

Family-based treatment via videoconference: Clinical recommendations for treatment providers during COVID-19 and beyond

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Abstract

The necessity to employ distance-based methods to deliver on-going eating disorder care due to the novel coronavirus (COVID-19) pandemic represents a dramatic and urgent shift in treatment delivery. Yet, TeleHealth treatments for eating disorders in youth have not been adequately researched or rigorously tested. Based on clinical experience within our clinic and research programs, we aim to highlight the common challenges clinicians may encounter in providing family-based treatment (FBT) via TeleHealth for children and adolescents with anorexia nervosa and bulimia nervosa. We also discuss possible solutions and offer practical considerations for providers delivering FBT in this format. Additional research in TeleHealth treatment for eating disorders in youth may lead to improved access, efficiency, and effectiveness of FBT delivered via videoconferencing.

KEYWORDS

adolescents, anorexia nervosa, bulimia nervosa, COVID-19, dissemination, eating disorders treatment, family-based treatment (FBT), implementation, TeleHealth, videoconferencing

Eating disorders are serious illnesses with significant medical, psychiatric, and psychosocial consequences that impact approximately 2.8–10.5% of adolescents and young adults (Mitchison et al., 2020; Nagl et al., 2016; Silén et al., 2020; Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). However, the majority of impacted youth do not receive eating disorder treatment (Swanson et al., 2011), in part due to limited access to evidence-based treatments with qualified providers (Kazdin, Fitzsimmons-Craft, & Wilfley, 2017). Thus, removing access to care barriers is an important priority in disseminating eating disorder treatments for children and adolescents. The use of web-based technology platforms to provide treatment (TeleHealth) may increase access to care for individuals with limited resources to attend in-person psychotherapy (Langarizadeh et al., 2017; Ralston, Andrews, & Hope, 2019). Although the technology capabilities have been available for years (Ryu, 2010) with studies suggesting comparable outcomes to in-person care delivery across many psychiatric disorders (Backhaus et al., 2012; Berryhill et al., 2019; Hilty et al., 2013; Langarizadeh et al., 2017; Myers et al., 2017), relatively few clinical

providers have adopted and utilized TeleHealth within their standard patient care practices. In response to the novel coronavirus (COVID-19) pandemic, clinical providers have had to rapidly transition standard face-to-face patient care to remote virtual options in effort to promote physical health safety while continuing on-going care. The global crisis has triggered a need to consider the benefits and limitations of videoconferencing in the delivery and utilization of mental health care.

The integration of technology into the study and treatment of eating disorders in adults has taken many forms, including standalone web-based intervention platforms, virtual reality interventions, smartphone applications, and technology-based treatment adjuncts (Clus, Larsen, Lemey, & Berrouguet, 2018; De Carvalho, Dias, Duchesne, Nardi, & Appolinario, 2017; Juarascio, Manasse, Goldstein, Forman, & Butryn, 2015; Melioli et al., 2016; Schlegl, Bürger, Schmidt, Herbst, & Voderholzer, 2015; Shingleton, Richards, & Thompson-Brenner, 2013). Reviews have also highlighted the utilization and efficacy of virtual guided self-help and technology-based interventions

(e-treatments) for eating disorders in adults (Aardoom, Dingemans, & Van Furth, 2016; Bauer & Moessner, 2013; Traviss-Turner, West, & Hill, 2017); however, these studies often focus on new interventions and adjuncts to treatments rather than changing the delivery platform of established evidence-based care. A recent review found only five articles (four in adults; one in adolescents) on clinician-led video TeleHealth treatment for eating disorders (Sproch & Anderson, 2019). To date, only a handful of randomized controlled trials (RCTs) have compared in-person to TeleHealth eating disorder treatments for adults (Agras, Fitzsimmons-Craft, & Wilfley, 2017; Bauer & Moessner, 2013; Mitchell et al., 2008; Sproch & Anderson, 2019; Zerwas et al., 2017). Akin to other psychiatric disorders, results from these studies generally suggest comparable outcomes to in-person psychotherapy (Mitchell et al., 2008; Zerwas et al., 2017). Less is known about the use of TeleHealth to deliver established eating disorder treatments in children and adolescents.

Family-based treatment (FBT) is an empirically supported treatment for child and adolescent anorexia nervosa (AN) and bulimia nervosa (BN) (Couturier et al., 2020; Hay et al., 2014; Le Grange, Lock, Agras, Bryson, & Jo, 2015; Lock & Le Grange, 2015; National Institute for Health and Care Excellence, 2017), with preliminary evidence suggesting effectiveness in Avoidant Restrictive Food Intake Disorder (ARFID) (Lock, Robinson, et al., 2019; Lock, Sadeh-Sharvit, & L'Insalata, 2019). FBT is also promoted by experienced eating disorder clinicians as a first-line treatment in the care of adolescents with AN (Buchman, Attia, Dawson, & Steinglass, 2019). Nonetheless, FBT is not commonly available outside specialty eating disorder programs, and many families with children diagnosed with an eating disorder do not have access to it. One opportunity for increasing access to experts in FBT is to provide the treatment remotely. Such an approach has been only tentatively explored. To date, there is only one case series of FBT provided remotely (Anderson, Byrne, Crosby, & Le Grange, 2017) and there are no published RCTs in children and adolescents. Thus, it is largely unknown if eating disorder psychotherapy outcomes for children and adolescents are comparable to standard face-to-face delivery of previously established evidence-based treatments.

In the context of the recent COVID-19 pandemic, there has been wide-spread transition of in-person mental health care to videoconferencing. Specifically, this transition has afforded an opportunity to explore whether and if so, how FBT can be delivered using this modality. A recent paper provided timely guidance on adapting cognitive behavior therapy (CBT) delivered via videoconferencing for adolescents and adults with eating disorders (Waller et al., 2020). The practical tips outlined in this article likely extend to treatment modalities beyond CBT and are a helpful reference for clinicians providing eating disorder treatments at a distance. Given that eating disorders are life-threatening illnesses, continued psychological and medical treatment remains necessary for patients with eating disorders, even in the midst of the global health crisis. Thus, the purpose of this article is to discuss the challenges and opportunities when adapting FBT to be delivered via a videoconferencing platform (TeleHealth FBT), based on clinical experience both prior to and during the COVID-19 pandemic.

Throughout this article, the use of the term TeleHealth FBT will refer to providing clinician-led FBT to patients at a remote distance with the use of a videoconferencing platform. Although common challenges and potential solutions are presented below, this manuscript is not intended to be a fully comprehensive list nor should it be interpreted as a prescriptive treatment manual. When delivering TeleHealth FBT, clinicians should strive to be flexible and adapt to the particular needs and situations of individual patients and families, recognizing that these may evolve throughout the course of treatment.

1 | CHALLENGES AND SOLUTIONS IN DELIVERING FBT VIA TELEHEALTH

There are many general challenges in the delivery of psychiatric clinical care via TeleHealth that are not unique to eating disorders and have been discussed elsewhere (see Kramer & Luxton, 2016 and Langrizadeh et al., 2017 for review). These include patient privacy, internet connectivity challenges, technology platform issues, patient safety, legal and regulatory considerations, and therapist comfort delivering virtual interventions which span across psychiatric disorders and treatment modalities. For best practices in using videoconferencing for TeleHealth, the guidelines from the American Psychiatric Association and American Telemedicine Association (Shore et al., 2018) and practice parameters from the American Academy of Child and Adolescent Psychiatry (Myers & Cain, 2008) are excellent resources.

Therapists should anticipate common dilemmas that arise when conducting therapy remotely with multiple people (e.g., family therapy, couples therapy) are likely to occur in TeleHealth FBT sessions, including: information loss, communication difficulties, and alliance building challenges. Information loss occurs in part because there are more limited social and body language cues available using video treatment delivery. In addition, communication challenges may be more difficult because it is sometimes unclear to whom questions are directed or when to respond. Thus, clinicians may need to clearly state names when asking questions and overtly direct interactions and conversations when using TeleHealth compared to in-person visits. It is possible the clinicians will feel less connected and more distant to families when conducting therapy remotely. The authority of the therapist may also be altered when providing treatment solely through a video format. Patients and/or family members may feel less connected and accountable in sessions done remotely, which could lead to increased distraction during the session. Although overall acceptability, user experience, and therapeutic alliance is often rated highly by individuals receiving TeleHealth psychotherapy (Jenkins-Guarnieri, Pruitt, Luxton, & Johnson, 2015; Simpson & Reid, 2014), some studies note mixed findings and cite lower clinician-rated alliance (Ertelt et al., 2011; Lopez, Schwenk, Schneck, Griffin, & Mishkind, 2019; Richards, Simpson, Bastiampillai, Pietrabissa, & Castelnovo, 2018; Simpson & Reid, 2014). This may also apply to TeleHealth FBT though this has not been explicitly studied. Clinicians should stay attuned to the therapeutic relationships throughout TeleHealth FBT and work to

mitigate and/or repair any ruptures that occur, particularly those resulting from the use of technology to deliver treatment. It is also recommended that FBT clinicians stay up-to-date on best practices for conducting family therapy via TeleHealth, including ethical and legal considerations (Wrape & McGinn, 2019), informed consent procedures (Caldwell, Bischoff, Derigg-Palumbo, & Liebert, 2017), and safety protocols (Crum & Comer, 2015).

In addition to adapting FBT to address these general concerns, delivery of TeleHealth FBT also brings forth unique challenges. We focus on several of these below based on clinical experience from our outpatient clinic and clinical research trials. For an overview and summary of common challenges and solutions in TeleHealth FBT, please see Table 1. We focus particularly on the changes necessary in the first few sessions of FBT and the first phase of the approach because data on early response and fidelity suggest these sessions are key if recovery is to be achieved (Doyle, Le Grange, Loeb, Doyle, & Crosby, 2010; Forsberg et al., 2015; Le Grange, Accurso, Lock, Agras, & Bryson, 2014; Le Grange, Doyle, Crosby, & Chen, 2008; Madden et al., 2015).

1.1 | Adhering to the structure of FBT

Providers should strive to deliver intervention components in FBT as they were empirically studied (Agras et al., 2014; Le Grange, Crosby, Rathouz, & Leventhal, 2007; Lock et al., 2010). Briefly, FBT is a family psychotherapy treatment consisting of between 10 and 20 sessions conducted over 3 phases lasting between 6–12 months. Sessions in FBT include not just the patient but also parents/guardians, siblings, and anyone living within the home. Each session begins with the therapist weighing the patient followed by a private one-on-one check-in between the patient and therapist for the first 5–10 minutes. The family then joins for the remainder of the session. Consistent across all eating disorder diagnoses, FBT takes an agnostic stance towards the development of the eating disorder, encourages externalization of the illness, and seeks to empower parents as the agents of behavioral change in helping patients disrupt behaviors that maintain the eating disorder. The therapist maintains a consultative rather than directive stance to facilitate parental learning. Phase 1 of FBT is typically 6–10 sessions in length and focuses on re-nourishment efforts in AN (Lock & Le Grange, 2015), regular eating and reduction of purging behaviors in BN (Le Grange & Lock, 2009), and re-nourishment, expansion of food selection, or presentation of feared foods in ARFID depending on patient's clinical presentation (e.g., sensory difficulties, fear of adverse consequences of eating, or low appetite) (Lock, Robinson, et al., 2019; Lock, Sadeh-Sharvit, et al., 2019). Sessions 1 and 2 include specific interventions, such as emphasizing the severity of the eating disorder and the medical, social, and psychological dangers of not acting immediately to reverse starvation or other serious disordered eating behaviors (orchestrating an intense scene), reviewing the family's previous attempts to help their child through circular questioning, and, charging parents with the responsibility of taking control of eating and activity until their child is better able to manage

these in an age-appropriate and healthy way. In session two, FBT includes promoting parental learning about how to work together, setting appropriate goals for meal consumption, and direct coaching about how parents can change their strategies to promote weight gain or disrupt other eating disorder behaviors (see Le Grange & Lock, 2009; Lock & Le Grange, 2015). Sessions are held weekly during this initial phase. Phase 2 (spanning over 4–6 sessions) consists of returning independence around food and eating back to the adolescent with special focus on a return to age-appropriate social eating. Sessions are typically spaced out in Phase 2 to allow for increased opportunities for the patient to practice these goals. In Phase 3 (spanning over 2–3 sessions), sessions are spaced to every 4–6 weeks and focus on helping the family establish healthy relationships that are not centered around the eating disorder. Often, discussions in Phase 3 focus on adolescent development issues that exist in the family, as it is important to ensure the adolescent remains on track with development once the eating disorder has resolved. Given the younger age of many patients with ARFID, Phase 3 tends to occur less often as it is not relevant for pre-adolescent patients (Lock, Robinson, et al., 2019). In general, the interventions, timing, and phase structure of manualized FBT should be maintained when delivering the treatment virtually.

1.2 | Initial pre-therapy contact

The pre-therapy contact is an important component of FBT designed to not only explain the context of treatment to the family but also to establish and reinforce the crisis of the eating disorder and parental authority in managing this illness. When conducting FBT remotely, the treating clinician should still contact the family prior to initiating treatment. We recommended that the pre-treatment contact be conducted via video rather than a phone call. Whenever possible, the therapist should use the same video conferencing platform or software they intend to use throughout treatment. This will allow the family to become familiar with the technological aspects of conducting remote therapy prior to the first session. This pre-therapy contact also provides an opportunity to check internet speed and connectivity with the therapist available to help trouble shoot any technological problems without disrupting the first psychotherapy session. The therapist should create a plan with the family in case future technological difficulties arise during a session (e.g., the connection is unstable, the need to use a back-up video platform, the use of a phone for audio and the screen for video, if needed). It is not recommended that FBT sessions, in particular sessions in Phase 1, be conducted solely by phone. The information lost without visual feedback is likely to negatively impact the effectiveness of the intervention and hinder the therapist from communicating effectively with the patient and family. That said, use of phones to augment audibility when platforms or networks are not performing optimally is sometimes a helpful adjunct to video.

In addition to establishing the crisis and enhancing parental authority, the therapist should also use this pre-therapy contact to

TABLE 1 Common TeleHealth family-based treatment (FBT) challenges and solutions

TeleHealth FBT consideration	Challenge	Solution
Medical monitoring	<ul style="list-style-type: none"> No eyes on patient 	<ul style="list-style-type: none"> Regular coordination with medical providers through various methods such as secure messaging, encrypted email, phone calls, faxes, and use of patient's electronic medical record
Obtaining session weights	<ul style="list-style-type: none"> Patient not physically present in office for weighing Scale at home Accuracy of home weights 	<ul style="list-style-type: none"> Patient weigh at home Parents weigh patient Therapist joins patient virtually for weighing Weights obtained at medical providers Provide psychoeducation to parents/patient about weighing Recommend parents limit scale access Focus on changes session-to-session, not exact weights
Patient one-on-one check-in	<ul style="list-style-type: none"> Privacy Family re-join session 	<ul style="list-style-type: none"> Confirm patient privacy Patient takes device to private space inside home or outside Use of headphones, fans, or "white noise" machine Ask patient to re-join family Set a time with family members to re-join Use a "waiting room" feature, which is particularly helpful for blended or divorced families using multiple devices and screens
Rapport building	<ul style="list-style-type: none"> Displaying warmth and positive regard at a distance 	<ul style="list-style-type: none"> Use visuals in home environment to connect with patient Exaggerate facial cues Greater reliance on verbal communication as opposed to subtle body language cues Look at the camera rather than the screen to promote "eye contact"
Communicating FBT expectations	<ul style="list-style-type: none"> Family involvement Therapy in the home environment 	<ul style="list-style-type: none"> Require participation from all family members Set clear expectations about participation Address family members by name when asking direct questions Limit distractions in the home environment whenever possible Ask family members to arrange themselves in a circle or semi-circle rather than a straight line to promote greater communication among family members
Setting the intense scene	<ul style="list-style-type: none"> Impact of intense scene may be muted when delivered at a distance 	<ul style="list-style-type: none"> Greater use of verbal communication than body language Use intonation and cadence of voice to communicate severity Grave and concerned facial expressions; may need to be intensified to communicate over video Hold emotional tenure of session regardless of distractions within family home Strategic use of silence, given expectations to talk when on screen
Family meal	<ul style="list-style-type: none"> Difficulty seeing the meal over video Empower parents in re-nourishment efforts 	<ul style="list-style-type: none"> Work with family members to position camera appropriately to maximize visualization of the meal and patient eating Ask more clarifying questions about food served and eaten Ask for explicit descriptions of the meal Reframe as opportunity to practice re-nourishment efforts within the home context Discuss changes of where family members sit during mealtimes before and after the eating disorder Access to additional food and supplies at home Impact of family pets may be addressed
Managing in-session behaviors	<ul style="list-style-type: none"> Patient leaves session Patient refuses to be on video Patient disconnects video session 	<ul style="list-style-type: none"> Continue session, as long as safety concerns are adequately addressed Manage as if behaviors occurred in office setting (e.g., support parent management of behaviors without telling them what to do) Ask patient to rejoin session when ready Ask patient to join by voice until ready Have family contact information handy for all video sessions Attempt to re-connect with family Establish back-up method of communicating (e.g., call on another device, phone call to help family problem-solve and re-start video session)

clarify family behavioral expectations for TeleHealth FBT. Because therapy is not taking place in the therapist's professional office where the setting typically imposes behavioral expectations in line with visiting a clinician, it may be less clear to patients and families how to behave helpfully in a therapeutic session conducted remotely. Thus, it may be important to clarify that family members, including siblings, are not allowed to come and go throughout the session but rather explicitly state that everyone is expected to be present and fully engaged for the duration of the video session. Younger patients as well as siblings may have more difficulty focusing during videoconferencing sessions compared to standard in-person office visits. It may be helpful for clinicians to anticipate this ahead of time and provide guidance to parents on what to expect as well as model appropriate redirection strategies in session. For families with very young children (e.g., under 5 years old), the therapist should discuss appropriateness for attendance in sessions and problem-solve with the family how best to incorporate young children, who may need parental supervision and oversight.

The therapist should ask the family to hold TeleHealth FBT sessions in a confidential, quiet space and minimize distractions to the greatest extent possible. This may include turning off the television or other devices, or moving family pets to a different room. As with any therapy delivered via TeleHealth, patients and families should not be driving or riding in a car during session to minimize the risk of harm. The therapist can also address how mental health safety concerns, including acute suicidality, will be managed should they occur during the course of treatment. Similarly, the therapist should review with the family what they plan to do if their child attempts to leave the session unexpectedly.

If possible, encourage the family to arrange themselves in a semi-circular formation around the camera for TeleHealth FBT sessions. The impact of the physical placement of patients and families in family therapy is quite important. With TeleHealth, families may have a tendency to look at the video screen when speaking rather than communicating with one another. The process work that occurs within an FBT context may be hampered if family members cannot easily see and communicate with one another. In a traditional office setting, the therapist has control over the setup of the "therapeutic space," but considerably less when the family is in their own home. Similarly, the physical arrangement of family members may be impacted by the type of device used for the videoconferencing session, limitations related to screen size and camera angles, and the availability and size of confidential space within the home. Nonetheless, the therapist should feel comfortable asking the family to arrange themselves in a manner most conducive to the family therapy session and be prepared to work with the family to solve any logistical or technical barriers that may arise. The arrangement must balance the need for interaction among the family members with the need for the therapist to see and hear what is happening.

The therapist should also strive to be mindful of cultural and socio-economic factors when conducting TeleHealth FBT. The delivery of culturally-competent care should continue much the same as in-person psychotherapy (American Psychological Association, 2017;

Sue, 2006; Sue, Zane, Nagayama Hall, & Berger, 2009), though may require thoughtful consideration when delivering TeleHealth treatment (Brooks, Spargo, Yellowlees, O'Neill, & Shore, 2013). Not all families needing specialty eating disorder treatment will have access to the equipment required to conduct remote therapy. Further, families will have differing levels of familiarity as well as access to technology, with practical implications for how treatment sessions can be conducted (e.g., access to a computer or smartphone with video capabilities; comfort using videoconferencing software; internet and data plans). Throughout the current COVID-19 crisis, many families have had to adapt to remote work and online school and thus may have additional familiarity with technology platforms that allow for virtual communication. As many clinicians have also had to adapt to working remotely, often from their own homes, it is important to consider what impact viewing therapists' personal living spaces may have within the therapeutic relationship. Therapists should strive to be aware of how visible social and cultural differences may be impacting treatment delivery and patient care.

1.3 | Medical monitoring and weighing

Patient medical safety for outpatient psychotherapy is a priority for patients with eating disorders regardless of diagnosis or age of the patient (Academy for Eating Disorders' Medical Care Standards Committee, 2016). Similar to in-person care, providers should work in close collaboration with medical providers to ensure the on-going medical safety of patients for outpatient treatment. Physician clearance forms attesting to the safety for patients to participate in outpatient care are a helpful tool, especially for clinicians that cannot monitor vital signs as they typically would in a clinic setting. Frequent communication as to the medical status of patients can help put providers using TeleHealth at ease. The use of remote technology, such as electronic medical records, secure messaging platforms, encrypted emails, or simply phone calls and faxes can facilitate communication among the treatment team.

Weekly weighing should continue to occur when conducting sessions via TeleHealth. Although all eating disorder treatments, including FBT, are about more than just weight restoration (Lock & Nicholls, 2020), the weights at each session provide objective data points across eating disorder diagnoses (AN, BN, and ARFID) that serve as one important marker of progress. The weights help clinically inform treatment sessions with the family about the effectiveness of their interventions designed to promote weight gain and disrupt other behaviors that are maintaining the eating disorder. However, in the one-on-one short meeting with the therapist and patient, discussion of his or her response to weekly weight change can be used to gauge the adolescent's state of mind and to evaluate changes in mood and cognitions. Specifically, the discussion of weight progress can be a helpful tool in assessing patient flexibility and strength of the eating disorder, particularly in AN and BN where overvaluation of shape and weight are core features of the disorder. Thus, it is important to continue assessing and discussing weights in TeleHealth FBT.

However, there are challenges when assessing weight progress that are not present in standard FBT when the therapist weighs the patient in-person. There are many ways to obtain weight information without actually weighing the patient in the office. Some patients are comfortable weighing themselves ahead of session, but they may not always be reliable reporters. One alternative is for the therapist to be present on camera observing the process of self-weighing at the beginning of the session to provide support in case the patient becomes upset when taking his or her own weight. Another alternative is to ask parents to take the child's weight on a home scale before session. If using home weights, it may be useful to provide additional education to parents and patients regarding how best to obtain weights for treatment sessions (e.g., weigh at the same time each week, ask patient to use the restroom prior to weighing, weigh patient in light clothing, limit weighing to once a week or just for treatment sessions and/or medical visits). If a family does not have a home scale, they may buy or borrow one or ask that the provider or clinic supplies them with one for use in treatment. As is the case in office-based FBT, it is important to review the potential consequences of frequent weighing with the family and patient and encourage parents to keep possession of the scale to prevent unlimited weighing by patients if they foresee this becoming an issue. Additionally, the clinician should be mindful that self or parent reported weights could be less accurate than those taken by the clinician in traditional face-to-face therapy. Finally, it may be possible to schedule weight checks with their primary care doctor's office or nearby medical clinic. It is important to endeavor as much as possible to obtain weights on the same day as treatment sessions and from a consistent scale and weighing procedure to provide the most accurate data to help guide the session and intervention focus.

One additional adjustment is the charting of the weights collected to illustrate patterns of weight change over time. Parents can make these plots; however, it may be difficult to see and read the weight chart over a screen. The use of a digital weight graph or screen sharing tool may circumvent these difficulties. Thus, clinical providers may need to take extra care to clearly explain and explore weight differences and overall trajectories if the visual impact is impaired by the use of technology.

1.4 | Patient one-on-one check-in

As noted above in the context of weighing, when delivering TeleHealth FBT, the clinician should continue to meet with the patient privately for the first 5–10 min of the session. To do so via TeleHealth presents a few logistical challenges. Patient privacy will be an important element to consider as therapists build rapport and engender participation from the adolescent in session. Given that patients and providers only have a limited view through a screen of the TeleHealth therapy space, a brief discussion reviewing the privacy of the space and other confidentiality measures at the beginning of sessions could help maintain a similar environment to the therapist office. It is important to confirm that the patient is indeed in a private space that prohibits family members from listening, either intentionally or

inadvertently. In practice, this often necessitates asking the patient to take the phone, computer, or device to another room or private space in their home. Some patients may need to participate in this portion of the therapy session from places outside of the home, such as the car, garage, or backyard to ensure privacy. When space is limited and/or safety concerns exist that limit options outside of the home or shared space, privacy can be enhanced by wearing headphones, placing a noise maker or fan outside of a door, or using a "white noise" application on a cellphone or other device.

It is recommended to set a plan ahead of time to reconvene with all family members after the individual check-in is completed. The therapist will need to be explicit in stating this in a TeleHealth session, as the therapist does not, as noted above, have control over the therapeutic environment as they would in an office setting. This may occur as a brief conversation led by the therapist at the start of each session, particularly in early sessions, before a routine has been established. For divorced or blended families across multiple households, providers may want to set a time with all family members to reconvene (i.e., "ok, everyone join the therapy call again in 10 minutes at 6:10pm") or ask one party to text the other party when it is time to rejoin. Some TeleHealth platforms have a "waiting room" feature that enables the therapist to let family members virtually join the session once ready to proceed. In contrast to sessions held in a physical office space, it may not be feasible for all family members to join session together on the same screen, particularly if parents are separated or divorced and shared living space does not exist. Recent public health directives to "shelter-in-place" and maintain physical distancing designed to limit the spread of COVID-19 may also impact a family's ability to be in a shared space using one screen. Thus, it is recommended that the videoconferencing platform used in TeleHealth FBT sessions allow for multi-point video (e.g., multiple screens) so as to not exclude family members who may not live together that are deemed essential in the treatment or re-nourishment process.

1.5 | Rapport building

The therapist should also be mindful of how TeleHealth could impact rapport building with the patient. There may be both advantages and challenges in building therapeutic alliance via video for adolescents with eating disorders. The ego-syntonic nature of AN, the shame and guilt often associated with BN and binge eating (Blythin et al., 2020), and the anxiety that often accompanies ARFID (Fisher et al., 2014) may complicate this whether in person or over a video screen via distance. Additionally, youth with eating disorders are often not particularly motivated for treatment, especially those with AN. This may present an additional barrier in connecting and delivering treatments via TeleHealth. With TeleHealth, the patient has control over the screen and may feel a greater autonomy over their choice to engage or not with the therapist from the comfort of their home environment. In patients with AN, denial of the illness may lead some patients to refuse to meet with the therapist altogether. In BN, patients may experience increased shame or discomfort at seeing their own body

projected on the video screen during therapy sessions. Younger patients with ARFID may need additional parental support and supervision to work TeleHealth video platforms. On the other hand, TeleHealth may enhance rapport building in some cases. For patients with high levels of social anxiety, providing remote care through a screen may increase comfort and decrease performance concerns. Adolescents socialize regularly through the use of technology and screens, and thus some patients may feel more comfortable receiving therapy in this format. For patients with BN, the protection afforded by therapy at a distance may decrease shame and improve willingness to disclose eating disorder behaviors. Among younger patients with ARFID, TeleHealth may boost rapport building as the therapist can find unique ways to connect and engage virtually with the assistance of technology.

Similarly, rapport building with parents and other family members may be impacted when conducting FBT via TeleHealth. Virtual treatment delivery may make the therapist's efforts at rapport building with patients and families even more difficult, as the therapist may have to work harder at displaying warmth and positive regard that typically is expressed with body language or more subtle cues. If parents or family members are spread out across multiple households or screens, such as may be the case when providing treatment to separated or divorced parents, the therapist may need to also work harder to connect with and include all family members in relevant treatment processes. It could be easier for individuals on one screen to pay less attention or become distracted by factors external to the session if multiple screens are used. The therapist should closely watch for this and work towards engagement of all family members, much the same as would occur during in-person sessions.

At the start of FBT, the therapist might expect parents and guardians to feel a stronger therapeutic alliance with the clinician than the adolescent patient (Forsberg et al., 2014), though this difference may be less pronounced for patients with BN (Zaitsoff, Doyle, Hoste, & Le Grange, 2008). Yet, there could be unique opportunities for relationship building via TeleHealth that are not available in a traditional office setting, such as gaining insight into the patient's home environment, noticing items in the house, commenting on decorations in the patient's room, or meeting the family pet. There could be additional advantages that these glimpses into a family's home environment provide, such as meeting other family members (e.g., a grandparent or adult sibling) that may be helpful in the patient's recovery. Therapeutic alliance may play an important role in FBT outcomes (Pereira, Lock, & Oggins, 2006), particularly in psychological improvements when strong alliance with the patient is established early (Isserlin & Couturier, 2011). All of these additional visual clues may help the therapist form a relationship with the patient apart from his or her eating disorder and show interest in the development of the healthy child or adolescent.

1.6 | Session 1: Setting the FBT framework and the intense scene

There are several critical intervention components that the therapist seeks to accomplish in the first session of FBT. Given that early

treatment response in FBT is indicative of improved outcomes in AN (Doyle et al., 2010; Le Grange et al., 2014; Madden et al., 2015) and BN (Le Grange et al., 2008; Matheson et al., 2020), inciting behavior change from the very beginning of treatment is critical. As is the case with FBT conducted in the office setting, the therapist should work to ensure that all family members are present and encourage active participation in session, through the use of circular questioning and other therapeutic techniques (Lock & Le Grange, 2015). The therapist must also consider how to address each family member when visual communication cues, such as turning to face a person when speaking to them, are inhibited over video conferencing. Using names and directing questions to particular people helps therapists to overcome this limitation.

The therapist should be careful to not dampen down the intervention that highlights the dangers of on-going eating disordered behaviors (e.g., the intense scene) at the climax of Session 1. The impact of this intervention may be muted when delivered via TeleHealth for any number of reasons, including unstable video connection, technological difficulties, relaxed atmosphere of the home environment, among other factors. Nonetheless, the therapist should continue to convey the severity of the illness and the need to act urgently to prevent the dangers to life, social and physical development, and mental health that keeping the eating disorder risks. The therapist may accomplish this by changing the intonation or cadence of their voice, demonstrating grave and concerned facial expressions, leaning towards the computer screen, and holding the frame despite distractions that may be occurring within the family's home environment. The strategic use of silence can be impactful, although challenging via TeleHealth given presumed expectation of the need for someone to talk while on screen. While this may come easily to a therapist in a typical office setting, adjustments such as augmenting or exaggerating these skills may be needed to communicate over video to patients at a distance.

1.7 | Session 2: The family meal

Specific interventions utilized in FBT, such as the family meal in session 2, may also look and feel different to the clinician when conducted at a distance, but in reality the goals and process are identical to FBT conducted in a therapist's office. The purpose of the family meal is to assess the family's, and particularly the parents', understanding of how and what to feed their child, identify negotiations and compromises that are maintaining the eating disorder, and provide an in-vivo opportunity to align parents in their goals to disrupt eating disorder behaviors. While it is unknown what impact conducting FBT via TeleHealth may have on achieving these goals, several suggestions about what therapists can do to be effective in this session are discussed below.

From a practical standpoint, clinicians may need to work with the family to position the camera in order to see everyone at the meal differently than when conducting other FBT sessions. This set up may not be readily available in patient's homes and thus can take some logistical problem-solving at the start of the session. Therapists will

likely need to ask more clarifying questions about the meal itself than they would in their offices when they are unable to see the food being eaten or served. Also, it may be necessary for the clinician to ask for explicit descriptions of the meal, such as what the meal is, how it was prepared, how much was plated, etc. The information that may have been more easily gleaned by simply examining the meal session or observing the parents plate the food in the office may be lost over video. Though asking about all this in a detailed manner may seem awkward at first, in fact, this will allow the therapist to use this information gathering process to facilitate a deeper discussion and understanding of the choices the parents made in preparing and serving the meal. Finally, providers may want to encourage families to monitor the movements of family pets, as the eating disorder may enlist the help of household animals to finish unwanted food. Again, the role of pets at the family meal would not typically be part of a meal session in a therapist's office, but may be an important factor when the family is eating and trying to change eating at home. By conducting the family meal session at home, parents may learn that pets should be separated for all meals, not just the one during therapy.

Another goal of the family meal in Session 2 of FBT is to empower parents in re-nourishment efforts by breaking up the routine at home and allowing parents to try something new to increase their effectiveness against the illness. This may be more difficult to achieve in the family's regular eating environment. The office space could provide a physical "reset" or alternative learning environment that may allow families to become "unstuck" easier than the familiar home routine. On the other hand, being in the home provides unique opportunities to practice mealtime behaviors in the home context. The therapist will be able to see where family members naturally sit during a meal within their home environment. The therapist should ask whether preferred seats have changed since the eating disorder developed. The use of TeleHealth allows for this important process piece to become more salient and naturally leads into a discussion around the impact of the eating disorder on mealtime routines. As done in-person during the family meal, the clinician may encourage family members to switch seats or ask parents to sit on either side of the patient to provide additional support. In situations where the eating disorder becomes activated and food is removed, destroyed, or thrown away before being eaten, parents may more easily replace the food at home than if they were in an office setting with limited access to additional food sources or supplies. While meal coaching may also feel a bit different at a distance than providers are used to, it may be more empowering to parents because they are the ones implementing strategies in their own home with their own child while the therapist remains a remote presence. This is in contrast to meal coaching that happens in an office setting, where parents may attribute progress to the therapist or clinical setting rather than to their own improved skills.

1.8 | Managing in-session behaviors

Patients may act out in ways at home that would not happen in a clinical office setting or less familiar environment. This may include leaving

the therapy session, disconnecting the video conferencing call, or physically moving to a different space where they cannot be seen on screen. In our anecdotal experience, patients that leave a TeleHealth FBT session typically remain close by and are still listening. Patients often interject or even come back to session. Thus, as long as patient safety is not a concern, we recommend continuing forward with the session and encouraging the patient to re-join once emotions are regulated. Similarly, situations may arise in which patients or parents become distraught, feel overwhelmed, or respond in overtly critical or hostile ways. Across family therapy modalities, it is not uncommon for arguments to escalate during treatment sessions and require intervention or redirection by the therapist. TeleHealth FBT providers are encouraged to manage similar situations in much the same way they would in a clinic setting; that is, to ask the parents how they want to respond to this behavior and support their thoughtful deliberations about how best to proceed without the therapist trying to direct the parents or tell them what to do. Patients occasionally leave the room during in-person FBT sessions due to high levels of emotion or distress. Unlike an office or clinic-based setting, parents and family members have the advantage of knowing the layouts of their homes, insight into patient's typical patterns of behavior in the home environment, and awareness of the resources they have to manage escalated behaviors at home. Additional emotion regulation strategies may be available to patients and family members that are traditionally unavailable in a therapy office, such as separate spaces, self-soothe items, and other comforts of home. Clinicians providing TeleHealth FBT may want to consider helping parents plan ahead at the outset of therapy how they would like to handle and respond to behaviors should they occur during sessions.

Patients may also become distressed discussing eating disorder behaviors and weight while viewing themselves on the screen during video sessions. Patients may insist on appearing off camera for this very reason. Practically, switching the presentation view in the video conferencing platform to minimize patient's on-screen appearance or enabling functions that hide the patient's view of themselves may alleviate some of the in-session distress. Alternatively, the therapist may help the patient reframe their discomfort as an exposure opportunity and assist patients in acclimating to viewing their bodies on screen, much the same as if they were on a video call with family or friends or in front of a mirror. This can also provide a learning opportunity for family members to experience firsthand the patient's distress around body image concerns and position families to provide in-vivo support to patients.

1.9 | Phases 2 and 3

In contrast to Phase 1, the use of TeleHealth to deliver FBT is thought to impact interventions in Phases 2 and 3 to a lesser degree. As the eating disorder symptoms resolve, parental oversight begins to retreat and the adolescent plays a larger role in his or her recovery. It will be important to help facilitate conversations among family members that also allows for the adolescent's voice to be heard. This may be more

difficult if all family members are positioned facing the screen rather than one another. The natural inclination to converse with the therapist, rather than within the family, may be more salient when delivering family treatment via TeleHealth. Additionally, it is possible that therapists may notice a decline in session attendance and the learning of the patient and family in remote therapy with the transition to Phases 2 and 3 and the spacing of treatment sessions. The reinforcement from in-person contact with a therapist may be of value in keeping some families moving forward with treatment goals; without it, families may stop prioritizing treatment. Thus, clinicians might need to emphasize the importance of adhering to the treatment plan in these later phases more than they would with in-person therapy sessions. When preparing for termination in Phase 3, therapists often revisit earlier intervention techniques to indicate treatment progress, such as re-drawing the Venn diagrams that represent the proportion of the patient eclipsed by the eating disorder (Lock & Le Grange, 2015). The therapist can ask families to draw the Venn diagrams using their own materials or may consider the use of a “whiteboard” share feature on video conferencing platforms when completing this exercise. Termination in TeleHealth FBT occurs in much the same way as it does in person. Although the therapy is happening remotely, it is recommended that the clinician continue to provide time and space for thoughtful reflection and saying good-bye when completing treatment with a family.

Within the current COVID-19 pandemic in which families and patients are sheltering in place in line with public health directives, patients may not be able to progress on the typical goals of Phase 2, including social eating with peers. As schools and restaurants are closed, the opportunities to practice social eating outside the family may be limited. Families may need additional guidance on creative ways to continue helping the adolescent progress through appropriate developmental steps in return to eating. The previous treatment goals related to adolescent developmental themes that arise in Phase 3 may also need to be shifted during this time. Typical adolescent routines including attending school, afterschool activities, sports practices and athletic events, in-person socialization with peers, and memorable moments such as prom and graduation have all been suddenly suspended with no clear return date in sight. Moreover, adolescents are spending an increased amount of time at home with their parents and families, with less opportunities to interact and socialize with same-age peers. This shift towards more family interaction is actually developmentally inappropriate, as one of the primary goals of adolescence is to individuate and achieve independence from the family unit. The added stress, anxiety, and grief teenagers may feel during this time could contribute to increased family conflict as well as a worsening of eating disorder symptoms. The therapist should anticipate these potential challenges and help families problem-solve barriers that inhibit the patient from achieving age-appropriate developmental goals. Further, parents may be tempted to increase monitoring of eating disorder behaviors or supervision at mealtimes given increased time at home. The therapist may need to help manage parental anxieties while continuing to assist families in moving forward with treatment goals in the midst of the abrupt changes to socialization and normalcy this pandemic has caused.

1.10 | Therapist fidelity

Ensuring therapist fidelity and adherence to evidence-based interventions delivered remotely presents its own unique challenges for consideration. Studies are needed to explore best methods in evaluating clinician adherence and fidelity to manualized-based treatments delivered via TeleHealth, including FBT. Online platforms that allow for video recording of sessions can be used in supervision or coding structures to assess these metrics. Importantly, technology can also be used to provide wide-spread specialized training in eating disorder modalities such as FBT (Darcy & Lock, 2017; Lock & Le Grange, 2019), which will undoubtedly increase provider access to training resources with the hopes of improving treatment fidelity. The logistics of how clinicians will be monitored to account for drift in delivering treatments via TeleHealth warrants further exploration.

2 | FUTURE DIRECTIONS AND A CALL TO RESEARCH

It is uncertain what lessons mental health care will take from the current COVID-19 pandemic. It is not yet known whether the rapid transition to TeleHealth delivery of treatments will prompt continued, or at the very minimum, increased levels of remote care once it is safe again to treat patients in office and clinic settings. However, given the concerns about access to care, particularly for specialized care like eating disorder treatment, it is likely that TeleHealth will continue to be a sought-after mechanism of delivering treatment. Importantly, the lack of research into the use of TeleHealth in delivering evidence-based eating disorder treatments for children and adolescents remains. Clinicians and researchers should work collaboratively to address these gaps. The use of TeleHealth services as a necessity for continuity of care during the COVID-19 crisis provides unique opportunities to collect data on the feasibility and acceptability of this treatment format. Studies are currently being conducted to collect both quantitative and qualitative data regarding the opportunities and challenges in providing psychotherapy using videoconferencing platforms, including FBT specifically. The data from these studies may help guide clinicians in evaluating the appropriateness of using videoconferencing to deliver FBT in specific clinical situations. It will also be important to observe if differences in acceptability and clinical outcomes exist between patients that initially began treatment remotely compared to patients that were transitioned from in-person to TeleHealth. It is likely that rapport established during in-person sessions will translate over a video screen, though this has yet to be empirically studied. Further investigation into the potential advantages of combining in-person and distance-based care could guide treatment decisions moving forward. Measurement-based outcomes may be useful in assessing patient progress and can continue to be administered remotely. It is important to note that research efforts undertaken in the midst of COVID-19 may be influenced by the rapid transition to TeleHealth rather than a systematic implementation driven by dissemination and implementation efforts. For example, many patients and

clinicians alike may not have had a choice in the transition to remote videoconferencing care, as public health directives mandated physical distancing, closure of workspaces, and safety protocols that limited in-person treatment opportunities. It is also unknown what impact the COVID-19 pandemic will have on patients' health and recovery efforts (Fernández-Aranda et al., 2020; Touyz, Lacey, & Hay, 2020). Patients with eating disorders may experience any number of recovery-related challenges due to the pandemic, including but not limited to reduced access to medical follow-up, changes in family eating habits, difficulty obtaining food or increased food insecurity, increased family time, higher levels of anxiety and depression, and restricted access to peers and routine adolescent activities. On the other hand, families may experience positive benefits during this time, including additional time to focus on re-nourishment efforts, increased opportunities to provide meal support to loved ones, improved family communication and cohesion, and a renewed focus on overall health and well-being. As such, it will be hard to separate the impact of these external factors from the impact adapting therapeutic practices to TeleHealth on clinical outcomes.

Adequately powered clinical trials are needed to ensure evidence-based treatments such as FBT, which were initially validated as face-to-face therapies, can be translated to TeleHealth without impacting effectiveness. If future research suggests comparable outcomes to in-person care, the dissemination and implementation of evidence-based treatments via videoconferencing platforms could reduce barriers for individuals without access to specialty treatment. Further study of TeleHealth practices is also warranted, as surveys suggest that 2/3 of adolescents would access online mental health treatments, with approximately 1/3 of adolescents preferring online compared to face-to-face therapy (Sweeney, Donovan, March, & Forbes, 2019). Future studies should also seek to better understand how therapeutic alliance may be impacted when treatment is delivered at a distance for this patient population. Noninferiority RCTs should be conducted to ensure equivalent outcomes and assess whether critical intervention elements can be translated across delivery methods. Specifically, studies should seek to investigate in-person versus TeleHealth FBT in randomized clinical trials to ensure comparable outcomes when delivering FBT at a distance.

3 | CONCLUSION

The necessity to employ distance-base methods to deliver on-going eating disorder care due to the novel coronavirus (COVID-19) pandemic represents a dramatic and urgent shift in treatment delivery. However, the potential benefits that TeleHealth offers in increased access to care for specialized psychological treatments, such as FBT, extend far beyond the current public health crisis. Further investigation of feasibility, acceptability, and efficacy of TeleHealth interventions are warranted. Studies should focus on the adaptation and implementation of existing evidence-based treatments to TeleHealth platforms in order to increase access to care and remove barriers from attending psychotherapy sessions in person.

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DATA AVAILABILITY STATEMENT

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