



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.



## Rebooting Mental Health Care Delivery for the COVID-19 Pandemic (and Beyond): Guiding Cautions as Telehealth Enters the Clinical Mainstream

Jonathan S. Comer, *Florida International University*

*Across the COVID-19 pandemic, we have witnessed perhaps the field's largest and most abrupt transformation in scope of practice. In the context of surging mental health needs and historically limited feasibility of traditional office-based services during the pandemic, telehealth has launched into the clinical mainstream and has become a dominant mode of outpatient mental health care delivery. The articles in this terrific Special Issue outline some of the field's most exciting innovations from the past 18 months. The present commentary discusses how these unprecedented times have prompted unprecedented resourcefulness and innovation in the field. Issues related to evolving and uncertain telehealth regulation and reimbursement policies are discussed, and cautions for the road ahead are offered as we prepare for post-pandemic practices. The commentary concludes with a call to redouble efforts to move beyond the use of telehealth to largely treat only those populations who already enjoyed access to traditional office-based services. Understanding and overcoming barriers to telehealth care and ensuring equitable access to telehealth options are critical steps for actualizing the great potential of telehealth strategies for increasing the reach of supported care to underserved populations.*

THE ONGOING coronavirus disease 2019 (COVID-19) pandemic and associated efforts to slow its societal spread have abruptly transformed nearly all aspects of human life. Over the past 18 months, hundreds of millions of COVID-19 cases have been confirmed, roughly 5 million people have died as a result of the disease, and millions more have developed long-term physical effects. In addition to the very serious physical health toll of the pandemic, COVID-19 prevention efforts and mitigation policies have resulted in massive financial and emotional strains. During the pandemic, ongoing uncertainty, widespread grief, a global recession and economic instability, rising unemployment and underemployment, disrupted routines, large shifts in work-life balance and family responsibilities, social unrest, and social isolation due to social/physical distancing guidelines (among many other pandemic-era hardships) have contributed to elevated rates of mental health problems (O'Connor et al., 2021; Pierce et al., 2020; Racine et al., 2021). And it is critical to recognize

that the burdens of the pandemic have not been shared equally across the population. Rates of COVID-related death, unemployment, and stress have been disproportionately high in communities of color and in under-resourced communities.

The emotional strains of the pandemic and surging mental health needs have been further compounded by an abrupt curtailment in the feasibility, acceptability, availability, and safety of traditional outpatient mental health care. From the very beginning of the pandemic, stay-at-home guidelines and physical distancing orders rendered office-based care largely out-of-reach. Virtual schooling and online instruction eliminated typical opportunities and channels through which school psychologists and counselors support children's mental health. At this time of greatest need, our field found itself without its traditional tools for helping affected individuals.

### Necessity Is the Mother of Innovation

Throughout the history of mental health care, accelerated innovation and large-scale transformations in the scope and location of clinical practice have often arisen out of urgent and unprecedented needs. For example, it was World War I and the need to evaluate new recruits for potential military service that gave rise

---

*Keywords:* telehealth; COVID-19; coronavirus; telemental health; treatment innovation

1077-7229/20/© 2021 Association for Behavioral and Cognitive Therapies. Published by Elsevier Ltd. All rights reserved.

to the first proliferation of mental health clinics (Sammons et al., 2020). It was World War II and the need to rapidly mend soldiers' suffering from combat-related stress that first gave rise to the development of formal, structured, and time-limited psychological interventions (Sammons et al., 2020a). And after World War II, with the largest population of veterans in U.S. history and the urgent need to provide treatment on a national scale to the millions of returning veterans, the modern Veterans Administration (VA) was created. This was accompanied by the propagation of clinical psychology training programs across the country to support the VA's rising behavioral health needs (Sammons et al., 2020a).

Unprecedented times call for unprecedented resourcefulness, and the COVID-19 pandemic has once again forced the field to develop new standards of care and transform the scope, delivery, and setting of mental health care to meet the unique needs of the day. Prior to the pandemic, *telehealth* strategies using synchronous (i.e., real-time) interactive audio and video communication platforms to remotely conduct treatment—also referred to in the literature as telemental health (Myers et al., 2017), telepsychiatry (Folk et al., 2021, or behavioral telehealth (Comer & Barlow, 2014)—accounted for only a very small proportion of service delivery. In the early weeks of the pandemic, the majority of providers reported that their caseloads and new intakes had both abruptly decreased (Sammons et al., 2020a). This introduced serious concerns about continuity of care for existing patients, as well as concerns for newly stressed individuals.

Prior to the pandemic, only 11% of surveyed clinical psychologists were using telehealth strategies in their clinical practices (Sammons et al., 2020b), but within weeks of the pandemic onset, roughly 80% of these clinical psychologists had already transitioned almost exclusively to telehealth practice (Sammons et al., 2020a). At this early point in the pandemic, however, only one in five of these clinical psychologists believed that most of their patients liked receiving telehealth services. By six months into the pandemic, telehealth practice was near ubiquitous, with only 5% of surveyed clinical psychologists continuing to see their entire caseloads in the office (Sammons et al., 2020b). And with telehealth services as the dominant mode of treatment delivery six months into the pandemic, clinical caseloads and new intakes were back at pre-pandemic levels. Further, at six months into the pandemic, 90% of surveyed clinical psychologists anticipated they would still use telehealth with their patients after the pandemic was over (Sammons et al., 2020b).

These national estimates are highly consistent with data in this Special Issue on providers of specific

evidence-based treatments. For example, Barnett et al. (2021) reported that during the pandemic roughly 80% of surveyed Parent-Child Interaction Therapy (PCIT) providers had transitioned to delivering PCIT via telehealth, and 80% of these providers planned to continue to deliver PCIT via telehealth after the pandemic. Similarly, Zalewski et al. (2021) reported that over 85% of surveyed Dialectical Behavior Therapy (DBT) providers transitioned to telehealth during the pandemic.

The articles throughout this extraordinary Special Issue highlight the exceptional resourcefulness, agility, and innovation the field has witnessed over the past 18 months, as surging mental health needs have been met with unprecedented barriers to traditional office-based mental health care. Many of these innovations directly addressed the unique stressors brought about by the pandemic—such as Hsu et al.'s (2021) very scalable single-session/brief intervention that draws on a range of supported treatments to address COVID-related stress, and Sheerin et al.'s (2021) trauma-informed secondary prevention program that adapted Skills for Psychological Recovery to specifically address COVID-related psychological distress. Given the particular challenges that children have endured across the past 18 months while also navigating critical windows of social and emotional development, it was encouraging to see the very promising work of Rodriguez-Quintana et al. (2021) who leveraged school mental health workers across a large state to provide virtual support to schoolchildren and help them cope with COVID-related stress. And given the unique stressors of caregivers during the pandemic—many of whom experienced abrupt shifts in work-life balance and caregiving responsibilities when their children's schooling transitioned to virtual schooling from home—Ehrenreich-May et al.'s (2021) brief transdiagnostic intervention for managing parent emotional distress during the pandemic fills a tremendous need. And Bailin et al. (2021) highlighted the importance of integrating advocacy for marginalized populations throughout our work. Collectively, the treatment methods and implementation descriptions outlined in these articles provide a great service to providers who are currently addressing COVID-related psychological distress in their patients and/or providers working in the context of future public health crises.

In addition, a number of other articles in this Special Issue outlined the use of telehealth strategies to deliver a wide range of evidence-based treatments for special clinical populations during the pandemic. For example, Twohig and colleagues' (2021; this issue) waitlist-controlled trial using Zoom to remotely deliver ACT-enhanced behavior therapy to treat adolescents

with trichotillomania adds to a growing body of literature highlighting the value of using videoconferencing to deliver cognitive-behavioral therapy to treat pediatric obsessive-compulsive and related disorders (e.g., Comer, Furr, Kerns, et al., 2017; Himle et al., 2012).

### **Telehealth Is Not New. But Its Regulatory Landscape and Widespread Acceptance Is**

It is important to recognize that telehealth is not new to the field. In fact, its roots go back to the 1960s, with early pioneering work conducted at the Nebraska Psychiatric Institute and at Massachusetts General Hospital. Over the years, despite some early hesitation, providers in rural regions, such as in the Pacific Northwest, have increasingly incorporated telehealth practices to deliver mental health care to individuals dwelling in remote and underserved regions.

Across past decade, there has been a very sharp uptick in the number of randomized controlled trials evaluating telehealth methods for remotely delivering mental health care (e.g., Comer, Furr, Kerns, et al., 2017; Comer, Furr, Miguel, et al., 2017; Comer et al., 2021; Fernandez et al., 2021). Consistently, this body of work has found no evidence that treatment is any less effective when delivered via telehealth than when delivered in-person (Bastastini et al., 2021; Comer, Furr, Kerns, et al., 2017; Comer, Furr, Miguel, et al., 2017; Comer et al., 2021; Fernandez et al., 2021). In fact, there is some evidence from controlled trials that telehealth formats can, at times, even *outperform* office-based treatment. For example, in a randomized trial Comer, Furr, Miguel, et al. (2017) found a significantly higher rate of posttreatment “excellent responders” (as rated by independent evaluators masked to treatment conditions) among children treated with Internet-delivered PCIT (iPCIT) versus those treated with office-based PCIT. The findings were interpreted as potentially highlighting the incremental utility of treating children in their natural settings (e.g., their homes) rather than in a mental health clinic. It may be that telehealth formats not only expand the reach of services, but can also enhance the ecological validity of treatment by intervening directly in the very settings that are problematic (see Comer & Timmons, 2019). Moreover, increasing research has found that mental health patients participating in telehealth services report very high satisfaction with their treatment (e.g., Bastastini et al., 2021; Carpenter et al., 2018; Comer, Furr, Kerns, et al., 2017; Comer, Furr, Miguel, et al., 2017; Comer et al., 2021; Fernandez et al., 2021), and report significantly fewer perceived barriers to care than those participating in traditional office-based care (Comer, Furr, Miguel, et al., 2017).

This was a consistent theme throughout many of the articles in this Special Issue.

Despite accumulating evidence from controlled trials supporting the acceptability and efficacy of telehealth treatment formats, prior to the pandemic telehealth services accounted for only a very small proportion of all mental health services. Regulatory policies were somewhat stacked against the widespread uptake of telehealth, and discouraged providers from incorporating telehealth into their practices. For example, prior to the pandemic, very few insurance providers reimbursed for telehealth services, especially when such services were delivered to patients in their homes. Accordingly, prior to the pandemic most telehealth services were restricted to either (a) patients who could afford to pay out of pocket, (b) patients receiving services at no cost to them that were covered by service contracts, or (c) patients receiving services as part of research trials. Moreover, prior to the pandemic a majority of providers were reluctant to offer telehealth services, fearing that technology-related breaches of confidentiality (e.g., hacking incidents) result in significant professional and personal penalties.

In the United States, a number of federal and state emergency orders enacted in the early weeks of the pandemic, and a number of expanded reimbursement policies, cleared the way for telehealth to take over as the primary strategy for maintaining continuity of care across the pandemic. For example, emergency orders essentially waived any penalties against providers in the event that confidentiality breaches occurred in the context of good-faith telehealth practice. Providers were now allowed to use highly accessible, consumer-grade teleconferencing platforms with relatively relaxed encryption without the same level of liability concerns. Further, in the early weeks of the pandemic, federal and state policymakers mandated that insurance plans provide coverage for telehealth services, including services delivered directly to patients in their own homes. Collectively, these expanded reimbursement policies and relaxed regulations removed substantial barriers and paved the way for widespread implementation of telehealth practices.

### **Cautions as Telehealth Enters the Clinical Mainstream**

Over the past 18 months, we have witnessed perhaps the largest and most abrupt transformation in the history of mental health care delivery. And the widespread uptake and relatively high acceptability of telehealth among providers and patients suggest that telehealth will likely outlast the pandemic and remain as a dominant mode of mental health care delivery. As the

expression goes, “it’s not so easy to put the toothpaste back in the tube.”

That said, it is important to pause and reflect as we think ahead to post-pandemic practices. Out of necessity, when the pandemic began providers everywhere began conducting telehealth seemingly overnight, despite the fact that the vast majority of them had no formal training in telehealth. In the urgent context of a public health emergency, providers began advertising that they were a “teletherapist” and that they provided “teletherapy,” despite the absence of any standard definition of what it meant to be a “teletherapist.” At the very moment telehealth finally launched into the clinical mainstream, and in the context of emergency orders that temporarily relaxed the regulatory landscape, most clinical practices were not implementing telehealth in manners that were concordant with existing practice guidelines (see Myers et al., 2017).

The long-term regulatory landscape for telehealth remains unclear. Over the past 18 months, many in the field have become accustomed to using consumer-grade videoconferencing platforms with minimal encryption to provide telehealth services to their patients. Although emergency orders have removed liability concerns for providers, this does not mean that such practices do not still pose serious confidentiality risks for patients. Moreover, we do not know whether relaxed pandemic-era liability policies will become permanent. At this point, to avoid potential disruptions in the continuity of care, providers should be developing plans for their telehealth practices should the emergency orders abruptly reverse.

Moreover, it is clear that the training of mental health providers must include formal training in telehealth practices. Currently, accreditation standards for training in clinical psychology, social work, and counseling do not include any requirements for telehealth training, and as a result, very few training programs include formal telehealth training. If telehealth is to remain as a major format for the delivery of mental health care, this gap must be addressed to prepare the workforce. Such training needs to include expanded training in cultural factors and working with diverse populations. Telehealth offers new opportunities to treat individuals in underserved communities. Although telehealth can overcome logistical barriers and enable providers to reach previously underserved communities, this does not mean that individual providers are necessarily prepared with the appropriate cultural knowledge and cultural humility to work with these new communities. This has been an important lesson learned from extensive telehealth

work with rural indigenous populations (Goss et al., 2017).

As we look ahead to post-pandemic practice, it is also clear that we need to be more flexible in our thinking about telehealth. Most of the research and clinical descriptions in the literature have focused on fully telehealth strategies, or have compared fully telehealth strategies to fully office-based strategies. Hybrid options that involve some in-person components and some telehealth components are likely to fill important clinical needs going forward, although, to date, there has been almost no research on such hybrid treatment models.

And on a final note, despite the ubiquity of telehealth in mental health practices across the past 18 months, it is not yet clear whether telehealth opportunities have done much to expand treatment accessibility beyond populations who already had no difficulty reaching mental health care prior to the pandemic. One of the great promises of telehealth is its potential to overcome barriers and reach new, previously underserved populations. Telehealth must be about more than simply adding more convenient options and alternatives for patients and providers. As a field we must redouble our efforts to use telehealth to meaningfully expand the scope and reach of care to new and underserved populations. Telehealth offers extraordinary possibilities, but without focused effort, telehealth practices will fall short of their potential.

## Concluding Thoughts

Against a backdrop of surging mental health needs and historically limited access to traditional office-based care, the field has shown remarkable agility and accelerated innovation in redefining clinical practice. The articles in this Special Issue outline some of the field’s most exciting innovations from the past 18 months. As we prepare for post-pandemic practice, the road ahead is uncertain. To ensure that telehealth practices continue to play a prominent and meaningful role in clinical practice, this is now the time to ensure that providers are all appropriately prepared for telehealth, and that such practices are implemented responsibly and in a manner that allows telehealth to actualize its great potential to extend the reach of supported care to underserved populations. As a field, we must move beyond using telehealth to simply reach those who already enjoyed access to brick-and-mortar mental health care. Focused efforts are needed to understand barriers to telehealth among communities of color and marginalized populations, including logistical obstacles (e.g., access to technology and Internet), cultural divides, institutional mistrust, gaps in cultural humility of the mental health workforce, and systemic

inequities. Only then can telehealth be considered a serious public health strategy for improving the reach of supported mental health care.

### Disclosure

Dr. Comer receives royalties from Macmillan Learning for work unrelated to the present manuscript, and receives a stipend from the Association for Behavioral and Cognitive Therapies (ABCT) for editorial duties.

### Funding

None to declare.

### References

- Bailin, A., Burton, S., Rego, S., Alpert, J., & Pimentel, S. (2021). Integrating advocacy for marginalized children and families into evidence-based care during COVID-19: Clinical vignettes. *Cognitive and Behavioral Practice*. <https://doi.org/10.1016/j.cbpra.2021.04.004>.
- Barnett, M. L., Sigal, M., Rosas, Y. G., Orcoran, F., Rastogi, M., & Jent, J. (2021). Therapist experiences and attitudes about implementing Internet-delivered Parent-Child Interaction Therapy during COVID-19. *Cognitive and Behavioral Practice*. <https://doi.org/10.1016/j.cbpra.2021.03.005>.
- Bastastini, A. B., Paprzycki, P., Jones, A. C. T., & MacLean, N. (2021). Are videoconferenced mental and behavioral health services just as good as in-person? A meta-analysis of a fast-growing practice. *Clinical Psychology Review*, *83*. <https://doi.org/10.1016/j.cpr.2020.101944>
- Carpenter, A. L., Pincus, D. B., Furr, J. M., & Comer, J. S. (2018). Working from home: An initial pilot examination of videoconferencing-based cognitive-behavioral therapy for anxious youth delivered to the home setting. *Behavior Therapy*, *49*, 917–930.
- Comer, J. S., & Barlow, D. H. (2014). The occasional case against broad dissemination and implementation: Retaining a role for specialty care in the delivery of psychological treatments. *American Psychologist*, *69*, 1–18.
- Comer, J. S., Furr, J. M., del Busto, C., Silva, K., Hong, N., Poznanski, B., Sanchez, A. L., Cornacchio, D., Herrera, A., Coxé, S., Miguel, E., Georgiadis, C., Conroy, K., & Puliafico, A. C. (2021). Therapist-led, internet-delivered treatment for early child social anxiety: A waitlist-controlled evaluation of the iCALM Telehealth Program. *Behavior Therapy*, *52*(2), 1171–1187.
- Comer, J. S., Furr, J. M., Kerns, C. E., Miguel, E., Coxé, S., Elkins, R. M., Carpenter, A. L., Cornacchio, D., Cooper-Vince, C. E., DeSerisy, M., Chou, T., Sanchez, A. L., Khanna, M., Franklin, M. E., Garcia, A. M., & Freeman, J. B. (2017). Internet-delivered, family-based treatment for early-onset OCD: A pilot randomized trial. *Journal of Consulting and Clinical Psychology*, *85*, 178–186.
- Comer, J. S., Furr, J. M., Miguel, E., Cooper-Vince, C. E., Carpenter, A. L., Elkins, R. M., Kerns, C., Cornacchio, D., Chou, T., Coxé, S., DeSerisy, M., Sanchez, A. L., Golik, A., Martin, J., Myers, K., & Chase, R. (2017). Remotely delivering real-time parent training to the home: An initial randomized trial of Internet-delivered Parent-Child Interaction Therapy (I-PCIT). *Journal of Consulting and Clinical Psychology*, *85*, 909–917.
- Comer, J. S., & Timmons, A. (2019). The other side of the coin: Computer-mediated interactions may afford opportunities for enhanced empathy in clinical practice. *Clinical Psychology: Science and Practice*, *26* e12308.
- Ehrenreich-May, J., Halliday, E. R., Karlovich, A. R., Gruen, R. L., Pino, A. A. C., & Tonarely, N. A. (2021). Brief transdiagnostic intervention for parents with emotional disorder symptoms during the COVID-19 pandemic: A case example. *Cognitive and Behavioral Practice*. <https://doi.org/10.1016/j.cbpra.2021.01.002>.
- 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 of targets of treatment. *Clinical Psychology and Psychotherapy*.
- Folk, J. B., Schiel, M. A., Oblath, R., Feuer, V., Sharma, A., Khan, S., Doan, B., Kulkarni, C., Ramtekkar, U., Hawks, J., Fornari, V., Fortuna, L. R., & Myers, K. (2021). The transition of academic mental health clinics to telehealth during the COVID-19 pandemic. *Journal of the American Academy of Child and Adolescent Psychiatry*.
- Goss, C. W., Richardson, W. J. B., Dailey, N., Bair, B., Nagamoto, H., Manson, S. M., & Shore, J. H. (2017). Rural American Indian and Alaska Native veterans' telemental health: A model of culturally centered care. *Psychological Services*, *14*(3), 270–278. <https://doi.org/10.1037/ser0000149>.
- Himle, M. B., Freitag, M., Walther, M., Franklin, S. A., Ely, L., & Woods, D. W. (2012). A randomized pilot trial comparing videoconference versus face-to-face delivery of behavior therapy for childhood tic disorders. *Behaviour Research and Therapy*, *50* (9), 565–570. <https://doi.org/10.1016/j.brat.2012.05.009>.
- Hsu, K. J., Carl, E., DiVita, A., Feldman, T., Foulser, A. A., Freihart, B., Madole, J., McNamara, M. E., Rubin, M., Stein, A. T., Tretyak, V., & Smits, J. A. J. (2021). Rising to the occasion of this COVID-19-impacted nation: Development, implementation and feasibility of the Brief Assessment-Informed Skills Intervention for COVID-19 (BASIC). *Cognitive and Behavioral Practice*.
- Myers, K. M., Nelson, E. L., Hilty, D. M., Rabinowitz, T., Barwell, S. S., Bernard, J., Boyce, G., Bufka, L., Cain, S., Chui, L., Comer, J. S., Craddock, C., Varrell, J. R., Goldstein, F., Johnston, B., Krupinski, E. A., Lo, K., Luxton, D., McSwain, D., McWilliams, J., North, S., Ostrowski, J., Pignatiello, A., Roth, D., Turvey, C., & Wright, S. (2017). American telemedicine association practice guidelines for telemental health with children and adolescents. *Telemedicine and e-Health*, *23*, 779–804.
- O'Connor, R., Wetherall, K., Cleare, S., McClelland, H., Melson, A., Niedzwiedz, C., O'Carroll, R. E., O'Connor, D. B., Platt, S., Scowcroft, E., Watson, B., Zorzea, T., Ferguson, E., & Robb, K. (2021). Mental health and well-being during the COVID-19 pandemic: Longitudinal analyses of adults in the UK COVID-19 Mental Health & Wellbeing Study. *British Journal of Psychiatry*, *218*(6), 326–333. <https://doi.org/10.1192/bjp.2020.212>.
- Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., Kontopantelis, E., Webb, R., Wessely, S., McManus, S., & Abel, K. M. (2020). Mental health before and during the COVID-19 pandemic: A longitudinal probability sample survey of the UK population. *Lancet Psychiatry*, *7*(10), 883–892. [https://doi.org/10.1016/S2215-0366\(20\)30308-4](https://doi.org/10.1016/S2215-0366(20)30308-4).
- Racine, N., McArthur, B. A., Cooke, J. E., Eirich, R., Zhu, J., & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: A meta-analysis. Published online August 9, 2021. *JAMA Pediatrics*. <https://doi.org/10.1001/jamapediatrics.2021.2482>.
- Rodriguez-Quintana, N., Meyer, A. E., Bilek, E., Flumenbaum, R., Miner, K., Scoville, L., Warner, K., & Koschmann, E. (2021). Development of a brief group CBT intervention to reduce COVID-19 related distress among school age youth. *Cognitive and Behavioral Practice*. <https://doi.org/10.1016/j.cbpra.2021.03.002>.
- Sammons, M. T., VandenBos, G. R., & Martin, J. N. (2020a). Psychological practice and the COVID-19 crisis: A rapid

- response survey. *Journal of Health Service Psychology*, 46, 51–57. <https://doi.org/10.1007/s42843-020-00013-2>.
- Sammons, M. T., VandenBos, G. R., & Martin, J. N. (2020b). Psychological practice at six months of COVID-19: A follow-up to the first national survey of psychologists during the pandemic. *Journal of Health Service Psychology*, 46, 145–154. <https://doi.org/10.1007/s42843-020-00024-z>.
- Sheerin, K. M., Tugendrajch, S. K., Presser, N. R., & Bell, D. J. (2021). Implementing skills for psychological recovery at a psychological training clinic during COVID-19. *Cognitive and Behavioral Practice*. <https://doi.org/10.1016/j.cbpra.2021.03.001>.
- Zalewski, M., Walton, C. J., Rizvi, S. L., White, A. W., Martin, C. G., O'Brien, J. R., & Dimeff, L. (2021). Lessons learned conducting Dialectical Behavior Therapy via telehealth in the age of COVID-19. *Cognitive and Behavioral Practice*. <https://doi.org/10.1016/j.cbpra.2021.02.005>.

Address correspondence to Jonathan S. Comer, Ph.D., Mental Health Interventions and Technology (MINT) Program, Center for Children and Families, Department of Psychology, Florida International University, 11200 S.W. 8<sup>th</sup> Street, Miami, FL 33199. e-mail: [jocomer@fiu.edu](mailto:jocomer@fiu.edu).

Received: September 15, 2021

Accepted: September 15, 2021

Available online 20 September 2021