



DREXEL UNIVERSITY

Attachment-Based Family Therapy Program

College of Nursing and Health Professions

ABFT VIA TELEHEALTH & COVID-19

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Pandemic Impact

As of late April, there have been 3.02 million confirmed cases and over 207,000 deaths related to the coronavirus disease 2019 (World Health Organization, 2020). The pandemic has had a huge impact on the structure and routine of daily life, and the overall sense of wellbeing in communities across the globe. To prevent the spread of the virus, many countries have required communities to shelter in place, schools and businesses have closed, and general social distancing measures have been encouraged. In some areas, these public health measures have significantly impacted the workforce and, as a result, the rate of unemployment has increased. Individuals and families are facing the compounded stressors of health-related anxiety, financial instability, isolation, limited physical and social outlets, and general lack of normalcy. Consequently, the “new normal” has contributed to mental health concerns, interpersonal difficulties, and increased stress on the family unit. Among other changes, family conflict or withdrawing may have increased resulting in a renewed reliance on old patterns of behaviors.

Many therapists in the ABFT community are continuing to provide ABFT to their clients through this time of quarantine and physical distancing. For some families, the usual stressor of peers and school have decreased and thus, so have behavioral management conflicts. This might even create an opportunity for more quality time together. However, for many families, quarantine can exacerbate existing problems and increase conflict or distance. In ongoing treatments these changes may present as a setback for some, removing previous treatment gains made. For these families especially, participating in family therapy can be a lifeline for managing unescapable family conflicts, teens’/young adults’ mental health, and the family’s anxiety related to COVID-19. Thus, clinicians should explore, assess, and process stressors related to the pandemic to promote understanding and motivation for change throughout the course of treatment as it relates to the presenting problem and attachment related goals. Providers have not been unaffected by this situation. We are all navigating life during this pandemic, so self-care and community support are vital to our wellbeing and our ability to provide care for families.

ABFT & Telehealth

The ABFT Training Program has developed suggestions and recommendations for conducting ABFT via telehealth to assist our therapists. Some guidance is technical; information about the set-up and structure of telemedicine. However, most of the document reviews some important clinical challenges that present in telemedicine in general and issues specific to managing COVID-19 within ABFT. As with ABFT, these recommendations must be tailored to the needs of individual families, but there are some generic things to think about when considering telehealth. Providers should expect some challenges with providing ABFT via video conferencing; however, these challenges can be mitigated with forethought, preparation, and real time flexibility.

It is important to keep in mind that any procedures or organizing around telehealth is not just a problem to be solved, but a *clinical opportunity* to promote the quality of relationships and interpersonal skills.

Understanding how families engage in these challenges and how collaborative family members are, can help therapists engineer opportunities to improve caregiver and teen/young adult negotiation skills. Some caregivers need to be more patient with and inclusive of their adolescent's/young adult's point of view. Other caregivers need to be more decisive without being rigid or critical. Some adolescents/young adults need to be more regulated and cooperative, while others need to speak up for themselves. Every organizational problem is an opportunity to challenge these weaknesses and promote more attachment promoting strengths.

We provide guidance in the following domains:

- General Issues Related to Conducting Therapy via Telehealth
- Managing Suicide Risk in Telehealth from a Family Perspective
- Conducting Deep Therapy Work Online
- Utilizing Covid-19 as a Therapeutic Tool in ABFT
- ABFT Specific Telehealth Considerations

1.0 General Issues Related to Conducting Therapy via Telehealth

1.1 Security of Telehealth Systems

At a basic level, before beginning telehealth, therapists should take care to research which web-conferencing system meets their needs for: 1) interacting with their clients, 2) promoting ease in client use, 3) maintaining the necessary security features to protect their clients' protected health information; and 4) meeting the standards of privacy set by therapists' organizations and countries. For therapists in the United States, please review the United States Department of Health and Human Services statement on telehealth and acceptable platforms during the COVID-19 crisis (<https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf>). If therapists have questions regarding whether or not a particular program is legal to use in their state or country, they should contact their local licensing governing body or local professional organization for advice.

The ABFT Training Program does not endorse or require any specific program.

We do however, encourage you to take this issue seriously and do the necessary research to make sure the system you choose is in compliance with your state's and/or country's laws.

Regardless of program used, there are some common strategies that therapists can use to determine whether clients' devices are secure and that their information is kept confidential:

- 1) After determining which device(s) (e.g., computers, smart phones, etc.) clients will be using to join sessions, ask how the device is protected (e.g., password protected and/or encrypted?)
- 2) Ask clients about their internet connection/Wi-Fi. Do they have their own Wi-Fi with a password or do they share a public network?
- 3) Advise clients to update their devices regularly to make them more secure.
- 4) Keep in mind that families (e.g., teen, mom, etc.) may all be using different devices for therapy. It is important that each family member keeps their device as secure as possible.

1.2 Preparing for ABFT Work Online with an Attachment Frame

- **Existing Clients**
 - **Reach out:** Therapists should show their clients they are there for them. Before starting online ABFT with current cases, check in with them:
 - How are they doing now?
 - Do they want online therapy?
 - **Refusal of Online ABFT.** Some adolescents/young adults and or caregivers may refuse to engage in video calls and want to wait until in-person sessions are possible again to resume therapy. If they refuse,

it is important to explore why. If their reasons are in relation to safety or privacy, we address their concerns. If they continue to decline online services, then we think about how to proceed.

- Work with individual family units. One strategy is to offer to work with the individual family units.
 - Caregivers. We have conducted a lot of productive ABFT therapy with just seeing the caregivers. We use Task 3 as the organizing structure: getting to know them, understanding their attachment histories and how it impacts parenting, addressing caregiver teamwork and relationship conflict if needed, and then coaching them to handle problems differently. We help them be less reactive, more regulated, work better as a team and try to hold their relational conflicts (if relevant) at bay.
 - Adolescent's/Young adults. We also can do extended work with youth alone. Here we use the Task 2 structure to join with adolescents/young adults, understand their presenting problem narrative to find motivation for change, uncover their attachment narrative to help them better understand why they have difficulty with their caregivers. We then coach them to try and manage all this better so they do not bury their own life potential. Skill building can be a big part of this as well.
- Maintaining the secure base stance. If the family just refuses to do online therapy, it is important for the therapist to show the family members that you are thinking about them, and are available for support during this time of physical distancing by reaching out through:
 - Two-way communication: Conduct check-in calls or use chat applications.
 - One-way communication: Send a text-message, email, post card, inspirational quotes, picture, audio or video fragment... to check-in. These methods show the family members that we are thinking about them, wishing them courage during these stressful times and are available to the family. This will demonstrate to the family, that even when physically distant, we as therapists care about them, hold them and want to support them through these difficult times, that they are in our mind and heart, and that we remain a secure base/haven, even when they don't feel like engaging in video calls

1.3 Keeping Clients Informed (if existing or new clients want online therapy)

- **Send an email with information** about therapy via telehealth before the first session which includes following information.
 - **Informed consent form.** Regardless if we are continuing therapy with previous clients or beginning therapy with new clients, therapists should obtain consent to conduct online therapy and to utilize the telehealth platform with their clients. Include information about **privacy of the platform being used** in accordance with your local licensing governing body or local professional organization. If beginning with new clients, all of the regular consenting documentation should occur as well.
 - **Information about installing and using the telehealth application.** Therapists should provide information to their clients about how to install the telehealth platform being used, access it when needed, and use it during meetings. It can be helpful to provide a link of a tutorial for how to install and use the software.
 - **Recommendations on which type of device to use.** We advise that, if possible, clients use computers or tablets for sessions rather than smartphones. The images on smartphones are quite small and it can be difficult to see other family member's and the therapist's nonverbal communications.
 - **Recommendations for conditions of device use.** We advise clients about the following issues:
 - Proximity to Wi-Fi. In order to be able to communicate effectively, clients will need adequate Wi-Fi signals.
 - Device placement. Devices should be placed on a stable surface during sessions so that their image is not moving around.

- **Power supply.** Devices should have a full battery or be plugged in so the device does not shut-off in the middle of the session.
- **Lighting.** Preferably, clients should be in a room with good lighting. We request that clients do not sit in front of a window or with backlight because facial expressions are less visible (black faces).
- **Clothing.** Be clear about expectations for clothing (e.g., can they wear pajamas?)
- **How the therapist will send a link for a session.** Be clear about how the family members will receive the link for the session and access it each time
- **Information regarding payment for services.** Therapists need to be clear about how they will bill for and receive payment for telehealth services.

1.4 Therapist Preparation and Engagement

- **Setting.** Before beginning telehealth, as therapists we need to be mindful of the kind of atmosphere we want to set for our clients.
 - **Room.** What is your background, is it neutral or are there private things in the background? If possible, conduct therapy in a place familiar to your clients.
 - **Seating.** Test out in advance how you look on camera. Where will you sit in relation to the camera? Will it be important for clients to see your body language?
 - **Lighting.** We need to make sure we have good lighting so that clients can see our faces during sessions.
 - **Distractions.** Make sure other programs on the computer you are using during a session are shut-down (e.g., email, social media).
 - **Wi-Fi.** We need to make sure the room we conduct therapy in has strong Wi-Fi. Alternatively, hardwire into your network.
- **Privacy.** If therapists are continuing to go into their office, this is less of an issue. For therapists who need to work from home, it's important to think about how one can maintain privacy during sessions. This includes arrangements regarding children and pets.
- **Engagement.**
 - During the session look directly into the camera so as to increase opportunities for eye contact.
 - During sessions with multiple people, use their names to make it clear who you are talking to. Use your body to turn to someone to make clear you want to talk to him/her.
 - Just like during in-person therapy, during joint sessions, the therapist will have to monitor the reactions of all clients in the session at once.

1.5 Pre-therapy Online Meeting

There are several general issues to work out with clients prior to beginning telehealth. We recommend having a pre-therapy meeting with families to review several logistical issues as well as specific issues related to conducting ABFT online. Each therapist will need to determine if they will bill for this meeting with families.

This is not just a business meeting however. Everything is therapy. How the family problem solves, how they include or don't include the ideas of everyone, who takes lead, who gets left out, who dominates, who supports provides a window into how the family functions. Be observant and if you want, use this task to challenge these dynamics. If this is a new family, we notice more and challenge less. If we have an existing relationship with them, we can use this task to reorganize roles and relationships.

- **Test the platform with the clients.** Conduct a test run of the telehealth platform with clients. Test out if you can hear and see each other. Determine what will be better for understanding clients, speakers or headphone. Introduce them to the features of the platform and address questions.
- **Set the limits.**

- **Chat function.** If therapists decide to use the chat function in the platform of choice, set the parameters for the use of chat. For instance, what types of communication will be allowed via the chat function? We recommend that therapists check their settings to make sure chat discussions are not automatically saved if they decide to use them.
- **Clients recording sessions.** If clients have the ability to record sessions in the platform being used, discuss the parameters around this.
- **Negotiate the clients' setting.** When sessions are in person, therapists arrange the setting choosing the arrangement of seating, what is present in the room (e.g., tissues, décor), where people will sit. We need to think about how we want the setting meeting virtually. How much control do you want? What is important to address to have productive sessions?
 - **Seating arrangements.**
 - Where. Where is each person most comfortable meeting during individual and family sessions? Together in a room? In separate rooms? If together in a room, all on one couch or different seats with multiple computers or devices?
 - How. Come to an agreement about how clients sit. Will you want them sitting up in a chair or allow them to lay down in a bed or on a couch? When people web conference, they often only show their shoulders and face. Some therapists find it harder to connect with clients because they cannot always see client's body language. For some clients, their body language tells a very different story than their words. If a therapist finds it difficult to connect with a client for this reason, we recommend asking the client to sit further away from the camera to better simulate meeting in person.
 - **Distractions.** Discuss how the clients will limit distractions during the session.
 - Ask them to switch off phones and social media apps during the session.
 - It may be helpful during individual sessions for clients to wear headsets to block out extraneous noise.
 - Clients or the therapist may be uncomfortable seeing themselves on camera. Therapists can recommend clients put a piece of paper or an empty word document over their own image to reduce distraction. If you believe this is a clinical issue (e.g., body image issues), use this as an opportunity to explore this issue further.
 - **Comfort.** Help clients think about what they may want in the room with them during a session (e.g., tissues, a beverage). Be clear about what they should not have (e.g., food).
- **Managing technical difficulties.** Be prepared to manage technical challenges. Many telehealth systems are overburdened at this time due to increased usage. Create a plan for what to do if you get disconnected. Families who are not used to using telehealth may be confused if the therapist becomes “frozen” or suddenly is gone from the screen. In ABFT, we believe in preparing families for challenges and issues in communication that may arise. We recommend you discuss these challenges with each family member and how you can resolve them as swiftly as possible.
 - If the call freezes, whom should call whom? If the internet is unstable or the someone becomes “frozen” how should this be managed?
 - If the telehealth platform has a chat box, therapists can choose to use the chat box for this purpose.
 - Obtain a back-up phone number for the clients in case they are unable to be reached via their regular numbers.
- **Privacy.** Conducting therapy via telehealth when all family members are in their home can be challenging. Caregivers and/or the adolescent/young adult need to be assured that they will have privacy when talking to the therapist 1:1 or from other family members during family sessions.

- **Location.** Discuss where each family member can talk with you that is private. If there is no space in the house where privacy can occur, is there a space outside that is safe for family members to speak with you while also physically distancing themselves from others (i.e., sitting in their car)?
 - If there are other family members in the home besides the caregivers and adolescent/young adult, discuss how a private space with no (or limited) interruptions will be created for the family sessions.
- **Confidentiality.** Discuss how privacy will be maintained.
 - Therapists may suggest clients use a sound machine or sound machine noise app on their phone and put it by their door when meeting with the therapist on a separate device.
- **Safety of (other) children when caregivers are in session.** The therapist should discuss with the caregivers how when they are in session, they will manage the children in the house (the identified patient and other children). Caregivers should plan for what the children can and cannot do (e.g., watch television vs. cook, play with toys inside vs. be outside alone) while the caregivers are in session. Caregivers should discuss with their children how the children can access the caregivers during a session if they need them (e.g., knock on the door, send them a text) and parameters for when the children can and cannot interrupt a session (e.g., someone is hurt vs. they want to ask permission to do something).
- **Additional issues to Discuss with New Clients**
 - **Intake & Engagement.** An intake with the youth and caregivers separate and together should occur if not already completed. During these meetings therapists will begin building rapport with family members addressing the issues below. If the intake was conducted by someone other than the therapist, we recommend the therapist takes some time prior to Task 1 to engage the youth and caregivers separately in the below conversation.
 - Coping with Covid-19. We want to understand how they are coping with Covid-19.
 - Family safety concerns. In separate meetings with youth and caregivers, we also want to explore and understand any safety concerns they have about participating in family therapy online, problem-solve where possible, and prepare the individuals to discuss these concerns together.
 - Caregiver concerns. It's often caregivers who are initiating therapy in this context as a result of feeling frustrated, afraid, or overwhelmed by their youth's behavior on top of the other stressors associated with Covid-19. Caregivers may need to have some time to vent about their youth and be prepared for what we need them to do in Task 1 in order for us to increase the chances for a successful Task 1.
 - **Safety planning (if applicable).** When working with a client who has suicidal ideation or behaviors or self-harm, it will be important to develop a safety plan with the youth and caregivers (if working with a young adult, you will need the young adult's consent to involve a caregiver). See section 2.0 Managing Suicide in Telehealth from a Family Perspective.
 - **Family Safety Discussion.** Meet with the youth and caregivers together to discuss family safety concerns related to participating in online therapy (if applicable). Help the family develop a plan to address these concerns if needed (see 5.3 Family Meeting Pre-Task 4 below).

2.0 Managing Suicide Risk in Telehealth from a Family Perspective.

Safety of clients, while participating in ABFT, is of the utmost concern. Below are safety concerns therapists may have about working with patients expressing suicidal thoughts and/or behaviors via telehealth and ways to manage them.

2.1 Safety Planning

Similar to when therapists see clients in person, if working with a client with a history of suicidal ideation and/or behaviors, we recommend developing **a safety plan with the adolescent and caregivers** during the

assessment/intake phase of therapy. Keep in mind that any pre-existing safety plans may need to change for clients if they are now in a new context. For safety planning, we help our clients identify warning signs and triggers of a crisis as well as identify and learn coping skills and ways to distract themselves when they are distressed. We also give them a hierarchy of who to reach out to for support. Given physical distancing, these strategies may need to change (e.g., go to the pottery studio to unwind vs. find a place in your home where you can work on your pottery). Engage the caregivers and adolescent in conversations about the safety plan issues throughout the process. In this way, the safety plan is a therapeutic opportunity, not just a behavior plan to be put in place.

Some therapists have found that, during this time especially, **safety planning apps** have been useful. We recommend the MY3-Support Network App. When using apps, keep in mind that some allow therapists to “monitor” or “view” client activity. Make sure to consult with your organization or privacy laws before using a new app with your clients.

Full guidance on how to do a safety plan can be found here: http://suicidesafetyplan.com/Home_Page.html.

2.2 Rating Scales for Suicidality

As part of the safety plan, we recommend you check in with the client at the beginning of each session. We recommend checking the client’s suicidal ideation, and also determining whether there is plan and intent. Therapists can utilize an empirically supported rating scale. Some examples are:

- Columbia Suicide Severity Rating Scale (http://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf; suicide ideation subscale)
- The Ask Suicide Screening Questions Tool Kit (ASQ; <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml>)
- Suicide Ideation Questionnaire-JR (adapted for 1-week timeframe)
- The Behavioral Health Screen (Diamond et al, 2010) offers a suicide assessment scale but also covers a broad range of mental health domains and risk factors (see www.Mdlogix.com for details). This tool is a bit longer and is often used to measure baseline and outcomes, rather than used as a weekly monitoring tool.

If therapists are unable to use an empirically-supported scales, then conducting a brief assessment regarding ideation, behaviors, plan, and intent will be important. (<https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/outpatient/brief-suicide-safety-assessment-guide.shtml>)

2.3 Involving the Caregiver in Maintaining Safety

- In this pandemic environment, we need **the caregiver to take a much stronger role in monitoring** the adolescent and getting them help if necessary. This often requires a direct conversation with the family. The aim here is to make this an act of love and protection, not control and criticism. When working with young adults, we also prefer to enlist the help of their caregivers, partners and/or other responsible adults in maintaining the young adult’s safety.
 - **Begin with the adolescent/young adult.**
 - Adolescent Therapists may want to begin the conversation with the adolescent by saying, “We are going to need your caregiver to help keep you safe. So I will be talking with them a bit more than usual about this. The things that we talk about alone I will still keep private, even though you know anything important, I will be encouraging you to eventually discuss it with your caregivers. But while I cannot check in with you in person, I need your caregivers to be my eyes. So I will likely be asking them to check in on you more than they do now. Let’s talk about how you feel about that.”
 - Young Adult. Therapists may want to begin the conversation with the young adult by saying,

“I’m worried about your safety. I would like to enlist the help of your caregiver/partner to help keep you safe during this time. I would like to be able to discuss your safety with him/her/they. The things we talk about alone I will still keep private, even though you know anything important, I will be encouraging you to eventually discuss it with your caregivers/partner. But while I cannot check in with you in person, I would like for your caregivers/partners to be my eyes. I would like to be able to ask them to check in on you more than they do now. Let’s talk about how you feel about that.”

- **Discuss concerns.** Therapists will need to discuss adolescents’/young adults’ concerns regarding more caregiver monitoring. While some adolescents/young adults welcome the attention, others find caregivers’ attention irritating or intrusive, or some adolescents/young adults do not want to burden their caregivers. This resistance is a core target of ABFT (e.g., what gets in the way of going to your caregivers for help?), but in these complicated times, the need to bridge this divide is all the more important. Caregivers/partners are often the only people seeing these adolescents/young adults daily. In this regard, all the themes of ABFT are present: does the adolescent/young adult rely on his caregiver/partner, if not why and can the adolescent/young adult help the caregiver understand these barriers in a way that will motivate the caregivers to listen and change.

- **Talk with caregivers.** With caregivers, we also recommend a direct conversation about this.

“Look, I will be working with you and your youth as much as I can through web-conferencing. However, I will need more help from you. I need you to keep a better eye on your child’s mood and behavior. I will coach you on this; we cannot be intrusive into your child’s privacy, but we also cannot be too hands-off. Also, this should not feel like a punishment. It has to feel like an act of love and protection.”

- Consider if it would be helpful for the caregiver to involve other family members in the home in this process. For example, if the adolescent has siblings whom they get along with, consider how the caregiver can enlist their support. For instance, maybe the siblings can relax together, exercise, do something fun, talk, etc. We have to be careful however to not put a sibling in the role of taking care of a depressed or suicidal teen/young adult. Instead, we are using this crisis as leverage to motivate caregivers and adolescents/young adults to be better with each other. We use the leverage of death to motivate caregivers and adolescents/young adults to be open to new ways of reaching out to each other.

- **Discussion with caregiver and adolescent/young adult (if young adult grants permission).** We then help caregivers/partners and adolescents/young adults negotiate how caregivers/partners can support the adolescent/young adult during this time, in a way that will help provide comfort and security and not exacerbate conflict. In this way, monitoring suicide risks becomes a Task 5 topic. We help families engage in a discussion of what kinds of interpersonal feelings and behavioral needs need to get addressed in order for the caregivers and adolescent/young adult to cooperate as a team around the goal of safety. Caregivers need to be more definitive, but softer and more collaborative (e.g., “Look, I need to keep a closer eye on you, but we do not want to baby you. What do you need from us to make this work?”). Adolescents/young adults need to be more direct and honest rather than sulky, irritable or withdrawn (e.g., “Look Jonny, your parents are here to work with you and support you. Tell them what you need from them to make this work. This is your chance to have a say in how things go in your life.”). Then we guide families to come up with a reasonable and successful plan to keep the adolescent/young adult safe.

- **Safety first.** If issues of safety arise from the assessment, **safety is prioritized over the ABFT agenda.**
 - **Adolescents.**

- Acute risk. If there is acute risk (i.e., there is plan and intent) and therapists are working with an adolescent, **the caregivers need to be informed immediately.** This could come up in an individual session with the adolescent or in a group/family call. If in family sessions, the therapist needs to decide if they should talk to the adolescent alone first or continue the conversation in the family session. Having the caregivers be part of this conversation is ideal, but making sure one gets all the necessary information is paramount. If this comes up in an individual session, then the therapist needs to do a proper assessment and then bring the caregivers into the conversation.
 - Ideally, the therapist has established enough trust between the caregivers and adolescent so they can step in and provide the necessary supervision and monitoring. On the other hand, a suicidal crisis can sometimes be used to motivate the caregivers to follow the therapeutic plan (be empathic and focus on feelings rather than be critical and focus on behaviors). Although suicide ideation is stressful and scary, it is also **an opportunity to mobilize change.**
- Psychiatric evaluation needed. If therapists deem a psychiatric evaluation necessary, caregivers will have to take their adolescent to the local hospital or crisis response center for guidance. Currently, many health institutions are restricting who can come in-person and are conducting initial screens via telehealth. Therapists need to familiarize themselves with their local emergency services' current protocols so they may guide families appropriately.
- **Young adults.** If therapists are working with a young adult, therapists must abide by whatever arrangement was established regarding **confidentiality**, while also ensuring safety.
 - Permitted to talk to others. If therapists are permitted to talk with the young adult's caregiver, partner, or other responsible adult, therapists should involve the other adult(s) in the conversation of safety. If therapists deem further evaluation is necessary, follow the guidance above.
 - Not permitted to talk to others. If therapists are not permitted to involve other responsible adults in the care of the young adult and deem further evaluation is necessary, have the young adult call their local ER or crisis response center for evaluation with the therapist on the call to assure the young adult follows through on the call. It is important for therapists to be aware of where their clients are located before every session so they can help mobilize resources accordingly.
 - If therapists are not permitted to involve other responsible adults, and it is deemed that the young adult is at risk and the young adult will not call their local ER or crisis response center, we recommend therapists call their local emergency services to consult and eventually get the client the care they need.
- **Evaluation refusal.** In instances where caregivers and adolescents/young adults **refuse to go to the hospital**, we recommend insisting on 24/7 watch for the adolescent/young adult (the client must be in the presence of the caregiver (or other responsible adult) 24 hours a day, 7 days a week. They are not allowed to go to the bathroom with the door closed, they must sleep in the caregivers' room (on the floor if necessary), etc. If possible, require the family meet with you the next day for another session where you can re-evaluate the adolescent/young adult. Therapists may want to follow up with a check-in call that evening if possible. Again, this is not a punishment but protection. We often say to caregivers "when your child was young and dysregulated you would swaddle him/her (wrap him/her tight in a blanket). This is how you keep him/her safe now."
- **Check-in.** With any level of risk, we recommend **continually checking in on the use and relevance of the adolescent's/young adult's safety plan and modify it if necessary.** All patients should be provided with hotline numbers and the address of their local ER or crisis response center. Families are encouraged to call their therapist if they have concerns. Patients can also call hotlines if they need to talk and cannot reach the therapist. Families are advised that, if they are worried about their child's immediate safety and cannot reach their therapist, they should call or take them directly to their local ER.

We find that many high risk suicidal adolescents/young adults do not need to go to the emergency room. Often they are sent home because by the time they get to the ED they have calmed down. In addition, inpatient admission is often not that helpful, and only used for crisis management, medication check and then youth are discharged. This is a critical service when the time is right, but the therapist has to think about if they can use the suicidal crisis safely as an intervention opportunity or the admission is needed.

2.4 Other Practical Issues

- **Assess location.** It is best practices in telehealth, and ABFT, to always ask for the locations of all our clients before each session. While most families will be in their home while meeting, there may be times that clients are in different places. Therapists might want to document the location in case emergency assistance is needed. Knowing where clients are located for sessions allows the therapists to familiarize themselves with local resources should they need to be mobilized.
- **Don't leave client alone.** As is standard crisis management practice, if an adolescent or young adult is at-risk, do not leave them alone. If you are web conferencing, make sure they stay in your sight while you engage caregivers/mobile resources. If you are on the phone, keep them on the line while you use a different device to contact caregivers/resources. We also recommend coming up with a plan (in advance of starting telehealth) for what to do if your connection is disrupted.

3.0 Conducting Deep Therapy Work Online.

ABFT is a depth focused, trauma informed, and emotion/process oriented therapy. This happens in individual sessions with both caregivers and adolescents/young adults alone, as well as in family sessions. Many therapists wonder if this kind of work is possible and recommended online. Can we expect the same level of intensity via telehealth?

In general, we assume therapy over the phone or via video conferencing can be just as powerful as face-to-face therapy. Some clients, in fact, feel more comfortable talking over the phone or video conferencing than in person. These technologies have become so much a part of our life that we have become socialized to this method of communicating. Still, it can feel strange to conduct therapy in this way.

3.1 Help Clients Feel Comfortable.

When starting with new clients or if current clients seem uncomfortable with sharing deep emotion, we recommend taking time to do the following:

- **Join/Re-Join.** Take time to connect/reconnect with clients in this new medium and utilize the space they are in to get to know them in a different way. Some examples are:
 - Therapists may choose to engage the clients playfully to help them get to know the telehealth-medium. Explore the technology together.
 - Ask clients about things observed in their environment as a way to get more familiar with them. For example, a child or pet may pop up in the screen. Be sure to say hello or ask about them. Show warmth and comfort with these life interruptions.
 - Explicitly thank clients for letting you into their house/private space
- **Objects of comfort.** When doing telehealth, as therapists we are more physically distant than in face-to-face contact, making it more difficult to use our usual signals of comfort and empathy (e.g., moving closer to client, a pat on the back, etc.). Some clients, may find it helpful to bring an object that represents comfort/support to utilize when meeting. We recommend discussing this with clients. Mostly this will be the youth we work with. However, if therapists sense a caregiver they work with may benefit from this type of comfort, then the therapist should discuss this with the caregiver.

- If clients choose an object, ask them about it. Understand why this object brings them comfort. This experience may bring you even closer to clients.
- If they choose to bring an object, then when they are overwhelmed by emotions in session and they need comfort, asking the client to hold the object may be helpful.
- **Checking in.** After the initial one or two sessions of getting clients comfortable with the platform, we recommend not calling attention to the platform if it can be helped. However, if the conversation starts to become more intense during the call, you might ask the client if they are alright continuing the conversation online (much like we would check-in with someone in a session if the conversation was getting emotionally intense and we were worried about them).
- **Switch off/on time.** For clients that have difficulty transitioning from their home life to the session or take a while to settle into the session, therapists may want to ask clients to take time before sessions to reflect and get into a therapy headspace. Likewise, therapists may ask clients to take time after sessions to “switch” off the therapy mode before transitioning back to family life.

3.2 Skills to Help Deepen and Take care of Emotions Online

In ABFT, we aim to attune to and deepen clients’ emotions. We want to continue using emotion deepening skills (e.g., validation, reflection, episodic memories, etc.). However, deepening emotions over web conferencing can be more challenging. Therapists should consider:

- **Your body language.** In addition to using our voice tone and pacing to evoke emotions, we should use our body language when possible. For instance, putting one’s hands together as if praying, or holding your own chin, mimics emotions like thoughtfulness or sadness and can be ways of physically expressing the feelings we are trying to explore.
- **Pacing.** Even online, our pacing remains important. To intensify, we might slow down, repeat ourselves, or reflect on small parts of the conversation.
- **Be transparent.** When the therapist senses the client feels emotional or upset, ask about it. For example, “It seems you are getting upset or something. I cannot see your face so well today; can you tell me what you’re feeling?”
- **Narrate.** When the therapist is with the youth or youth and caregivers are in different rooms during family sessions:
 - **Body language.** When family members are in different rooms, you might need to narrate what you see going on. For example, in a T4 when trying to deepen affect, “Mom, you may not be able to see but your daughter is crying right now.”
 - **Caregiving action.** Naming the action, you would like to see if the caregivers were in person. “Mom, I bet this is a moment you would really like to hug your son? Can you tell him that and why?”

4.0 Utilizing Covid-19 as a Therapeutic Tool in ABFT

The experiences surrounding the pandemic are similar to other major life events; however, it is a unique multipronged stressor that can have major, cumulative, and prolonged effects on the family. Clinicians should explore, assess, and process stressors related to the pandemic to promote understanding and motivation for change throughout the course of treatment as it relates to the presenting problem and attachment related goals. Use the framework and principles of ABFT to navigate treatment. This crisis is an opportunity. We must empathetically hold the distress of families, and also use that distress to motivate change, and move the treatment toward symptom reduction and attachment related goals.

Naturally, we want to be present and responsive to the distress of families. As we explore and assess these stressors, we want to use the ABFT framework and therapeutic skills to navigate the session and have

meaningful moments of intervention. This includes providing an empathetic and reflective response, highlighting individual strengths (i.e., bravery, selflessness, perseverance, resilience), normalizing fears when appropriate, giving context to new problems or exacerbations of previous struggles, and deepening emotion when appropriate. We want to provide the felt response of being heard and understood in times of distress that we want to echo in the caregiver-child relationship.

Below we outline ways to address issues related to COVID-19 throughout the tasks of ABFT.

4.1 Non-Task Specific Check-In

- **Check in.** Regardless of the task of therapy therapists are in with a family, therapists should check in on the family's they work with about the Covid-19 crisis. Create space for family distress and slow down as needed. Exploring and assessing the impact of the pandemic on the family can happen in any task; however, it is always useful to have some individual contact with family members.
- **Timing.** Use clinical judgment to decide the timing within the Task. Some families may need to start a session with this topic, other times, the topic may be something to introduce and discuss further into the session.
- **Questions/assessment.** It is important to assess the impact that Covid-19 has had on the family and individual family members. Some clinical sites use formal measures to assess needs related to the pandemic. These measures can be a useful tool to aid this conversation. In lieu of a formal measure, it can be helpful to ask about the following domains:
 - How is the family coping?
 - What challenges has it caused in the family?
 - What are the family member's fears?
 - Is there anyone close to the family that is going to work that the family members are worried about?
 - How are they taking care of themselves and coping?
 - What (if anything) have they liked about this experience?

Addressing the stressors that the family is experiencing will help develop and maintain the therapeutic relationship, promote accurate conceptualizations of therapeutic need, and help the clinician adjust treatment plans as needed.

- **Coping.** Therapists may help families think about how to structure their life to be more satisfying (e.g., not working all the time). Dan Siegel's website (https://www.drdansiegel.com/resources/healthy_mind_platter/) has good tips on this. A few things to think about.
 - time **work/study** or something where they **feel useful** (garden, social engagement, etc.),
 - time **to rest** and chill,
 - time **for physical activity**
 - time **to reflect** (families can reflect together as well (almost like T5) about how they will manage living in a small place together, how to spend time together and separate, how to find private time, how to deal with the household chores, etc.),
 - time to **play** (together?)
 - time to **sleep** (How are you sleeping?)
 - time to **connect** with others, as family. This might be in the different aspects as work, chilling, household chores, play, move. And in creativity in connection with the grandparents, important family members, friends, etc.
- **Educate (when necessary).** Families may have questions as clinicians explore the topic of Covid-19. Clinicians should be prepared to provide basic educational information about the coronavirus as needed.

4.2 Task 1: Relational Reframe with New Clients.

- **Keep the principles of Task 1.** Don't forget about the principles of Task 1. The phases of the task are meant to provide guidance in session, but not restrict therapists.
- **COVID-19 as a Therapeutic Tool.** There are several ways to integrate Covid-19 into the session and utilize it as a therapeutic tool.
 - **Family context.** When exploring the family's context, therapists can inquire about how the family is coping. What are the family member's fears? What issues has it caused in the family? Are things getting worse or are they getting used to the situation? As a family are they making time to discuss the difficulties? What do they like about "sheltering at home"?
 - **Relational reframe.** Therapists may choose to organize the relational reframe around Covid-19 themes. What does the adolescent/young adult experience as stressful or what is he/she anxious about during the lockdown-period? Is he/she reaching out for support/comfort from caregivers? Why not?

4.3 Task 2 and 3 each session

- **Check-in.** In addition, to the normal Task 2 and 3 issues to discuss, each session, it's important to check-in about how the youth and caregivers are managing the quarantine conditions. Data shows that violence and psychiatric issues increase during a quarantine ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)). We want to make sure youth and caregivers remain safe. What are their current stressors? How are they coping? Assess for abuse if that is a concern.
- **Self-care.** If youth or caregivers are struggling related to Covid-19, it's important to help them think about how they are taking care of themselves.
- **Regulation skills.** Therapists may find that youth and caregivers are more dysregulated than normal as a result of being confined to one's home and in close quarters with family members. Families with many stressors in their lives and less resources may find it even more difficult to regulate. Therapists may need to spend time in session helping the youth and caregivers regulate and teach them skills to regulate on their own.

4.4 Task 2 Covid-19 and Conceptualization

Making connections or links in the treatment is still about asking the right questions and developing the adolescent's/young adult's narrative in the context of a sound conceptualization that take pandemic stressors into account.

- **Presenting Problem and Attachment Narrative.** Therapists should take into consideration how current stress related to Covid-19 relates to the adolescent's/young adult's presenting problem and attachment narrative.
 - **Clinical example:** Darren (12) and his mother presented for services after Darren was referred from his school counselor for symptoms of anxiety and major depressive disorder with suicidal ideation. The family was in the second session of Task 2 & 3 when schools and non-essential businesses closed. As a pharmacy technician, Darren's mother was an essential worker.

In his attachment narrative it was clear that Darren felt abandoned by his dad, whom he never knew. His relationship with his mother was described as "fine", but unpacking "fine" revealed a cold and distant relationship that involved a lot of anger filled interactions. According to Darren, his mom was "always" angry and irritated at him ("Why is she always mad at me?" "I can't do anything right in her eyes."). Notably, his mom's disposition during Task 1 was quite irritable in general. Darren learned not to talk to his mother about anything "unnecessary", he just "stayed out of her way" because of her temper. The pattern of their relationship left him feeling sad, defeated, and worthless. During Task 2, Darren expressed being worried his mother would become infected with the virus at work ("she's all I have"), ("I worry about her but she wouldn't even care if I died.")

While addressing the narrative of the presenting problems and the attachment narrative a clinician might say, “You’ve been really scared your mom will get sick [with coronavirus]. That on top of everything you were already dealing with has made it harder for you to cope with this worry, the video games aren’t helping much anymore. You want to have your mother in your life, like you said, she is all you have, but it’s been so sad for you that all her anger has gotten in the way.”

And later in the task when exploring Darren’s attachment narrative, “You can’t talk to your mom because she’s so angry all the time and you see her leave every day to help other people. What’s that like for you?” The therapist would also want to ask, “What does it make you think? How does it make you feel?” The therapist would also want to explore the meaning Darren has ascribed to his experience, “does it feel like she doesn’t care about you?”

Through this process, the therapist discovered that Darren internalized a lot of feelings and deep-down thought there was something unlovable about him that would make his father leave and his mother be so angry and unavailable to him.

4.5 Task 3 Extra Care needed

- **Revisit Stressors.** While this is a stressful time for everyone, caregivers are carrying an unusual burden during quarantine. Revisit current stressors related to the changed context (e.g., home-schooling children, worry about financial and economic implications of the lockdown, worry about the health of family/friends/people they know with Covid-19; possible losses due to Covid-19; tele-working while children are in the house) Many caregivers are in survival mode. Give them space to discuss how they are affected.
- **Covid-19 Related Stress May Trigger Old Attachment Wounds.** Many of the caregivers we work with have experiences from childhood where their attachment needs were not met by their caregivers. When the caregivers were young and felt alone, sad, scared, helpless, etc. no caregiver stepped in to offer them comfort and support. For many of our caregivers, their experience of this pandemic and related feelings can feel similar to their childhood experience. There is fear, anger, feelings of helplessness but no answers or certainty and a lack of resources and support. We can help caregivers better understand how their current experience may be related to their own childhood experiences of unmet attachment needs as another way to motivate caregivers to be empathic toward their child and willing to make changes in their relationship with their youth.
- **Covid-19 and Impact on Parenting.** When Covid-19 makes caregivers more anxious, depressed, and/or angry than normal, this can result in them being short-tempered with their youth, being insensitive, losing confidence in their parenting, etc. Therapists need to help caregivers understand how their experience of Covid-19 is impacting their parenting.
- **Example.** This is an illustration of how the present and the past themes and stressors can interact in ABFT during Task 3.
 - A mother and daughter present to treatment due to her daughter’s major depressive disorder. The mother grew up in a house where her mother prioritized her romantic relationship over her children. The family was poor due to her stepfather’s gambling addiction. She blamed her 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 mom was recently unemployed due to the pandemic and her anxiety related to financial concerns increased. She worked hard in life to prevent “being like [her] mother” and having to experience significant financial struggles again.

To connect a past attachment theme to a current feeling, a clinician might say “I wonder if it feels now like it did when you were a kid, when you didn’t have anything or anyone?” Helping the mom to see herself in light of the challenges she’s experienced and to understand why her current unemployment may be particularly difficult for her. Later in the session, the clinician can bring in the effect this stressor had on her parenting. The mother was less emotionally available and had an even harder time empathizing and responding well to her daughter’s distress. The clinician could also help the mother 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, if it feels like she’s blaming you?”

- **Offer support.** Therapists should be mindful to remain empathic towards the caregivers’ struggles. As noted, above, caregivers many need help with regulation as well. Therapists need to continue to assure caregivers that they are not alone. Continue to assess the caregiver’s support system and make referrals when appropriate. Therapists may find that caregivers require increased levels of coaching in joint sessions as well.

4.6 Task 4 Addressing Covid-19 Issues to Facilitate a Corrective Attachment Experience

- If conversations about the pandemic have not successfully happened among the family, it can be helpful to discuss this topic in the family sessions even in the context of a Task 4.
- **Corrective Attachment Experience.** When adolescents/young adults only have attachment injuries to discuss with their caregiver and experience a lot of distress related to Covid-19, the therapist may guide the family to discuss issues of COVID-19 after the attachment injuries are discussed in order to facilitate a corrective attachment experience.
- **COVID-19 as a Precursor to Attachment Ruptures Discussion.** There may be times that family members receive distressing news related to COVID-19 that makes it difficult for them to focus on discussions of the ruptures. When this occurs, we can help the family discuss this issue utilizing the process of Task 4 (caregivers help the adolescent/young adult discuss their experience and then caregivers can share their experience) and the skills (adolescent/young adult speaks about their concerns in a “more” regulated way, caregivers use emotion coaching skills). If the caregivers can respond in a caring and empathic manner, this can build goodwill between the caregivers and adolescent/young adult. Then the therapist can guide the family to begin discussing the attachment ruptures.
 - Example: This is an illustration of how a clinician can be flexibly guided by the ABFT framework to make clinical decisions with consideration for the treatment goals.

During the Task 2 session that focused on preparation for Task 4, the adolescent (16) had recently found out that her grandmother’s nursing facility had a few confirmed cases of the coronavirus. She was worried that her grandmother would be infected and how she would deal with the loss if she died. The adolescent was usually more difficult to engage in treatment and had long history of being silent about her distress due to negative relational cycles and resulting attachment themes of being dismissed and ignored by her parents. The clinician processed these worries and concerns with the adolescent. She hadn’t spoken to her parents about this, so the clinician asked if the adolescent may want to start Task 4 by talking about her concerns about the grandmother. The thought behind this shift was that this conversation would engage her and help her find her voice. The therapist knew the parents were also concerned, and the therapist thought the parents’ softened affect around this subject may help them acclimate to listening and being curious about their daughter’s feelings. This also was a shared experience that could help them feel more connected as a family.

The parents were prepared for the Task 4. During the Task 4 session the adolescent was able to start with her fears about her grandmother. The clinician facilitated the session so that the parents would not just say “everything’s going to be ok” and try to move on, but that they would hold their daughter’s distress and respond empathetically. The parents were able to admit a shared concern, and reassured her that they will all get through this scary time together. The adolescent was relieved to hear about the things the facility was doing to prevent the spread of the virus, and she teared up and needed some help sharing how overwhelming it was to feel heard “because you would always just blow me off!” she said abruptly. The parents continued doing their best at being curious as she recounted a salient attachment rupture event where she was ignored. The adolescent and the parents did a lot of good things during their conversation that were highlighted at the end of the session by the therapist and everyone felt like they were on their way to being better able to talk to one another.

4.7 Task 5

Of course, we want to help families continually address and negotiate Covid-19 related issues as they arise when in Task 5. Covid-19 creates many opportunities for caregivers to support their youth in managing this stressful time. Working cooperatively to develop a “Covid-19 survival plan” may be an opportunity to promote more caregiving from parents (being available without being intrusive) and more appropriate adolescent connection and autonomy (committed to having dinner every night, but allowed to be on his or her phone at night).

4.8 Therapist and Self of the Therapist

We cannot forget that we as therapists are also human and experiencing this pandemic as well. We may be afraid, worried about loved ones, disconnected from family and friends, balancing child or elder care and working. Online therapy can also take more energy as we do not have any transition time from work to personal life. Physically it may also be an adjustment to remain in a chair all day and look at a computer screen.

- **Empathy for Self.** We may find ourselves reacting more strongly, or with less curiosity to clients (e.g. having less empathy caregivers criticizing their child in Task 3). We may have difficulty separating our feelings from clients’ feelings when they discuss their own anxiety related to Covid-19. We must be kind and forgiving to ourselves in these moments and make sure we take responsibility for our actions towards clients.
- **Take Care of Yourself.** We need to make sure we practice what we preach and find time to recharge, move, play, connect, reflect and sleep (Dan Segal). Take time between sessions. Try to get some fresh air!

5.0 ABFT Specific Telehealth Considerations

As noted above, when beginning telehealth with new clients or pre-existing clients, therapists should engage families in a pre-therapy meeting to set the parameters for the meeting and establish safety. For the most part, we do not anticipate therapists will need to alter Tasks 1-3 all that much. There are a few key factors to consider however.

5.1 Task 1 Use Your Judgment

- **Family Safety.** When facilitating a Task 1 via Telehealth, the therapist will need to keep in mind the family safety concerns that have been discussed in the pre-treatment meeting. Therapists should use their judgement regarding how deep to take clients given the family safety concerns.
- **Managing difficult dynamics.** In general, many of the ways therapists manage difficult moments during in-person therapy can be simulated in tele-therapy. If the therapist is unable to manage family dynamics with everyone online at once, they can always ask someone to temporarily leave the session just like we would in an in-person session. If the family is all together in a room, we can ask someone to step out temporarily and

send someone to get the person who stepped out when ready. If family members are in separate rooms and we need to speak with someone alone, we can ask someone to log off of the telehealth platform and then call or text them when they should come back online. Some telehealth platforms, such as Zoom, allow the host of the meeting to place participants in breakout rooms where they cannot hear others talk. This is also an option during the meeting.

5.2 Preparing for Task 4 in Tasks 2 and 3.

Conducting Task 4 sessions while the entire family is together in the home and the therapist is only present via a computer can be quite concerning when working with some families. We recommend discussing concerns and establishing rules of engagement with families prior to conducting Task 4. The conversation about whether the family feels safe engaging in Task 4 conversations, given the current telehealth circumstances, should begin in the preparation phases of Tasks 2 and 3.

- **Assess concerns.** What are the adolescent/young adults and caregivers' concerns about discussing the ruptures when the therapist will not physically be in the room with the family?
 - This should include a discussion of concerns both during the session (e.g., if my mother blows up, therapist will be less able to regulate the session; I'll feel attacked by my child) and after the session (e.g., my mom will be nice during the sessions but then after we end the call, she will scream at me; what if my child doesn't listen to me around the house after I acknowledge their feelings?). Youth and caregivers often have these same concerns even with office-based sessions.
- **Maintaining safety.** What will the adolescent/young adult and caregivers need during the session in order to feel safe? Some issues to consider:
 - **Seating.** Where will clients feel comfortable sitting during the session?
 - **Same room.** Do they prefer to be all in the same room?
 - Everyone needs to be seen on camera during the session. If they prefer to all be in the same room, can they use a 2nd device (microphone muted and sound off to avoid feedback) so everyone can be seen but sit comfortably? It can be quite uncomfortable and awkward for a family to be all lined up on a couch together to be seen on camera.
 - As we do in in-person Task 4 sessions, the therapist might ask for a specific arrangement (e.g., caregivers on one screen, while adolescent/young adult is on another) in order to facilitate the process.
 - **Different rooms.** Does the adolescent/young adult prefer to be in a different room during the joint sessions?
 - Some of the therapists who have already begun conducting ABFT via telehealth had some adolescents report that they were not comfortable discussing the ruptures directly with their caregivers in the same room if the therapist was not physically present. However, the adolescents were comfortable engaging in the Task 4 if they could sit in a separate room. Some adolescents reported that this arrangement helped them be more vulnerable because they didn't have to be sitting on the same couch and wondering how their caregivers would react in the room. They could sit in their room with the door closed and say what needed to be said.
 - **Determining ruptures to discuss.**
 - **Adolescent/young adult.** There may be certain ruptures the adolescent/young adult feels are too intense to discuss in the telehealth context. Helping the adolescent/young adult develop a hierarchy of ruptures to discuss is always encouraged in ABFT. Therapists should help adolescents/young adults determine what is most important or most difficult to discuss and when is the best time to discuss the ruptures together. The therapist should help the adolescent/young adult sort out which ruptures should be discussed via telehealth and which should be saved for a future face-to-face meeting.

- **Caregiver.** Are there certain issues the caregiver is not comfortable discussing with their youth via telehealth? If therapists have concerns about particular topics, they should ask the caregivers about them.
- **Therapist support during the session.** How can the therapist support the adolescent/young adult and caregivers during the session?
 - The therapist should help the family members' problem-solve concerns. As is typically done in final phases of Task II and Task III, the therapist should determine the best ways to support each family member.
 - With the remote platform, creative techniques are encouraged (e.g., if your platform has a chat feature, you might have the adolescent send you a confidential message saying "stop" if they need a break). As with any technology, be careful that any strategy you use will be used the way you intend. As with the example above, be prepared for adolescents to accidentally chat the whole family (when they intended it just for the therapist!). Therapists should be well-versed in whatever technological platforms they ask their clients to engage with and should be prepared to discuss the benefits and drawbacks with families.
- **Coping post session.** What will the adolescent/young adult and caregivers need after the session in order to feel safe?
 - Will it be helpful to speak with the therapist 1:1 for 5-10 minutes at the end of the session to process the session?
 - Will they need time alone to decompress?
 - Will they need a check-in call from the therapist that evening or next day?

5.3 Family Meeting Pre-Task 4

After the preparation work is complete in Tasks 2 and 3, if you are worried about proceeding with Task 4 with a particular family, we recommend having a pre-Task 4 meeting with the family to discuss their level of comfort with moving forward with Task 4. Discuss the need for everyone to feel comfortable, speak honestly, be vulnerable and still feel safe after the conversation. Guide the family in a discussion about the rules of engagement they want to establish based on preparation discussions in Tasks 2 and 3.

- **Seating.** Talk about family members' individual preferences for where they are during these conversations (in the same or different rooms). Help negotiate differences.
 - If the adolescent/young adult chooses to be in a separate room, discuss whether or not they will allow their caregivers to enter the room to comfort them if they get upset.
- **Family Safety Plan.** Does the family want to create a joint safety plan to manage safety during and after the meeting?
 - For some families, it will be important to help the family develop a plan to manage hurt/angry/etc. feelings during and after tense or sensitive conversations with one another. Some questions and issues to pose to the family:
 - If there are behaviors individuals are worried about that occur during the session, or if family members get very reactive during session how can family members maintain safety?
 - Is it okay for people to leave the room if needed? If they leave, how do we assure safety?
 - Will people need breaks in the room together?
 - What cues will therapists give if they need family members to stop or slow down?
 - If family members want time alone to decompress after sessions:
 - How do they alert one another of their needs?
 - Where can individuals go to decompress?
 - How can the family guarantee they won't interfere in one another's decompression time?

- How can a caregiver check-in with the adolescent/young adult if safety is a concern after the session?
- **Holding off on Task 4.** Even with the planning above, there will be some families where, no matter what safety measures the therapists puts in place, it won't feel safe to move forward with Task 4 with the family trapped together at home. In these circumstances, we recommend putting the Task 4 conversations on hold.
 - Instead help the family discuss relevant Task 5 issues so they can navigate day-to-day issues living in quarantine together. The therapist will coach the caregivers and adolescents/young adults in these conversations utilizing the skills of Task 4 (discussion of experiences/thoughts/feelings/etc.).
 - If the therapist can make these conversations successful, trust will build and maybe the family will begin to feel safer engaging in Task 4. However, they may not ever feel safe enough to do Task 4 in quarantine, but the therapist has now built a stronger foundation for successful Task 4 conversations once regular in-person sessions can resume. In the meantime, the therapist is helping the family navigate this new life that we all share and hopefully making their family situation better.

5.4 During Task 4 & 5

As in all Task 4 sessions, the therapist should be attuned to the need for all family members to feel safe. The therapist must remain the secure base for the adolescent/young adult and caregivers. As usual, the therapist should help the family process the experience at the end of the session.

- **Managing difficult dynamics.** As noted above, if the therapist is not able to manage difficult family dynamics with all family members online, the therapist may ask a family member to log off temporarily or put them in a “waiting room” in order to regulate another family member(s). Once the family member is regulated, the therapist can bring the other family member back into the session.
- **Extra care.** If the therapist feels like someone particularly struggled or family members are really dysregulated, the therapist may want to save time and meet with the adolescent/young adult and/or caregivers alone for 5-10 minutes at the end of the session to help them regulate.

We hope these suggestions help therapists utilize ABFT successfully and safely transition their work to telehealth. We appreciate all you have done and continue to do for families.