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Southern California

# **A**dolescent **T**rauma **T**raining **C**enter

## **Trauma Teletherapy for Youth in the Era of the COVID-19 Pandemic: Adapting Evidence-Based Treatment Approaches**

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## Chapter 1. The Need for New Trauma Treatment Delivery Models in the Era of COVID-19

The novel coronavirus SARS-CoV-2 (COVID-19) pandemic has caused not only illness, death, and financial disruption throughout the world, but also significantly impacted the delivery of mental health services at a moment when they are most needed (Xiang et al., 2020). In many cases, those who have experienced trauma are no longer able to attend one-to-one therapy sessions, given the requirements of social distancing and the general chaos currently affecting health service delivery systems. As well, COVID-19 is itself traumatizing, producing widespread stress and intensifying previous trauma-related psychological difficulties (Fegert et al., 2020; Qiu et al., 2020). These effects can be exacerbated by the social conditions faced by many traumatized youth, including racism, homophobia/transphobia, poverty, and inadequate access to safe living spaces.

The intersection of social maltreatment and the COVID-19 pandemic is especially clear at the time of this writing. The killings of George Floyd, Ahmaud Arbery, Breonna Taylor, and other people of color in the first half of 2020, in the context of a long history of slavery, discrimination, police brutality, and race-related violence in America, have triggered [demonstrations in thousands of cities and towns in the US and countries throughout the world](#). At the same time, the pandemic has revealed a vast overrepresentation of COVID-infections among:

- [racial and ethnic minorities](#)
- [those identifying as LGBTQ](#)
- [those experiencing poverty](#)
- [incarcerated youth](#)

Immigrant minors in detention are another high risk group, so much so that a [U.S. District judge recently ordered them released from all holding facilities](#), albeit with unclear intervention plans and unknown consequences for further spread of the virus.

Beyond an elevated likelihood of infection, the risk of dying from the coronavirus is highest among African American and Latinx populations (Garg et al., 2020), in part because racism, social marginalization, and economic deprivation are associated with medical risk factors like obesity, hypertension, and diabetes, as well as reduced access to adequate health care



(Mukherji, 2020). Together, these social adversities compound COVID-19 effects and have major impacts on the delivery of services to traumatized youth (for examples, see [National Center for Transgender Equality: Coronavirus \(COVID-19\) guide](#); and [University of Michigan: Surviving the Coronavirus while Black](#)), leading to pervasive feelings of anger and fear, and distrust of authority, including, in some cases, White, heterosexual, and cisgender therapists, as well as clinicians associated with governmental agencies and institutions.

### **Benefits and challenges of teletherapy**

Given the above, the benefits of trauma-informed teletherapy are significant. In particular, it may be easier for youth who face the dual threats of social maltreatment and the COVID-19 pandemic to access treatment from their home or other safe, local environments. Teletherapy reduces the likelihood of acquiring a COVID-19 infection, and does not require the adolescent to find safe and reliable transportation to a sometimes-distant location, thereby reducing the likelihood of illness, physical violence outside the home, and missed sessions. As well, clinicians who operate from home or in isolation at an office are not only less likely to contract and transmit COVID-19 but also may be able to assist more clients than would be possible if services were provided in a traditional face-to-face context. For these reasons, teletherapy is currently the recommended vehicle for providing psychological services to youth and others during the pandemic. Many guides and factsheets are in development worldwide and a number of these resources are listed in Appendix B.

Despite these benefits, teletherapy can also present some challenges. These include logistical issues, such as insufficient supplies of smartphones, tablets, or computers that enable youth to interact with therapists; access to reliable internet; the new skills necessary for clinicians to provide telehealth services; and the potential (although not inevitable) impacts of remote therapy on the therapeutic relationship and treatment process.

### **This treatment guide**

This guide was developed in response to these issues, in consultation with a panel of trauma treatment providers and clinicians in our monthly [USC Adolescent Trauma Training Center \(USC-ATTC\)](#) video consultation group, and following a review of research papers and materials from professional and trauma websites. It also reflects our experiences as consultants and content developers within the National Child Traumatic Stress Network ([NCTSN](#)), which

is increasingly being asked about alternatives to in-person treatment during the COVID-19 pandemic.

As evident above, the reader will notice ongoing references to social marginalization and maltreatment in this document, as this is intrinsic to the lived experience of many clinically-presenting youth today. The trauma of prior victimization and the current COVID-19 crisis cannot be separated from the pervasive harm associated with ongoing social maltreatment, and thus any modern treatment approach, virtual or otherwise, must attempt to address these issues simultaneously.

This guide specifically outlines a telehealth model in which the client interacts with the therapist via phone or computer-based HIPAA-compliant platforms<sup>1</sup>, such as:

- [Zoom](#) or [Zoom for Healthcare](#)
- [Doxy.me](#)
- [WebEx](#)
- [Thera Nest](#)
- [Simple Practice](#)
- [Thera-LINK](#)

In the current context, specific suggestions are provided for modifying and adapting *Integrative Treatment of Complex Trauma for Adolescents* (ITCT-A; Briere & Lanktree, 2013), an evidence based, multicomponent intervention for multitraumatized, often socially-marginalized youth, which is briefly described in Appendix A. However, these suggestions are equally appropriate for integration into other trauma therapies. Not included in this guide is specific advice on the relative benefits of different teletherapy platforms, information on HIPAA regulations, or specific professional rules or guidelines for different disciplines (e.g., psychology, social work, or psychiatry) regarding client privacy, informed consent, or statutory restrictions on telehealth

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<sup>1</sup> Note that this list does not include Apple's FaceTime, which is not HIPAA compliant. Nevertheless, some clinicians report that clients either prefer this platform or, for whatever reasons, it is the only one available to them. In some cases, FaceTime may be preferable to no video at all. However, threats to confidentiality are real, and clinicians should consult their state regulatory agency and/or professional association to determine whether this platform is a permissible option.

practice. Clinicians are advised to consult federal, state, agency, professional, and/or organization protocols relevant to their specific practice.

## Chapter 2. Clinician Stress Management and Self-Care

Before considering ways in which trauma therapy for youth can be adapted to address the COVID-19 pandemic, it is important that clinician self-care be considered. Like their clients, therapists are subject to the stresses associated with fear of infection or spreading the disease to family members and others, as well as the impacts of social, economic, and work-related stressors. There also may be challenges related to working in one's home environment, including, in some cases, having to provide childcare and home schooling, or having limited space for confidential sessions.

It also can be taxing, if not boundary-challenging, to inadvertently reveal aspects of one's appearance or home environment when working via video platforms. Conversely, some clinicians report that video exposure to the client's environment can be distressing. For example, therapists have reported hearing gunfire outside a client's home during a therapy session, and instances of an intoxicated parent screaming threats in the background. As well, the technical intricacies of teletherapy, for example, setting up video cameras, installing video programs, using screen-sharing functions for assessments or psychoeducation, and making decisions about masking backgrounds (e.g., in Zoom calls) can be challenging, especially for clinicians who are relatively unfamiliar with such technology. Finally, working from home or alone in an office typically means reduced consultation and/or supervision, and diminished peer support, all of which can lead not only to feelings of isolation, but also reduced feedback on clinical issues. Clinicians report doing a variety of things to reduce stress and increase self-care during the COVID-19 crisis, including the following:

### **Differentiate the home and office environments**

- Create, when possible, a home office or working space that is physically separate from your living space.
- Have a regular routine each workday, with work starting and ending at the same times you would typically work.
- Whether doing teletherapy at an outside office or “seeing” clients at home, change your clothes before and after such transitions (e.g., intentionally wear “work” versus “home” clothes).

- If children or adolescents are in the home, ensure breaks from parenting responsibilities while working, if possible.

### **Provide clear boundaries between sessions**

- Intentionally take 5- or 10-minute breaks between sessions to “reset,” potentially engaging in a brief mindfulness, relaxation, stretching, and/or grounding exercise.
- Be mindful of any tendency to let sessions run longer than usual, so that there is no break in between them.
- Between sessions, regularly reflect on compassion for yourself and the previous client, and set your intention to be compassionate and accepting with yourself and others during the next session.
- Between sessions, focus on any sense of gratitude that you can marshal, including for the opportunity to help others at such a critical time, and for the support of your partner or children, if relevant.
- Whenever possible, reduce back-to-back sessions, which allows you to take brief walks, engage in exercises, play with pets, and/or, if relevant, check-in with children, partners, or others.

### **Engage in regular physical self-care**

- Have a daily exercise regimen, whether jogging, walking, biking, dancing, or doing push-ups or sit-ups.
- Within the bounds of social distancing, make sure to go outside several times a day to breathe the air and appreciate any beauty you find there.
- Monitor your alcohol or other substance consumption, so that you do not become “shut down,” numb, or avoidant on a regular basis.
- Eat nutritious meals at scheduled times, as opposed to skipping meals.
- Ensure sufficient sleep at night.

### **Engage in regular emotional self-care**

- Take up or devote more time to daily yoga, meditation, prayer, or mindfulness exercises, including, if desired, using phone apps such as [CALM](#) or [Headspace](#). Many apps are available at no cost, including [Mindful USC](#), [iChill](#) (developed by the

Trauma Resource Institute) and [Liberate Meditation](#) (developed specifically for the Black, Indigenous, and People of Color community).

- Begin a new hobby, take up an extracurricular activity, or read a new book.
- Engage regularly in creative pursuits such as cooking, gardening, writing, playing a musical instrument, or an art activity.
- Initiate or continue your own therapy.
- Create your own journal.
- Intentionally limit your exposure to news media.

### **Reach out to others frequently (by phone or video)**

- Seek consultation on specific cases whenever necessary and possible.
- Debrief with colleagues, managers, or supervisors on a regular basis, whether by phone, text, or video.
- Stay engaged in your professional environment by attending virtual professional activities, such as university grand rounds, clinical meetings, seminars, or conferences. Activities like these are provided by the American Professional Society on the Abuse of Children ([APSAC](#)) and the International Society for Traumatic Stress Studies ([ISTSS](#)). Networking workshops and trainings are sponsored by groups such as the National Child Traumatic Stress Network ([NCTSN](#)) as well as professional organizations such as the [National Association of Social Workers](#) and the [American Psychological Association](#).
- Regularly “check in” with other clinicians who are dealing with the COVID-19 pandemic, to receive and provide support and maintain interpersonal connections;
- Explicitly make time to spend with partners and family members in home, if relevant, including sharing meals with them when possible.
- Stay connected with friends and family who are outside the home via video chats or phone calls, in order to experience nonclinical interactions and maintain relationships outside of your pandemic-related duties.

## Chapter 3. Client Safety

### The problem

As emphasized in many trauma intervention models, it is important that the clinician focus on the client's physical and psychological safety throughout the treatment process. This is generally true for all trauma clients, since those with trauma histories are often at continued risk in their environments, whether from previous or new perpetrators, dangerous environments, or social maltreatment. These risks likely escalate for traumatized adolescents, who are typically more physically and psychologically vulnerable than adults, and who may engage in risky behaviors associated with a history of childhood maltreatment. Finally, and especially relevant to this guide, COVID-19 factors exacerbate dangers to the client in a myriad of ways, including by:

- Constraining them to potentially harmful locations, such as home environments where abuse has occurred and/or may be imminent, or crowded residential settings (e.g., for transition age youth and those in foster care) where danger from peers may be present and supervision may be reduced.
- Increasing financial and social stress on caretakers and family members, who, as a result, may respond abusively or neglectfully to the adolescent.
- For adolescents who are themselves parents, reducing access to childcare and other resources for managing their children's needs.
- Decreasing access to prosocial outlets (such as school, work, peer groups, team activities, etc.).
- By virtue of crowded conditions, depriving the youth of privacy and confidentiality during virtual therapy sessions, potentially leading to lessened communication with the therapist (including about any current danger), and/or of being overheard by abusive others when discussing sensitive topics, including current or past victimization.
- For transitional age youth, increasing dependence on abusive or exploitive partners for shelter or meeting basic needs.
- Decreasing surveillance by, and the availability of, child protection services, potentially leading to ongoing abuse, neglect, or exploitation.

- Increasing the risk of substance abuse and risky behaviors, as forms of avoidant coping.
- Increasing the danger of becoming infected with coronavirus (and/or spreading it to others) because the youth does not (or is unable to) engage in social distancing, regular handwashing, wearing a mask, etc.
- For those disproportionately impacted by COVID-19 due to racial, ethnic, or sexual orientation/gender discrimination, reducing trust in governmental institutions regarding advice around safety and social distancing.

### **Potential adaptations to treatment that may reduce coronavirus-related dangers**

Interventions that address psychological and physical safety during the COVID-19 crisis may be more relevant to one adolescent than another, in part depending on the extent to which the youth is at risk of physical or psychological maltreatment or infection. For example, an unhoused adolescent may need more attention to immediate safety from dangerous environments and people, and may have fewer options for privacy and confidentiality, than another youth who lives in a protected environment where they are safe and can speak to the therapist in a private context. Even this seeming dichotomy may be too simplistic, however; some clients may appear to be in a safe, stable environment when, in fact, there is undisclosed danger from sexual or physical abuse, including the possibility that one or more of the caretakers at home are undisclosed perpetrators. For this reason, it is recommended that safety not be assumed in any case, and that it be reassessed at the beginning of each session.

### **Physical safety**

Physical safety in the current context refers to the extent to which the client is safe from physical harm, whether from COVID-19 infection, maltreatment by others, serious neglect, or from their own risky behaviors. An early and ongoing focus on physical safety is not specific to coronavirus-related interventions, of course; virtually all treatment approaches for traumatized adolescents stress that such youth are often at elevated risk of further victimization or maltreatment and prioritize safety interventions. Unfortunately, the COVID-19 environment—with its increased isolation of the youth, decreased clinician capacity to assess the client's current level of danger, and reliance on remote interventions rather than in-person ones—can increase the potential risks for traumatized youth. The following strategies or adaptations of standard treatment may help ameliorate these risks.



### **Increasing “buy in” by safe caretakers**

Pandemic-adapted teletherapy should include as much involvement from nonmaltreating caretakers as possible. Following attention to all relevant confidentiality issues, this often means that the importance of therapy is explained to parents or other caretakers, and their agreement obtained to:

- Provide a regularly available, safe space where the youth can speak to the therapist in private.
- Ensure that the client has access to a cell phone, computer, or other device.
- Authorize (via written or electronic consent forms) the use of teletherapy for the youth.
- Enable any platform (e.g., Zoom, WebEx) necessary for telehealth interactions.
- Communicate with the clinician between sessions if they have concerns about the youth’s well-being or safety.

In some cases, especially when poverty and/or social marginalization are present, some or all of these conditions may not be feasible. The family may be without housing or living in a very crowded environment where privacy and safety cannot be guaranteed; phones or internet devices may not be available; internet may be unreliable or nonexistent, and/or caretakers (and their children) may not be able to access programs used for teletherapy. In such instances, it may be up to the clinician to help the caretakers and family procure internet services and internet devices from other sources and, if possible, help them set up a HIPAA-compliant teletherapy platform. Even in these cases, however, caretaker buy in is still necessary, or else the youth may be forbidden or impeded in accessing trauma therapy.

### **Deciding on session logistics**

Beyond caretaker buy in, it is important that the client and therapist determine when and where teletherapy takes place. Timing should reflect not only when the clinician is available, but also when the client is most able to engage in regularly scheduled (as opposed to ad hoc) sessions. The optimal location for sessions should also be agreed upon beforehand—generally the safest, most private place in the client’s environment, for example, a bedroom or another room where the client can be alone. Some youth have opted to use a parked car, a bathroom, a laundry room, a safe outdoor space, or even a closet to sit in during their session. When possible, the client

might consider some sort of signal or action that identifies to caretakers and other family members that a session is impending, and the youth requires privacy. For example, some clients take a kitchen chair into their bedroom and close the door. This signifies to others that a session is about to occur, as well as differentiating the time as involving a therapeutic session, as opposed to other virtual interactions with friends, family, or school.

### **Assessment of immediate danger, location, and privacy**

It is generally suggested that the client be asked about their immediate environment at the beginning of each session, including their physical address if not already known. Beyond their location, this will involve specific questions about whether the client is in any immediate danger and whether anyone else is present, answerable in a “yes” or “no” format, or via the video platform “chat box,” so that any listener(s) cannot determine the question or the meaning of the answer. Privacy can also be increased by the youth using headphones during teletherapy, although some trauma survivors avoid anything that decreases their ability to detect danger in the immediate environment, for example when an abusive caretaker enters the room.

When there is some known likelihood that the youth might not be safe from others during the call, it is a good idea for the client and therapist to agree beforehand, typically in the first session, on a code word or phrase that the youth can say or type into a chat box to signal that they are unsafe but unable to explain exactly what is happening (e.g., if they are being abused and the abuser is in the home), and what should be done if the code is used. The word or phrase should be something that might naturally occur in a conversation, such as “I’m hungry” or “I have a headache.” In some cases, there may be two different codes, one for immediate danger and one indicating that someone is in the immediate area and therefore the call is not private.

### **Safety planning**

ITCT-A and some other interventions explicitly include safety planning as a way for youth to escape immediate violence from an abusive caretaker or some other potentially violent or sexually exploitive person. Safety plans typically involve detailed strategies for exiting the home or environment when imminent danger is present and, ideally, gaining assistance from others who can intervene to provide safety. In some environments, unfortunately, this may not include calling on authorities (e.g., police), given the youth’s prior negative experiences with institutional racism, violence, or disrespect. As a result, the clinician must be careful to ascertain who the youth trusts and views as “safe.”

Much of the benefit of safety planning resides in preplanning specific actions, so that when escape is necessary, the youth can immediately turn to a defined strategy (Briere & Lanktree, 2013). Safety plans are perhaps even more important during the COVID-19 pandemic, since the adolescent is typically confined to a specific environment, typically the home, where there may be some risk of violence. Further, because of social distancing, the client may feel they have less permission to run to a neighbor or friend's house or reach out to a stranger. Calling police or other authorities—in addition to its associations with danger for many minority youth—may be even more difficult for the client who is under the control of an abuser or other dangerous person.

While these concerns make safety planning more complex, it is crucial that the clinician have safety conversations on a regular basis with any youth who is in potential danger. This should occur at the beginning of each session, as well as any other time when the client appears stressed or anxious. Safety planning will vary from youth to youth, but may include specific strategies for:

- exiting the home, having a packed bag, a mask, and a clear escape route;
- calling or texting safe people in the community who have already been made aware that they might be called upon for shelter or support;
- calling the police or other law enforcement (e.g., by calling 911);
- reaching the therapist—or a designated crisis line or mobile crisis team—in an emergency; and
- locating shelters for youth in the near vicinity.

### **Deescalating caretakers**

Although safety planning is an important component of work with traumatized youth, perhaps especially during the COVID-19 crisis, it also may be possible to interact with angry, neglectful, or punitive parents or caretakers directly, rather than relying solely on the youth to increase their safety. Assuming that confidentiality issues are addressed, and that the caretaker is at least partially invested in the adolescent's wellbeing, the clinician may be able to speak on the phone with the caretaker to prevent possible danger to the client. In such cases, the therapist should be prepared to “talk down” the parent/caretaker in a nonblaming or nonthreatening way. This may involve asking the caretaker what is going on, whether they would like to talk about what is upsetting them, and helping them to problem-solve the immediate situation so that the

youth (and the caretaker) will be safe—in some cases even suggesting that the caretaker leave the environment or go to an emergency room.

It should be noted that this intervention must be applied carefully, since it may involve having the youth tell their activated and potentially threatening parent to speak on the phone with the clinician. If the therapist regularly checks in with the caretaker before sessions with the client, and a relationship has been established, it is typically easier to engage the caretaker in support, problem-solving, and, ultimately, de-escalation. In other cases, either because the caretaker has been unwilling to participate in their child's treatment, or because they are especially overwhelmed, they may become even more upset or angry at the youth's attempt to reach out to the therapist, potentially increasing the risk to them. For this reason, the following is recommended, when possible:

- The client and the clinician work out ahead of time how deescalation might work, including whether:
  - the client asks if the caretaker can call the clinician to get help;
  - the client directly calls the clinician, and hands the phone to the caretaker; or
  - the client texts or calls the clinician regarding the situation, and the clinician then calls the caretaker directly.

Also discussed should be whether the client should leave the home once contact has been made between the therapist and the caretaker, or whether staying in the home is the safest option.

- If direct contact with the caretaker is possible (e.g., in the client's and therapist's estimation, the caretaker generally cares for the child, but "just" gets frightening or potentially abusive when they are triggered or stressed), the clinician and caretaker may agree early in treatment on the clinician or caretaker calling when the caretaker "could use the help." In these instances, the therapist may provide immediate crisis intervention and emotional support and, in some cases, may refer the caretaker to other agencies or professionals.
- Importantly, caretaker deescalation activities are only relevant when the caretaker is not currently dangerous. When there is acute danger, direct escape by the client—or intervention by law enforcement—should supersede clinician contact with the caretaker.

## **Harm reduction for substance abuse and other risky behaviors**

Beyond the youth's risk from caretakers and others, they may engage in behavior that is risky or self-harming. Like others in the pandemic crisis, the client may start—or increase—using psychoactive substances as a way to reduce pandemic-related stress, including, in some cases, when previously prescribed medications (e.g., antidepressants) cannot be easily accessed. Such substance use may occur on a chronic basis, or when triggered by specific upsetting events in the home/family environment. Other adolescents may use additional distress reduction behaviors such as risky or problematic sexual activity, aggression, or self-injury. Approaches to substance use and other risky behaviors in traumatized adolescents can be found in the [ITCT-A treatment guide](#), and in specific ITCT-A guides for working with [self-injury](#) (Briere et al., 2019) and [substance use issues](#) (Briere & Lanktree, 2014). These guides offer a nonblaming, nonshaming perspective that frames such behaviors not as “acting out,” but rather as coping strategies with unfortunate downsides.

## **Teaching social distancing and other infection-related prevention strategies**

Adolescent clients can also be made safer when the clinician teaches and/or reinforces strategies like physical distancing, use of face masks, and regular handwashing. Such psychoeducation is likely to be most effective in the context of a conversation in which the reasons for such activities are actively explored, along with discussion of specific instances in which such prevention activities are warranted. They may be further facilitated when social marginalization and injustice is explicitly taken into account, for example, the reduced opportunities to “shelter-in-place” among those whose economic circumstances require them to work—often in risky contexts—during the pandemic, those who cannot avoid crowded living environments, and those without housing at all.

During such conversations, the clinician also may have the opportunity to challenge misinformation regarding COVID-19, its prevention, and its treatment—for example questioning the value of ingesting bleach, the supposed invulnerability of young people to infection, the irrelevance of masks, and other inaccurate and problematic beliefs. As noted in the ITCT-A treatment guide, it is important that such psychoeducational discussions are interactive, collaborative conversations that do not devolve into arguments, lectures, or shaming.

## Psychological safety

In the current context, psychological safety refers to aspects of the session and the therapist's behavior that increase the client's sense of security and trust during treatment. Although the principles of psychological safety are articulated in many trauma therapies, they require some adaptation during the COVID-19 pandemic, as described next.

- In the first session, have an explicit discussion regarding confidentiality and its limits during the pandemic. This should include the extent to which the teletherapy platform is protected from internet-specific eavesdropping (e.g., through encryption), is HIPAA-compliant, and does not allow other people to monitor or overhear the conversation at the therapist's end.
- It may also be important to state, if true, that the therapeutic interaction is not being recorded (several teletherapy platforms have recording options), and thus will not be shared with others, including parents or authorities. If the session must be recorded (e.g., for supervision purposes), this should be clearly stated at the outset, and specified in the telehealth consent form. Be aware that, based on unpleasant social media phenomena (e.g., cyber-bullying and revenge porn), some youth are particularly concerned that their private interactions might be posted on the internet without their permission.
- In order to reinforce the reliability and stability of the therapeutic environment, the clinician should dress as they normally would when providing treatment in the office, as opposed to more casual wear that might signal a loosening of boundaries and possibly increased danger. Especially for youth who have been sexually abused or exploited, it is suggested that the clinician start the session while standing in front of the camera to nonverbally reassure the client that the therapist is fully dressed.
- Similarly, it may be important for some clients that the background behind the therapist looks "professional," as opposed to involving a bedroom or another personal, potentially triggering environment. Background issues may be addressed by using the virtual background option on some video platforms (e.g., Zoom), ideally involving a calming scene or a picture of the therapist's physical office that is used during all sessions. However, some clinicians who treat maltreated youth suggest avoiding virtual backgrounds because the client may wonder what the clinician is hiding,

especially the possibility that someone else is present and observing the session. It is often helpful to discuss these options with clients to determine what background they prefer.

- Despite the clinician's best efforts, there may be times when their family member(s) inadvertently intrude on a video session, a baby cries from another room, or conversations elsewhere in the home can be overheard. Although this eventuality should be avoided whenever possible, the clinician may find it helpful to warn the client beforehand about potential disruptions at their end, and be prepared to discuss with the youth any inadvertent effects of such interruptions.
- If the youth previously attended therapy sessions in the clinician's physical office, consider having one or more objects from that office (e.g., a statue, figurine, or picture; or for younger clients, a stuffed animal or other toy) visible in the client's video feed. Such items can serve as transitional objects that reinforce a sense of continuity from the previous physical setting to the new virtual one.
- In almost all cases, therapists should refrain from looking at their phone or other internet device "off camera," thereby conveying that they are not distracted, not interacting with unseen others, and that the client has their full attention. In some cases, it may be helpful to explicitly mention to the client that you only have necessary applications open, and that your phone is put away. If typing or phone activities are necessary for some reason, be sure to inform the client about what you are doing, and why.
- Many trauma-focused treatment approaches, for example [Trauma-Focused Cognitive Behavioral Therapy](#) (TF-CBT; Cohen et al., 2006) and ITCT-A include some form of exposure to, and processing of, traumatic memories. Therapeutic exposure, whether written or more explicitly verbal, can be helpful for traumatized clients in one-to-one therapy and in telehealth contexts (Rothbaum & Schwartz, 2002; Tuerk et al., 2010). However, the various issues described in this guide (e.g., high stress environments, reduced privacy, and less opportunities for the clinician to monitor the client during treatment) may constrain, to some extent, how and when exposure methodologies are used. If the clinician is planning on using telehealth exposure procedures in the current COVID-19 environment, it is important that:

- they only be used by those already trained to provide such interventions (note that this does not preclude the informal exposure involved in almost any discussion of prior traumas between clients and therapists);
  - therapists adjust the extent of exposure based on the client's capacity to tolerate stress, which may be lessened in dangerous or unstable environments and among those with emotional regulation problems associated with severe complex trauma exposure; and
  - because exposure requires clinician attunement to the client's moment-by-moment responses, the client be consistently visible on the clinician's screen throughout the session.
- It is recommended that the clinician carefully consider whether any aspect of the teletherapy process is potentially triggering to the client. At the clinician's end, this includes, as mentioned earlier, avoiding anything that might be construed as suspicious or dangerous, such as working from one's bedroom, or behaving in a less professional way that might signal loosened boundaries. At the client's end, it is important that they not attend the session from a place in the home that is potentially triggering, such as sitting on a bed where they experienced sexual abuse, or a location where they were physically abused or emotionally maltreated. As mentioned earlier, this includes making sure that the youth is separate—and safe—from any potentially abusive people in their living space.
  - Because of the disproportionate impacts of COVID-19 on people of color, LGBTQ individuals, and other marginalized groups, as well as recent violent events by police and others, clinicians must work hard to gain the trust of their clients if they wish to hear their stories and help them to process experiences of social maltreatment, including as they relate to life during the COVID crisis.



## **Chapter 4. Addressing Teletherapy-Related Threats to Rapport**

Although there is good evidence that trauma-focused teletherapy can be successfully applied in various contexts (e.g., Moring et al., 2020; Tuerk et al., 2010), treatment via computer or phone is a relatively constrained process that, in some cases, may challenge or reduce the effectiveness of the therapeutic relationship. This can be problematic, given research and clinical experience that the quality of the therapeutic relationship is one of the most powerful predictors of improvement in psychotherapy (Beutler et al., 2012). In this regard, some adolescent (and adult) clients complain that video-based therapy doesn't seem as "real," and note that subtle cues and responses between client and therapist are harder to perceive, sometimes triggering the youth and/or leading them to experience decreased interpersonal connection, hypervigilance, and a reduced sense of being "seen" by the clinician.

Reduced information associated with teletherapy may also cause the clinician to miss indications of client distress, such as finger picking, bouncing knees, or changes in breathing patterns, potentially leading them to insufficiently titrate aspects of the therapeutic process. As well, technical difficulties associated with video sessions (e.g., moments when the video "freezes" or becomes distorted, the sound drops out, an unstable internet connection causes the session to dramatically pixelate or abruptly end, or data-lagging causes one party to inadvertently speak over the other) can be frustrating and highlight the perceived artificiality of the teletherapy process. Finally, the distant location of the clinician relative to the client may lead the youth to feel that the therapist is not as physically available were there to be an acute crisis or emergency.

Although client and/or therapist concerns about decreased therapeutic rapport and relatedness are often not born out (e.g., Germain et al., 2010), presented below are some ways in which video- or phone-based treatment can be adjusted to increase the client's sense of rapport and alliance with the therapist.

### **Manage one's own technology fears**

It is important that the clinician not project their anxiety or concerns about teletherapy onto the youth, who easily may be more technologically adept and therefore more accepting of remote interpersonal interactions. In fact, many adolescents have lived their recent lives in the context of smart phones, video games and devices, and computers, and appear to be less concerned about the psychological distance inherent in teletherapy. The issue of the therapist's— as opposed to the client's—reluctance to use remote therapy technologies often arises as a topic

in consultation groups, and suggests the need for the clinician to confront their discomfort before assuming that it is mirrored by the client. Nevertheless, some youth do have concerns about attenuated rapport, potentially based on insecure attachment dynamics or generalized distrust, and this should be assessed early in the treatment process.

### **Normalize the teletherapy process**

The therapist should discuss and normalize the teletherapy process and its potential inadequacies, and, if possible, offer the client multiple platform options—for example phone versus video, or Zoom versus WebEx. The client should be given explicit permission to speak about their comfort with, or reservations about, the teletherapy process, and be invited to provide feedback throughout therapy when remote treatment feels problematic.

### **Plan for possible session disruptions**

Given the vagaries of internet and cyber technologies, it is important that the therapist and client agree on a plan for how the teletherapy session can be resumed should either party's internet connection fail or the session is otherwise interrupted. Often, the back-up plan will be to try to reconnect for a specific period of time (e.g., 5 minutes), and then, failing that, switch to a phone conversation.

### **Maintain eye contact**

When possible and culturally appropriate, maintain as much eye contact as is reasonable with the client, as opposed to regularly glancing away to one's phone or other objects in the room. In many cases, eye contact tends to increase rapport and helps the client to feel seen despite the constraints of remote treatment.

On the other hand, this is not always true, and should be assessed based on the youth's responses. Some clients avoid extensive eye contact because it is threatening, or because their culture interprets too much eye contact as being rude or intrusive. In other cases, reduced eye contact is a way for the youth to titrate the intensity of the session, either because it reduces trauma activations, or because they are generally shy or socially avoidant.

### **Monitor the need for greater therapeutic connection**

In instances where the client appears to need more therapeutic connection than they may be experiencing or perceiving during the session, the therapist should, within the bounds of authenticity:

- Consider increasing their visible expressiveness on video calls.
- Verbalize appreciation of the youth's willingness to participate in teletherapy.
- Communicate acceptance, compassion, and support on a regular basis.
- Regularly check in with the youth regarding their feelings about the session.

### **Be attuned to the transference**

Because the youth may have less moment-by-moment information on the therapist and their response to the client than often is the case with in-person therapy, teletherapy sometimes activates stronger transference to the therapist. This arises based not only on what is happening in the session, but also what the client expects from attachment or authority figures in general, including dominant culture (e.g., White or cis-gender) professionals, whether it be rejection, abandonment, disrespect, or maltreatment. As a result, the clinician should be attuned to what appear to be inaccurate perceptions of them during treatment, and work to counter these reactions with empathy, compassion, positive regard, and in some cases, an emotional regulation intervention. Often, these responses fade as the client adjusts to teletherapy and is less likely to respond to diminished information with expectations based on earlier victimization or neglect.

### **Be aware of the placement of cameras**

The client's and therapist's distance from their phone or computer camera may cause the youth to feel that the clinician is too close (i.e., potentially intrusive or threatening) or too far away (i.e., potentially disengaged or emotionally distant). In some cases, the client's camera may not be centered midscreen, but instead is placed to the side (for example if the youth is a "gamer" or, on rare occasions, has multiple screens), making it difficult to maintain eye contact. For this reason, the client and therapist should explicitly discuss camera placement at the outset of treatment, so that the client can determine the optimal distance and focus. In any case, it is important that the therapist's face be sufficiently "zoomed-in" that their facial expressions are readily observable by the client.

### **Discuss the presence of pets during the session**

If the youth (or therapist) has a pet, for example, a dog or cat, discuss whether they can or should be present during treatment. Some writers note the benefits of having a therapy animal present in the clinician's office, or of the client bringing one to therapy (Lanktree & Briere, 2016). On the other hand, other clients may not want the therapist's pet present because it may

be distracting, may seemingly compete for the clinician's attention, or is frightening in some way. Because these issues vary from case to case, an early conversation is recommended regarding whether pets can be present in the client's or therapist's room. In many cases, adolescent trauma survivors appreciate the support of a pet during treatment, and the informality and format of teletherapy can allow this to happen.

## Chapter 5. Using Shared Materials: Assessments, Activities, and Exercises

Providing teletherapy to youth impacted by complex trauma requires careful planning regarding the use of shared materials within sessions. This includes assessment measures, therapy worksheets or activities, and other concrete materials that the clinician might normally provide or administer during face-to-face sessions. Whereas a clinician might be able to pull a distress tolerance handout or exercise from a desk drawer during in-person treatment, in the teletherapy context equivalent actions often require advanced planning and organization (Stewart et al., 2017). This might include, for example, with appropriate attention to confidentiality and consent issues:

- mailing or e-mailing materials to the client in advance
- dropping off materials at the client's living space (e.g., a shelter or a home)
- organizing documents and logistics for administration via a telehealth platform

### Recommendations for assessment via telehealth

A thorough assessment of the client's trauma history and symptoms is often critical when providing effective trauma therapy, perhaps especially when the clients' symptoms are likely to fluctuate due to stressors surrounding COVID-19. Some clinicians, especially those new to trauma therapy, may hesitate to explicitly evaluate trauma exposure and symptomatology when working in a telehealth format, for fear that the client will become overwhelmed. In our clinical and consulting experience, however, the effects of the assessment process rarely differ according to whether the assessment is in-person or online.

This does not mean that—as is also true for in-person assessment—some clients do not experience some degree of anxiety or sadness when speaking of their past traumas. However, such reactions, if they occur, are typically not detrimental or sustained, hence the recommendation of major professional or governmental organizations (e.g., the International Society for Traumatic Stress Studies, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and the American Professional Society on the Abuse of Children) that a trauma assessment be part of trauma treatment, whether in-person or via a telehealth platform.

Although assessment is typically helpful in the treatment of traumatized youth, there may be aspects of its application in teletherapy contexts that present difficulties. First of all, when

treatment is limited to phone contact, and telehealth video platforms (e.g., Zoom) are unavailable, the clinician has no access to the client's nonverbal responses (e.g., facial expressions, bodily movements, changes in posture). Even during video-based interactions, the youth's responses may be less easily "read" than is the case during in-person therapy, especially if the youth feels less emotionally engaged with the therapist than would be the case during an actual office visit. In this regard, clinicians have reported that some youth are less forthcoming, make less eye contact, and/or speak in a more monotonous tone during teletherapy sessions relative to in-person ones. This problem may wane as the client becomes more comfortable with internet-based interactions, and the therapist becomes more adept at (a) eliciting client responses despite the limitations of teletherapy, and (b) discerning the client's psychological state as it presents in video contexts.

### **Psychological testing**

In addition to the constraints on informal assessment, the teletherapy environment may also impact the use of psychological tests. For example, in most cases, psychological inventories are normed and standardized in contexts wherein the individual reads a series of test items, and then writes their responses on an answer sheet. In the teletherapy environment, however, clinicians sometimes read test items to clients during the video session, and then record their verbal responses. This can make test interpretation difficult, since the clinical meaning of the client's responses may be harder to compare to normative data based on a different form of test administration. There are several potential workarounds to this problem, fortunately. These include:

*Administer tests that have been adapted for telehealth settings.* Some psychological test companies have developed online assessment packages wherein test items are presented to the client online, the client clicks or otherwise indicates their answer on an online answer sheet, and then these responses are transmitted back to the clinician or the assessment company. In such cases, the standardization requirements of the test are essentially met, since the process involves written responses to written items, and the clinician is not directly involved. Although this solution can be a good one, not all relevant psychological tests have been adapted and validated for online administration. Further, this assessment approach relies heavily on the privacy of the resultant test data, and thus HIPAA and other confidentiality rules and regulations must be strictly adhered to, both by the clinician and the test company.

***Verbally administer existing written tests online.*** Given the above, the clinician should consider any potential effects of deviating from the original standardization procedure. Although such deviations are not uncommon in teletherapy contexts, they can be problematic to the extent that it is unclear whether a given client’s symptom endorsement reflects solely their response to a given test item, or also includes reactivity to verbally sharing responses with the clinician. For example, items that ask about potentially embarrassing or socially inappropriate behaviors might be endorsed at lower levels when they are reported verbally to the therapist, as opposed to in a noninteractive, written context.

The clinician is referred to the [APA's Guidelines for the Practice of Telepsychology](#), which encourages assessors to account for “the potential difference between the results obtained when a particular psychological test is conducted via telepsychology and when it is administered in-person,” and to specify in any subsequent written report “that a particular test or assessment procedure has been administered via telepsychology, and describe any accommodations or modifications that have been made.”

***Use assessment instruments that are interview-based.*** In the case of interviews, the standardization requirements are typically met. The initial measure was based on verbally asking the client questions, and the clinician does the same, albeit through the internet as opposed to in an office session. For example, the [UCLA Posttraumatic Stress Disorder Reaction Index for DSM-5](#) (Kaplow et al., 2020) can be administered in an interview format, and yields reliable information on the extent to which the youth reports symptoms of PTSD. This instrument has also been adapted to screen for coronavirus-related PTSD. The [UCLA Brief COVID-19 Screen for Child/Adolescent PTSD](#) (The Regents of the University of California, 2020) also is available on the web and can be downloaded at no cost.

***Administer tests that typically do not have standardization requirements or normative comparison data.*** Such tests (e.g., the [Adolescent Dissociative Experiences Scale](#) (A-DES; Armstrong et al., 1997) are often used for screening purposes. Clinicians usually read test items to clients during the teletherapy session and record their verbal responses, or use the “screen sharing” option in video platforms such as Zoom. In this later case, clients read the items on their screens (as opposed to having the therapist read to the client), and then indicate their responses to the therapist. Note that because these tests are not standardized or normed, their interpretive value may be reduced (Dalenberg & Briere, 2017).

**Use ITCT-A assessment tools.** Finally, there are several ITCT-A tools that have been used in trauma-relevant assessment via teletherapy. These nonstandardized measures and interviews are freely available to all clinicians (see [USC-ATTC treatment guides and assessments](#)). They include the *Initial Trauma Review for Adolescents* (ITR-A-II), the *Assessment Treatment-Flowchart for Adolescents* (ATF-A-II), the *Possible Interview Question Topics for Adolescents* (PIQT-A-II), and the *ITCT-A Symptom Scan for Adolescents* (ISS-A-II).

**Other assessment resources.** The clinician is referred to [screening and assessments](#) in the Treatments and Practices section of the NCTSN website for a detailed list and review of trauma-informed screening and assessment measures.

### **Assessment format and structure**

The following should be considered when planning the assessment process for traumatized youth:

- The clinician should consider how many sessions they anticipate having with the client, and the format that they will use to assess the client's trauma history and trauma symptoms. For example, the clinician might choose a briefer assessment process if they will only have six sessions with a client as compared to when they have six months.
- It may be helpful to consider shortening the assessment battery for telehealth. Assessments sometimes take longer via telehealth, due to logistics, technology, or privacy/confidentiality issues. In some cases, it may be best to limit assessment tools to one trauma exposure measure and one trauma symptom measure.
- When using a screen sharing function for test administration, it is important that the client can see both the assessment questions and the clinician's face. This can reassure the client that the therapist is present and available for support, as opposed to seemingly abandoning them to the assessment process.
- The clinician should also be able to see the client's face throughout the testing process, so that the adolescent's nonverbal responses and emotional reactions can be monitored on an ongoing basis, and testing can be paused or terminated if the youth appears to be experiencing difficulties or distress.



## **Discriminating client symptoms from COVID-19 stressors**

A new concern voiced by clinicians working in the era of COVID-19 involves discriminating coronavirus-related stressors from more chronic trauma-related symptomatology. For example, a youth might be experiencing anxiety or stress associated with the current pandemic, which, if not identified as such, might be misattributed to the effects of prior trauma. This is an emerging topic, and clear guidelines for clinicians have not yet been developed. Fortunately, as noted earlier, the recently released [\*UCLA Brief COVID-19 Screen for Child/Adolescent PTSD\*](#), is available in both English and Spanish, and can be used to help separate these issues. This assessment tool can be downloaded at no cost.

The effects of COVID-19 stress also may be discriminated from prior trauma through the creation of a *symptom timeline*, in which the timing of the client's various symptoms is considered in terms of (a) when they began, (b) if relevant, when they worsened, (c) if relevant, when they resolved, and (d) what unwanted events transpired prior to the onset or exacerbation of each.

It should be noted, however, that the therapist is rarely concerned only with the effects of prior traumas. They should also be prepared to address current stresses associated with COVID-19, or pandemic-related losses such as the death of a family member or friend. The primary reason for discriminating these stressors from other trauma symptoms is that the former may require different interventions (e.g., grief therapy, advocacy with the health system) than the latter (e.g., classic trauma therapy).

## **Logistics of conducting activities and exercises via teletherapy**

Especially when new to telehealth, it is not unusual for clinicians to struggle with how to plan and implement therapeutic activities that they would normally provide during in-person sessions. This is a natural reaction for those whose work has rapidly pivoted to an entirely new therapeutic modality, and does not indicate a lack of clinical competence. Trauma teletherapy is in its infancy, and the relative lack of established protocols requires that therapists draw on their own creativity and inventiveness.

When planning activities for clients in teletherapy, it is important that the clinician first conceptualize the specific treatment goals to be addressed, and then what activities can be conducted remotely with the client. For example, if the youth struggles with easily triggered feelings and behaviors, the therapist may decide that a trigger management exercise or activity is

indicated. In the ITCT-A context, this might include using the [Trigger Grid](#) (TG-A-II) worksheet to identify triggers and triggered responses, viewing a YouTube video to provide psychoeducation on triggering, or conducting a relaxation or mindfulness exercise to bring down arousal and reactivity.

Use of these activities may depend on the available technology, including (a) the quality of the internet connection on both the client's and therapist's end, (b) whether file or screen sharing is possible, and (c) what device the youth has access to. Ultimately, some of these activities may not be feasible via teletherapy. It is recommended that the clinician practice exercises or activities with a colleague before actually conducting them with the youth—for example, doing a rehearsal involving screen-shared worksheets, or running videos remotely—until the clinician feels confident in their actual clinical use.

It is also helpful to have back-up plans for any given teletherapy activity, lest there be technology issues on either side. In one case, for example, when suddenly slow internet speed prevented a clinician from showing a planned YouTube video, she was able to use Zoom's whiteboard feature to graphically outline the relevant concepts to the client. Had that not been available, she might have defaulted to a psychoeducational conversation without any technological assistance. In any event, by preparing for the possibility of internet bandwidth problems, her work with the client was not stymied by the YouTube failure.

It is important to keep in mind that many socially or economically marginalized clients may not have access to video internet devices, a reliable internet connection, or any internet at all. In some cases, the clinician can help the youth or their caretakers access municipal, county, or state programs that provide tablets (e.g., iPad) or smartphones to those who need them for telehealth or education purposes. This process is sometimes more successful if the clinician is directly involved in contacting such agencies or institutions.

In other cases, the client may only have access to a smartphone, which obviously further limits what activities can be implemented during teletherapy. However, even in this instance, therapeutic conversations can occur, and Zoom and other platforms offer phone apps that provide some visual input. The clinician also may be able to text or email video links to the client, as long as they can ensure HIPAA-level confidentiality of these messaging systems.

Similarly, many marginalized or impoverished clients and their families have limited access to printers within the home, art supplies, or other therapeutic materials. It is

recommended that the clinician assess the client’s situation in this regard and be mindful not to inadvertently shame or trigger them by instructing the client to print or obtain materials (e.g., art supplies) for session themselves, when that is not possible given their circumstances. As noted below, however, and subject to confidentiality constraints, it may be possible for the therapist to mail or otherwise provide writing materials or art supplies. The following are a few other recommendations that may be helpful to consider.

***Advanced planning.*** Clinicians often report that they spend more time planning sessions when doing teletherapy as compared to in-person sessions, although this sometimes becomes less of an issue when the therapist is more familiar and comfortable with remote treatment. Planning may include:

- if security is maintained and parental consent has been provided for minor-age clients, mailing or emailing handouts, worksheets, or materials to the client ahead of the session;
- shortening sessions, for example, to 30 minutes;
- creating PowerPoint slides to share psychoeducational information with the client;
- curating a YouTube playlist of videos (and even, on occasion, songs) specific to the client’s needs; or
- when appropriate, dropping off materials (e.g., fidgets, art supplies, or a journal) to the client’s living space.

For more ideas about the planning aspects of trauma therapy via telehealth, the reader is encouraged to view materials at [TF-CBT telehealth resources](#).

***Videoconferencing setup.*** As noted previously, when using a videoconferencing platform, it is helpful to ensure that the client and therapist can see each other, including when using a screen sharing or whiteboard feature to complete a worksheet or watch a video. In support of this, some clients may need assistance with setting up split screens, screen sharing, or other platform components. However, not all young clients feel comfortable with being on camera, under all circumstances. For this reason, the issue of “camera vs. no camera” must ultimately be decided by the client, ideally after a discussion with the therapist.

***Therapist communication during the session.*** The clinician may find that teletherapy communication can be augmented or improved by attending to verbal and nonverbal aspects of their conversation with the youth. For example, increasing facial animation has been helpful in

making the process more engaging for clients (R. Stewart, personal communication, March 27, 2020). Pausing longer and using shorter sentences can help address issues related to slow internet connections. Such adaptations can help ensure that the client understands what the clinician is trying to communicate before the discussion moves on to other topics.

***Consider the possible range of activities.*** As clinicians become more comfortable within the telehealth process, they often report increased creativity when approaching the types of activities possible over this medium. Whereas worksheets, whiteboard features, apps, and videos are easily translatable to teletherapy, teletherapy does not require that the client be immobile in front of their screen or device for the entirety of the session. If the client can safely move around their space, not harm their device, and keep the device on, the therapist can try facilitating other activities more typically done within the office. This might include mindful walking, yoga, attunement exercises, body scans, art, or music activities. As noted earlier, clinicians report that some clients are including pets in the session to help with grounding activities. Others have played instruments or danced while engaging in titrated exposure to traumatic memories.

***Vary the medium or activity.*** While structure and predictability are critical within any trauma therapy, the therapist should consider ways to vary the type of activities used during treatment, to increase client engagement. A wider range of activities may also promote more comprehensive memory processing and extinction (Craske et al., 2014). For example, the therapist may verbally check-in at the beginning of the session, lead the client through a mindfulness activity, show a video on complex trauma, and then use a whiteboard feature to do trigger management or psychoeducation. In some cases, adolescent clients have taken the therapist on a virtual tour of their room, house, or backyard, or screen-shared their favorite websites or videos. It is often helpful to seek feedback from each client about their preferred types of activities. For example, some clients have requested more use of music while others prefer work with the whiteboard feature.

***Storing therapeutic activities completed via telehealth.*** A natural question from clinicians wanting to engage in teletherapy is what to do with materials completed during the session, so that the client's safety and confidentiality are maintained. How providers approach this issue will depend on the client's perception of physical and psychological safety within their home environment. Clients who have a safe location within their home to store materials may choose to personally keep such materials under their own control. Even when this is the case, however, it

is recommended that they discuss with the clinician what might happen if someone discovered the materials, and what kind of safety plan they could envision in this eventuality.

In many cases, however, therapists find that young clients have difficulty accurately judging or anticipating danger within their own home. In this instance, a more conservative approach is indicated, i.e., that the clinician, not the youth, maintain storage of all therapy materials. For example, it might be preferable for the therapist to store an electronic copy of the Trigger Grid or a drawing about abuse, while the client might destroy any physical copies they have. Some clinicians have emailed clients screen shots of work via HIPAA-compliant email. If clients have smartphones that can be locked with a password, they may choose to take a picture of the material if they need to reference the document/work between sessions. In any event, the clinician should consult with legal counsel and professional societies regarding best practices of teletherapy-generated material.

***Expect the unexpected.*** Despite the best of plans, the nature of telehealth, the chaotic environment experienced by many socially marginalized youth, and possible difficulties at the clinician's end, may result in rapidly changing dynamics during the session. Therapists have found it helpful to embrace the unexpected with humor and be transparent with the client when things go awry. For example, one ITCT-A provider had a youth leave the session to “get a snack” only to discover that they had decided to bake cookies; another showed the therapist an urn of ashes during exposure therapy; and several therapists have been asked by clients to accompany them by smartphone on a bathroom break. While these experiences can be disconcerting, and some require intervention, most clinicians report that these unexpected moments offer additional clinical information, increase provider empathy toward the client, often add humor, and can ultimately enrich the treatment process.

## Chapter 6. Involving and Supporting Family Members

As noted in Chapter 3, teletherapy should include as much involvement from nonmaltreating and potentially supportive caretakers as appropriate, with the explicit permission of the adolescent client. When possible, the caretaker should be enlisted to help ensure a safe, confidential space for the telehealth session and provide access to the technological equipment (e.g., smartphone, tablet, or computer) required for the session. Especially with younger clients and those adolescent clients who can benefit from caretaker support, the therapist may choose to allocate a portion of the session time to communicate with the caretaker(s). A separate time for a collateral session in conjunction with the client's session also may be necessary if a caretaker has concerns that they prefer not to share with their teen. Such issues might include how the caretaker is being re-activated regarding their own trauma history, especially in relation to the additional economic, occupational, and social stressors associated with this pandemic. It may be important for the caretaker to attend their own therapy sessions—with a different clinician—so that they can be optimally supportive and emotionally available to the adolescent client.

### Information gathering

As part of the assessment with complex trauma cases, the therapist will need to gather as much information as possible from the caretaker. This may include family medical and mental health history; the client's substance abuse history, medical and mental health history, and trauma history; current social functioning for the adolescent and family; and (if relevant) placement history—just as would occur if the therapist was seeing the adolescent and their caretaker at the office. Notably, assessment may also include exploring with the client and family their experiences of social maltreatment (e.g., of racism or ethnophobia), both in general and as it impacts their specific trauma responses.

Because many schools and government offices are closed during the COVID-19 crisis, teachers, school counselors, and child protection workers are typically less available, and thus the clinician may not have as much access to collateral information. As a result, they should attempt to gather as much background information from the involved caretakers as possible, including potential concerns and issues the caretakers may have that could impact the adolescent client.

### **Offering support to caretakers for pandemic-related stressors**

The caretaker is often striving to balance a variety of stressors associated with the pandemic. These include possible financial hardship; loss of employment; fear of infection (especially if they are an essential worker or healthcare worker); triggering of previous traumatic experiences; health-related concerns or risk factors that are associated with more severe outcomes; one or more family members becoming ill with COVID-19; increased isolation and reduced access to their usual support system (e.g., church, work colleagues, friends, family members, their own face-to-face therapy sessions); and increased parenting responsibilities including pressures associated with home schooling, sheltering in place, and possibly, working from home.

The risk of intimate partner violence, child abuse, and neglect can also increase in relation to these stressors. As discussed in Chapter 3, if there is any risk of family violence or abuse, the clinician should ensure that there is a safety plan to prevent their occurrence and a strategy about what to do if a family member begins to engage in violent or abusive behavior. In such cases, the clinician also should be prepared to notify child protection or law enforcement, if necessary. In addition, the clinician might

- explore with the caretaker how they might gain some temporary respite from parenting responsibilities,
- discuss whether the family is able to meet their basic needs,
- provide advice or referral regarding a potentially violent family member, and/or
- assist the family in finding safe housing, if necessary.

In response to these issues and stressors, and typically subject to the youth's consent, the clinician also may consider providing limited collateral teletherapy sessions for the caretaker or caretakers separate from the adolescent client's session. Such sessions, which are focused on the well-being of the youth, may include emotional support, discussion of parenting strategies, and information and/or referrals for additional resources such as food banks, COVID-19 testing sites, medical support, social services, and on-line parenting classes. Should the stressors become so overwhelming that the caretaker becomes severely depressed, highly anxious, suicidal, or otherwise debilitated, a higher level of intervention may be required, such as a psychiatric evaluation, medication, and/or possible hospitalization.

## **Supporting the caretaker’s support of the adolescent client**

It is important to engage the caretaker in supporting the adolescent client’s physical and emotional well-being. Before beginning a teletherapy session with the adolescent client, the therapist may check in with the caretaker, either separately from the client or in a brief joint session—especially if the caretaker is a reliable source of support and has the capacity to accurately represent their child’s concerns and responses. In such cases, the focus should be on how the client is doing and how the parent(s) or caretaker(s) can facilitate the youth’s wellbeing and progress in therapy. It is important that—in the absence of client consent—the clinician not disclose any confidential information gained during the client’s treatment, while still being open to getting information from, and providing support to, the caretaker.

There may be other possible sources of support for the youth, for example from other family members or caretakers (e.g., a grandparent, aunt, or divorced parent) who reside elsewhere. When it might be helpful to the client, and they agree, the therapist may occasionally include supportive family members in teletherapy sessions. In this event, signed informed consents from participating family members and caretakers are generally required, as well as signed or verbal assent from the client.

## **Triggering during teletherapy sessions**

As noted earlier, some adolescents are sheltering-in-place in the same home where they were abused, neglected, or witnessed family violence. When this occurs, there is a significant likelihood of the youth being triggered by a caretaker or another family member, including during teletherapy sessions. For example, the client may hear yelling from another room, an abusive or nonsupportive caretaker may interrupt the session, or the client may have experienced a conflict with a family member just before the session. As a result, the triggered youth may be emotionally activated or overwhelmed, and may not be able to attend to—or benefit as much from—the teletherapy session.

Although there is only a certain amount that can be done when the adolescent client is forced by government mandated “safer-at-home” rules to remain in a triggering family environment, the therapist nevertheless may be able to mitigate aspects of the triggering process in a number of ways. These include:

- Before the session, ask the nonabusive caretaker to make sure that the client is in a private, safe place where they will not be triggered during sessions, and to keep other



- family members (for example, siblings) from yelling or “fighting” during the client’s session.
- At the beginning of each session, ask the client to describe “how it’s going” at home to elicit information on family-related triggering.
  - If certain interactions with family members are especially triggering, including when the family member attends sessions with the client, it is important that critical issues be at least partially addressed, processed, and/or problem-solved.
  - In general, respond to the youth in explicitly supportive, compassionate ways, so that the difference between triggering family interactions and teletherapy are immediately obvious, potentially reducing triggered responses during the session.
  - When possible, consider using the ITCT-A Trigger Grid to determine the nature and circumstances of triggers in the home environment, so that the youth may be more able to avoid triggering situations and manage triggered states.
  - Per the ITCT-A treatment guide and other therapy manuals, teach emotional regulation activities that can deescalate triggered thoughts and feelings during family interactions. These can include slow, deep breathing; positive self-talk; mindfulness exercises; and grounding activities, such as holding and stroking an object, toy, or pet associated with positive feelings.

### **Sessions with family members**

Subject to client consent, video-based family therapy may be indicated once it has been determined that the client and family members are able to engage in, and benefit from, such sessions. If family members and the youth live in different locations, the session can be conducted using separate video (e.g., Zoom) windows. In some cases, young adults or transitional age youths may be residing with romantic partners with whom they are having conflictual relationships. In which case they, too, might be included in family treatment, or offered conjoint couple sessions, ideally with another therapist.

One common challenge for the therapist during video family therapy sessions is to ensure that family members—who may be in different locations—are communicating with each other and not just addressing the therapist. Consequently, the clinician may need to be more directive than usual in ensuring that interaction is occurring between family members. It is also recommended that all participating family members be simultaneously visible to the therapist

and other family members—as opposed to leaving the room, turning off their video, or otherwise disengaging from the session.

As is generally recommended for family therapy, virtual or otherwise, the therapist should review treatment guidelines with all members before the session, especially with regard to confidentiality, the goals of the session(s), and the importance of listening to and respecting each other, rather than verbally attacking or interrupting others. Ideally, and consistent with in-person therapy, goals of family teletherapy include:

- improving communication of feelings and experiences, including those related to extended interactions with other family members during this “lock down;”
- increasing support and empathic attunement within the family;
- reinforcing appropriate boundaries and safety issues, which may be repeatedly challenged by multiple family members confined in a small living area for an extended period of time;
- ensuring that the expectations of the adolescent client and other minors in the family are developmentally appropriate;
- processing of acute traumas, when possible—both for the client and other family members; and
- increasing trigger management, which may require bolstering emotional regulation skills for all family members.

## Chapter 7. Returning to the Office or Clinic

At the time of this writing, North American clinicians have yet to return to face-to-face therapy in large numbers. This may change, however, as the pandemic wanes, social distancing and other prevention strategies prove their effectiveness, and/or an effective vaccine and better COVID-19 treatment options are developed. This chapter summarizes ways in which the “new normal” may differ from pre-pandemic clinical practice. This is predicated on the likelihood of a hybrid treatment model in the future, in which some clients continue to be seen via teletherapy, some return to the physical office or clinic, and some alternate between the two.

### **When is remaining with telehealth the preferred choice?**

Even as some therapists begin to reopen their physical offices or clinics, it is likely that a significant proportion of traumatized youth will continue to be seen via teletherapy. There are several reasons for this:

*Client prefers distance sessions to in-person ones.* Some adolescents (and adults) have informed therapists that they favor teletherapy because it is logistically more convenient, or it allows them to titrate their exposure to therapy or the therapist. Interestingly, this response also has been reported among combat veterans, some of whom prefer the less threatening and triggering aspects of remote treatment.

*Client or therapist has tested positive or is at high risk for infection.* The American Psychological Association’s (APA) guidance for reopening private practices and offices recommends that “practitioners providing routine outpatient care continue to use telehealth as much as possible to reduce the risk of coronavirus transmission” ([COVID-19: When is it OK to resume in-person services?](#)). This reflects not only the need for young clients to be as safe as possible from viral infection, but also the fact that some psychotherapists are at greater risk of experiencing severe COVID-related symptoms than others, especially if they are older and/or have underlying health conditions. In either instance, if there is a risk of infection or severe outcomes, teletherapy is far preferable to in-person therapy.

*Client is progressing well and has no compelling reason to attend in-person sessions.* Given the benefits of teletherapy, there is seemingly little reason to revert to the risks and inconvenience of in-person sessions.

*Logistical issues continue to make face-to-face therapy difficult or impossible.* As noted earlier, traumatized youth are often embedded in environments and contexts that include danger,

poverty, and social marginalization. As a result, it may be difficult for them (or their caretakers) to find or afford reliable transportation to the therapist's office or clinic on a regular basis. As well, the chronic violence and chaos of some clients' living environment may make it difficult to travel safely to and from appointments. When there is no compelling reason why the client must travel to the clinician's location, teletherapy is often the better option.

### **When is returning to face-to-face therapy feasible or indicated?**

In instances when teletherapy has proven problematic, for example when rapport is inadequate and/or remote treatment does not seem to be working; the client is in a crisis or emergency that requires the clinician be more directly involved; or teletherapy devices or internet access are unavailable; face-to-face sessions may be more helpful or feasible than teletherapy. In some cases, the physical clinic or therapy office also may provide resources (e.g., more extensive or complete psychological testing equipment; group therapy rooms; allied professionals who can provide additional social or medical services; or, for younger adolescents, play therapy materials) that are not available or possible through teletherapy. As well, the client may simply value face-to-face interactions over virtual ones, experiencing them as more confidential, less triggering, and safer than their home environment.

If in-person therapy is necessary or preferred, the APA suggests that certain conditions or requirements be in place. The APA has compiled [Telehealth Guidance](#) and emergency orders for all 50 states in response to COVID-19. Although intended for psychologists, it may be useful for other mental health clinicians. Importantly, any such changes should be discussed with the youth and their family ahead of time, their objections taken seriously and, if possible, problem-solved. Common issues that should be addressed:

- Conduct adequate screening and, when possible, testing, to determine that the client and clinician are noncontagious, symptom-free, and not in contact with others who are at high risk of viral infection.
- If testing or symptoms point to possible COVID-19, the client should be informed beforehand regarding what procedures will be followed as a result. Note that screening and testing can occasionally become an issue when clients or their caretakers are triggered or are concerned about alerting others to the possibility of their having contracted the coronavirus.

- Implement waiting room rules (e.g., how many clients may be present at any given time and physical distance between clients). It may be preferable to avoid the waiting room entirely, with the client waiting in the caretaker’s car until the scheduled session time.
- Maintain consistent, regular, and thorough disinfection of surfaces, tools, and toys in the therapist’s clinic, office, and waiting room.
- Have a clear discussion and agreement between client and therapist as to the rules of social distancing (e.g., at least six feet between the youth and the clinician; no touching, hugs, or sharing of objects).
- If warranted, consider the use of masks and gloves (although this can trigger some trauma survivors, and thus should be discussed beforehand), as well as disposable sofa or chair covers, and other hygiene practices.
- In most cases, revised informed consent materials will need to be developed, which describe:
  - the potential continuing risk of infection;
  - requirements and responsibilities of the therapist and the client to maintain a safe environment;
  - if required in the clinician’s specific state or province, conditions under which the client’s usual rights of confidentiality can be abrogated (e.g., there may be a requirement to report to public health officials or others that a COVID-19 positive client has been physically present in the office).

It is recommended that the clinician review the APA’s [\*sample informed consent form for resuming in-person services\*](#) for an example of what a post-pandemic consent form might contain.

### **What might a hybrid model look like?**

Although some clinicians and clients will choose an exclusive teletherapy or in-person approach to therapy, it seems likely that most will move beyond this dichotomy to a more hybridized model of service delivery. In general, and assuming that insurance companies and government programs choose to continue reimbursing for virtual sessions, this might involve an initial face-to-face session in which rapport is established and assessments are performed, followed by a series of teletherapy sessions, with the option to return to the office or clinic in the event of a crisis or symptom exacerbation, or when a face-to-face termination session is desired.

Seager van Dyk et al. (2020) have compiled a number of useful tips for introducing young clients to teletherapy and building rapport via telehealth.

## **Conclusion**

It is virtually impossible to predict the future of mental health services delivery at the time of this writing. Although stabilizing in some locations, the spread of COVID-19 remains relatively unchecked, and is increasing in certain areas of the world, including parts of the United States. Some epidemiologists predict additional waves of this disease (e.g., Wise, 2020), especially given the waxing and waning of the population's enthusiasm for testing, contact tracing, social distancing, and preventative hygiene. This uncertainty will continue until an effective vaccine for COVID-19 is developed, and/or effective treatments are available. Even then, the likelihood of future viral pandemics suggests the need for permanent modifications in how health and mental health services are provided, including how psychotherapy will be delivered to traumatized populations.

Fortunately, clinicians and researchers are proving to be resilient and creative, and new evidence-based trauma therapies are constantly in development, even amid a global pandemic. It is unclear whether future interventions will continue to include in-person sessions or will involve telehealth approaches alone. The good news is that rapid developments in this area mean that, whatever else the future holds, clinicians will have a range of validated intervention strategies available to them and can continue to assist traumatized youth and others in meaningful and effective ways.

## Appendix A. Integrative Treatment of Complex Trauma for Adolescents

(ITCT-A; Briere & Lanktree, 2013)

ITCT-A is an evidence-based, multi-component, culturally-informed therapy for socially marginalized youth that integrates treatment principles from the complex trauma literature, attachment theory, and cognitive-behavioral and relational therapies. ITCT-A involves semi-structured protocols and interventions that are customized to the specific issues, capacities, and social context of each client, since complex posttraumatic outcomes are notable for their variability across different individuals, cultures, and environments. This treatment was developed for the National Child Traumatic Stress Network and funded by the Substance Abuse and Mental Health Services Administration.

The [USC-ATTC website](#) contains information about ITCT-A, including webinars, intervention tools, treatment outcome research, and a set of five ITCT-A guides:

1. [\*Integrative treatment of complex trauma for adolescents \(ITCT-A\): A guide for the treatment of multiply-traumatized youth \(2nd ed.\)\*](#) (Briere & Lanktree, 2013)
2. [\*Treating substance use issues in traumatized adolescents and young adults: Key principles and components\*](#) (Briere & Lanktree, 2014)
3. [\*Using ITCT-A to treat self-injury in traumatized youth\*](#) (Briere et al., 2019)
4. [\*Integrative Treatment of Complex Trauma for Adolescents \(ITCT-A\): An Implementation Guide for Organizations\*](#) (Chen et al., 2019)
5. [\*Increasing mindfulness and metacognitive awareness in multitraumatized adolescents: An optional module for ITCT-A and other treatment approaches\*](#) (Semple & Briere, 2020)

All ITCT-A guides, assessment tools, and other resources are available at no cost.

## Appendix B. Additional Resources

- Amato, J. (2020, April 21). African American community experiences physical, mental effects from COVID-19. *CentralJersey.com*. <https://centraljersey.com/2020/04/21/african-american-community-experiences-physical-mental-effects-from-covid-19>
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- Trauma-Focused Cognitive Behavioral Therapy (2020, April 3). *TF-CBT telehealth resources*.  
<https://tfcbt.org/telehealth-resources>
- UCLA-Duke ASAP Center for Trauma-Informed Suicide, Self-Harm, & Substance Abuse Prevention and Treatment. (2020, May 16). *Trauma informed telehealth considerations for youth with suicidal and self-harm ideation and behaviors*. <https://www.asapnctsn.org/wp-content/uploads/2020/05/Pediatric-Telehealth-Recommendations.ASAP-Center.05.16.2020-Final.pdf>
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