar and experiences by the client and clinicians were positive (Kneeland et al., 2021).

According to Bulkes (2022), studies done prior to the COVID-19 pandemic by many different researchers showed that telehealth and in-person treatment efficacy was similar and patient satisfaction did not vary between delivery methods. Hilty et al. (2013) noted that healthcare providers have been trying to find ways to deliver healthcare remotely for about six decades and only recently have begun trying to deliver these services on videoconferencing platforms. Past studies noted that using teleconferencing reduced the cost to the patient for traveling and in some instances also increased their attendance due to the convenience of not having to leave their house for services (Rabinowitz et al., 2010). Burhani and Naqvi (2020) noted that telehealth offered a way for those patients to get the care they needed without having to leave their homes and risk exposure to those who were more severely ill. Bulkes (2022) looked at the efficacy of telehealth as a delivery method for intensive outpatient and partial hospitalization services during COVID-19 and found that there was no significant difference reported between groups and both delivery methods showed improvement overall in a patient's quality of life self-report

Efficacy Results From Prior Studies

Kneeland et al. (2021) reported that the efficacy of telehealth has been studied by many researchers since its introduction in as early as 2013 when it was looked at as a viable alternative to in-person sessions. This method is primarily used when there was a need to deliver services to clients either in remote areas or who have barriers to transportation to in-person sessions. Fletcher et al. (2018) and Gros et al. (2013) both noted that the results of their efficacy studies showed consistently comparable outcomes for those enrolled in telehealth services as those

enrolled in in-person sessions. Further, there was empirical data that showed that symptoms of depression, anxiety, and relapse improved similarly for those receiving services through telehealth as those receiving in-person services (Kneeland et al., 2021).

Burhani and Naqvi (2020) reported some of the benefits of telehealth include providing health awareness and prevention services to groups of people, enhance treatment to remote areas with limited resources, may accessibility for individual treatment easy to get from home, help with the individual cost of travel for treatment and education for providers, and keeping clients safe from exposure to illnesses and keeping them out of emergency rooms and clinics. Mochari-Greenberger & Pande (2021) found that in a study on the effectiveness of the telehealth platform used by the company AbleTo, there was a reduction in symptoms of depression by 50% in the 2,356 adults in America that were using the service for mental health treatment.

Efficacy of In-Person Compared to Telehealth Treatment Prior to COVID-19

In-person psychotherapy has historically been considered the standard model of mental health treatment delivery (Kazdin, 2015). Comparative studies conducted prior to the COVID-19 pandemic generally reported no significant differences in symptom reduction between video-delivered and in-person treatment modalities (Fernandez et al., 2021; Lin et al., 2022). However, these studies often aggregated heterogeneous populations and intervention types, raising questions about contextual applicability. Examining comparative efficacy research conducted prior to pandemic-related disruptions provides a foundation for understanding how delivery modality may influence treatment outcomes under routine conditions.

Kazdin (2015) found that while in-person or one-to-one treatment is the main delivery model for psychotherapy, it does not have the ability to reach everyone in need. While shown effective for years there often is not enough mental health providers to meet the needs of the

population, especially in rural areas and for those with severe mental health issues (Comer & Barlow, 2014). The World Health Organization (2017) reported that the ratio of mental healthcare providers in low-income countries was about 2 per every 100,000 people and in high-income countries, it was around 70 per every 100,000 people. Fernandez et al. (2021) reported that while in-person treatment is noted as the model of delivery for mental health there is no way that providers can keep up with the demand to help those in need of treatment.

Norwood et al. (2018) looked at 12 studies done on individual adults in cognitive behavioral therapy treatment that participated in treatment either in-person or through video conferencing and found in both treatment modalities symptoms were reduced. A meta-analysis was conducted by Fernandez et al. (2021), and they studied the effect size of 56 within-groups and 47 between-group studies of in-person and video-delivered psychotherapy. They hypothesized that while the video-delivered psychotherapy group would show improvement in symptoms from the beginning to end of treatment, there also would be no difference between video-delivered and in-person treatment.

Osenbach et al. (2013) continued prior research of fourteen other studies and found similar results in that using telehealth platforms to deliver therapy for depression showed similar results to those participating in in-person sessions. A meta-analysis was conducted by Wootton (2016) and included eighteen prior studies on the telehealth treatment of obsessive-compulsive disorder using cognitive behavioral therapy and it was concluded that those who participated in the treatment had significant improvements in symptoms. This study did not compare results to those who were engaging in in-person treatment but rather just focused on the outcomes of those using telehealth platforms. Lin et al. (2022) noted that while many studies in the past have looked at the efficacy of telehealth, they have mainly focused on different types of treatment delivered to

various populations of clients but have not compared their results to those participating in the same treatment in an in-person setting. Further, they noted that there is not any research done to date that has focused on putting telehealth in direct comparison with in-person treatment controlling for participants and type of therapy delivered. Lin et al. (2022) completed a meta-analysis of 20 studies that were done with the intent of comparing the efficacy of in-person therapy to teletherapy. Lin et al. found that results posttreatment in both the teletherapy groups studied and the in-person therapy groups studied yielded similar outcomes. Further, it was noted that while results of studies show that telehealth efficacy is similar to that of in-person, many therapists still prefer in-person treatment so the use of it may not be utilized as it was during the pandemic.

Research Needed

The existing body of literature provides substantial evidence that telehealth is a feasible and often effective modality for delivering mental health services. Across a range of diagnoses—including depression, anxiety disorders, obsessive-compulsive disorder, and posttraumatic stress disorder—studies have reported comparable symptom reduction outcomes between telehealth and in-person psychotherapy (Osenbach et al., 2013; Wootton, 2016; Fernandez et al., 2021; Lin et al., 2022). Meta-analytic findings have further suggested that video-delivered interventions can produce statistically similar posttreatment improvements relative to traditional face-to-face care (Fernandez et al., 2021; Lin et al., 2022). Collectively, these findings support the clinical viability of telehealth as an alternative method of service delivery. However, important methodological and contextual limitations within this body of work constrain the strength and generalizability of conclusions regarding delivery modality equivalence.

A central limitation concerns the focus of prior research. Much of the pre-pandemic telehealth literature examined specific diagnoses or particular therapeutic approaches rather than isolating delivery modality as the primary independent variable (Wootton, 2016; Gros et al., 2013). While such studies demonstrate that telehealth can facilitate symptom reduction within defined treatment protocols, they do not consistently determine whether modality alone influences how clients experience and evaluate treatment when therapeutic model and population are held constant. As a result, it remains unclear whether equivalent outcomes reflect intervention efficacy independent of delivery format, or whether certain modalities interact with contextual variables that shape client perceptions of benefit.

In addition to diagnostic and treatment-specific constraints, many telehealth studies prior to COVID-19 were conducted within specialized populations, including veterans receiving care through the Veterans Affairs system, individuals in rural or geographically isolated communities, and populations with limited access to traditional outpatient services (Kane & Gillis, 2018; Hilty et al., 2013). Although these studies demonstrate telehealth's accessibility advantages and clinical promise, they limit generalizability to broader outpatient populations engaged in routine psychotherapy within community-based settings. The general outpatient population represents a clinically distinct context in which clients often have the option to choose between modalities rather than relying on telehealth due to structural barriers alone. Comparative research within this population is therefore necessary to determine whether delivery modality influences perceived therapeutic effectiveness under conditions of choice rather than necessity.

Interpretation of pandemic-era research further complicates the literature base. During the early phases of COVID-19, telehealth implementation occurred under emergency conditions characterized by rapid regulatory changes, inconsistent technological infrastructure, clinician

adaptation curves, and elevated societal stress (Kopelovich et al., 2020; Pierce et al., 2021). These factors introduce potential confounds that obscure whether observed outcomes reflect true modality effects or crisis-related instability. Telehealth delivered during emergency substitution may differ meaningfully from telehealth delivered under stabilized practice conditions, where clinicians possess greater experience, workflows are standardized, and client expectations are normalized. As telehealth has transitioned from temporary accommodation to sustained integration within behavioral health systems, research conducted in post-crisis contexts is necessary to determine whether previously observed equivalence persists under routine conditions.

Although several meta-analyses have reported no statistically significant differences between telehealth and in-person outcomes (Fernandez et al., 2021; Lin et al., 2022), these analyses frequently aggregate heterogeneous samples across diagnoses, therapeutic models, age groups, and outcome measures. Such aggregation may obscure modality-specific effects that are detectable when examining more narrowly defined constructs. In particular, limited research has focused explicitly on client-perceived session efficacy within general outpatient settings. Symptom reduction represents one dimension of treatment outcome; however, perceived helpfulness, relational quality, and collaborative fit are also central to how clients evaluate therapy experiences. These constructs may be influenced by contextual and interpersonal variables that differ across delivery modalities.

From a social psychology perspective, this distinction is theoretically significant. Psychotherapy outcomes are shaped not only by intervention techniques but also by clients' interpretations of relational cues, perceived empathy, responsiveness, and emotional attunement. Although telehealth preserves many communicative elements such as facial expression, tone of

voice, and turn-taking, it alters environmental context, embodied co-presence, and certain nonverbal dynamics. Existing literature has not sufficiently examined whether these contextual differences influence clients' social-cognitive evaluations of session effectiveness when telehealth is delivered as routine outpatient care rather than emergency substitution. Understanding whether relational perception processes remain stable across modalities is essential for determining whether telehealth equivalence extends beyond symptom metrics to client-experienced therapeutic value.

Demographic and contextual moderators further warrant examination. Age, digital familiarity, privacy access, and prior expectations about therapy may shape modality preference and engagement patterns (Chiauzzi et al., 2020; Lin et al., 2022). However, limited research has systematically evaluated whether these variables alter perceived efficacy within general outpatient samples. Without such analysis, conclusions regarding telehealth equivalence risk overgeneralizing findings from select populations or crisis-specific conditions.

Finally, the sustainability of hybrid service models in contemporary behavioral health practice depends on evidence that telehealth maintains clinical integrity while expanding access. Utilization data clearly demonstrate substantial increases in telehealth adoption during and following the pandemic (Connolly et al., 2020; Johnson, 2021; Pierce et al., 2021). Yet utilization trends alone do not establish equivalence in therapeutic value or client-perceived benefit. Clinics must determine not only whether telehealth increases reach, but whether it supports comparable therapeutic experiences that justify long-term integration alongside in-person services.

Taken together, these limitations underscore the need for research that isolates delivery modality as the independent variable, examines general outpatient populations under stabilized

post-pandemic conditions, and evaluates client-perceived efficacy as a meaningful outcome construct. Such research extends prior literature by moving beyond crisis-era implementation contexts and diagnosis-specific efficacy studies to address whether telehealth and in-person psychotherapy produce comparable perceived benefit within routine practice environments. Grounded in a social psychology framework that emphasizes relational evaluation processes, the present study seeks to clarify whether delivery modality meaningfully influences how clients experience and evaluate therapeutic effectiveness in contemporary outpatient care.

Summary

Meier et al. (2021) noted that learning from what happened during the COVID-19 pandemic is essential for future studies on behavior as we are not immune as a society to going through another pandemic in the future. There will always need to be time spent studying behaviors, responses, and resources to help those struggling the most during these times so we can better adapt and provide for each other in the future (Meier et al., 2021). For the most part, our society is a prosocial society, and social connections are invaluable to having ideal mental and physical health.

In a survey done by Glueckauf et al. (2018), it was found that between the years of 2013 and 2016 around 43% of therapists reported that they had provided telehealth therapy services for some hours during their work week. Communicating with clients over the phone or through telehealth video conferencing platforms leads to challenges in creating a trusting therapeutic relationship, especially with those who had underlying paranoia and psychosis (Kopelovich et al., 2020). Lin et al. (2021) noted that new therapists were more hesitant to use teletherapy services due to not feeling as confident in building the therapeutic relationship and using their skills as more seasoned therapists. They also noted that it may take therapists more sessions to

build a therapeutic connection with clients through teletherapy as it is in-person and therefore it may not be appropriate to use with all clientele.

A huge gap in prior studies that were done was the populations of people that were studied. Kane and Gillis (2018) looked at the use of telehealth services with veterans that were engaged in treatment for mental health with the Veteran's Affairs Hospital system. Further, telehealth or teletherapy is suggested to be a preferable delivery method of treatment for females and younger adults due to it being a familiar and more convenient way for them to participate in treatment (Chiauzzi et al., 2020). On the flip side, a barrier noted for older senior clients to using telehealth services is that they do not have as much experience with technology as younger clients and they are noted to prefer in-person treatment over telehealth services (Lin et al., 2022). Other researchers looked at populations in other countries, and those that were participating in treatment who had severe mental illness diagnosis. Much research is needed to assess how effective telehealth services are with the general population of people who seek outpatient therapeutic services in a normal outpatient setting.

Beyond population limitations, literature has also been constrained by timing and context. Many studies conducted during early COVID-19 relied on conditions that were inherently unstable (e.g., emergency policy changes, clinician learning curves, rapidly shifting client stressors, and inconsistent telehealth infrastructure). These conditions complicate interpretation of comparative efficacy because they may confound modality effects with crisis-era disruptions. As telehealth has transitioned into routine practice, a more informative question is whether client-perceived efficacy remains comparable when remote care is delivered with stabilized workflows and normalized expectations. Addressing this question supports both clinical decision-making (e.g., when to recommend telehealth versus in-person) and organizational

planning (e.g., how to structure sustainable hybrid models without assuming reduced clinical quality).

Hoever, gaps in the literature remain. Further research was called for about the efficacy of telehealth compared to that of in-person treatment by looking strictly at the delivery method. Kneeland et al. (2021) noted that prior to the COVID-19 pandemic, there was only around 1% of people that were engaging in mental health treatment, which drastically changed once the country went on lockdown. Most of the prior research, as is noted by Lin et al. (2022), was completed by investigating certain populations, diagnoses, and treatment methodologies (i.e., CBT, DBT, exposure therapy, etc.) and not just simply comparing the delivery method of telehealth vs in-person. Further research was needed in this area to extend the social psychology theory to include less in-person interaction and more online therapy.

In summary, although existing research demonstrates that telehealth can produce outcomes comparable to in-person psychotherapy across various diagnoses and treatment models (Lin et al., 2022; Fernandez et al., 2021), important limitations remain. Much of the prior literature focused on specific populations, intervention types, or crisis-era implementation conditions rather than isolating delivery modality as the independent variable within stabilized outpatient settings. Additionally, rapid shifts in modes of utilization during the COVID-19 pandemic complicate interpretation of modality effects independent of contextual disruption (Kneeland et al., 2021; Pierce et al., 2021). These gaps highlight the need for post-pandemic research examining client-perceived efficacy of telehealth and in-person psychotherapy within general outpatient populations. Addressing this limitation contributes to both theoretical understanding of relational processes in mediated interaction and practical decision-making regarding sustainable service delivery models.

Chapter 3: Research Method

The problem that prompted this study was a lack of understanding about differences in efficacy between in-person and telehealth counseling modalities. According to Czeisler et al. (2021), more than 2 in every 5 Americans faced adverse mental health symptoms since June of 2020. Reserachers noted a paucity of mental health services or funding to help those in need (Kopelovich, 2021). One strategy to address inadequate mental health services was virtual telehealth services (Greenberger & Pande, 2021). However, there was a lack of understanding about the efficacy of such services (Mochari-Greenberger, 2021). Researchers called for information about the efficacy of delivering mental health services through virtual modalities (Bush et al., 2019; Mochari-Greenberger, 2021; Kopelovich, 2021). Specifically, research was needed about mental health services efficacy comparisons between in-person and virtual treatments (Burhani & Naqvi, 2020; Mochari-Greenberger & Pande. 2021). This information was needed to determine how to respond to the increased need for mental health services during this pandemic, and the years following, now that we are in a new normal as a country and adjusting for upcoming crises in which people may be homebound (Soklaridis, 2020).

The purpose of this quantitative method and causal-comparative design study was to determine if there was a difference in the efficacy of mental health therapy between telehealth, or in-person methods of the delivery of therapy. The study population was people engaged in outpatient mental health services in the State of Utah. The sample included people engaged in in-person mental health treatment, as well as those who were getting services through telehealth modalities. The sample was recruited from an outpatient clinic in Utah who had clients that used both methods of in-person and telehealth treatment for mental health therapy. The independent variable was the treatment delivery method (telehealth or in-person). The dependent variable

was the efficacy of treatment, as measured by the self-report Session Rating Scale (SRS). Data was collected via a self-report survey emailed to participants by the researcher. Data was analyzed using a two-sample t-test with IBM SPSS Statistics 24.

The following pages introduce the study research method and design, population and sample, the materials and instruments that were used, and give a definition of the variables that were studied. Furthermore, it describes the specifics of the study procedures and data analysis and reviewed any ethical concerns and considerations for the study. The research methodology chosen was a causal comparison design and compared the delivery methods of therapy and determined if there were any differences in the efficacy of therapy sessions.

Research Methodology and Design

A quantitative research method using a causal comparison was used for this current study. Quantitative research according to Smith (2021), was based on empirical data collected via surveys or experimental research studies. This type of design allowed for the researcher to find cause and effect or comparisons between two or more different variables. A qualitative design was not used as research called for a comparison between two groups using quantitative data collected from surveys, rather than other data collection methods such as interviews and focus groups as are used in qualitative designs.

This study used a causal comparison design to ascertain if there was a statistically significant difference between one variable compared to another variable. Post hoc analysis indicated which had higher means than the other. This design was selected because the study research questions and hypotheses were about the difference between a non-manipulated independent variable. Based on the nature of the independent variable, a true experiment was not considered appropriate (Smith, 2021). A correlational design was also not selected because

the relationship between two variables was not being compared for similarities, but rather the effectiveness of two different deliveries of treatment.

Population and Sample

The population for this study was adults receiving outpatient mental health counseling in the state of Utah. This population was appropriate to address the problem of determining if there was a difference in the delivery method of individual outpatient therapy, because they were receiving outpatient services either by telehealth or in-person and were representative of the overall population of people in the State of Utah with mental health or substance use diagnosis and receiving treatment. There were 17,373 mental health centers in Utah at the time this study was completed that helped serve the 26.2% of the population of adults in the state of Utah that reported having any type of mental health diagnosis. It was also important to note that according to Orgero and Panchal (2022), 206,000 people in the state of Utah who reported having mental health diagnoses, and need for treatment, reported not being able to receive help due to their inability to access services.

The gender of people receiving mental health counseling in Utah was equally divided between males and females. Some also identified as non-binary and transgender and this was notated in the results. They were primarily Caucasian, and religious preference varied greatly, but most were of the LDS religion. Participants varied in age from age 18 to 65. They also varied in socioeconomic status. The reason for the use of this population was that they were representative of the population most affected by the change in the mental health delivery methods since the onset of COVID-19 and the years following. Their participation gave a report on the missing data that had not been collected previously by other studies.

The sample included 70 participants in total. Half, or 35, of which were seeing therapists in person and half, or 35, that were seeing therapists through telehealth. Participants were recruited from a client list of individuals receiving mental health counseling from an outpatient treatment center in Utah. The clinic's IT Services provided a list of all active clients with an appointment in a two-month time frame. Potential participants were emailed a recruitment letter by the researcher. If they agreed to participate, they were then emailed the consent form and SRS survey by the researcher to complete and email back.

The population that was sampled was appropriate to carry out the purpose of determining the efficacy of therapeutic services because of their participation in outpatient treatment either in-person or telehealth. Half of the participants were those participating in therapeutic services in-person, and half of them were participating in therapeutic services via telehealth.

The sample size was determined by g-power analysis using the effect size of .80. It was determined from the g-power analysis that including 35 people in each group for a total of 70 participants would be. Inclusion criteria were clients with a mental health or substance use diagnosis receiving outpatient treatment either in-person or through telehealth at a clinic in Utah. Participants were recruited by email from the email list that was provided by the outpatient clinic through their information technology department for those having active appointments within a 2-month period of time (see Appendix A for the recruitment letter and Appendix C for G-power analysis data).

Instrumentation

The data for this study was collected by a distribution of the Session Rating Scale (SRS), which is a self-report questionnaire (see Appendix D), delivered via email to participants that had appointments with their therapist either in-person or telehealth over a two-month time frame.

This information was obtained through the outpatient clinic's information technology department and given to the researcher to send from the researcher's email through the company's email platform. The study questionnaire included questions for the dependent variable from the already published and validated Session Rating Scale (SRS) score and the independent variable of delivery type (2 levels: in-person or telehealth). The email sent to participants included a fillable word document version of the SRS.

Session Rating Scale (SRS V.3.0) (dependent variable). The Session Rating Scale (SRS), developed by Duncan et al. (2003), is a 4-item visual analog scale in which clients rate their satisfaction of their session with their therapist. This survey was created by Duncan and Miller in order to help clinicians determine if their sessions with their clients were effective and if clients are getting what they hoped to get out of their sessions. It was also meant to be able to assess their progress and therapeutic relationship with their therapist. Duncan et al. (2003) developed this scale due to there being no way to measure therapeutic alliance and the efficacy of therapy sessions. The main idea behind the scale was for use in outpatient therapy settings to help the clinician to be able to determine if they are being effective at building a therapeutic alliance and meeting the goals of their clients. The four areas being assessed are relationship, goals and topics, approach or method, and overall satisfaction.

The reliability of the SRS scale was shown using Cronbach's coefficient alpha as a .88 for all administrations (Duncan et al, 2003). The scale's reliability was tested using the test-retest method and the coefficient alpha was scored favorably according to Duncan et al. (2003). They reported that Pearson's r for the SRS was .64 for the first round and .70 for the second round. In summary, they found the validity and reliability of the test to show that the survey can reliably

measure what they want it to measure. They also found that the brevity of the survey yielded a higher response rate compared to other surveys that were longer (Duncan et al, 2003).

The study questionnaire was completed by all participants in both groups. The delivery method was a fillable word version of the SRS survey that was sent to the participant's email by the researcher through the researcher's email from the company to assure that the email did not go into the participant's junk mail. Participants completed the survey and emailed it back to the researcher. There were participants who were unable to complete the survey on their electronic device and they were directed, by the researcher, to print out the survey and fill it out by hand then email it back to the researcher. Data was analyzed using a t-test with the use of IBM SPSS Statistics 24, which is a software that analyzes statistics. Demographic questions including information about their age and gender were also included on the survey in order to track the demographics of the participants, and keep their identities private. Permission to use this survey was obtained from the co-creator Scott D. Miller, Ph.D. (see Appendix D).

Operational Definitions of Variables

There were two variables proposed for this study: one independent variable and one dependent variable. The independent variable was the delivery method of the therapeutic services. The dependent variable was the perceived efficacy of the participants' therapy sessions, as measured by the SRS survey questions.

Independent variable: Delivery method of therapeutic services. There were two types of delivery methods being reviewed, in-person, and telehealth. There were approximately an equal number of participants surveyed that participated in in-person, meaning that they attended therapy in an office face-to-face with a therapist. The other method of delivery was telehealth, meaning the use of live video through programs such as WebEx, Zoom, or Go To Meeting,

software on a computer, tablet, or smartphone for face-to-face treatment with a therapist (Burhani & Naqvi, 2020). One question on the study questionnaire was used to determine the delivery method of the selected independent variable for each participant. This was measured by assigning each group a number and ordinal number, either 1 for in-person or 2 for telehealth. The number was used to differentiate between each group.

Dependent variable: Perceived efficacy of treatment scores. The perceived efficacy of treatment score was assessed by using the questions from the SRS included in the study questionnaire. According to Duncan et al. (2003), this also looked at the relationship that the therapist had with the client and if the delivery method affects the efficacy of delivery. The four questions on the SRS are measured using a visual analog scale in nominal format where participants were to rate the questions on a scale from 1-4. The high score would be 16 and the low score would be 4. A high score indicated high efficacy and a low score indicated low efficacy, meaning the therapeutic session did not create an alliance and the client felt as though their needs were not met (Duncan et al., 2003).

Duncan et al. (2003) reported that one of the main predictors of the success of a therapy session and treatment with a client, in general, was the therapeutic reliance that a client had with their therapist. This furthers the social psychology theory that people need to have connections with others in order to succeed and that they need to connect to have better mental wellness. Using the SRS gave us a better idea if the therapeutic alliance can be created through telehealth as it was through in-person sessions. This was of course a self-report questionnaire and from a client's perception of their treatment. A participant's mental health diagnosis may affect their perception of treatment.

Study Procedures

Before the collection of data for this study, approval from the National University (NU) Institutional Review Board (IRB) was obtained. A study recruitment email was emailed to potential participants that were identified by the information technology services as active clients participating in outpatient therapy and had appointments in the next two months. The researcher then emailed them a recruitment email and requested their voluntary participation in the study. The email also included information about the research, contact information, the benefits and risks of participation, and the time and effort required to participate. Participants were asked to contact the researcher by phone or email if they were interested. Upon contact, the researcher then emailed the consent forms and SRS scale including demographic questions (see Appendix D). This documentation was administered to them with instructions from the researcher to complete about the last therapy session they attended. The participants completed the SRS once during the study.

Data analysis

Data was analyzed using a two-sample t-test to determine if there was a difference between groups. More specifically to see if there was a difference between the means of each group to either prove H1O or H1A. Assumptions for a two-sample t-test included homogeneity of variance, observations are independent of each other, and the dependent variable is a continuous level of measurement and normally distributed. In order to evaluate the assumption of homogeneity of variance, a Levene's test was conducted. To evaluate the assumption that the dependent variable was normally distributed, a histogram was used. The IBM SPSS Statistics 24 software was used to analyze data and generated tests as mentioned above. Lastly, it looking at the observations being independent required that the researcher looked at the design of the study.

Collecting this data was important to be able to compare the means of each sample to see if the two groups reported similar scores, meaning that the delivery method did not matter and efficacy was similar with each group.

Assumptions

One assumption of this study was that participants were honest with their self-report questionnaire. The explanation of the benefits of their participation and confidentiality in this research study was included in their informed consent letter and hoped to ensure that they were able to answer questions honestly. Another assumption was that the SRS functioned as an effective way to be able to measure the efficacy of the delivery method of therapy, and measured what it was intended to measure.

Limitations

There was potential for response bias as a limitation of this study. The survey asked about a participant's personal experience with their therapist and their therapeutic alliance with their therapist may have affected their responses. It was also a self-report survey, and depending on the clients' mental health status when they participated in the survey, may have affected their response to the questionnaire. The study was not about the actual efficacy of treatment but rather their perception of the efficacy at the time they received services. Another limitation was that this study was limited to those who received treatment in one of many outpatient clinics in the state of Utah which limited the generalization of the results to larger populations.

Delimitations

The study was delimited in scope to people who engaged in outpatient mental health treatment in a chain of outpatient clinics owned by the same company. It was also limited to those who primarily have socioeconomic means to receive treatment as it was not a community-

based treatment center. This may have skewed results based on the fact that it might have excluded those on the state or county-funded insurance plans, which may have excluded some people who have higher acuity mental health diagnoses.

Ethical Assurances

This research project was conducted in accordance with NCU Standards, guidelines (Northcentral University, 2016), and the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2010). Reasonable efforts were made to protect all participants from harm and to provide them with informed consent. Participants were also informed of the ability to quit the study at any time and included information about the aims and findings of the study. In addition, participants' right to privacy was protected.

Protecting participants from harm. Due to this study collecting data from self-report questionnaires and not being an experimental research study, the nature of the study as proposed by Duncan et al. (2003) only poses a risk on the relationship between the participant and their individual therapist session if the session rated in the self-report questionnaire did not go well, as per participant report. Survey results were kept confidential and used for research purposes only.

Informed consent. Informed consent was obtained from each participant through a form that was sent to them in the email invitation to participate in the survey. The form included information about the purpose of the study with an option to choose not to participate, the assessment of the risks and benefits of participation, and steps that were taken to assure the confidentiality of their responses. It also included a clear explanation that no compensation was provided for completing the questionnaire.

Right to privacy. All research materials were stored in a secured online location that was available to the researcher only and other approved members of the research team (Northcentral

University, 2022). Research findings were presented in a way that individual participants were not identifiable. References to gender, race, age, or any other identifiable information was not provided in the findings of the study. Participants were informed of any legal or ethical exceptions that may result in the release of information as part of the informed consent process before participation in the study as per Standard 4.05 of the American Psychological Association, (2010). Lastly, per NCU's (2016) policy, all records will be destroyed after seven years.

Summary

The purpose of this quantitative method and causal-comparative design study was to determine if there was a difference in the efficacy of mental health therapy between telehealth or in-person methods of the delivery of therapy using the SRS. The study population was adults who received treatment in an outpatient clinic in the state of Utah. The sample included 168 people who received mental health counseling from an outpatient treatment center in Utah. Data was collected via an emailed survey that participants completed online. The study variables were independent of the delivery method of therapy, either in-person or telehealth. The dependent variable was the treatment efficacy scores. Data was analyzed using a t-test.

All assurances were made to assure all research activity complied with NCU's IRB guidelines (Northcentral University, 2016) and the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2010). All participants received comprehensive informed consent, and the privacy and confidentiality of all participants was protected. Study limitations were also discussed. The following chapter includes the results from the study.

Chapter 4: Findings

The purpose of this quantitative causal-comparative study was to examine whether there is a statistically significant difference in the perceived efficacy of mental health therapy based on delivery modality: in-person or telehealth. This study's independent variable was the treatment delivery method (telehealth or in-person), and the dependent variable was perceived therapy efficacy as measured by the Session Rating Scale (SRS; Duncan et al., 2003). A purposive sample of 70 adult clients receiving outpatient mental health services from a single clinic in Utah participated, with 35 in the in-person group and 35 in the telehealth group. The use of the SRS provided a standardized, validated measure of perceived therapy quality across both modalities.

The chapter aims not only to report the statistical results but also to situate these results in the broader context of the COVID-19 pandemic's impact on mental health care delivery, highlighting the importance of understanding efficacy across delivery methods. This chapter presents the results of the data analysis, beginning with a review of assumption testing to confirm the appropriateness of the statistical procedures used. The findings are then described in detail, followed by an evaluation of those findings in relation to the study's research question, theoretical framework, and previous literature. The chapter concludes with a summary that integrates the implications of the results for clinical practice and future research.

Validity and Reliability of the Data

To ensure the validity of the statistical analysis and the appropriateness of the independent samples t-test, several assumption tests were conducted: (1) normality, (2) homogeneity of variances, (3) absence of extreme outliers, and (4) independence of observations. Confirming these assumptions is essential to avoid bias in hypothesis testing and to strengthen the internal validity of the study.

The assumption of normality was assessed through both visual and statistical methods. Histograms and Q–Q plots suggested approximately normal distributions of SRS scores for both the in-person and telehealth groups. The Shapiro–Wilk test supported this conclusion with non-significant results for both groups (see Table 1). These findings confirmed that the normality assumption was satisfied. Levene's test for equality of variances indicated no significant difference in variances between the two groups, demonstrating that the assumption of homogeneity of variances was met. This suggests that the variability of perceived efficacy scores was comparable across delivery methods.

An analysis of boxplots and standardized residuals indicated that there were no extreme outliers (all scores fell within ±3 standard deviations of the mean). Because no extreme outliers were detected, all participant data were retained in the final analysis (see Tables 2 & 3).

Table 1 Shapiro–Wilk Test

Shapiro-Wilk		
Statistic	**df**	**Sig.**
.752	**35**	**<.001**
.758	**35**	**<.001**

Table 2-Tests of Normality

	t-test for Equality of Means		**95% Confidence Interval of the Difference**	
	Mean Difference	**Std Error Difference**	**Lower**	**Upper**
Equal variances assumed	**.11429**	**.37586**	**.63574**	**.86431**
Equal variances not assumed	**.11429**	**.37586**	**.63589**	**.86447**

Table 3-Population Pyramid Frequency

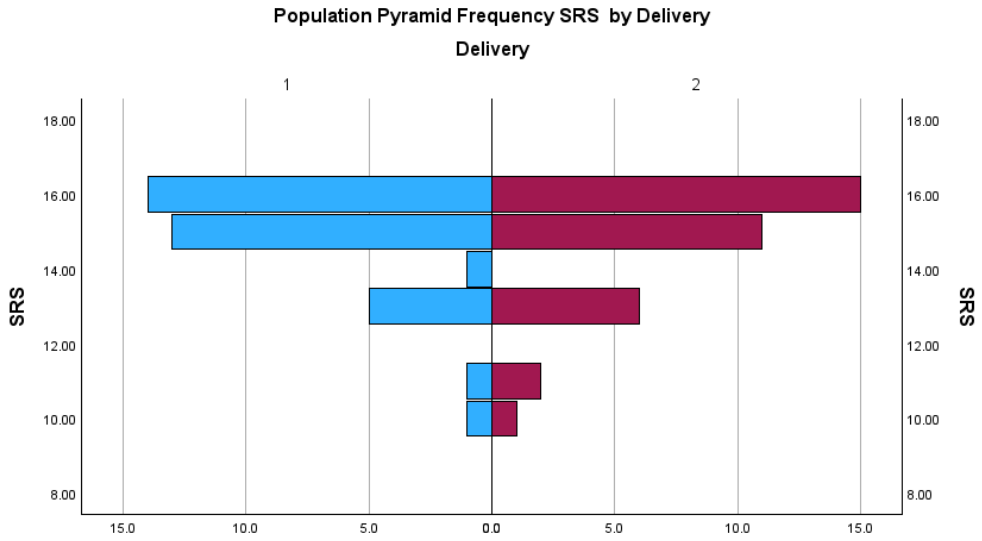
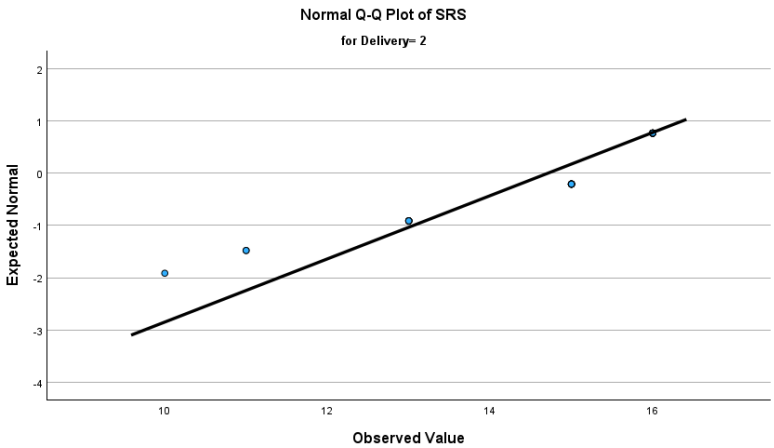


Table 4– Levene's Test for Equality of Variances

Levene's Test for Equality of Variances					Significance	
	F	Sig	t	df	One-sided p	Two-sided p
Equal variances assumed	.791	.377	.304	68	.381	.762
Equal variances not assumed			.304	67.215	.381	.762

Table 5– Boxplot Analysis of Outliers



Results

The data analysis began with descriptive statistics to summarize participant demographics and SRS scores for both delivery groups. Following descriptive analyses, an independent samples t-test was conducted to determine whether the differences in perceived therapy efficacy between the in-person and telehealth groups were statistically significant. Effect sizes were also calculated to assess the practical significance of any observed differences.

Demographic characteristics of the sample.

The study sample consisted of 70 adult participants, evenly divided between the two treatment modalities: 35 receiving therapy in-person and 35 receiving therapy via telehealth. Participants were recruited from an outpatient mental health clinic in Utah that serves diverse clients across different socio-economic and age groups. Gender and age were the primary demographic variables collected.

The mean age of participants in the in-person group was 41.08 years, while the mean age for the telehealth group was 39.20 years. The in-person group comprised 17 females (48.6%) and 18 males (51.4%), whereas the telehealth group consisted of 14 females (40%) and 21 males (60%). All 70 participants completed the SRS, and there were no cases of missing data.

Table 6– Demographic Characteristics of Participants by Treatment Modality

Delivery Method Characteristics	In-person (n=35)	Telehealth (n=35)
Age (M)	41.08	39.20
Gender breakdown		
Female	17 (48.6%)	14 (40%)
Male	18 (51.4%)	21 (60.0%)

Study Variables

The dependent variable, perceived efficacy of therapy, was measured using the Session Rating Scale (SRS), a widely used and validated self-report instrument. The SRS has

demonstrated strong internal consistency in previous research, with Cronbach's alpha coefficients typically ranging from .88 to .95 (Duncan et al., 2003). In this study, the SRS achieved an internal consistency reliability coefficient of $\alpha = .89$, which falls within the established high reliability range. This strong reliability enhances confidence that the SRS accurately and consistently captured participants' perceptions of therapy quality.

Descriptive statistics for SRS scores revealed a similar distribution of perceived efficacy across the two delivery modalities. Scores ranged from 8 to 16, with higher scores reflecting higher perceived session quality. The mean SRS score for the in-person group was 14.83 (SD = 1.48), while the mean score for the telehealth group was 14.71 (SD = 1.66).

Table 7– Descriptive Statistics for SRS Scores by Group

Group	Mean	SD	Minimum	Maximum
In-Person	14.83	1.48	11.00	16.00
Telehealth	14.71	1.66	8.00	16.00

Research Question 1 Analysis

For the inferential analysis to address the research question, an independent samples t-test was conducted to assess whether there was a statistically significant difference in perceived efficacy scores between participants who received therapy in-person and those who received therapy via telehealth. The results showed no statistically significant difference: $t(68) = 0.30$, $p = .765$, 95% CI [–0.54, 0.76]. These results suggest that perceived therapy efficacy did not differ meaningfully by delivery modality.

Effect size calculations further supported this conclusion. Cohen's d was 0.08, indicating a negligible effect size. Both Hedges' g and Glass's delta yielded similar small estimates,

reinforcing the conclusion that the method of therapy delivery—whether telehealth or in-person—did not have a meaningful impact on client-perceived therapy efficacy.

Table 5– Independent Samples Test Results with Effect Sizes

	t-test for Equality of Means		95% Confidence Interval of the Difference	
	Mean Difference	Std Error Difference	Lower	Upper
Equal variances assumed	.11429	.37586	.63574	.86431
Equal variances not assumed	.11429	.37586	.63589	.86447

Evaluation of Findings

The primary research question asked whether therapy delivery method (in-person vs. telehealth) affected perceived treatment efficacy. The findings indicated no statistically significant difference between the two groups, supporting the null hypothesis that delivery modality does not influence perceived therapy quality. The negligible mean difference (Mdiff = 0.11) and small effect size (Cohen's d = 0.08) imply that clients in both modalities perceived similar levels of session quality and therapeutic benefit. This finding has important implications for service delivery models, especially in the context of expanding telehealth services.

From a theoretical perspective, the current findings align with the Social Psychology framework that underscores the importance of human connection in shaping self-perception and mental health outcomes. Despite the lack of physical presence, clients appeared to experience a comparable sense of therapeutic alliance and engagement when services were delivered via telehealth. This suggests that the social and relational aspects of therapy can transcend physical location when facilitated effectively through technology.

The current findings support those of Hall and McGraw (2014) who demonstrated that telepsychiatry delivered through video conferencing was a feasible, acceptable and effective method of providing mental health services. Similarly, Whaibeh et al. (2020), Price-Haywood et al. (2020), Kopelovich et al. (2020) and Kneeland et al. (2021) found that telehealth was comparable to in-person therapy in producing satisfactory treatment outcomes. The results of this study reinforce the previous findings suggesting that client's perceived efficacy of treatment does not vary between delivery method.

This study extends the work of Lin et al. (2022), who identified a lack of research directly comparing the efficacy of telehealth and in-person modalities among general outpatient populations. Much of the existing literature has focused on diagnosis-specific samples or interventions, such as cognitive behavioral therapy or trauma-focused modalities. By isolating delivery modality as the independent variable and using a validated measure of perceived efficacy (the Session Rating Scale), this study provides empirical evidence that reinforces telehealth's generalizability beyond diagnosis- or treatment-specific contexts.

Additionally, these findings build upon Kneeland et al. (2021), who noted that rapport and engagement in telehealth can be strengthened when clinicians make intentional adaptations—such as increasing transparency, enhancing eye contact, and addressing environmental distractions. The present study extends these conclusions, confirming that therapeutic alliance—and by extension, perceived efficacy—can remain stable across both physical and virtual environments. The negligible difference in outcomes between modalities suggests that therapeutic processes are largely modality-independent when relational integrity is preserved.

The findings of this study add to the literature by providing new, post-pandemic data that affirm telehealth as a sustainable, long-term treatment model. Bulkes (2022) and Wootton (2016) emphasized the need for contemporary research validating telehealth's effectiveness in non-emergency contexts, as much of the early evidence emerged during crisis-driven transitions. By examining an outpatient population that has normalized telehealth as part of routine care, this study demonstrates that client satisfaction and perceived therapeutic benefit remain consistent even after the transition from pandemic necessity to everyday practice.

This study also contributes to closing the empirical gap identified by Lin et al. (2022) regarding direct modality comparisons. By offering a balanced, real-world sample and employing rigorous statistical validation, the present study strengthens the case for telehealth as an evidence-based, standard component of mental health delivery. In doing so, it supports continued expansion of telehealth services, policy integration, and professional training in hybrid or fully remote care models.

Summary

This chapter presented a comprehensive analysis of the findings from a quantitative causal-comparative study examining differences in perceived therapy efficacy between in-person and telehealth delivery modalities. Assumption testing verified the suitability of the independent samples t-test. Descriptive statistics indicated similar mean SRS scores across groups. Inferential analysis confirmed no significant differences in perceived therapy efficacy.

This study's findings are consistent with previous research indicating that telehealth is a satisfactory and effective alternative to in-person therapy. For example, the current findings support those of Hall and McGraw (2014) demonstrated the feasibility of telepsychiatry in delivering quality care remotely, and the current study extends that evidence by confirming that

comparable client-perceived efficacy holds true in a post-pandemic outpatient setting. The current findings also support those of Whaibeh et al. (2020), Price-Haywood et al. (2020), Kopelovich et al. (2020), and Kneeland et al. (2021) whereby each reported that telehealth can achieve treatment outcomes similar to in-person care when implemented with attention to therapeutic alliance and technological reliability. The current study's findings reinforce these conclusions and support the integration of telehealth as a mainstream modality in mental health care delivery. While the findings align with most prior studies, they also contribute uniquely by providing post-COVID-19 data specific to a Utah outpatient clinic sample, offering additional external validity to the growing literature on telehealth efficacy. The study findings strengthen the existing research showing that telehealth is perceived to be an effective delivery method.

Chapter 5: Discussion, Recommendations, and Study Summary

The research problem prompting the need for this study was a lack of understanding about differences in perceived efficacy between in-person and telehealth counseling. The general societal problem is the COVID-19 pandemic has increased the need for more mental health services, as more than 50% of Americans reported increased stress, worry, and anxiety which has negatively impacted their mental health (Johnson, 2021). According to Czeisler et al. (2021), more than two in every five Americans experienced adverse mental or behavioral health symptoms beginning in mid-2020, with service utilization rising rapidly as traditional in-person care became less accessible. At the same time, telehealth use expanded more rapidly than at any other point in history, shifting from an adjunctive or specialized method of care to a primary mode of service delivery in many settings.

The purpose of this quantitative method and causal-comparative design study was to determine whether there is a difference in the perceived efficacy of mental health therapy based on the delivery method of telehealth or in-person treatment. While prior research has suggested that telehealth can be equivalent to in-person care (Fernandez et al., 2021; Hall & McGraw, 2014; Varker et al., 2019; Wootton, 2016), most studies conducted before or during the early stages of the pandemic were either modality-specific—focusing on one therapeutic orientation—or population-specific, such as veterans, rural residents, or diagnostic subgroups (Connolly et al., 2020; Kopelovich et al., 2020; Lin et al., 2021). The present study expands this inquiry by examining a general outpatient population in a post-pandemic context, where telehealth is no longer a temporary accommodation but a normalized component of behavioral health infrastructure (Pierce et al., 2021; Turner & Siegel, 2022; Lin et al., 2022).

COVID-19 served not merely as a contextual backdrop but as a transformational variable that permanently reshaped how mental health services are delivered (Pierce et al., 2021; Richie et al., 2023). Before the pandemic, telehealth was often treated as an accessibility workaround, reserved for rural populations, specialized programs, or crisis conditions (Burhani & Naqvi, 2020; Connolly et al., 2020). Following widespread lockdowns and the rapid transition to remote care, telehealth became a central, rather than peripheral, mode of treatment (Fernandez et al., 2021; Turner & Siegel, 2022). This shift raised an important theoretical and practical question: if therapy can be delivered effectively without physical co-presence, then what accounts for the mechanisms of change (Czeisler et al., 2021; Cherry, 2020; Kashima, 2021)?

In order to investigate whether modality influenced client perception of therapeutic effectiveness, this study employed a quantitative causal-comparative design. This design was appropriate because it enabled the comparison of two naturally occurring groups—clients receiving therapy via telehealth and those receiving therapy in person—without manipulation of the independent variable. A causal-comparative approach was also suitable because it reflects real-world clinical conditions rather than a controlled or experimental treatment setting, allowing the results to be interpreted within the context of typical outpatient mental health service delivery.

Participants were drawn from a purposive sample of 70 adult outpatient clients receiving services from a mental health clinic in Utah, with 35 clients in the telehealth group and 35 in the in-person group. Perceived efficacy was measured through the Session Rating Scale (SRS; Duncan et al., 2003), a brief, validated instrument designed to capture clients' perceptions of therapeutic alliance, engagement, and session quality. The SRS was selected for its empirical

support, clinical relevance, and sensitivity to the interpersonal and relational dimensions that are central to this study's theoretical grounding in social psychology.

Statistical analyses of the assumptions included tests of normality, homogeneity of variances, and absence of outliers to confirm the validity of the independent samples t-test as the inferential procedure. The results indicated no statistically significant difference (p value goes here) in perceived treatment efficacy between telehealth and in-person therapy conditions. Effect size analysis further demonstrated that any observed differences were negligible in practical terms. These findings suggest that from the client's perspective, the therapeutic process is experienced similarly regardless of modality.

The results of this study indicated that perceived treatment efficacy does not differ significantly between delivery modalities, which suggests that the core mechanism of therapeutic change is not the medium itself, but the relational process facilitated between therapist and client. This aligns with the principles of social psychology theory, which emphasize that human connection, validation, and perception of self-occur within relational exchange rather than geographical proximity. In this way, the findings of the present study do not merely confirm equivalency between modalities but contribute to understanding why such equivalency exists. These results indicate that the essential drivers of perceived therapeutic efficacy appear to be independent of delivery format and more closely aligned with the quality of interpersonal exchange that occurs within the therapeutic relationship. This interpretation is compatible with the theoretical assumptions discussed in Chapter 2 and provides a conceptual foundation for examining the broader implications of the findings in relation to existing literature, the role of telehealth in contemporary clinical practice, and future directions for research.

Although the results of this study provide meaningful insight into the relationship between delivery modality and perceived therapeutic efficacy, they must be interpreted within the boundaries of the study's scope. The sample was drawn from a single outpatient clinic located in Utah, which limits generalizability beyond similar practice settings. Additionally, the design relied on self-report data, which may be influenced by individual differences in response style or client engagement. However, these limitations do not undermine the validity of the findings; rather, they contextualize the results within a naturalistic practice environment that reflects real-world service delivery.

Despite these limitations, the study makes a significant contribution to the growing body of research on telehealth and in-person therapy by demonstrating that perceived efficacy is not dependent on physical co-location. Instead, the results suggest that the therapeutic mechanisms leading to perceived benefit may be relational and process-oriented rather than format-dependent. In this way, the study extends the literature by shifting the interpretive focus from what platform is used to how therapeutic connection is experienced.

The remainder of this chapter expands on the meaning and implications of these findings. The discussion that follows examines the results through the lens of existing literature and the theoretical framework presented in Chapter 2, explaining how the findings support, extend, and contribute to current scholarly understanding. Following the discussion, recommendations for practice are presented, emphasizing how clinicians, agencies, and behavioral health systems may apply these findings in real-world settings. Recommendations for future research are then provided to outline directions for continued scholarly inquiry. The chapter concludes with a study summary that synthesizes the overarching conclusions and reinforces the significance of the study's contribution to the field.

Discussion

The central finding of this study—that there is no statistically significant difference in perceived efficacy between in-person and telehealth counseling—suggests that client outcomes are driven more by relational processes than by the physical format through which therapy is delivered (Fernandez et al., 2021; Lin et al., 2022; Varker et al., 2019). In other words, the client's experience of therapy appears to be shaped primarily by the interpersonal quality of the therapeutic exchange rather than the location or technological medium in which that exchange occurs (Kneeland et al., 2021; Turner & Siegel, 2022). This interpretation is consistent with the broader body of research indicating that the therapeutic alliance is the most reliable predictor of perceived benefit and treatment engagement across modalities (Hall & McGraw, 2014; Kopelovich et al., 2020; Wootton, 2016).

These findings reinforce the premise that the mechanism of change in psychotherapy is fundamentally relational rather than structural. If modality were a primary determinant of therapeutic experience, one would expect meaningful statistical differences in perceived efficacy between the two groups. The negligible effect size observed in this study indicates that the client's sense of connection, safety, understanding, and emotional resonance with the therapist, as reflected in the Session Rating Scale and representative of the measured dimensions of therapeutic efficacy, supersedes the influence of modality. This interpretation aligns with the social psychology theoretical framework underpinning the study, particularly the view that human behavior and meaning making are mediated by social interaction and interpersonal perception rather than physical environment (Cherry, 2020; Kashima, 2021).

Furthermore, the absence of modality-based differences highlights a conceptual shift in what constitutes the "space" of therapy. Historically, the physical therapy room has been

regarded as the primary site of therapeutic change—a controlled, bounded environment designed to contain and process emotional material (Hall & McGraw, 2014; Mohr et al., 2008). However, the findings of this study suggest that the psychological space between therapist and client—rather than the physical space—may serve as the true locus of therapeutic engagement (Cherry, 2020; Kashima, 2021; Kneeland et al., 2021). This reframing is particularly relevant in a post-pandemic landscape, in which the traditional boundaries of the therapeutic setting have expanded to include virtual environments mediated by technology (Pierce et al., 2021; Fernandez et al., 2021; Turner & Siegel, 2022).

The findings also suggest that clients may evaluate therapy effectiveness based on internal relational cues such as attunement, empathy, responsiveness, and perceived safety, which are not inherently tied to physical presence. These interpersonal factors are consistent with alliance-based predictors of outcome identified in prior psychotherapy research (Hall & McGraw, 2014; Kneeland et al., 2021; Wootton, 2016), reinforcing that it is the quality of interaction rather than the medium of interaction that carries the greatest therapeutic weight. This interpretation is further supported by the social psychology literature, which identifies co-regulation, validation, and perceived interpersonal closeness as key drivers of positive relational appraisal (Cherry, 2020; Kashima, 2021).

Additionally, the results provide evidence that clients may no longer attribute therapeutic legitimacy to the physical office setting itself. Historically, the therapy room functioned both symbolically and procedurally as the central site of containment (Hall & McGraw, 2014; Mohr et al., 2008). The post-pandemic clinical landscape, however, appears to have reshaped expectations of that container. The findings of this study suggest that the perception of containment now emerges from the therapeutic relationship rather than the physical space,

indicating a conceptual decentering of in-person proximity as a necessary condition for psychological safety in treatment.

These outcomes indicate that perceived therapy efficacy is increasingly decoupled from the material components of service delivery and instead rooted in the interpersonal dynamics of the therapeutic encounter. This reorientation has significant implications for both theoretical and clinical practice models, as it strengthens the argument that therapeutic change is relationally mediated and not modality dependent. The next section builds on this premise by examining the therapeutic alliance as the primary mechanism of change and clarifying how modality equivalence operates at the interpersonal level rather than the procedural level.

These findings establish a conceptual foundation for understanding that modality alone does not account for client-perceived therapeutic benefit. If the effectiveness of therapy were structurally determined by the format of delivery, a measurable difference would have emerged between in-person and telehealth groups. Instead, the absence of such a difference necessitates a closer examination of the interpersonal mechanisms responsible for perceived therapeutic value. The most prominent of these mechanisms, supported across decades of psychotherapy literature, is the therapeutic alliance.

Therapeutic Alliance as the Primary Mechanism of Change

The therapeutic alliance is consistently identified as one of the most robust predictors of treatment outcomes across theoretical orientations, clinical populations, and delivery methods (Fernandez et al., 2021; Hall & McGraw, 2014; Wootton, 2016). The results of this study reinforce this principle by demonstrating that client perceptions of therapeutic effectiveness remain stable regardless of modality. This indicates that the alliance, rather than the technological or physical context in which therapy occurs, is the variable most strongly

associated with perceived benefit. In this respect, the findings support a process-based rather than modality-based understanding of outcome determinants.

Therapeutic alliance encompasses several interrelated components, including emotional attunement, collaborative goal alignment, trust, and perceived therapist responsiveness (Kneeland et al., 2021; Varker et al., 2019). These qualities map directly onto the domains measured by the Session Rating Scale (SRS), which evaluates the client's experience of relational connection, agreement on treatment direction, and level of engagement during the session (Duncan et al., 2003). Because these elements are relational rather than spatial, they can be effectively established in either an in-person or virtual setting, provided that communication is perceived as direct, supportive, and emotionally congruent (Kopelovich et al., 2020; Turner & Siegel, 2022).

Empirical research has demonstrated that clients often prioritize interpersonal resonance over logistical features when evaluating their therapeutic experience (Lin et al., 2022; Mohr et al., 2008). The present findings align with this body of literature by suggesting that clients interpret therapy through a relational lens and assess its value based on how "known," "heard," or "understood" they feel. The technological interface appears to serve as a delivery vehicle rather than a determinant of experiential quality. As a result, the alliance functions as the mediating variable that explains the observed equivalence between modalities (Fernandez et al., 2021; Hall & McGraw, 2014). The stability of perceived efficacy across modalities further indicates that clients assess therapeutic quality based on subjective experience rather than structural features of the session (Cherry, 2020; Kashima, 2021). This reflects the broader empirical trend within psychotherapy research demonstrating that client perception of being understood, validated, and emotionally supported is a stronger determinant of satisfaction than

the contextual factors surrounding service delivery (Hall & McGraw, 2014; Wootton, 2016). As such, modality may be best understood as a logistical variable rather than a therapeutic one. These findings also highlight that the therapeutic alliance may serve as a stabilizing factor that preserves continuity of care across changing conditions. During the pandemic, clients and clinicians were compelled to adapt rapidly to remote platforms (Connolly et al., 2020; Pierce et al., 2021). The persistence of perceived efficacy in this study suggests that clients did not conceptualize this adaptation as a reduction in therapeutic quality. Rather, the continuity of the therapist–client relationship allowed the therapeutic process to remain intact despite shifts in format (Kneeland et al., 2021; Turner & Siegel, 2022). This supports the conclusion that alliance-based factors are resilient across delivery conditions when relational attunement is maintained (Fernandez et al., 2021; Varker et al., 2019).

Additionally, the results of this study help clarify the role of client agency in therapeutic experience. Because perceived efficacy is influenced by the client's interpretation of the therapeutic encounter (Kopelovich et al., 2020; Lin et al., 2021), the relationship between therapist and client can override structural variables when clients feel safe, supported, and accurately mirrored (Hall & McGraw, 2014; Wootton, 2016). This aligns with existing research showing that client expectations, perception of collaboration, and relational trust strongly mediate treatment experience (Mohr et al., 2008; Fernandez et al., 2021). The absence of modality-specific discrepancy in perceived efficacy suggests that these interpersonal anchors carry more clinical weight than physical proximity.

These findings reinforce the understanding that the therapeutic alliance—not the format of service delivery—is the central mechanism through which clients evaluate therapeutic impact (Hall & McGraw, 2014; Kneeland et al., 2021; Wootton, 2016). This positions the alliance as the

explanatory factor behind modality equivalency and establishes a conceptual foundation for the subsequent theme regarding telepresence and psychological co-regulation in virtual therapy.

Telepresence and Psychological Co-Regulation in Virtual Therapy

The equivalency of perceived efficacy between modalities also suggests that clients are able to experience psychological presence—often referred to as telepresence—through virtual communication. Telepresence describes the felt sense of "being with" another person despite physical separation and is achieved when the quality of relational engagement overrides awareness of technological mediation (Lombard & Ditton, 1997; Lee, 2004; Oh et al., 2018). The findings of this study indicate that clients were able to experience this sense of presence in telehealth sessions to a degree sufficient to support therapeutic engagement, emotional attunement, and collaboration (Fernandez et al., 2021; Kneeland et al., 2021).

This is consistent with emerging research demonstrating that co-regulation—the interpersonal process through which emotional states are stabilized in the presence of another—can occur through visual and auditory cues even without physical co-location (Atzil & Barrett, 2017; Coan & Sbarra, 2015; Siegel, 2020). In virtual settings, facial expression, tone of voice, pacing of dialogue, and therapist responsiveness can still transmit the relational signals necessary for safety and connection (Knox et al., 2023; Lin et al., 2022; Turner & Siegel, 2022). The data from this study suggest that clients experienced these signals as intact within telehealth sessions, which helps explain why perceived effectiveness did not decline in the absence of shared physical space.

The ability of clients to experience psychological safety through technologically mediated interaction is especially notable given the historically entrenched assumption that therapeutic work requires physical proximity to be effective (Hall & McGraw, 2014; Mohr et al.,

2008; Wootton, 2016). The rapid normalization of telehealth during the COVID-19 pandemic appears to have accelerated a shift in the relational frame through which clients interpret therapeutic presence (Fernandez et al., 2021; Pierce et al., 2021; Turner & Siegel, 2022). Rather than locating presence in the physical environment, clients increasingly locate presence in interpersonal responsiveness (Cherry, 2020; Kashima, 2021; Kneeland et al., 2021). In this way, the pandemic may have served as a catalyst that decoupled "connection" from "physical location" in the therapeutic context.

In many therapeutic contexts, clients describe the experience of a strong alliance as feeling "fully seen" or "fully present with" the therapist, even when communication occurs through a screen (Knox et al., 2023; Lin et al., 2022; Turner & Siegel, 2022). This experiential quality is consistent with the concept of telepresence, in which the relational connection becomes perceptually more salient than the technological medium (Lombard & Ditton, 1997; Lee, 2004; Oh et al., 2018). When clients perceive attunement, emotional accuracy, and responsiveness from the therapist, psychological presence effectively substitutes for physical presence (Cherry, 2020; Kashima, 2021; Kneeland et al., 2021). This phenomenon helps explain why telehealth sessions were rated as equally effective in this study, despite operating outside of traditional in-person environments.

The findings also suggest that therapeutic presence may now be understood as a function of relational signaling rather than physical proximity. Because co-regulation can occur through vocal tone, pacing, facial mirroring, and empathic responsiveness (Atzil & Barrett, 2017; Coan & Sbarra, 2015; Siegel, 2020), the essential components of "felt safety" appear transferable to remote platforms. Rather than diminishing these processes, technology may simply alter the channel through which they are transmitted (Knox et al., 2023; Turner & Siegel, 2022). As such,

the virtual setting becomes a conduit rather than a barrier to connection when the therapist's relational responsiveness remains intact.

Importantly, the results indicate that the psychological distance sometimes assumed to exist in remote therapy (Connolly et al., 2020; Mohr et al., 2008; Wootton, 2016) is not experienced uniformly by clients. Instead, distance is minimized when the interpersonal field—defined by trust, emotional containment, and empathic engagement—remains stable (Hall & McGraw, 2014; Kneeland et al., 2021). This supports the interpretation that telehealth does not dilute relational quality but instead reframes the space in which connection occurs. These dynamics further reinforce the process-based explanation for modality equivalency and provide a conceptual bridge to the next thematic finding: technology as a logistical medium rather than a therapeutic determinant.

Technology as a Medium of Access Rather Than Outcome Determinant

The findings of this study further indicate that technology functions primarily as a medium of access rather than a determinant of therapeutic outcome. Because perceived efficacy remained stable across modalities, the technological interface did not appear to operate as a meaningful barrier to the client's experience of therapy. Instead, technology served as the conduit through which the therapeutic relationship was delivered. This reinforces the interpretation that modality is logistical in nature rather than clinical in function.

From a clinical perspective, this suggests that the therapeutic process remains intact so long as the relational components of therapy—attunement, trust, engagement, and collaboration—are preserved. The continuity of these processes across modalities underscores that therapeutic benefit is not inherently tied to geography, physical environment, or co-location. Instead, the client's sense of being heard, understood, and supported is the anchor that defines

the therapeutic experience. Technology, in this context, merely facilitates access to the therapist rather than altering the fundamental structure of the interaction.

At a systems level, this interpretation has meaningful implications for the organization and delivery of mental health care. If the perceived quality of therapy is not compromised by telehealth delivery, then technological access expands the points of entry into therapeutic services without reducing treatment value. This is particularly relevant for populations facing barriers to in-person care, such as rural residents, individuals with mobility limitations, caregivers balancing responsibilities, and clients managing chronic illness. In such cases, telehealth may not only maintain equivalency with in-person care but may function as preferable due to its ability to reduce logistical and structural burdens associated with treatment attendance.

The findings also support the interpretation that telehealth functions as a vehicle for expanding service accessibility without compromising the therapeutic experience. Because modality did not affect perceived efficacy, technology becomes a facilitator of therapeutic reach rather than a modifier of outcome quality. This reinforces the role of telehealth as a mechanism through which mental health services can be extended to clients who might otherwise face delays, barriers, or discontinuity in care. In this respect, telehealth is not merely equivalent to in-person caret is structurally advantageous in its capacity to reduce attrition related to logistical constraints.

The post-pandemic normalization of telehealth also suggests a shift in client expectations regarding how therapy may be accessed. Whereas telehealth was once framed as an accommodation or exception, it now functions as a standard option within clinical service delivery (Fernandez et al., 2021; Pierce et al., 2021; Turner & Siegel, 2022). The equivalency found in this study indicates that continued integration of telehealth is not only clinically

permissible but also systemically appropriate, as it increases flexibility while preserving treatment quality (Hall & McGraw, 2014; Lin et al., 2022; Varker et al., 2019). In this way, technology becomes an instrument of equity by reducing disparities linked to geography, transportation, scheduling limitations, and physical health barriers (Burhani & Naqvi, 2020; Connolly et al., 2020; Wootton, 2016).

Importantly, the results imply that the viability of telehealth is not contingent upon its ability to replicate in-person sessions, but rather upon its ability to transmit the relational aspects of therapy that clients experience as meaningful. When technology is conceptualized as a point of access instead of a proxy for physical proximity, its role in mental health care becomes clearer: it is a delivery channel, not a determinant of therapeutic value. This distinction also highlights why modality did not emerge as a significant predictor of perceived efficacy in this study.

The next thematic section builds on this foundation by examining the broader implications of these findings within the post-pandemic clinical environment, where hybrid models of care have become increasingly prevalent. In this context, the permanence of telehealth is not merely an artifact of crisis adaptation but a reflection of evolving client expectations, provider practices, and systemic restructuring in mental health care delivery.

The Post-Pandemic Permanence of Hybrid Care Models

The findings of this study must also be understood within the broader context of structural transformation in mental health care delivery following the COVID-19 pandemic. The shift to telehealth was not merely a temporary accommodation but a catalyst that redefined how therapeutic services are conceptualized, accessed, and delivered (Fernandez et al., 2021; Pierce et al., 2021; Richie et al., 2023). Rather than returning to pre-pandemic norms, the behavioral

health field has transitioned into a hybrid model of care in which telehealth is not an alternative to therapy but an established modality of equal legitimacy (Connolly et al., 2020; Lin et al., 2022; Turner & Siegel, 2022), a conclusion further supported by the findings of the present study. The results of this study provide empirical support for this transformation by demonstrating that perceived therapeutic efficacy is preserved across both formats (Hall & McGraw, 2014; Varker et al., 2019; Wootton, 2016).

The pandemic accelerated a reconfiguration of expectations around treatment accessibility, continuity, and client autonomy (Fernandez et al., 2021; Pierce et al., 2021; Turner & Siegel, 2022). Prior to 2020, in-person therapy functioned as the default structure for professional legitimacy (Hall & McGraw, 2014; Mohr et al., 2008), while telehealth was often seen as a secondary or situational substitute (Burhani & Naqvi, 2020; Connolly et al., 2020). Post-pandemic infrastructure, however, has normalized remote care to such an extent that physical presence is no longer culturally or clinically assumed to be necessary for therapeutic legitimacy (Lin et al., 2022; Richie et al., 2023; Wootton, 2016). The absence of modality-based differences observed in this study reflects this shift: clients now appear to evaluate therapy based on relational attunement rather than spatial configuration.

This transformation has implications not only for client experience but also for service delivery systems, reimbursement models, licensure regulations, and workforce development. As telehealth became structurally integrated into the mental health system, it moved from a compensatory model to a parallel delivery pathway. The present study's findings reinforce that this integration has not diminished perceived treatment value. Instead, equivalency across modalities supports the continued permanence of telehealth within hybrid care models where

choice, flexibility, and logistical accessibility are treated as core components of therapeutic infrastructure.

The permanence of hybrid care models is further reinforced by shifts in client behavior and utilization patterns (Fernandez et al., 2021; Pierce et al., 2021; Richie et al., 2023). During the pandemic, many clients who initially transitioned to telehealth out of necessity elected to continue remote treatment even after in-person services resumed (Connolly et al., 2020; Lin et al., 2022; Turner & Siegel, 2022). This trend reflects not only acceptance of telehealth but a recalibration of expectations regarding what constitutes legitimate therapeutic contact. For many clients, flexibility in location, reduced scheduling burden, and elimination of transportation barriers increased consistency of attendance, thereby improving continuity of care (Burhani & Naqvi, 2020; Wootton, 2016; Varker et al., 2019). In this respect, modality does not merely facilitate accessibility, it supports treatment adherence.

At the systems level, telehealth integration has also aligned with broader policy developments such as insurance reimbursement parity and interstate licensure compacts, which further institutionalize remote care as part of standard practice by enabling clinicians and clients to engage in treatment regardless of geographic location (Center for Connected Health Policy, 2023; Fernandez et al., 2021; Lin et al., 2022). These structural changes indicate that the health care system is adapting not just procedurally but philosophically, recognizing telehealth as a viable—and in some contexts preferable—pathway to treatment engagement (Pierce et al., 2021; Turner & Siegel, 2022; Richie et al., 2023). The findings of this study provide empirical justification for this ongoing restructuring, as they demonstrate that expanded access does not come at the expense of perceived treatment quality (Hall & McGraw, 2014; Varker et al., 2019; Wootton, 2016).

The persistence of hybrid delivery models also reflects an evolution in how therapeutic presence is conceptualized across digital and in-person environments (Cherry, 2020; Kashima, 2021; Kneeland et al., 2021). As remote service delivery becomes culturally normalized, physical proximity is no longer the defining marker of therapeutic legitimacy (Fernandez et al., 2021; Lin et al., 2022; Pierce et al., 2021). Instead, the therapeutic relationship functions as the stabilizing constant across changing service formats. This parallels broader post-pandemic workforce shifts in many fields in which technological mediation has replaced assumptions about where meaningful interaction "must" occur (Richie et al., 2023; Turner & Siegel, 2022). Within the mental health field, this marks a paradigm shift in which access and relational quality are treated as central, while modality is treated as adaptable (Hall & McGraw, 2014; Wootton, 2016; Varker et al., 2019).

These factors suggest that hybrid care models are not a transitional stage but a structurally stable endpoint of post-pandemic transformation. The findings of this study reinforce this perspective by demonstrating that modality does not adversely affect client-perceived efficacy. Therefore, the ongoing permanence of telehealth within hybrid systems is not simply a matter of convenience or crisis adaptation but is supported by outcome equivalency at the perceptual and relational levels of care. This provides a conceptual bridge to the final thematic component of the discussion, which situates the findings within the broader scholarly literature and theoretical framework presented in Chapter 2.

Integration With Theoretical Framework and Literature

The findings of this study support and reinforce the existing body of research demonstrating that telehealth is comparable in effectiveness to in-person therapeutic delivery. Hall and McGraw (2014) found that telepsychiatry delivered through videoconferencing

produced treatment outcomes that were clinically acceptable and equivalent to traditional in-person care. The present study is consistent with those results by showing no statistically significant difference in perceived efficacy between modalities, suggesting that technological mediation does not diminish the core therapeutic experience.

Similarly, research conducted during the COVID-19 pandemic, including Whaibeh et al. (2020), Price-Haywood et al. (2020), and Kopelovich et al. (2020), documented high levels of client satisfaction and therapeutic continuity within remote settings. The current findings align with these studies by demonstrating that clients evaluated the quality of therapy similarly across modalities, even when service delivery occurred outside of the conventional physical therapy space. This reinforces the interpretation that clients' perceptions of therapeutic benefit are preserved in virtual contexts.

The findings also support Kneeland et al. (2021), who observed that relational quality remains achievable in telehealth when therapists are intentional in their communication strategies. In line with their conclusions, this study found no evidence that telehealth reduces the perceived quality of the therapeutic process. Rather, the absence of modality-based differences indicates that the relational markers clients use to evaluate therapy—such as responsiveness, attunement, and empathy, including cues conveyed through facial expression and observable client behavior—can be transmitted effectively through both in-person and remote interactions.

Finally, these results are consistent with the social psychology theoretical framework that informed the study design. Social psychology emphasizes that perception, self-concept, and interpersonal meaning-making are fundamentally constructed through relational experience rather than environmental context (Cherry, 2020; Kashima, 2021). The current findings support this view by suggesting that therapeutic benefit is rooted in interpersonal connection rather than

physical proximity. In this way, the study confirms that the relational processes underpinning therapeutic alliance are sufficiently robust to transcend modality boundaries.

Research Extensions

While the findings are consistent with prior literature supporting modality equivalence, the present study extends existing research by addressing a gap identified in more recent scholarship. Lin et al. (2022) noted that although telehealth outcomes were becoming well-documented, few studies directly compared perceived efficacy between modalities in a general outpatient population after telehealth became normalized rather than crisis-driven, a gap the present study helps to address. The current study responds directly to that gap by evaluating modality differences in a post-pandemic context in which telehealth is no longer experimental, situational, or transitional.

This study extends existing research by examining telehealth efficacy within a post-pandemic service environment in which remote therapy has become normalized. Unlike early pandemic studies that evaluated telehealth during periods of emergency adoption, the present study examines client perceptions within a routine clinical context, after telehealth had become an established modality of care. In doing so, it provides a more stable assessment of perceived efficacy that is not shaped by novelty, disruption, or forced adaptation.

The study also extends prior literature by using a general outpatient population rather than a diagnosis-specific or demographically restricted sample. Much of the existing research has been conducted with specialty populations, including veterans, trauma survivors, or rural clients. By including a broader outpatient clinical sample, this study strengthens generalizability and situates modality equivalence within a more representative slice of contemporary therapeutic practice.

Earlier research primarily evaluated symptom reduction or treatment adherence, whereas the present study directly examines perceived therapeutic efficacy using the (SRS). By focusing on clients' relational and experiential evaluation of therapy rather than symptom outcomes alone, this study extends prior work by clarifying how clients judge effectiveness—through alliance-based perceptions rather than logistical delivery variables.

This study extends existing scholarship by interpreting modality equivalence through a process-based theoretical lens rooted in social psychology. Rather than framing telehealth as "equally effective" solely in outcome terms, this study explains why it is effective by locating therapeutic benefit in relational connection rather than environment. This theoretical extension deepens understanding of modality equivalence by linking it to interpersonal mechanisms of change.

This study adds to the literature by providing a theoretically grounded explanation for why telehealth is perceived as equally effective as in-person therapy. While earlier studies have demonstrated modality equivalence, most did not address the underlying mechanisms responsible for that equivalence. The present study clarifies that the driving factor behind perceived efficacy is the therapeutic relationship rather than the physical context of delivery. By situating modality outcomes within a process-based theoretical lens, this study contributes a conceptual explanation for equivalency rather than a descriptive one.

In addition to its theoretical contribution, the study adds empirical value by offering post-pandemic comparative data drawn from a general outpatient population. Much of the early literature on telehealth efficacy emerged either before normalization of remote care or from specialized treatment populations (Connolly et al., 2020; Kopelovich et al., 2020; Lin et al., 2021; Varker et al., 2019). This study contributes meaningful evidence that equivalency persists

after telehealth has transitioned from a temporary adaptation to an established treatment modality integrated into routine practice (Fernandez et al., 2021; Pierce et al., 2021; Turner & Siegel, 2022). This expands the literature by demonstrating that modality neutrality remains stable in non-crisis conditions (Hall & McGraw, 2014; Wootton, 2016).

This study contributes to practice-based scholarship by identifying telehealth as a structurally viable component of hybrid service delivery models. Because therapeutic benefit was preserved across modalities, the findings support continued integration of telehealth as a standard—not supplemental—form of care. In doing so, the study adds to the literature by reinforcing that hybrid models are not a contingency plan but a sustainable delivery framework capable of maintaining therapeutic quality while expanding accessibility.

Collectively, these contributions demonstrate that the value of telehealth lies not in its capacity to replicate in-person treatment environments, but in its ability to preserve the relational processes that constitute therapeutic change. By clarifying the mechanism through which modality equivalence occurs, this study moves beyond replication of prior findings and adds theoretical depth to the existing body of research.

Recommendations for Practice

Based on the findings of this study, the first recommendation is clinicians should approach service delivery from a hybrid-competence model in which therapeutic effectiveness is understood to derive from relational quality rather than modality. Because perceived efficacy remained consistent across both telehealth and in-person treatment formats, clinicians should prioritize the preservation and intentional cultivation of therapeutic alliance regardless of setting. The results suggest that the primary clinical task is not determining where therapy occurs, but ensuring that the relational conditions necessary for engagement, safety, and attunement are

maintained across modalities. Clinicians should view telehealth not as a secondary or lesser version of therapy, but as a parallel modality that requires its own set of clinical competencies (Hall & McGraw, 2014; Wootton, 2016). This includes the ability to translate core therapeutic skills—such as reflective listening, regulation of pacing, nonverbal responsiveness, and rupture-repair—into a digital environment (Kneeland et al., 2021; Turner & Siegel, 2022). Because clients perceive benefit through the relational process rather than through physical co-presence, the therapist's role involves ensuring that attunement and emotional availability are conveyed clearly through whichever platform is being used (Cherry, 2020; Kashima, 2021).

Second, clinicians should develop discernment around when a particular modality best serves the therapeutic process for a specific client or stage of treatment. A hybrid-competent approach does not assume that telehealth and in-person care are interchangeable in all cases, but rather that both can be equally effective when selected intentionally. For example, clients in early treatment who struggle with vulnerability may initially prefer in-person contact, while clients managing logistical or health barriers may experience greater consistency and emotional stability when care is delivered remotely (Fernandez et al., 2021; Lin et al., 2022). Modality selection should therefore be rooted in relational formulation rather than habit or default scheduling practices (Connolly et al., 2020).

Third, clinicians should implement explicit alliance-maintenance practices in telehealth settings to ensure that co-regulation is communicated across technological channels. This may include using intentional eye contact through camera positioning, increasing transparency about emotional or relational shifts, and inviting meta-reflection on whether the client feels "with" the therapist despite physical distance (Atzil & Barrett, 2017; Coan & Sbarra, 2015; Siegel, 2020). Because the present study demonstrates that psychological presence—not physical location—

predicts perceived benefit, clinicians should conceptualize telepresence as a core, developable therapeutic skill rather than a passive byproduct of technology use (Lombard & Ditton, 1997; Oh et al., 2018).

Finally, clinicians should engage in ongoing monitoring of client experience to ensure that telehealth continues to support engagement. The Session Rating Scale or other alliance-based feedback tools may be incorporated into telehealth sessions to strengthen responsiveness and deepen attunement (Duncan et al., 2003; Kneeland et al., 2021). This is especially important because relational misattunement can be harder to detect digitally if feedback is not actively solicited.

Overall, these findings indicate that clinicians should conceptualize hybrid competence as an essential therapeutic skill set. Telehealth should not be treated as a contingency arrangement or backup plan but as a clinically valid mode of care delivery that requires deliberate technique adaptation (Pierce et al., 2021; Turner & Siegel, 2022). In this respect, therapeutic effectiveness becomes a matter of how clinicians engage clients, rather than where the encounter occurs.

The findings of this study indicate that agencies and organizations should approach service delivery planning from a hybrid systems perspective in which telehealth and in-person care are treated as parallel modalities of equal clinical legitimacy. Because perceived efficacy remained stable across modalities, organizations should design infrastructure and workflow models that treat hybrid care as a normalized and sustained component of routine service delivery, rather than a temporary adaptation. This includes embedding modality flexibility into administrative processes, clinical protocols, and organizational culture.

Recommendations for Future Research

Because the results of this study suggest that therapeutic efficacy is preserved across modalities, future research should further investigate the mechanisms responsible for this equivalency. Instead of continuing to ask whether telehealth is as effective as in-person therapy, future studies should examine why therapeutic benefit is modality-neutral. This shift from outcome confirmation to mechanism clarification represents the next necessary stage of scholarly development on this topic.

Specifically, future research should examine the role of therapeutic alliance as a mediating variable. While literature consistently establishes alliance as a strong predictor of treatment outcomes, the present findings suggest that the alliance may not only predict improvement but may also neutralize environmental variability. Understanding the alliance as a stabilizing mechanism would deepen theoretical insight into its function and could help explain how therapeutic attunement compensates for differences in setting.

Future research should also explore the role of psychological presence and co-regulation as underlying processes that support modality equivalency. Qualitative or mixed-methods studies may be especially useful in identifying which relational cues clients experience as most salient in digital environments, as well as how therapists convey emotional availability and attunement through non-physical means. These findings could inform of a more refined theoretical model of remote therapeutic presence.

Additionally, future research should investigate whether the mechanism of change differs across subgroups or clinical presentations. For example, it is possible that clients with high relational sensitivity or trauma histories experience modality differently than clients whose therapeutic needs are primarily cognitive or behavioral. The present findings provide evidence of

overall equivalency, but future work should address whether the mechanism of equivalency varies as a function of client characteristics, developmental history, or presenting concerns.

Finally, future theoretical development should examine whether hybrid care creates a new relational paradigm rather than simply duplicating existing models in multiple formats. If clients increasingly experience therapeutic presence as independent of physical location, this will indicate a conceptual redefinition of the therapeutic frame—one in which psychological connection replaces physical co-presence as the anchoring feature of treatment.

Future research should also examine whether modality equivalency functions differently across specific populations or clinical subgroups. While the present study demonstrates overall parity in perceived efficacy, the mechanisms that support relational connection may not operate identically among all clients. Exploring population-level differences would help determine whether hybrid care is uniformly experienced as equivalent or whether certain groups experience unique relational facilitators or barriers in telehealth settings.

One important direction for future research involves underserved and historically marginalized populations. Because telehealth reduces logistical barriers associated with transportation, financial constraints, disability, stigma visibility, and rural isolation, it may disproportionately benefit groups who have traditionally faced structural obstacles to care. Future studies should investigate whether telehealth is not just equivalent, but preferable for some clients because it reduces psychosocial or systemic burden. This would deepen understanding of telehealth as not only a modality of delivery, but also a tool of equity in behavioral health access.

In addition, future research should explore whether clinical presentations moderate the relationship between modality and perceived efficacy. Clients with trauma histories, for example, may experience safety differently in telehealth versus in-person care, depending on their

relational template and tolerance for proximity. Conversely, telehealth may benefit clients with social anxiety or agoraphobia by removing environmental pressures associated with physical attendance. Research examining these subgroup differences would clarify whether modality equivalency is global or diagnosis contingent.

Further, future studies should examine hybrid sequencing as a potential moderator of perceived efficacy. It is possible that the order or timing of modality use—such as beginning treatment in person and transitioning to telehealth or using a hybrid rhythm intentionally—affects alliance development or rupture-repair processes. Understanding whether some clients are better suited to telehealth or in-person therapy would support more personalized and theoretically grounded treatment planning.

Finally, research should address whether cultural variables influence modality perceptions. Clients from collectivist cultural backgrounds or those with relational trauma may assign different meaning to physical presence than those from highly individualistic contexts. Investigating cultural moderators would allow future research to refine how hybrid care can be attuned not only to client preference but also to cultural frameworks of trust, intimacy, and safety.

Study Summary

The emergence of hybrid therapy as a standard feature of contemporary mental health care reflects a broader structural transformation in how therapeutic presence and accessibility are conceptualized (Fernandez et al., 2021; Lin et al., 2022; Pierce et al., 2021). The post-pandemic landscape has accelerated a shift away from viewing physical proximity as the defining condition of therapy and toward an understanding of psychological connection as the primary anchor of the therapeutic encounter (Cherry, 2020; Kashima, 2021; Kneeland et al., 2021). As service delivery

has expanded beyond the traditional therapy room, the field has begun to reconceptualize where and how meaningful relational work can occur (Turner & Siegel, 2022; Richie et al., 2023). This transition signifies not merely an expansion of treatment modalities, but a reorientation of the therapeutic frame itself (Hall & McGraw, 2014; Wootton, 2016).

Within this larger evolution, the findings of the present study contribute evidence that perceived therapeutic efficacy is not tied to the physical setting in which therapy takes place. Instead, the results indicate that clients evaluate therapy based on relational factors such as attunement, emotional presence, and collaborative engagement—elements that can be sustained across both in-person and telehealth environments. These findings reinforce a process-based interpretation of treatment effectiveness: it is the interpersonal quality of the therapeutic relationship, rather than the modality of delivery, that most strongly predicts whether clients experience therapy as beneficial.

By demonstrating no statistically significant difference in perceived efficacy between telehealth and in-person sessions, this study clarifies that modality functions as a logistical variable rather than a therapeutic determinant. This distinction carries theoretical implications by underscoring that the mechanism of change in psychotherapy is rooted in psychological resonance and co-regulation, not in physical co-location. It also carries empirical implications by providing post-pandemic data showing that telehealth remains effective after the emergency conditions of early adoption have passed. Finally, it carries practice implications by supporting hybrid service models that preserve client choice and continuity of care.

The study also contributes to the ongoing development of telehealth scholarship by extending research into a general outpatient population and by situating findings within a post-normalization environment. Earlier telehealth research often evaluated adaptation under crisis

conditions, whereas this study examines modality equivalency in a stabilized care ecosystem. As a result, the findings speak not only to feasibility or acceptability, but to the sustainability of hybrid models as a long-term feature of the therapeutic landscape.

These findings illustrate that telehealth should not be conceptualized as a substitute for in-person therapy, but as a parallel modality capable of delivering equivalent relational benefit. The shift toward hybrid care models therefore represents not a departure from traditional psychotherapy, but a continuation of its core principles in an expanded format. Therapeutic alliance remains the central mechanism of change; the setting through which it is transmitted is adaptable.

The implications of this study point toward a future in which clinical training, organizational infrastructure, and regulatory policy increasingly align with a process-based rather than location-based understanding of therapy. As hybrid delivery becomes the norm, competence in maintaining psychological presence across modalities will become as fundamental as any other therapeutic skill. At the same time, system-level support for modality flexibility will be essential to ensuring equitable access to care, particularly for clients who face structural or logistical barriers to in-person services.

In this respect, the study's findings reinforce an emerging paradigm shift: therapeutic presence is no longer defined by shared physical space, but by sustained relational attunement. The profession is moving toward a model in which the essence of therapy is located not in the environment, but in the encounter. This reorientation holds significance for clinicians, organizations, and the broader behavioral health system alike. By clarifying that the heart of therapy is the relationship rather than the room, this study contributes to a field-wide repositioning of modality as a tool of access rather than a determinant of outcome.

As mental health care continues to evolve, future research, training, and implementation efforts will likely build on this relational foundation. The permanence of hybrid delivery models reflects not a temporary response to external circumstances, but a meaningful expansion of where and how healing relationships can occur. The findings of this study support a forward-looking view of psychotherapy in which clinical process, systemic equity, and theoretical development converge to sustain therapeutic connection across diverse settings. In this convergence lies the future of hybrid care—not as an alternative—but as an integrated and enduring dimension of modern therapeutic practice.

References

Arpino, B., Pasqualini, M., Bordone, V., Sole-Auro, A. (2021). Older people's nonphysical contacts and depression during the COVID-19 lockdown. *Gerontologist, 61*(1) 176-186.

Bajaj, G. S., Yadav, H., Sahdev, H. S., Sah, S., & Kaur, P. (2021, September 24). *Mental health analysis during COVID-19: A comparison before and during the pandemic.* [Conference presentation]. IEEE 4th International Conference on Computing, Power, and Communications Technologies.

Bayern, M. (2021). COVID-19 Mental Health Long Haulers. *Psychiatric Times*, *38*(7), 4–6.

Bockler, A. (2019). Why we share our cookies: Prosocial behavior from a psychological perspective. *Anthropol Anz, 76, (3*), 181-194. doi:10.1124/anthraz/2019/0880

Burhani, T. S., & Naqvi, W. M. (2020). Telehealth - a boon in the time of Covid 19 outbreak. *Journal of Evolution of Medical and Dental Sciences*, *9*(29), 2081–2084. https://doi.org/10.14260/jemds/2020/454

Cherry, K. (2020, April 29). *Social psychology studies how we interact with the world*. Verywell Mind. Retrieved January 23, 2022, from https://www.verywellmind.com/things-you-should-know-about-social-psychology-2795903

Chiauzzi, E., Clayton, A., & Huh-Yoo, J. (2020). Videoconferencing-based telemental health: Important questions for the COVID-19 era from clinical and patient-centered perspectives. *JMIR Mental Health*, *7*(12), e24021. https://doi.org/10.2196/24021

Cole, C, Waterman, S., Hunter, E. (2020). Effectiveness of small group cognitive behavioral therapy for anxiety and depression in Ebola treatment center staff in Sierra Leone. *International Review Psychiatry.* https//doi.org/10.1016/j.ijnurstu.2005.03.006

Connolly, S. L., Stolzmann, K. L., Heyworth, L., Weaver, K. R., Bauer, M. S., & Miller, C. J. (2020). The rapid increase in telemental health within the Department of veterans affairs during the COVID-19 pandemic. *Telemed Journal of Health*. https://doi.org/110.1089/tmj.2020.0233

Czeisler, M. E., Howard, M. E., & Rajaratnam, S. M. W. (2021). Mental health during the COVID-19 pandemic: Challenges, populations at risk, implications, and opportunities. *American Journal of Health Promotion*, *35*(2), 301-311. https://doi.org/10.1177/0890117120983982

Fernandez, E., Woldgabreal, Y., Day, A., Pham, T., Gleich, B., & Aboujaoude, E. (2021). Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment. *Clinical Psychology and Psychotherapy*, *28*, 1535-1549. https://doi.org/10.1002/cpp.2594

Hamlin, M., Ymerson, T., Carlsen, H. K., Dellepiane, M., Falk, O., Ioannou, M., & Steingrimsson, S. (2022). Changes in psychiatric inpatient service utilization during the first and second waves of the COVID-19 pandemic. *Frontiers in Psychiatry*, *133*, 1-9. https://doi.org/10.3389/fpsyt.2022.829374

HealthLeaders (2022, April 8). *Trends in outpatient mental healthcare during the pandemic have telehealth implications*. Healthcare Leadership Review. Retrieved March 26, 2023, from hcpro.com

Johnson, S. (2021). Addressing mental health and substance use disorders amid and beyond the COVID-19 pandemic. *American Journal of Health Promotion*, *35*(2), 299-301. https://doi.org/10.1177/0890117120983982

Kneeland, E. T., Hilton, B. T., Fitzgerald, H. E., Castro-Ramirez, F., Tester, R. D., Demers, C., & McHugh, R. K. (2021). *Providing Cognitive Behavioral Group Therapy via Videoconferencing: Lessons Learned from a Rapid Scale-up of Telehealth Services*, *6*(4), 221–235. https://doi.org/10.1037/pti0000154

Kopelovich, S. L., Monroe-DeVita, M., Buck, B. E., Brenner, C., Moser, L., Jarskog, L. F., Harker, S., & Chwastiak, L. A. (2020). Community Mental Health Care Delivery during the COVID-19 Pandemic: Practical strategies for improving care for people with serious mental illness. *Community Mental Health Journal*, *57*(3), 405–415. https://doi.org/10.1007/s10597-020-00662-z

Lin, T., Heckman, T., & Anderson, T. (2021). Zoom-in to zone-out: Therapists report less therapeutic skill in telepsychology versus face-to-face therapy during the COVID-19 pandemic. *Psychotherapy.*

Lin, T., Heckman, T., & Anderson, T. (2022). The efficacy of synchronous teletherapy versus in-person therapy: A meta-analysis of randomized clinical trials. *Clinical Psychology: Science and Practice*, *29*(2), 167-178. https://doi.org/10.1037/cps0000056

Mendell, G. (2021). Addressing the addiction crisis during a pandemic. *American Journal of Health Promotion*, *35*(2), 319. https://doi.org/10.1177/0890117120983982

Miles, A., Andiappan, M., Upenieks, L., & Orfanidis, C. (2021). Using prosocial behavior to safeguard mental health and foster emotional well-being during the COVID-19 pandemic: A registered report protocol for a randomized trial. *PloS One 16(1).* https://doi.org/10.1371/journal.pone.0245865

Mochari-Greenberger, H., & Pande, R. L. (2021). Behavioral health in America during the COVID-19 pandemic: Meeting increased needs through access to high quality virtual care.

American Journal of Health Promotion, *35*(2), 312-317. https://doi.org/10.1177/0890117120983982

Mohr, D. C., Vella, L., Hart, S., Heckman, T., & Simon, G. (2008). The effect of telephone-administered psychotherapy on symptoms of depression and attrition: A meta-analysis. *Clinical Psychology: Science and Practice*, 15(3), 243-253. https://doi.org/10.1111/j.1468-2850.2008.00134.x

Pal, K., & Danda, S. (2023). Stress, anxiety triggers, and mental health care needs among general public under lockdown during COVID-19 pandemic: A cross-sectional study in India. *International Journal of Mental Health an Addiction*, *21*, 321-332. https://doi.org/10.1007/s11469-021-00596-x

Parmanto B, Lewis AN Jr, Graham KM, Bertolet MH, (2016), "Development of the Telehealth Usability Questionnaire (TUQ)", Int J Telerehabil, 8(1):3-10. DOI: 10.5195/ijt.2016.6196. PMID: 27563386

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

Ramirez, D., Rufino, K. A., Rech, M. E., Poa, E., & Patriquin, M. A. (2022). Increased symptom severity in adults and adolescents admitting to an inpatient psychiatric hospital during the COVID-19 pandemic. *Psychiatry Research*, *316*, 1-8. https://doi.org/10.1016/j.psychres.2022.114758

Richie, F. J., Langhinrichsen-Rohling, J., Kaniuka, A., Wilsey, C., Mennicke, A., Harris, Y., Sullivan, S., Gray, G., & Cramer, R. J. (2023). Mental health services for all: Factors

influencing desire for mental health services among underresourced adults during COVID-19. *Psychological Services*, *20*(1), 144-148. https://doi.org/10.1037/ser0000644

Schenker, J. D., & Rumrill, P. D. (2004). *Causal-Comparative Research Designs*, *21*, 117–121. https://doi.org/1052-2263/04

Soklaridis, S., Lin, E., Lalani, Y., Rodak, T., & Sockalingam, S. (2020). Mental health interventions and supports during COVID- 19 and other medical pandemics: A rapid systematic review of the evidence. *General Hospital Psychiatry*, *66*, 133–146. https://doi.org/10.1016/j.genhosppsych.2020.08.007

Summers, L., Meppen, D., & Ball, S. (2020). Utah's mental health system. *Informed Decisions*, 1-38. https://doi.org/gardner.utah.edu

Sumner, J. A., Koenen, K. C., & Kubzansky, L. D. (2021). The long arm of mental health: New urgency with the COVID-19 pandemic. *American Journal of Health Promotion*, *35*(2), 311-312. https://doi.org/10.1177/0890117120983982

Team, G. T. E. (2018, May 6). *Cognitive-behavioral therapy (CBT)*. Learn about Cognitive Behavioral Therapy and Therapists. Retrieved December 19, 2021, from http://www.goodtherapy.org/learn-about-therapy/types/cognitive-behavioral-therapy

Tucker, P., & Czapla, C. (2021). *Post-COVID-19 Stress Disorder: Another Emerging Consequence of the Global Pandemic*, *38*(1), 8–11.

Turner, B., & Siegel, S. (2022). Telemedicine and mental health care of young adults during COVID-19: A qualitative study. *Practice Innovations*, *7*(1), 64-70. https://doi.org/10.1037/pri0000170

Varker, T., Brand, R. M., Ward, J., Terhaag, S., & Phelps, A. (2019). Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress

disorder, and adjustment disorder: A rapid evidence assessment. *Psychological Services*, *16*(4), 621–635. https://doi.org/10.1037/ser0000239

Waller, G., Pugh, M., Mulkens, S., Moore, E., Mountford, V. A., Carter, J., Wicksteed, A., Maharaj, A., Wade, T. D., Wisniewski, L., Farrell, N. R., Raykos, B., Jorgensen, S., Evans, J., Thomas, J. J., Osenk, I., Paddock, C., Bohrer, B., Anderson, K., … Smit, V. (2020). Cognitive-behavioral therapy in the time of coronavirus: Clinician tips for working with eating disorders via telehealth when face-to-face meetings are not possible. *International Journal of Eating Disorders*, *53*(7), 1132–1141. https://doi.org/10.1002/eat.23289

Wang, J., Spencer, A., Hulme, C., Corbett, A., Khan, Z., Vasconcelos Da Silva, M., O'Dwyer, S., Wright, N., Testad, I., Ballard, C., Creese, B., & Smith, R. (2022). Healthcare utilisation, physical activity, and mental health during COVID-19 lockdown: An interrupted time-series analysis of older adults in England. *European Journal of Ageing*, *19*, 1617-1630. https://doi.org/10.1007/s10433-022-00741-y

Wootton, B. M. (2016). Remote cognitive-behavior therapy for obsessive-compulsive symptoms: A meta-analysis. *Clinical Psychology Review, 43*, 103-113. https://doi.org/10.1016/j.cpr.2015.10.001

Appendix A: Recruitment and Informed Consent Letter

My name is Jeanna Cunningham, and I am a Doctoral Student at Northcentral University (NCU). I also hold a role as a Clinical Mental Health Counselor at Highland Springs Specialty Clinic.

I am conducting a research study of the efficacy of therapy dependent on the delivery method via in-person or telehealth sessions. The purpose is to see if the delivery method of outpatient therapy is the same by WebEx as it is in person. The name of this research study is "Mental Health Therapy Efficacy Differences as a Function of the Delivery Method of Telehealth or In-person." I am seeking your consent to participate in this study.

Please read this document to learn more about this study and determine if you would like to participate. Your participation is completely voluntary, and I will address your questions or concerns at any point before or during the study.

Eligibility

You may participate in this research if you meet all of the following criteria:

1. You are participating in individual outpatient therapy either in-person or via telehealth
2. Are age 18 or older

I hope to include 100 people in this research.

Activities

If you decide to participate in this study, you will be asked to do the following activities:

Complete a self-report questionnaire entitled the Session Rating Scale. It is a brief 4-question survey that will be completed online.

During this activity, you will be asked questions about Your therapeutic relationship with your individual therapist.

All activities and questions are optional: you may skip any part of this study that you do not wish to complete and may stop at any time.

If you need to complete the activities above in a different way than I have described, please let me know, and I will attempt to make other arrangements.

Risks

There are no foreseeable risks or discomforts associated with this study. You can still skip any question you do not wish to answer, skip any activity, or stop participation at any time.

Benefits

If you participate, there are no direct benefits to you. This research may increase the body of knowledge in the subject area of this study.

Privacy and Data Protection

I will take reasonable measures to protect the security of all your personal information, but I cannot guarantee the confidentiality of your research data. In addition to me, the following people and offices will have access to your data:

- My NCU dissertation committee and any appropriate NCU support or leadership staff
- The NCU Institutional Review Board

This data could be used for future research studies or distributed to other investigators for future research studies without additional informed consent from you or your legally authorized representative.

I will securely store your data for 3 years. Then, I will delete electronic data and destroy paper data.

How the Results Will Be Used

I will publish the results in my dissertation. I may also share the results in a presentation or publication. Participants will not be identified in the results.

Contact Information

If you have questions, you can contact me at: j.cunningham4039@o365.ncu.edu.

My dissertation chair's name is Dr. Jill Blackwood. They work at Northcentral University and supervise me on the research. You can contact them at: ***mblackwell@ncu.edu***

If you have questions about your rights in the research or if a problem or injury has occurred during your participation, please contact the NCU Institutional Review Board at irb@ncu.edu or 1-888-327-2877 ext. 8014.

Appendix B: Session Rating Scale (SRS V.3.0)

Name: _____ Age (Yrs)_____

ID #_____ Sex M/F

Session #_____ Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood, and respected.	I----------I----------I---------I	I felt heard, understood, and respected.
We did not work on or talk about what I wanted to work on and talk about.	I----------I----------I---------I	We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.	I----------I----------I---------I	The therapist's approach is a good fit for me.
There was something missing in the session today.	I----------I----------I---------I	Overall, today's session was right for me.

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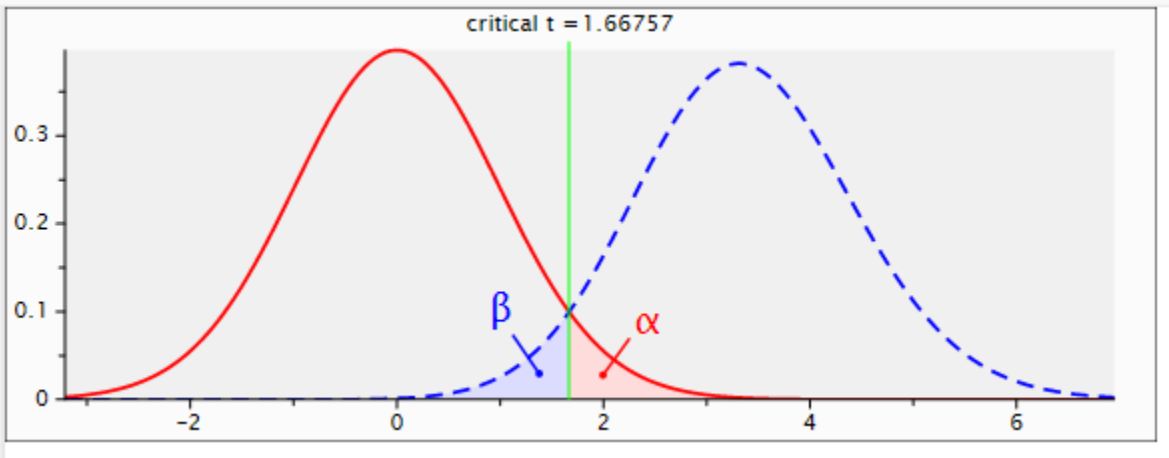
Appendix C: G-Power Analysis



Input Parameters

Tail(s)	One
Determine => Effect size d	0.80
α err prob	0.05
Power (1-β err prob)	0.95
Allocation ratio N2/N1	1

Output Parameters

Noncentrality parameter δ	3.3466401
Critical t	1.6675723
Df	68
Sample size group 1	35
Sample size group 2	35
Total sample size	70
Actual power	0.9523628

Appendix D: Permission to Use Session Rating Scale

Scott D. Miller, Ph.D. Mon, Mar 6, 6:58 AM (4 days ago)

to me

Yes, that is acceptable.

S

From: Jeanna Cunningham <jeanna93@gmail.com>

Sent: Sunday, March 5, 2023 4:52 PM

To: Scott D. Miller, Ph.D. <scottdmiller@talkingcure.com>

Subject: Re: SRS for dissertation research

Would it be permissible for me to email the survey to them for them to print, fill out then scan and send back to me?

Jeanna Cunningham MS, CMHC

On Sun, Mar 5, 2023, at 3:04 PM Scott D. Miller, Ph.D. <scottdmiller@talkingcure.com> wrote:

Thanks Jeanna.

Unfortunately, no digitalization I permitted. This is clearly stated in the license.

Two options:

1. Paper and pencil.

2. Using one of the authorized systems.

Both are described on my website: www.scottdmiller.com.

Let me know.

Scott

-------- Original message --------

From: Jeanna Cunningham <jeanna93@gmail.com>

Date: 3/5/23 2:52 PM (GMT-06:00)

To: "Scott D. Miller, Ph.D." <scottdmiller@talkingcure.com>

Subject: Re: SRS for dissertation research

I have three ideas for this, and your permission and feedback would be needed to move forward.

Idea 1: Emailing participants a fillable PDF.

Idea 2: Converting it to a Google form that would be emailed to participants

Idea 3: Utilizing Survey Monkey to administer an electronic version of the form and send participants a link to complete the survey.

Thank you for your help,

Jeanna Cunningham MS, CMHC

On Sat, Mar 4, 2023, at 3:41 PM Scott D. Miller, Ph.D. <scottdmiller@talkingcure.com> wrote:

Hi Jeanna …

How are you planning on administering the tool in your study?

Scott

From: Jeanna Cunningham <jeanna93@gmail.com>

Sent: Saturday, March 4, 2023 4:36 PM

To: info@scottdmiller.com

Subject: SRS for dissertation research

Mr. Miller,

I am a therapist in the state of Utah, and I am working on my dissertation for my Ph.D. research on the efficacy of telehealth post-pandemic in an outpatient setting. I was wondering if I could get permission to use your SRS as a tool to give to clients at a clinic in the state of Utah for this research. It would be given to approximately 150 people depending on how many responses I get If things go well it is projected for the study to take place this summer.

Thank you for your help and consideration.

Jeanna Cunningham MS, CMHC

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