Continuation of Teletherapy After the COVID-19 Pandemic: Survey Study of Licensed Mental Health Professionals

Rashmi Gangamma1, PhD; Bhavneet Walia2, PhD; Melissa Luke3, PhD; Claudine Lucena1, MA

1Department of Marriage and Family Therapy, Falk College of Sport and Human Dynamics, Syracuse University, Syracuse, NY, United States
2Department of Public Health, Falk College of Sport and Human Dynamics, Syracuse University, Syracuse, NY, United States
3Department of Counseling & Human Services, School of Education, Syracuse University, Syracuse, NY, United States

Corresponding Author:
Rashmi Gangamma, PhD
Department of Marriage and Family Therapy
Falk College of Sport and Human Dynamics
Syracuse University
Peck Hall
601 E Genesee Street
Syracuse, NY, 13202
United States
Phone: 1 614 325 4029
Email: rgangamm@syr.edu

Abstract

Background: The use of teletherapy has exponentially increased in the context of the ongoing COVID-19 pandemic. Studies on teletherapy documented substantial benefits of accessibility and convenience even before the start of the pandemic. Although recent studies show that this modality of therapy delivery is here to stay, few have studied who will most benefit from this trend.

Objective: In this paper, we report predictors of continued teletherapy usage in a sample of licensed mental health professionals in the United States during a time period when pandemic-related restrictions began diminishing. As such, it is one of the first studies to examine factors related to continued benefits of teletherapy postpandemic.

Methods: Participation from licensed mental health professionals was sought on listservs of national organizations of multiple mental health organizations. Data were collected via an anonymous link to a survey on Qualtrics between January 2021 and April 2021. Participants responded to questions on therapist demographics, practice setting, experiences of shifting to teletherapy, perspectives on continued use of teletherapy, and their client characteristics. Findings related to client characteristics that predicted continued teletherapy usage are presented here.

Results: A total of 186 individuals consented to participate in the survey, with a final sample of 114 with complete data. A majority of participants identified as female (92/114, 80.7%), White (94/114, 82.5%), and having a master's degree (75/114, 65.5%) from a nationally accredited program (106/114, 93%). Data were analyzed using heteroskedastic regression modeling with client-related factors as predictors. Two models were run with and without distance travelled by clients as a control variable. Model estimates from both models showed that continued use of teletherapy postpandemic was predicted by the following factors: higher percentage of clients from rural areas, younger and older adult clients, clients with Medicare, and clients with marginalized gender and religious/spiritual identities. Significantly, having a higher percentage of clients from lower socioeconomic status, a higher percentage of those with Medicaid coverage, and a higher percentage of couples and families as clients predicted decreased use of teletherapy postpandemic.

Conclusions: Findings from the study suggest that while some groups of clients are more likely to continue to receive benefits of teletherapy, vulnerable groups such as those in lower socioeconomic conditions, Medicaid beneficiaries, and those who seek couple and family therapy may be less likely to be served by it. These differences point to a need to address factors driving telehealth care disparities such as access to technology, housing, and childcare issues, as well as the need for continued training for licensed professionals.

(JMIR Form Res 2022;6(6):e32419) doi: 10.2196/32419
KEYWORDS
teletherapy; relational teletherapy; teletherapy predictors; postpandemic teletherapy; mental health; telemedicine; COVID-19; telemental health

Introduction

The COVID-19 pandemic and subsequent social measures drastically impacted society [1], shifting education, work, health care [2,3], and mental health [4]. Telemental health, referred to as teletherapy, has been used over the past 20 years [5] with demonstrated effectiveness [6,7]. Teletherapy refers to the use of electronically based communication such as videoconferencing, telephone calls, and mobile apps to provide access to mental health services, typically across distances [8]. Rapid legislative changes, training, and guidelines resulted in an exponential increase in teletherapy when compared to prepandemic levels [9,10]. The increase in relational teletherapy (teletherapy with couples and families) has been particularly important given increased risks for distress, anxiety, grief/loss, substance abuse, and family violence in children [11] and adults [12-14] during the pandemic. Before the COVID-19 pandemic, scholars contended that historically underserved populations derived more benefits from the flexibility and accessibility of teletherapy [15,16]. As COVID-19–related restrictions are lifted, teletherapy will remain part of the mental health landscape [17]. However, given the existing challenges of the need for training, technological advances, and other barriers to effective use [8,18-20], we are yet to understand whether teletherapy will be accessible equitably postpandemic.

In this paper, we present findings from a study on predictors of continued teletherapy practice postpandemic from a sample of licensed mental health practitioners. Specifically, our research question was “What factors of therapist practice predict their intention for continued use of teletherapy practice postpandemic?” Existing literature suggests that distance from services, client profile [15,16], and vulnerability of selected client populations [6-8,18-20] may influence provision of teletherapy. Clarifying predictors would strengthen recent research on therapists’ experiences transitioning to the use of telehealth [18] and may assist in identifying factors in disparities in telehealth care postpandemic.

Methods

Recruitment

Participation was open to licensed mental health professionals who were currently providing teletherapy. Upon institutional review board approval, a link to an anonymous Qualtrics survey was posted on multiple listservs including the American Association for Marriage and Family Therapy, the American Counseling Association, as well as professional groups for social workers. Data were gathered between January 2021 and April 2021, when increased vaccinations were driving gradual removal of public health reductions [20]. Survey questions included therapist demographics, practice setting, experiences of shifting to teletherapy, perspectives on continued teletherapy use, and client characteristics. No incentives were provided; instead, a donation was made to a nonprofit chosen by participants. A total of 186 individuals consented to participate in the survey, with a final sample of 114 with complete data.

Ethics Approval

This study received ethics approval from Syracuse University’s Institutional Review Board (IRB #20-310).

Statistical Analysis

Descriptive statistics and regression analyses were conducted using Stata software (version 14; StataCorp LLC) [21]. A residual plot revealed increasing standard deviation of residuals in the independent variables (ie, heteroskedasticity). Given that errors were normally distributed and mean and variance functions were correctly specified, we ran hetregress regression models with maximum likelihood estimator [21]. Using G*Power power analysis, setting a medium effect size with 10 predictors in our model, we determined that our final sample of 114 was sufficient for regression analysis [22].

Results

Participants were from 27 states in the United States, with a majority identifying as female (92/114, 80.7%), White (94/114, 82.5%), and with a master's degree (75/114, 65.5%) from a nationally accredited program (106/114, 93%). Less than half of participants (45/114, 39.5%) reported prepandemic experience practicing teletherapy. Table 1 shows other practice profiles of participants and Table 2 shows client profile factors used as independent variables in the regression models.

Table 3 shows coefficient values of regression models run without and with control for distance travelled by clients (models 1 and 2, respectively). We controlled for distance from a health setting in model 1 to limit multicollinearity and increase robustness of estimates. Both models were estimated with therapist gender as a cluster variable.

Among factors examined, statistically significant predictors were (1) higher percentage of clients living further from a metro area, particularly those in rural areas ($β$=38.578, $P<.01$), (2) higher percentage of clients who are younger (<30 years; $β$=186, $P<.001$) or older (65-80 years; $β$=634, $P<.001$), (3) higher percentage of clients who identified with a minoritized gender ($β$=223, $P<.001$) and religious/spiritual identity ($β$=153, $P<.001$), and those with disabilities ($β$=399, $P<.001$), and (4) higher percentage of clients with Medicare ($β$=457, $P<.001$). Conversely, therapists for whom couples/families were >75% of their caseload were less likely to continue teletherapy compared to therapists with caseloads of couples/families <25% ($β$=19.876, $P<.001$), 25%-50% ($β$=32.040, $P<.001$) and 50%-75% ($β$=28.927, $P<.001$). Similarly, therapists with a higher percentage of clients from lower socioeconomic backgrounds ($β$=.285, $P<.001$) and a higher percentage of clients with Medicaid coverage ($β$=.143, $P<.05$) were less likely to continue teletherapy postpandemic.
Table 1. Practice profiles of participants (N=114).

| Practice profile of participants | Participants, n (%) |
|----------------------------------|---------------------|
| **Type of license**              |                     |
| Marriage and family therapy      | 77 (67.5)           |
| Mental health counselor          | 21 (18.2)           |
| Clinical social work             | 5 (4.4)             |
| Clinical psychologist            | 4 (3.5)             |
| Other                            | 7 (6.1)             |
| **Geographical location**        |                     |
| Large metro                      | 36 (31.9)           |
| Medium metro                     | 32 (28.3)           |
| Small metro                      | 27 (23.9)           |
| Rural area                       | 6 (5.3)             |
| Small town                       | 5 (4.4)             |
| **Distance travelled by clients**|                     |
| <25 miles                        | 98 (85.8)           |
| 25-50 miles                      | 13 (11.5)           |
| >50 miles                        | 3 (2.4)             |
Table 2. Descriptive of client profile factors used in regression models.

| Client profile                                      | Average percentage<sup>a</sup> |
|-----------------------------------------------------|-------------------------------|
| **Age group (years)**                               |                               |
| <30                                                 | 44.05                         |
| 30-49                                               | 38.75                         |
| 50-64                                               | 10.83                         |
| 65-80                                               | 4.20                          |
| >80                                                 | 0.34                          |
| **Gender**                                          |                               |
| Female                                              | 56.42                         |
| Male                                                | 34.81                         |
| Nonbinary/gender expansive                          | 5.19                          |
| Transgender                                         | 4.81                          |
| Other                                               | 1.39                          |
| **Marginalized identities**                         |                               |
| Marginalized gender identities                       | 15.22                         |
| Marginalized sexual identities                       | 17.79                         |
| Marginalized racial/ethnic identities               | 26.22                         |
| Marginalized religious/spiritual identities         | 10.01                         |
| Lower socioeconomic status groups                   | 28.38                         |
| Having a disability                                 | 15.91                         |
| Veterans                                            | 5.96                          |
| **Payer mix**                                       |                               |
| Medicaid                                            | 13.01                         |
| Medicare                                            | 4.42                          |
| Private health insurance                            | 27.81                         |
| Veterans Health Care                                | 2.19                          |
| Self-pay                                            | 43.71                         |
| Other                                               | 8.63                          |
| **Percentage of couples and families in case load** |                               |
| <25%                                                | 42.98                         |
| 25%-50%                                             | 0.34                          |
| 50%-75%                                             | 11.40                         |
| >75%                                                | 12.28                         |

<sup>a</sup> Absolute values are unavailable because the average percentage was calculated for each group.
Table 3. Regression model of client factors predicting therapists’ postpandemic teletherapy usage.

| Factors                          | Model 1 (n=94) | Model 2 (n=94) |
|----------------------------------|----------------|----------------|
|                                  | Coefficient    | SE             | Coefficient    | SE             |
| Practice setting                 |                |                |                |                |
| Fringe large metro               | 6.792          | 0.436          | 9.670          | 0.499          |
| Medium metro                     | 7.495<sup>a</sup>| 3.418          | 5.545<sup>b</sup>| 1.876          |
| Small metro                      | 6.620<sup>a</sup>| 3.960          | 5.401          | 0.928          |
| Micropolitan                     | 16.804<sup>a</sup>| 2.804          | 15.939<sup>a</sup>| 3.028          |
| Rural                            | 39.843<sup>c</sup>| 1.970          | 38.578<sup>c</sup>| 2.079          |
| Percentage of couples and families in case load |                |                |                |                |
| <25%                             | 25.291<sup>a</sup>| 3.518          | 19.876<sup>a</sup>| 2.993          |
| 25%-50%                          | 39.158<sup>a</sup>| 29.207         | 32.040<sup>a</sup>| 9.333          |
| 50%-75%                          | 35.416<sup>a</sup>| 5.746          | 28.927<sup>a</sup>| 4.351          |
| Client age (years)               |                |                |                |                |
| <30                              | 0.213<sup>a</sup>| 16.047         | 0.186<sup>a</sup>| 7.052          |
| 30-49                            | 0.277<sup>a</sup>| 28.157         | 0.226<sup>a</sup>| 5.083          |
| 51-64                            | -0.215         | -0.655         | -0.135         | -0.365         |
| 65-80                            | 0.661<sup>c</sup>| 2.468          | 0.634<sup>a</sup>| 2.961          |
| Percentage of clients with marginalized identities |                |                |                |                |
| Racial/ethnic identities         | 0.089          | 0.921          | 0.134          | 1.129          |
| Sexual identities                | 0.005          | 0.033          | 0.009          | 0.079          |
| Gender identities                | 0.276<sup>a</sup>| 4.766          | 0.223<sup>a</sup>| 6.154          |
| Religious/spiritual identities   | 0.109<sup>c</sup>| 2.069          | 0.153<sup>b</sup>| 1.855          |
| Lower socioeconomic status       | -0.341<sup>a</sup>| -3.879         | -0.285<sup>a</sup>| -3.264         |
| Disability                       | 0.417<sup>a</sup>| 6.261          | 0.399<sup>a</sup>| 3.734          |
| Client payment modality          |                |                |                |                |
| Medicaid                         | -0.066         | -0.871         | -0.143<sup>b</sup>| -1.649         |
| Medicare                         | 0.390<sup>a</sup>| 4.139          | 0.457<sup>a</sup>| 4.823          |
| Private insurance                | -0.071<sup>a</sup>| -4.344         | -0.079<sup>a</sup>| -3.712         |
| Other pay                        | 0.148<sup>a</sup>| 3.151          | 0.090<sup>a</sup>| 2.787          |
| Constant                         | -83.033<sup>a</sup>| -6.727         | -87.333<sup>a</sup>| -6.786         |
| Insigma 2 Constant               | 6.068<sup>a</sup>| 58.085         | 6.161<sup>a</sup>| 54.540         |

<sup>a</sup><i>P</i>&lt;.001.<br/><sup>b</sup><i>P</i>&lt;.05.<br/><sup>c</sup><i>P</i>&lt;.01.

Discussion

Principal Findings

Results illuminate the potential types of clients most likely to continue to receive teletherapy postpandemic from licensed mental health professionals in our sample. In addition to supporting earlier literature on use of teletherapy with clients with disabilities and from rural areas [23,24], our findings suggest that younger and older adult clients, those on Medicare, and clients who identified with marginalized gender or religious/spiritual identities are most likely to continue to receive teletherapy. It is likely that legislative actions leading to waivers of restrictions and increased coverage of teletherapy [25,26]
benefited older adult clients and those with Medicare coverage. For clients with minoritized social identities who could also access teletherapy, changes during the pandemic may have highlighted the relative safety of seeking therapy via technology.

We also found that therapists were less likely to continue teletherapy when they had a higher percentage of clients from lower socioeconomic backgrounds and with Medicaid coverage or had a higher percentage of caseloads with couples and families. Given that the pandemic has disproportionately impacted those who are underresourced, decreased teletherapy usage with those with lower socioeconomic status suggests that unless structural issues of accessibility are addressed, vulnerable groups may be left behind. Studies report technological difficulties, lack of confidential space, and privacy concerns hinder relational teletherapy [27]. It is possible these barriers are indicative of a need for structural changes (eg, access to adequate housing, broadband internet, and childcare) to prevent deepening disparities. Although therapists with a higher percentage of Medicare clients were likely to continue its use, those with a greater percentage of Medicaid clients were less likely to do so. Given both Medicare and Medicaid coverage of teletherapy began at the same time, this difference may be a factor of available client resources or discrepancies in support between the two programs at state and local levels.

Another significant finding is therapists with the highest percentage of couples and families in their caseload were less likely to continue teletherapy. Although we did not ask for their reasons, this is consistent with earlier studies identifying challenges of training [8], difficulties in de-escalating, and simultaneous engagement with multiple family members [28]. Although teletherapy presents several advantages for access and convenience drive teletherapy use [36], our study suggests that after the pandemic, licensed professionals are less likely to continue teletherapy for clients in lower socioeconomic groups as well as for many couples and families. We contend that training clinicians and addressing structural barriers to teletherapy access may decrease deepening disparities in teletherapy provision.

Conflicts of Interest
None declared.

References
1. Van Lancker W, Parolin Z. COVID-19, school closures, and child poverty: a social crisis in the making. Lancet Public Health 2020 May;5(5):e243-e244 [FREE Full text] [doi: 10.1016/S2468-2667(20)30084-0] [Medline: 32275858]
2. Holmes E, O’Connor RC, Perry V, Tracey I, Wessely S, Arseneault L, et al. Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. Lancet Psychiatry 2020 Jun;7(6):547-560 [FREE Full text] [doi: 10.1016/S2215-0366(20)30168-1] [Medline: 32304649]
3. Wallia B, Shridhar A, Arasu P, Singh GK. US Physicians’ Perspective on the Sudden Shift to Telehealth: Survey Study. JMIR Hum Factors 2021 Aug 12;8(3):e26336 [FREE Full text] [doi: 10.2196/26336] [Medline: 33938813]
4. Luiggi-Hernández J, Rivera-Amador A. Reconceptualizing Social Distancing: Teletherapy and Social Inequality during the COVID-19 and Loneliness Pandemics. Journal of Humanistic Psychology 2020 Jul 03;60(5):626-638 [FREE Full text] [doi: 10.1177/0022167820937503]
5. TeleMental Health in the Department of Veteran Affairs. U.S. Department of Veterans Affairs. URL: https://www.va.gov/anywhere真正做到where/docs/TeleMental_Health_factsheet.PDF [accessed 2021-07-20]
6. Rees C, Maclaine E. A Systematic Review of Videoconference – Delivered Psychological Treatment for Anxiety Disorders. Australian Psychologist 2020 Nov 12;50(4):259-264 [FREE Full text] [doi: 10.1111/ap.12122]
7. Wrape E, McGinn M. Clinical and Ethical Considerations for Delivering Couple and Family Therapy via Telehealth. J Marital Fam Ther 2019 Apr;45(2):296-308 [FREE Full text] [doi: 10.1111/jmft.12319] [Medline: 29361194]

8. Pickens J, Morris N, Johnson D. The Digital Divide: Couple and Family Therapy Programs' Integration of Teletherapy Training and Education. J Marital Fam Ther 2020 Apr;46(2):186-200. [doi: 10.1111/jmft.12417] [Medline: 31820834]

9. McKee P, Pierce B, Tyler C, Perrin P, Elliott T. The COVID-19 Pandemic’s Influence on Family Systems Therapists’ Provision of Teletherapy. Fam Process 2022 Mar;61(1):155-166 [FREE Full text] [doi: 10.1111/famp.12665] [Medline: 33913526]

10. Mishma F, Milne E, Bogo M, Pereira L. Responding to COVID-19: New Trends in Social Workers’ Use of Information and Communication Technology. Clin Soc Work J 2021;49(4):484-494 [FREE Full text] [doi: 10.1007/s10615-020-00780-x] [Medline: 3320542]

11. Golberstein E, Wen H, Miller B. Coronavirus Disease 2019 (COVID-19) and Mental Health for Children and Adolescents. JAMA Pediatr 2020 Sep 01;174(9):819-820 [FREE Full text] [doi: 10.1001/jamapediatrics.2020.1456] [Medline: 32286618]

12. Cluver L, Lachman J, Sherr L, Wessels I, Krug E, Rakotomalala S, et al. Parenting in a time of COVID-19. Lancet 2020 Apr 11;395(10231):e64 [FREE Full text] [doi: 10.1016/S0140-6736(20)30736-4] [Medline: 32220657]

13. Hammonds C, Kerrissey J, Tomaskovic-Devey D. Stressed, Unsafe, and Insecureul Workers Need A New, New Deal. University of Massachusetts Amherst Labor Center and Center for Employment Equity. 2020. URL: https://www.umass.edu/employmentequity/stressed-unsafe-and-insecure-workers-need-new-new-deal [accessed 2021-07-20]

14. Trzebiński J, Cabański M, Czarnecka J. Reaction to the COVID-19 Pandemic: The Influence of Meaning in Life, Life Satisfaction, and Assumptions on World Orderliness and Positivity. Journal of Loss and Trauma 2020 May 21;25(6-7):544-557 [FREE Full text] [doi: 10.1080/15566004.2020.1765098]

15. Goss C, Richardson W, Dailey N, Bair B, Nagamoto H, Manson SM, et al. Rural American Indian and Alaska Native veterans' telemental health: A model of culturally centered care. Psychol Serv 2017 Aug;14(3):270-278 [FREE Full text] [doi: 10.1037/ser0000149]

16. Snow W, Lamar M, Hinkle J, Speciale M. Current Practices in Online Counselor Education. TPC 2018 Jun;8(2):131-145 [FREE Full text] [doi: 10.15241/whs.8.2.131]

17. Sheperis D, Smith A. Telehealth Best Practice: A Call for Standards of Care. JTCES 2021;1(1):27-35 [FREE Full text] [doi: 10.1097/01.NPR.0000731584.40074.eb]

18. Orlowski E, Friedlander M, Megale A, Peterson EK, Anderson SR. Couple and family therapists' experiences with Telehealth during the COVID-19 pandemic: a phenomenological analysis. Contemp Fam Ther 2022;44(2):101-114 [FREE Full text] [doi: 10.1007/s10591-022-09640-x]

19. StataCorp. 2015. URL: https://www.stata.com/ [accessed 2022-05-25]

20. Schuchat A, Walensky R. Summary of Guidance Review. Centers for Disease Control and Prevention. URL: https://www.cdc.gov/coronavirus/2019-ncov/downloads/communication/Guidance-Review.pdf [accessed 2022-05-25]

21. StatA 14. StataCorp. 2015. URL: https://www.stata.com/ [accessed 2022-05-25]

22. G*Power. URL: http://www.gpower.hhu.de/ [accessed 2022-04-14]

23. Hines M, Bulkley K, Dudley S, Cameron S, Lincoln M. Delivering Quality Allied Health Services to Children with Complex Disability via telehealth: Lessons Learned from Four Case Studies. J Dev Phys Disabil 2019 Feb 16;31(5):593-609 [FREE Full text] [doi: 10.1007/s10882-019-09662-8]

24. Turogose D, Ashwick R, Murphy D. Systematic review of lessons learned from delivering tele-therapy to veterans with post-traumatic stress disorder. J Telemed Telecare 2018 Oct;24(9):575-585. [doi: 10.1177/1357633X17730443] [Medline: 28958211]

25. Rogers J. Coding telehealth services during COVID-19. Nurse Pract 2021 Feb 01;46(2):10-12 [FREE Full text] [doi: 10.1097/01.NPR.0000731584.40074.eb] [Medline: 33399335]

26. Lowey NM. Text - H.R.6074 - 116th Congress (2019-2020): Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. US Congress. URL: https://www.congress.gov/bill/116th-congress/house-bill/6074/text [accessed 2021-07-20]

27. Hardy N, Maier C, Gregson T. Couple teletherapy in the era of COVID-19: Experiences and recommendations. J Marital Fam Ther 2021 Apr;47(2):225-243 [FREE Full text] [doi: 10.1111/jmft.12501] [Medline: 33742712]

28. McCoy M, Hjelmsd L, Stinson M. The Role of Tele-Mental Health in Therapy for Couples in Long-Distance Relationships. Journal of Couple & Relationship Therapy 2013 Oct;12(4):339-358 [FREE Full text] [doi: 10.1080/15332691.2013.836053]

29. Lebow J. Family in the Age of COVID-19. Fam Process 2020 Mar;59(2):309-312 [FREE Full text] [doi: 10.1111/famp.12543] [Medline: 32412686]

30. Heiden-Roostes K, Ferber M, Meyer D, Zubatsky M, Wittenborn A. Relational teletherapy experiences of couple and family therapy trainees: "Reading the room," exhaustion, and the comforts of home. J Marital Fam Ther 2021 Apr;47(2):342-358 [FREE Full text] [doi: 10.1111/jmft.12486] [Medline: 33449401]

31. Patterson JE, Edwards TM, Griffith JL, Wright S. Moral distress of medical family therapists and their physician colleagues during the transition to COVID-19. J Marital Fam Ther 2021 Apr 09;47(2):289-303 [FREE Full text] [doi: 10.1111/jmft.12504] [Medline: 33751596]
32. Hertlein K, Drude K, Jordan S. "What Next?: Toward telebehavioral health sustainability in couple and family therapy. J Marital Fam Ther 2021 Jul;47(3):551-565 [FREE Full text] [doi: 10.1111/jmft.12510] [Medline: 33818791]
33. Eppler C. Systemic teletherapists' meaningful experiences during the first months of the coronavirus pandemic. J Marital Fam Ther 2021 Apr;47(2):244-258 [FREE Full text] [doi: 10.1111/jmft.12515] [Medline: 33774847]
34. Velasquez D, Mehrotra A. Ensuring The Growth Of Telehealth During COVID-19 Does Not Exacerbate Disparities In Care. Health Affairs Blog. URL: https://www.healthaffairs.org/do/10.1377/hblog20200505.591306/full/ [accessed 2022-05-25]
35. Devakumar D, Shannon G, Bhopal S, Abubakar I. Racism and discrimination in COVID-19 responses. Lancet 2020 Apr 11;395(10231):1194 [FREE Full text] [doi: 10.1016/S0140-6736(20)30792-3] [Medline: 32246915]
36. Stoll J, Müller JA, Trachsel M. Ethical Issues in Online Psychotherapy: A Narrative Review. Front Psychiatry 2019;10:993 [FREE Full text] [doi: 10.3389/fpsyg.2019.00993] [Medline: 32116819]