

Attachment-based family therapy in the age of telehealth and COVID-19

Suzanne Levy PhD¹  | Syreeta Mason PhD¹ | Jody Russon PhD^{1,2} | Guy Diamond PhD¹ 

¹Center for Family Intervention Science, Drexel University, Philadelphia, PA, USA

²Virginia Polytechnic Institute and State University, Blacksburg, VA, USA

Correspondence

Suzanne Levy, PhD, Center for Family Intervention Science, Drexel University, 1601 Cherry St., 2nd Floor, Philadelphia, PA 19102, USA.

Email: sal89@drexel.edu

Abstract

The COVID-19 pandemic has transformed so many aspects of our lives. For psychotherapists, telehealth is likely a permanent part of the future mental health landscape. For family therapists using a manualized treatment, this brings unique challenges and creative opportunities. In this article, we describe the adaptation of attachment-based family therapy (ABFT) in the context of telehealth and COVID-19. ABFT is an empirically supported treatment model designed for adolescents and young adults struggling with depression, anxiety, trauma, and suicide. ABFT is a semi-structured, process-oriented, and trauma-informed family therapy model which presents its own unique challenges and benefits in telehealth environments. We present our adaptations based on years of telehealth clinical experience and address how this model supports the impact of COVID-19 on families.

KEYWORDS

ABFT, COVID-19, telehealth

INTRODUCTION

As of June 2020, over six million confirmed cases of COVID-19 and over 350,000 COVID-19 related deaths have occurred (World Health Organization, 2020). The pandemic has impacted the structure, routine, and well-being in communities across the globe. To prevent the spread of the virus, many countries required communities to shelter in place, closed schools and businesses, and encouraged

We thank all the ABFT training staff who contributed to this document.

physical distancing measures. In some areas, public health measures have impacted the workforce and, as a result, the rate of unemployment has increased. Individuals and families are facing the compounding stressors of health-related anxiety, financial instability, isolation, limited physical and social outlets, and a general lack of normalcy. For many, family stress has increased, which can often undermine emotional support and lead to increased negative interactions. Consequently, the implications of COVID-19 have contributed to mental health concerns, interpersonal difficulties, and increased stress on families (Donker et al., 2020; Pfefferbaum & North, 2020; Prime et al., 2020; Usher et al., 2020). For some families, quarantine can exacerbate existing problems and increase conflict, distance, and risk for abuse and maltreatment, particularly when caregivers suffer from mental health problems themselves. (Westrupp, et al., 2020; Barboza et al., 2020; Russell et al., 2020).

While providers have been able to offer online services for years, the crisis has pushed insurance companies out of their reluctance to reimburse for telehealth services. Thus, the adoption and expansion of these services has grown exponentially and rapidly. As one example, for clients who are home-bound, Medicare now pays for office, hospital, and other visits, furnished via telehealth, across the country. A range of providers, such as marriage and family therapists, doctors, nurse practitioners, clinical psychologists, clinical social workers, and professional counselors can now offer telehealth services. This change has been followed up with numerous organizations offering recommendations on how to conduct telehealth, ensure client-safety, and maintain the privacy of protected health information (Centers for Medicare & Medicaid Services, 2020; King, 2017).

Unfortunately, a dearth of guidance is available for telehealth delivery of family therapy. Most recommendations focus on individual therapies (Langarizadeh et al., 2017). One might argue, however, that telehealth, by its nature, is a home-based therapy. When we enter clients' homes, we enter into their family system and have greater access to multiple family members (Hogue et al., 2020). This offers both therapeutic and pragmatic benefits. Not only do therapists have more capacity to understand the multitude of factors affecting families, but, for low-income families in particular, telehealth allows for the avoidance of public transportation and finding of childcare. It also eliminates the stigma of going to a mental health center. In this regard, telehealth is not a threat to family systems therapies, but an opportunity to expand the need for more systems-level thinking in any treatment modality.

Still, whether online or in-person, family therapy presents unique challenges. Multiple people, multiple relationships, and multiple agendas require therapists to have clarity of their theory, methods, and treatment goals. To this extent, empirically supported, manualized treatments have offered family therapy a road map for treatment delivery (Lebow, 2016). Unlike curriculum-based manuals (e.g., psychoeducational models), most family therapy manuals are principle-based. These principles provide clear theory, sequencing of therapeutic elements, recommended intervention strategies, and ideal treatment outcomes. In this regard, family therapy manuals might be easily adapted for telehealth delivery. To demonstrate this potential, this article focuses on how attachment-based family therapy (ABFT; Diamond et al., 2014) has been adapted for the unprecedented shift to telehealth over the last year. Second, we illustrate how ABFT has attended to the unique impacts of COVID-19 on families.

These adaptations have been derived from the clinical experiences of therapists utilizing ABFT, worldwide. ABFT is particularly suited to address the increase in mental health distress among adolescents as well as the parent-child interpersonal difficulties that have arisen or been exacerbated by COVID-19. ABFT explicitly targets the quality of adolescent-parent relationships and addresses stressors both inside and outside of the home. We begin with an overview of the treatment model and the five treatment tasks. Next, we discuss how we prepare for online attachment work. We describe how we convey our core treatment philosophy to the family via telehealth platforms in order to increase engagement. As emotion-deepening techniques are central to the ABFT model, we then describe how to attend to emotions remotely, via webcam, in our treatment tasks. We also provide the

methodologies we use when we need to scale-back goals due to the challenges associated with remote treatment. Finally, we discuss ABFT-specific telehealth techniques which serve to prepare families for a corrective attachment experience online. We end the article with a series of case examples for how the model has addressed COVID-19 related challenges emerging in youth-parent relationships.

OVERVIEW OF THE ABFT MODEL

Attachment-based family therapy is an empirically supported, attachment-based, trauma-informed, emotion-focused intervention for youth with suicidal ideations and behaviors, depression, and family trauma. Treatment aims to identify events or processes that have inhibited trust in the family, and, then, helps families address these issues in order to re-establish the family as a secure base.

Attachment-based family therapy treatment is based on five tasks. The *Relational Reframe* task (Task 1) helps families focus on relationship repair as the initial goal of therapy. Many families enter treatment focusing on behavioral issues. This task helps the family members agree to first focus the therapy on re-building trust and connection. The *Adolescent/Young Adult Alliance* task (Task 2) helps the youth link current distress to attachment ruptures and prepares them to talk about these ruptures with their caregivers. The *Parent/Caregiver Alliance* task (Task 3) focuses on increasing caregivers' empathy for their child by recognizing how caregivers' own current stressors and intergenerational experiences impact their parenting. The therapist then prepares them for Task 4 by teaching emotion coaching skills. The *Attachment* task (Task 4) brings the family members back together to discuss these attachment ruptures. This helps families resolve problems and practice new interpersonal and affect regulation skills. As trust re-emerges, therapy focuses on the task of *Promoting Autonomy* (Task 5) for the youth. Topics discussed among families in Task 5 might include responsibilities inside and outside of the home, identity development (e.g., sexual orientation and/or gender identity) and social challenges. ABFT is generally delivered in weekly sessions for 12–16 weeks. Diamond et al. (2014), Diamond et al. (2016, 2019) provides a thorough description of the ABFT model and review of research.

PREPARING FOR ATTACHMENT WORK ONLINE

Since the COVID-19 pandemic and the initiation of telehealth as the primary platform for mental health care, we have retained our commitment to engaging families. Our adaptations aim to offer more options for meeting families' needs during these challenging times. Using an attachment frame, we have adopted a method for helping families to feel safe engaging in online family therapy. These initial engagement conversations are not perfunctory. What concerns family members have, how they are expressed, and listened to, and how well the family can resolve them deeply reflects the family's organization and levels of trust and safety. The therapist uses these initial conversations to scaffold the process of starting therapy. These initial conversations also enable the therapist to be seen by the family as supportive. Centered on engagement and establishing a secure base, the recommendations in these next sections can be applied to many attachment-informed approaches to treatment and have particular utility for ABFT.

Managing concerns and promoting engagement

After receiving a treatment referral, the therapist contacts the youth and caregiver(s) individually to initiate the treatment. In this conversation, the therapist expresses both empathetic concern for the

family and a commitment to their care. It can be helpful to listen and allow the family members to vent and share some of their stressors. For example, caregivers may feel frustrated or concerned about their child's behavior. Providing space for them to vent over the phone helps caregivers feel heard and understood by the therapist, making them more likely to agree to family therapy. Approaching these conversations with a positive and responsive stance (e.g. validating the client's thoughts and feelings) early on in the therapeutic relationship has been associated with lower rates of early therapy termination (Elkin et al., 2014). This first experience begins to demonstrate the feasibility of telehealth.

The option or necessity of telehealth services is explicitly discussed during these first conversations. We respond to all questions and concerns family members may have about therapy in a telehealth format. For the intake, the therapist usually spends some time with the entire family together and also in assessments with the caregivers and the adolescent separately to gather initial information and orient the family members to the telehealth platform. During this orientation, therapists have an opportunity to describe the telehealth process in more detail, explore clients' concerns about confidentiality and privacy, and address other concerns about doing family work online.

Therapists also address the technology and mechanics of the sessions. We spend some time assessing the technology that the family has available and how to use it. If they do not have access to a computer, tablet, or cell phone that allows video conferencing, then we discuss ways they may get access (e.g., borrow a device, purchase an inexpensive prepaid cell phone). We may need to teach family members how to use the video conferencing software and functions. We also discuss the structure of the sessions: Who will be online; when to be all together and when to be on separate devices. We also review what to do if the equipment fails. Freezing, loss of connection and difficulties with audio and video can interrupt the process. We prepare families for the reality of technology inconsistencies and come up with a plan on how to reconnect (e.g., "If we get disconnected, we will try to reconnect for five minutes, then I will give you a call"). These preparatory conversations about technology prepare families for the online format and demonstrate our commitment to being helpful. ABFT therapists strive to promote reparative conversations and manage set-backs, challenges, discomfort, and unexpected issues as they arise. We anticipate the same with technology and prepare for this as well. Creating the opportunity to listen and respond to family concerns prior to the first session improves sustained engagement in the therapy (Wang et al., 2006).

Concerns about telehealth and privacy must also be addressed. Therapists must be using a HIPAA-compliant technology platform in order to ensure protection. There are also privacy matters to attend to when providing home-based therapy; how will our conversations not be overheard? Discussions about how to organize sessions, where and when people can have privacy, and how family members can support each other to provide privacy are essential pre-treatment conversations. The therapist helps the family negotiate how to ensure privacy of conversations and agree on rules of engagement during and after sessions to increase feelings of safety. Finally, the therapist needs to discuss safety with the family, especially when working with high-risk youth. Determining what happens if a youth gets agitated, or walks out of the room requires thoughtful discussion and negotiation with family members in advance. Again, these are not simply pragmatic issues, but go to the very heart of trust, respect, preparation, and protection.

Families may express hesitancy or concerns about engaging in telehealth services. During this time of COVID-19, some families have initially refused to engage in video calls and have requested to wait until in-person sessions resume. This may not always be wise given the crises experienced by some youth. This resistance may not be getting in the way of the therapy, but might actually be the initial target of the therapy. In other words, family members' concerns about telehealth may just be reflecting their concerns about therapy. Exploring these concerns about telehealth needs as much clinical thoughtfulness as any other therapeutic topic. Ultimately the therapist may need to provide a respectful rationale for starting the treatment immediately.

If individual family members decline online services, therapists must think flexibly. Therapists might offer to work with some family members until the others can be won over. Goals and processes in Tasks 2 and 3 help guide the focus of these sessions. For example, sessions with youth focus on joining, understanding, and expanding narratives about their problems and about their family relationships, finding motivation for change, and preparing to talk with caregivers. Sessions alone with caregivers would focus on current stressors, intergenerational attachment legacy, motivating parents to improve their emotional availability and teaching caregivers emotion coaching skills. In this regard, individual sessions with youth or caregivers, as described above, remain focused on relationship repair.

If the entire family ultimately refuses to do online therapy, it is important to provide resources for the family. This can range from referrals to services that may provide in-person therapy to helpful articles, books, and online resources. Therapists should also communicate that they remain available to answer the family's questions or concerns about telehealth as they arise and express a willingness to help the family, if they reconsider. By demonstrating our willingness to assist and remain responsive, some families respond with new-found interest.

Safety concerns about suicide

Families receiving ABFT often worry about ongoing suicidal ideation or self-harm behaviors. Caregivers wonder if safety concerns can be managed through telehealth. To help manage the caregivers' anxiety, therapists need to feel competent in assessing and managing suicidality via telehealth (see <http://zerosuicide.edc.org/covid-19>; Zero Suicide Initiative, 2020 for guidelines on providing suicide care during COVID-19). Therapists assess risk, suicidal ideation, and behaviors at intake, as well as at the beginning of each therapy session. Utilizing empirically supported rating scales is helpful (e.g., SAMHSA's SAFE-T for risk and the Columbia Suicide Severity Rating Scale for suicidal ideation and behavior). Therapists also develop a safety plan with the youth and caregivers to manage the youth's suicidality between sessions (Stanley & Brown, 2012). Given physical distancing due to COVID-19, typical coping strategies may need to change (e.g., cannot go to the park for sports). Therapists also ask the caregiver to take a stronger role in monitoring their youth's safety and reaching out for help if necessary. The aim of caregiver monitoring is to make this an act of love and protection, not control and criticism. Therapists help caregivers and youth negotiate how caregivers will support the youth during this time in a way that will help provide comfort and security and not exacerbate conflict.

ISSUES RELATED TO CONDUCTING DEEP THERAPY WORK ONLINE

Attachment-based family therapy is an emotion-focused, experiential treatment. Emotional processing is essential for allowing clients to recognize how their relationships, histories, and current stressors impact them. The focus on vulnerable emotion (whether it is sadness, fear, or anger) helps clients identify important experiences of interactions that become the focus of therapy conversations. Emotion work happens in individual sessions with caregivers and youth alone, as well as in family sessions. Many question if deep or more vulnerable emotional work is possible and recommended online and if the same level of intensity can be expected. We find it can. Some clients, in fact, feel more comfortable talking over video conferencing. Maybe the lack of physical proximity makes clients feel safer or less vulnerable. For the youth, they live much of their social/romantic lives online, so deep,

emotional conversations online seem natural. Still, an emotion-focused online therapy can feel strange and may need getting used to for both families and therapists.

As with any therapy, but especially with online work, it is essential to help clients feel at ease. With new clients or those transitioning to online work, we recommend therapists focus on building their bond through the remote platform. Take time to join or re-join. Recognize that families have let you into their homes, and let you see into their private lives in ways not previously common. Start by discussing their potential discomfort. With some clients, this may be an opportunity to become more familiar with them. Some clients have given us a short tour of their home or an intimate look at special areas or objects that have meaning to them. Therapists can ask clients about things observed in their environment such as a pictures, trinkets, or pets. If children show up in the screen, we show interest in them.

Even when the bond is strong, therapists may experience challenges deepening emotion during telehealth. Providing comfort or empathy can be difficult. In person, we might move closer, speak softer, or use body language that expresses concern. Showing empathy online can be more difficult. Important nonverbal information may be lost as well as the felt connection of being together. Some strategies can mitigate these challenges. Therapist still can use voice tone, pacing, and body language (Gellar, 2020). Most telehealth platforms allow therapists to see themselves, thus allowing them to monitor their own physical expression. Getting close to the camera, facial expressions that show empathy, hand gestures, (e.g., putting one's hands together as if praying or holding one's chin to mimic thoughtfulness or sadness) help us deepen emotion online. We accentuate these physical gestures with pacing (e.g., slowing down, whispering, repeating words, and holding still).

We find ourselves clarifying non-verbal behaviors and narrating acts of caregiving more than when conducting in-person therapy. To understand and deepen emotions, therapists need to accurately read the cues of clients. When clients sit too far from their camera, camera angles are poor, or lighting is insufficient, it is more difficult to recognize emotional shifts and client expressions. Therapists may need to explicitly ask more about the clients' nonverbal cues when conducting telehealth sessions (Burgoyne & Cohn, 2020; Ronen-Setter & Cohen, 2020). For example, "It seems you are getting upset. I cannot see your face so well today. Can you tell me what you're feeling?" When family members are in different rooms for a joint session (see below), therapists may need to narrate what they are seeing so that family members can respond appropriately (Hicks & Baggerly, 2017). If clients are reluctant to turn on their camera and we are not able to work through their concerns, we heavily rely on the client's description of what they are experiencing. If clients turn off their camera during an emotional moment, we honor their regulation strategy and attempt to have them explain what they are experiencing.

Some clients may experience difficulties transitioning from their home life to our therapy sessions. To help with this transition, we train our therapists to ask these clients to take time to become centered and focused before the session. This sometimes requires teaching skills to our clients (e.g., deep breathing techniques). Likewise, we encourage our therapists to ask some clients to take time after sessions to "switch" off from therapy before transitioning back to family life especially when a session has been very emotional (Gellar, 2020).

ABFT-SPECIFIC TELEHEALTH CONSIDERATIONS

Some of the challenges and opportunities we have experienced in telehealth are specific to ABFT interventions. Our therapists have to think thoughtfully about each task and how best to deliver it in an online format. In general, there are no universal adaptations (i.e., changes made for every family online)

for the ABFT model, delivered in the telehealth environment. Rather, our telehealth adaptations meet the unique needs of each family. With some families, ABFT online has looked quite similar to ABFT in-person with the exception of utilizing the online platform and the extra measures we take to deepen emotions. However, with some families, we drastically scale back goals or add additional meetings to increase feelings of connectedness and safety before conducting joint meetings. The major adaptations we have made for ABFT Telehealth involve preparation work with youth (Task 2), preparation work with caregivers (Task 3), and approaching repairing attachment conversations (Task 4).

Preparing for the attachment task with the subsystems

There are several considerations when conducting attachment task sessions (Task 4) via telehealth. While many families feel as though the therapist can support them via telehealth, some may not due to challenging family dynamics. Therefore, in our preparation work with the youth (Task 2) and caregivers (Task 3), we explore family members' concerns about what might happen during the attachment task (e.g., "My mother will blow up at me" or "I'll feel attacked by my child") and after the session (e.g., "My grandpa will be nice during the session, but after the session, he will scream at me"). Often caregivers worry that, if they acknowledge their child's feelings about these ruptures, their child will take this as freedom to say or do what they want afterward. Youth and caregivers express these same concerns with office-based sessions; however, the physical absence of the therapist can bring out additional hesitations.

Maintaining safety

We help family members think about what they will need during the joint attachment repair sessions to feel safe. There are several issues to consider. For one, therapists need to discuss the seating arrangement. Some families prefer to be in the same room for sessions, whereas others may prefer to be split up in different rooms. The decision for the same or different rooms is based on each individual family member's needs and sense of safety. If the youth and caregivers are in the same room, everyone needs to be seen on camera during the session in order to track the process and emotions. When it is difficult for the family to "fit" on one screen, one family member may use a second device (with microphone muted and sound off to avoid feedback). This arrangement allows the youth and caregivers to face one another while also allowing the therapist to notice and respond to more nuanced facial expressions and body language as they have a closer view of each person. Using a separate device can even help family members stay engaged with each other's facial expressions and better manage their reactivity in the moment (Burgoyne & Cohn, 2020). Intentionally arranging the seating to support the attachment task (Task 4) process is common practice for in-person sessions. For telehealth, therapists might ask for the family to plan a specific arrangement (e.g., caregivers on one screen, while the adolescent/young adult is on another).

Some families prefer to begin these conversations from separate rooms. Some youth report that this arrangement helps them to be more vulnerable because they feel less worried about their caregiver's response. Sitting in their own space, with a closed door, allows some youth to more freely discuss their attachment themes and ruptures. When this occurs, we plan with the family how caregivers may join the adolescent or provide care for the youth during this conversation, if needed.

Therapists must help family members determine if particular ruptures may be inappropriate to discuss via telehealth during the relational repair sessions (Task 4). Some families have expressed that

certain ruptures (e.g., historical abuse, sexual orientation, prior assault) may be too intense to discuss without the therapist physically present in the same room. Therapists encourage youth to develop a hierarchy of ruptures to discuss. Specifically, we help youth consider importance, urgency, difficulty, and potential for success. We also consider which issues can be explored on telehealth. Similarly, caregivers may have issues they prefer not to discuss online. These issues can be tabled until in-person sessions can occur. When families have successful conversations about the less difficult attachment ruptures first, many families begin to trust that they can handle discussing more difficult ruptures together in future telehealth sessions.

In ABFT, at the end of the individual preparation sessions (Tasks 2 and 3), therapists discuss how to best support the family members during the attachment task conversations (e.g., move closer to a client, utilize a breathing technique). In a telehealth environment, we employ creative strategies using the technology of the telehealth platform. For example, we prepare the family to use the chat function to say they need a break during the session. We coach parents to use the share screen feature to share a letter or a picture the youth has created. Therapists must, however, be mindful of misuse. One time a client intended to send a private chat to the therapist, but it went to all family members which resulted in an argument. Learning how to use the platform, oneself, and teaching the family how to use it is essential.

Family readiness for attachment task

Even with all of the preparation work, therapists or family members may have concerns about proceeding with the attachment task conversations (Task 4). In these cases, we recommend a pre-Task 4 meeting with the entire family to discuss their level of comfort with moving forward with Task 4. In this meeting, the therapist reviews the ground rules for the meeting: seating arrangements, who is in what room, how to support each other, a safety plan during the session, how to ask for a break, and what to expect after the sessions. For example, the therapist helps the family agree that anyone can leave the sessions, momentarily, if things become too emotional. We discuss how long a person can leave and who will check on someone if they do not return. Family members might consider how and where to have privacy after the sessions to decompress. If suicide has been a concern, we discuss how it will be monitored (assessment, check in, asking for help, activate safety plan, etc.) during and after the session. The therapist must keep in mind that, even though this is a “pragmatic” conversation, the Task 4 has begun; we are helping the family identify what they need from each other to reestablish trust.

Even with the planning above, some families will not feel safe moving forward with the Attachment Task online. In these circumstances, we recommend putting the attachment conversations on hold. Instead of conducting this task, the therapist helps the family discuss relevant autonomy promotion issues (e.g., school stress). The therapist coaches the caregivers and youth to have these conversations by utilizing the skills explored in the caregiver alliance task (e.g., emotion coaching). If the therapist can support the family in making these autonomy-building conversations more successful, trust will build. As trust emerges, families may be more willing to return to the attachment conversations. Some families, however, may never feel safe enough to do the attachment task online. For these cases, the therapist can continue to build skills during the caregiver and youth alliance tasks and try to have success in autonomy promoting conversations (Task 5). In either circumstance, the therapist is helping the family navigate autonomy challenges, and, hopefully, making family relationships stronger and less conflictual and/or distant.

Management of family affect in joint sessions

During Task 4, therapists should be attuned to the safety needs of all family members. If family dynamics become unmanageable online (e.g., a family member becomes explosively angry), therapists should consider multiple pathways to manage the situation. Ideally, the caregivers soothe the youth and each other. Therapists also might consider removing a family member (e.g., having youth or caregiver take a 5–10-min break). Typically, we ask the calmer party to leave so we can help regulate the person(s) struggling the most. This is an approach that is planned and negotiated with the family during Task 2 and Task 3 preparation or in the Pre-Task 4 meeting. Some youth like to know they can “take a break” if the session becomes challenging. Therapists must be attuned to issues of safety when deciding if a young person can be left alone. In circumstances where safety is a concern, it might be the caregiver who steps away for a moment. To step away, a family member might be put in a breakout or waiting room, or turn off their camera and sound, if in a different room. Either way, the therapist should know how to bring them back or check in with them at the end if they have not come back. If the therapist feels like someone particularly struggled or became dysregulated during the session, the therapist may want to meet alone with that individual at the end of the sessions for 5–10 min. Having this one-on-one time may require negotiation of privacy if the family was meeting in the same room. If a corrective attachment experience cannot be facilitated and ruptures are re-occurring, therapists may need to resort back to Task 2 and Task 3 processes for a session or two.

COVID-19 CLINICAL ADAPTATIONS FOR ABFT

As COVID-19 emerged, our clinical teams sought to provide uninterrupted, accessible, and effective mental health care. The pandemic is a unique, multipronged stressor that will have major, cumulative, and prolonged effects on families. Studies on the pandemic's impacts already demonstrate increased rates of depression and anxiety in children and adolescents (Racine et al., 2020). Moccia et al., (2020) found that, during the pandemic, children with an anxious attachment style may be at greater risk for distress than children with secure and avoidant attachment styles. Feelings of aloneness, abandonment, being dismissed or unloved may now be layered with the uncertainty, worries, and fears about the disease. Given these potential challenges, treatment must become flexible enough adapt to these changing circumstances. Luckily, the technology for telehealth exists widely. What is needed is a framework to guide the clinical and organizational elements of treatment during COVID-19. As always, alliance is the critical foundation for any therapy. Prioritizing a genuine therapeutic connection with families is essential. Without an empathetic connection, motivating caregivers to change their parenting beliefs and behaviors can be difficult, regardless of the delivery model (Moran & Diamond, 2008).

Youth and their caregivers have both been uniquely affected by the pandemic. For some youth, the pandemic and physical distancing has been beneficial. Stress from school performance, social pressures, or bullying have decreased. For some youth, sheltering in place has been like an early summer vacation with going to bed late, sleeping late, minimal school work, and lots of social media. For some families, this has created unexpected positive contact and dependency on each other. With caregivers at home, work, some families report an increase in family activity and time together. Healthier families have pulled together to protect each other by following precautions, not going out, and planning together how to keep safe. For some youth, this is the first time they have paid attention to current events and social development, outside of their small circle of friends. These positive developments can and should be used to amplify strengths and competency.

On the other hand, some youth are struggling even more as a result of physical distancing and sheltering at home. With sudden closures of schools, activities, and stores, and emphasis on physical distancing, some youth lament lost opportunities and milestones (e.g., graduation, school dances, sports, summer plans). Given this context, youth may experience increased mental health needs. Youth who relied on peers, teachers, grandparents, and other relationships outside of their caregivers may be left without support. Many youth are left to cope with this stress on their own, leaving them confused and distraught. These feelings can worsen their relationship with their caregivers. Helping families understand how the pandemic contributes to these stressors, should be an important target of the therapy.

Caregivers also have mixed experiences of the pandemic (Karpman et al., 2020). Working from home, homeschooling children, possible financial compromises, threats to health, worrying about elderly loved ones all contribute to great stress for caregivers. This can lead to impatience, short tempers, and insensitive, if not unavailable, parenting. Therefore, we spend a considerable amount of time asking about the caregivers' stress and mental health needs in individual sessions.

In addition to stressors, caregiver's own attachment experiences have shaped their parenting. Sadly, many of the caregivers we work with have experienced significant unmet attachment needs from their childhood. When they felt alone, sad, scared, or helpless, their caregivers failed to provide comfort and support. For many of our caregivers, their experience of this pandemic can feel similar to their childhood experience. There is fear, anger, and helplessness without any certainty about how to survive. Helping caregivers think about what they did not get from their own caregivers as children can help motivate them to try and provide a better family environment for their own children. Thinking about how they can protect their children and the families from the virus might be one opportunity for promoting responsive parenting.

To address all these possible concerns and experiences, we have initiated specific conversations about how COVID-19 has impacted individuals and family relationships. We ask about stress (e.g., financial, health), functioning (e.g., work, sleep), and coping (e.g., physical activity, rest, relationships). We explore what challenges and opportunities the pandemic has presented for families and how they are coping with these changes (e.g., everyone at home). We explore if the forced proximity of shelter-in-place has exacerbated existing attachment wounds or helped families overcome some of them. As we aim to build youth autonomy, we try to promote conversations where youth talk and caregivers listen. We help caregivers listen without being intrusive, judgmental, or reactive. We help them acknowledge the challenges of the pandemic while also recognizing the impact of how they respond to their child. We hope this attachment-informed communication process increases youths' trust in their caregivers' emotional attentiveness and availability. These "listening" episodes also help the youth improve their skills of emotional awareness, expression, and regulation. These corrective attachment sequences help youth feel worthy of being loved and help caregivers feel more competent as parents. In the clinical vignettes below, we demonstrate how we might use the pandemic as therapeutic content.

Clinical example 1

Rebecca (15) and her mother (Gail) initiated treatment due to Rebecca's major depressive disorder. Pre-COVID-19, the therapist explored the mother's attachment history in an individual Task 3 session in-person, which revealed that Gail grew up in a house where her mother prioritized her romantic relationships over her children. The family was economically instable due to her stepfather's gambling addiction. Gail blamed her own chronic depression on her lack of mothering and provision ("No one really cared for me. I took care of myself"), which led her to feel abandoned and alone growing up.

The shift to telehealth following this Task 3 session was sudden and difficult. Gail expressed some hesitancy with telehealth sessions. She was managing schedule changes due to her daughter's

school closure and changes at work. The family immediately missed 3 weeks of therapy. The therapist persisted in making short calls to check-in on their well-being, not only as a clinical duty, but also to communicate genuine care and concern for them. Although hesitant, Gail eventually agreed to discuss telehealth. Gail shared her concern about confidentiality (“I don’t want anyone to find out anything about me”). After a detailed overview of the confidentiality and privacy provided by the software used for video conferencing, as well as the therapist’s agreement that her sessions would not be recorded, Gail was reassured and agreed to receive telehealth sessions.

Prior to starting telehealth, Gail was developing some empathy for herself as a child and expressing more vulnerable emotions related to being a child who lacked a sensitive parent. It was a challenge to work back up to exploring those emotions via telehealth. Distractions (e.g., phone battery dying, loud noises outside the house) were creating regular interruptions as Task 3 telehealth sessions began, but the therapist was patient, knowing this was not an easy transition. The therapeutic relationship needed to build again in the new environment, so the treatment was slowed (e.g., additional sessions with Gail) to accommodate those needs.

Shortly after restarting therapy, Gail’s employment was affected by the pandemic. She was made a part-time worker at her job and there were rumors of her employer closing. She was able to support the family financially with her reduced work hours, but understandably, she continued to have anxiety related to financial concerns. The therapist attended to these new stressors, helping Gail develop a plan for temporary housing with family, if they faced eviction. Through this process it was evident that Gail worked hard in life to protect her daughter from the financial hardship she, herself, experienced growing up and she continued to do so during the pandemic.

Gail and Rebecca had a strained relationship. Gail struggled to tolerate her daughter’s sadness and their relationship was distant and businesslike. The therapist emphasized the love and protection Gail was showing her daughter by providing for her and planning for the provision of her needs. This softened Gail’s affect and lowered her defenses. It was rare for Gail to feel appreciated and to be seen as good and loving. Given her upbringing, the idea of goodness was intrinsically tied to provision or the lack thereof. As the therapeutic relationship grew stronger, the therapist could then highlight connections between Gail’s stressors, attachment history, parenting, and motivation to change.

As Gail discussed financial stress, the therapist sought to connect a past attachment theme to a current feeling by saying, “I wonder if it feels now like it did when you were a kid, when you didn’t have anything or anyone?” Exploring this thought helped Gail understand why her current situation made her particularly irritable and depressed, and, also, how her feelings of abandonment resurfaced and increased anxiety. With further exploration, Gail began to see how her past and COVID-19 were affecting her parenting; being less emotionally available and having little empathy for her daughter’s depression and response to the pandemic (e.g., missing friends, missing school).

As she started to see that she and her daughter had experienced similar themes in their attachment relationships, even though their experiences were very different, Gail said, “I swore I would never be like my mother.” It was difficult initially for Gail to fully express the sadness behind this thought, but it provided an opportunity for the therapist to explore and deepen her pain. From a place of honest sadness at the loss of her desired relationship with her daughter, Gail was able to examine her shortcomings and work toward taking the opportunity to be the mom she never had. Gail recognized that the challenges she and her daughter experienced during COVID-19 served as an important reason to make these changes now, rather than a reason to defer to a time “when the pandemic was over.” To help Gail make this shift, the therapist also helped connect her attachment narrative to her parenting by saying “You said you were so sad growing up that you didn’t want to be anything like your mother, and you worked so hard to provide a different life for your daughter. So, I’m wondering if, when she comes to you with her sadness, it feels like she’s saying you’re the bad mom now. Does it feel like she’s

blaming you?" These themes resonated with Gail and helped her have a more empathic stance toward her daughter as they moved forward in the Task 4 family sessions.

This case is an example of how we address issues of transitioning to telehealth and COVID-19 in Task 3 sessions. In this particular case, not only was COVID-19 related stressors impacting the caregiver's ability to parent, but it was also highlighting the mother's own attachment wounds from childhood.

Clinical example 2

Michelle (14) was referred by her primary care physician for major depressive disorder. She lived with her parents and 5-year-old sister. The therapist had a meeting with the family to orient them to the telehealth platform and to discuss the details of how the sessions would be set up. It was decided that Michelle and her parents would both use their tablets in the same room during the family sessions and, because the family had a rule about only using tablets in a community area in the home, Michelle was given special permission to use her tablet in her room for privacy during her individual sessions. The parents asked a neighbor to watch the younger sister during family sessions. The family did not have any safety concerns with participating in family therapy sessions via telehealth. The sessions generally ran smoothly with only mild connectivity issues.

In an individual Task 2 session, Michelle identified core attachment ruptures of neglect and abandonment as a result of her parent's prioritizing work over family life. Michelle also talked about her grandmother's nursing facility which now had 10 confirmed cases of COVID-19. She was worried that her grandmother would be infected and that she would lose her "nanna." Michelle had not spoken to her parents about this. In sessions alone with the parents, the therapist learned that the mother was depressed and coped by distracting herself with work and the father had a history of avoiding intimacy by overachieving, leaving him absent at home.

When it was time for the Task 4 family session, Michelle logged on for the session alone in her room instead of with her parents. She appeared sad and said she wanted to participate separately, from her room. The therapist asked for a few minutes to talk to Michelle alone in a breakout room on the video system. In the breakout room, Michelle worried that her parents could still hear the conversation, but once reassured, she shared that she worried her parents would be "normal" during the call, but upset after it was over. After agreeing to talk together about her concern with her parents, the therapist facilitated a brief conversation about Michelle's worries. The family agreed to a post-session coping plan that allowed Michelle to have space after the family session, if needed. The therapist also planned a post-session check-in with the parents to help them process their experience, which helped reassure Michelle that there would not be negative repercussions from the session. After this preparation, Michelle agreed to participate in the session from the same room as her parents.

Michelle was usually challenging to engage in treatment and often remained silent about her distress due to feeling that her parents' disregarded her experiences, but the rocky start of this session made the launching of the treatment even more difficult. Sensing the tension on the video call, the therapist suggested Michelle start by talking about her concerns about her grandmother. The therapist saw this as a less threatening topic than the attachment ruptures and hoped it would offer an opportunity for the parents and Michelle to share vulnerability, given the parents' own concerns about the grandmother. If the parents could show some softness and caring about this topic, it could demonstrate to Michelle that they might be responsive to her concerns about their relationship.

As Michelle began to talk about her grandmother, the therapist coached the mother not to dismiss the daughter's distress through reassurance (e.g., "Oh dear, everything's going to be okay.") and help

father stop avoiding (e.g., “You don't need to worry about things we can't control.”) Instead, the therapist helped the parents slow down and tolerate their daughter's distress and respond empathetically. The more the mother just listened, the more her own feelings of worry emerged. When the time was right, she started to share that she also was scared for the grandmother. With prompting from the therapist, the father assured Michelle that the nursing facility was doing all it could to keep “nanna” safe. Michelle was relieved to hear that, but was more moved by her mother's emotional attention and her father's attempts to comfort rather than avoid. When she expressed her relieve through crying, the therapist prompted the parents to ask about Michelle's tears. When the mother asked, Michelle said, “You never listen to me anymore. You just blow me off!” The therapist helped contain the mother's defensiveness by focusing on the moment. “Your mother is listening now, right mom?” Turning to the mother, the therapist said what a nice job she was doing, and she could see the mother was utilizing the skills they had talked about in their session alone. Moving toward a corrective attachment experience, the therapist, then, prompted the mother to ask Michelle more about what she means about feeling “blown off” in the past. As Michelle began to talk about her mother's absence in the home and how lonely she felt, she began sobbing. The therapist asked the mother to slide over on the couch and comfort her daughter while asking questions to understand Michelle's experience better. The father leaned in to support his wife. Michelle visibly relaxed and became more regulated as she received this comfort from her mother and prolonged engagement (rather than avoidance) from her father.

This case demonstrates how we may use Task 5 topics (challenges outside the family) to engineer a positive or successful caretaking moment. The intention of this is to build enough trust so that the family can address the harder Task 4 topics (interpersonal conflicts between caregivers and adolescent). Talking about COVID-19 is a shared trauma that requires caregivers to provide comfort and protection. The therapist assumed it would be easier to have success with this topic than some of the bigger, long-standing attachment disappointments. So a “win” around the COVID-19 topic might set a foundation for initiating the Task 4 corrective attachment experience as demonstrated in this case.

What have we learned from COVID-19

Therapists have to be flexible. Although in the initial stage of treatment, we view attachment ruptures as the core focus of treatment, the model cannot get in the way of addressing a crisis. We can use the pandemic to organize new kinds of family conversations and interactions that strengthen the family as a secure base. The focus of our content changes, but our principles and mechanism of change do not. Rather than see COVID-19 as a barrier, we see it as an opportunity. We also find that, within telehealth, there is both opportunity and innovation. Family attendance for sessions has increased. Youth like being online; this is where they live. Caregivers do not have to worry about transportation or childcare (Langarizadeh et al., 2017). Rural communities have much greater access to care with telehealth being covered by insurance. In terms of therapeutics processes, yes, of course, it is less personal than in-person. However, with a close-up screen of clients' faces, we find online therapy has the potential for just as much intimacy.

We are aware that these technical changes and troubling times can be stressful for therapists. Working from home, raising children, and keeping family members' safe burdens us as well as the families we work with. We may find ourselves reacting more strongly, or with less curiosity to clients. We may have difficulty separating our feelings from clients' feelings when they discuss their own anxiety related to COVID-19 (Amorin-Woods et al., 2020). We must be kind and forgiving to ourselves in these moments and make sure we are taking responsibility for our actions toward clients. We, as supervisors, should take extra time to check in with our teams and make sure we are a secure base for them.

FINAL THOUGHTS

We cannot end this article without addressing the pandemic of racism that has been pushed to the forefront of our awareness. This is an unprecedented time of social activism about discriminatory practices ingrained in our police forces and other institutions. The endless demonstrations give us great hope that this could be a time of change for everyone in our society. As we hope we have demonstrated, the goal of ABFT is to create a secure family base to support discussions and work through interpersonal, social, and developmental challenges. Placing racism and other systems of social injustice at the center of the conversation is completely consistent with ABFT (Diamond & Shpigel, 2014; Ibrahim et al., 2018). The question for us remains, do family members trust each other and feel safe enough to address these difficult and painful topics that cause or reinforce mental health distress? The ABFT structure aims to create such conditions. We hope this article helps our readers understand how one would bring topics, such as these, to the forefront of therapy with families.

ORCID

Suzanne Levy  <https://orcid.org/0000-0003-0991-205X>

Guy Diamond  <https://orcid.org/0000-0003-3789-5648>

REFERENCES

- Amorin-Woods, D., Fraenkel, P., Mosconi, A., Nisse, M., & Munoz, S. (2020). Family therapy and COVID-19: International reflections during the pandemic from systemic therapists across the globe. *Australian and New Zealand Journal of Family Therapy, 41*(2), 114–132. <https://doi.org/10.1002/anzf.1416>
- Barboza, G. E., Schiamberg, L. B., & Pahl, L. (2020). A spatiotemporal analysis of the impact of COVID-19 on child abuse and neglect in the city of Los Angeles, California. *Child Abuse & Neglect, 104*740. <https://doi.org/10.1016/j.chiabu.2020.104740>
- Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process, 59*(3), 974–988. <https://doi.org/10.1111/famp.12589>
- Centers for Medicare and Medicaid Services. (2020). Medicare telemedicine health care provider fact sheet. <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
- Diamond, G. S., Diamond, G. M., & Levy, S. A. (2014). *Attachment-based family therapy for depressed adolescents*. American Psychological Association.
- Diamond, G. S., Kobak, R. R., Ewing, E. S. K., Levy, S. A., Herres, J. L., Russon, J. M., & Gallop, R. J. (2019). A randomized controlled trial: Attachment-based family therapy and nondirective supportive treatments for youth who are suicidal. *Journal of the American Academy of Child & Adolescent Psychiatry, 58*(7), 721–731. <https://doi.org/10.1016/j.jaac.2018.10.006>
- Diamond, G., Russon, J., & Levy, S. (2016). Attachment-based family therapy: A review of the empirical support. *Family Process, 55*, 595–610. <https://doi.org/10.1111/famp.12241>
- Diamond, G. M., & Shpigel, M. S. (2014). Attachment-based family therapy for lesbian and gay young adults and their persistently non-accepting parents. *Professional Psychology: Research and Practice, 45*(4), 258–268. <https://doi.org/10.1037/a0035394>
- Donker, M. H., Mastrotheodoros, S., & Branje, S. (2020). Development of parent-adolescent relationships during the COVID-19 pandemic: The role of stress and coping. <https://doi.org/10.31234/osf.io/urmt9>
- Elkin, I., Falconnier, L., Smith, Y., Canada, K. E., Henderson, E., Brown, E. R., & McKay, B. M. (2014). Therapist responsiveness and patient engagement in therapy. *Psychotherapy Research, 24*(1), 52–66. <https://doi.org/10.1080/10503307.2013.820855>
- Gellar, S. (2020). Cultivating online therapeutic presence: Strengthening therapeutic relationships in teletherapy sessions. *Counseling Psychology Quarterly, 1*–17. <https://doi.org/10.1080/09515070.2020.1787348>
- Hicks, B., & Baggerly, J. (2017). The effectiveness of child parent relationship therapy in an online format. *International Journal of Play Therapy, 26*(3), 138–150. <https://doi.org/10.1037/pla0000033138>

- Hogue, A., Becker, S. J., Fishman, M., Henderson, C. E., & Levy, S. (2020). Youth OUD treatment during and after COVID: Increasing family involvement across the services continuum. *Journal of Substance Abuse Treatment, 120*, 108159. <https://doi.org/10.1016/j.jsat.2020.108159>
- Ibrahim, M., Russon, J., Levy, S., & Diamond, G. (2018). Promoting parental acceptance of bisexuality: A case study of attachment-based family therapy. *Journal of Family Psychotherapy, 29*(3), 223–251. <https://doi.org/10.1080/08975353.2018.1427401>
- Karpman, M., Gonzalez, D., & Kenney, G. M. (2020). *Parents are struggling to provide for their families during the pandemic*. Urban Institute.
- King, M. (2017). Guidelines for telemedicine policies and procedures. <https://www.magmutual.com/learning/article/guidelines-telemedicine-policies-and-procedures-0/>
- Langarizadeh, M., Tabatabaei, M. S., Tavakol, K., Naghipour, M., Rostami, A., & Moghbeli, F. (2017). Telemental health care, an effective alternative to conventional mental care: A systematic review. *Acta Informatica Medica, 25*(4), 240. <https://doi.org/10.5455/aim.2017.25.240-246>
- Lebow, J. L. (2016). Editorial: Empirically supported treatments in couple and family therapy. *Family Process, 55*(3), 385–389. <https://doi.org/10.1111/famp.12240>
- Moccia, L., Janiri, D., Pepe, M., Dattoli, L., Molinaro, M., De Martin, V., Chieffo, D., Janiri, L., Fiorillo, A., Sani, G., & Di Nicola, M. (2020). Affective temperament, attachment style, and the psychological impact of the COVID-19 outbreak: An early report on the Italian general population. *Brain, Behavior, and Immunity, 87*, 75–79. <https://doi.org/10.1016/j.bbi.2020.04.048>
- Moran, G., & Diamond, G. (2008). Generating nonnegative attitudes among parents of depressed adolescents: The power of empathy, concern, and positive regard. *Psychotherapy Research, 18*(1), 97–107. <https://doi.org/10.1080/10503300701408325>
- Pfefferbaum, B., & North, C. S. (2020). Mental health and the Covid-19 pandemic. *New England Journal of Medicine, 383*(6), 510–512. <https://doi.org/10.1056/NEJMp2008017>
- Prime, H., Wade, M., & Browne, D. T. (2020). Risk and resilience in family well-being during the COVID-19 pandemic. *American Psychologist, 75*(5), 631–643. <https://doi.org/10.1037/amp0000660631>
- Racine, N., Cooke, J. E., Eirich, R., Korczak, D. J., McArthur, B., & Madigan, S. (2020). Child and adolescent mental illness during COVID-19: A rapid review. *Psychiatry Research, 292*, 113307. <https://doi.org/10.1016/j.psychres.2020.113307>
- Ronen-Setter, I. H., & Cohen, E. (2020). Becoming “teletherapeutic”: Harnessing accelerated experiential dynamic psychotherapy (AEDP) for challenges of the COVID-19 era. *Journal of Contemporary Psychotherapy, 50*(4), 265–273. <https://doi.org/10.1007/s10879-020-09462-8>
- Russell, B. S., Hutchison, M., Tambling, R., Tomkunas, A. J., & Horton, A. L. (2020). Initial challenges of caregiving during COVID-19: Caregiver burden, mental health, and the parent–child relationship. *Child Psychiatry & Human Development, 51*(5), 671–682. <https://doi.org/10.1007/s10578-020-01037-x>
- Stanley, B., & Brown, G. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256–264. <https://doi.org/10.1016/j.cbpra.2011.01.001>
- Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International Journal of Mental Health Nursing, 29*(4), 549–552. <https://doi.org/10.1111/inm.12735>
- Wang, M.-N., Sandberg, J., Zavada, A., Mittal, M., Gosling, A., Rosenberg, T., Jeffrey, A., & McPheters, J. (2006). “Almost there”. Why clients fail to engage in family therapy: An exploratory study. *Contemporary Family Therapy, 28*(2), 211–224. <https://doi.org/10.1007/s10591-006-9001-3>
- Westrupp, E., Bennett, C., Berkowitz, T. S., Youssef, G., Toumbourou, J., Tucker, R., Andrews, F., Evans, S., Teague, S., Karantzas, G., Melvin, G. A., & Sciberras, E. (2020). Child, parent, and family mental health and functioning in Australia during COVID-19: Comparison to pre-pandemic data. <https://doi.org/10.31234/osf.io/ydrmq>
- (2020). World Health Organization. *Coronavirus disease (COVID 19) pandemic*. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>
- Zero Suicide Initiative. (2020). Providing suicide care during COVID-19. <http://zerosuicide.edc.org/covid-19>

How to cite this article: Levy S, Mason S, Russon J, Diamond G. Attachment-based family therapy in the age of telehealth and COVID-19. *J Marital Fam Ther.* 2021;47:440–454. <https://doi.org/10.1111/jmft.12509>