Assessing Changes in Parent Sensitivity in Telehealth and Hybrid Implementation of Attachment and Biobehavioral Catch-Up During the COVID-19 Pandemic

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Abstract
During the COVID-19 pandemic, home visiting services for families with young children pivoted to continue providing services virtually. One such service was Attachment and Biobehavioral Catch-up (ABC), a brief prevention/intervention program targeting increased parental sensitivity. 70 families participated in a sensitivity assessment before and after receiving ABC. Forty-three families received the program fully through telehealth, and 27 families received the program through an in-person/telehealth hybrid format. Parent sensitivity was assessed pre- and post-intervention, and results suggested that when ABC was delivered through a telehealth or hybrid format, parents showed increased following the lead and decreased intrusiveness from pre- to post-intervention, with moderate effect sizes. Ongoing supervision in the model, weekly fidelity maintenance checks, and the flexibility of families and parent coaches likely contributed to the maintenance of significant change in parental sensitivity from pre- to post-intervention during the move from face-to-face home visiting to the provision of virtual services.

Keywords
parental sensitivity, parent–infant dyads, attachment, telehealth

COVID-19 has had significant effects on most people in the United States, with families of young children experiencing particular challenges (Cameron et al., 2020; Russell et al., 2020; Tso et al., 2020). Families across the socio-economic spectrum faced increased burdens, such as reduced or non-existent child care options, school-aged children attending school virtually at home, outside support by vulnerable relatives reduced or eliminated, escalating feelings of civil unrest (e.g., publicized instances of police brutality and subsequent protests), and loss of income.

In a typical year, over 300,000 families in the United States receive home visiting services to support their parenting (National Home Visiting Resource Center, 2020). Several home visiting programs have a strong evidence base with positive effects seen on parental behavior and child outcomes (e.g., Chaffin et al., 2012; Dodge, 2018; Dozier & Bernard, 2019; Grube & Liming, 2018). During the pandemic, many home visiting programs moved to virtual service delivery (Rapid Response Virtual Home Visiting, 2020). Attachment and Biobehavioral Catch-up (ABC), an evidence-based 10-session home visiting program that specifically targets parental sensitivity, moved to a telehealth platform when in-person visits were no longer feasible. In this paper, we assess whether significant improvements in parental sensitivity, a key mechanism leading to positive child outcomes (Garnett et al., 2020; Lind et al., 2020; Raby et al., 2018) and an established indicator of program effectiveness (Bick & Dozier, 2013; Roben et al., 2017; Yarger et al., 2016), were maintained when ABC was delivered by telehealth and hybrid formats.

COVID-19 Effects on Home Visiting
In non-pandemic times, families experiencing a range of stressors would be eligible to receive home visiting services that could provide and/or refer for help in a variety of areas. The need for home visiting services became greater during the pandemic than it had been prior (Self-Brown et al., 2020). This need is consistent with an established pattern of increased reports of child maltreatment during natural disasters and conflicts (Barboza et al., 2020; Curtis et al., 2000; Seddighi...
et al., 2019), as increased contextual stressors may compromise caregivers’ abilities to respond to their children in sensitive ways.

In many parts of the United States, however, in-person provision of home visiting services became untenable; the Home Visiting Applied Research Collaborative reported that in the early days of the pandemic, 88% of local agencies were required to stop in-person home visiting and moved to providing services through telehealth, with 44% of home visits being implemented through interactive video conferencing in April 2020 (O’Neill et al., 2020). Some programs encouraged more frequent check-ins and contacts by texting or voice phone calls, while others moved to crisis-driven basic needs support (e.g., diaper drives, formula and food supplementation) (National Alliance of Home Visiting Models, 2020; Rapid Response Virtual Home Visiting, 2020).

Prior to COVID-19, early intervention models have had success with technology-enhanced engagement strategies (e.g., Bigelow, Carta, & Lefever, 2018) or virtual service provision (e.g., Comer et al., 2017; Traube et al., 2019). However, virtual services have often been delivered in the context of research studies and may lack real world application (Torus & Wykes, 2020). Transitioning to telehealth or hybrid services may be one way to increase family engagement and extend the reach of early intervention programs (Guastaferro & Lutzker, 2017) beyond pandemic times. Additionally, the option of telehealth services may have the potential to increase accessibility for families who could not be reached via in-person services even prior to COVID-19.

Examining the effect of home visiting services delivered virtually is important in ensuring the integrity of the field beyond the COVID-19 pandemic. This paper specifically focuses on ABC’s dynamic implementation pivot to providing intervention services through video-based telehealth to allow the parent coach to observe and comment on parent–child interactions in a manner as similar as possible to in-person observations (Roben Kipp et al., 2021).

**Overview of Attachment and Biobehavioral Catch-Up**

ABC is a 10-session home visiting program for parents of children between 6–24 months (ABC-Infant) or 24–48 months (ABC-Toddler) who have experienced early adversity, including but not limited to: maltreatment (abuse/neglect), disruption in caregivers or involvement in foster care, witnessing intimate partner violence, or time spent in a neonatal intensive care unit (NICU). ABC has been studied and found efficacious in randomized controlled trials with families referred by Child Protective Services, foster families, and parents adopting children from international orphanage care (Dozier & Bernard, 2019). ABC focuses on improving parental sensitivity by focusing on three target parenting behaviors identified as essential for children who have experienced early adversity: (1) responding to child distress with nurturance, (2) following the child’s lead with delight during everyday interactions and play, and (3) avoiding frightening behaviors (Dozier & Bernard, 2019).

Each week, ABC parent coaches discuss these targets with parents using manualized content that includes showing example videos, citing research support, and encouraging practice activities between parents and their children. Most importantly, target-relevant parent behaviors are also supported by parent coaches making frequent in-the-moment comments, the active ingredient of ABC in promoting sensitive parent behavior (Caron et al., 2018).

To become trained as an ABC parent coach, clinicians first undergo a 2-day intensive training (four half-days when provided virtually) that provides an introduction to ABC. The training is followed by twice-weekly supervision meetings that occur over the course of 1 year. In one of the weekly meetings, coaches participate in clinical supervision that is structured as a small group meeting of two to three parent coaches led by an ABC clinical supervisor. Clinical supervision is used to review session video and discuss case conceptualization, manual adherence, and logistics. In the second weekly meeting, coaches participate in fidelity supervision, which is an individual meeting led by an ABC fidelity supervisor. In these meetings, parent coaches and their fidelity supervisors review coding of their in-the-moment commenting and fidelity to the model (Caron & Dozier, 2019; Meade et al., 2014).

In clinical trials, ABC has shown efficacy in improving parent sensitivity (Bick & Dozier, 2013; Yarger et al., 2020), promoting secure attachment (Bernard et al., 2012) and child self-regulation (Lind et al., 2017), and normalizing patterns of diurnal cortisol production, an indicator of physiological regulation (Bernard, Dozier, et al., 2015; Bernard, Hostinar, & Dozier, 2015). Across these trials, improved parental sensitivity has emerged as an empirically tested mechanism of change for several of the positive child outcomes (Garnett et al., 2020; Raby et al., 2018). Therefore, parental sensitivity has been found to be a key proximal outcome in the ABC intervention. Given the importance of changing parental sensitivity, this construct has also been studied through observational assessment in community implementation settings, as ABC has been disseminated nationally and internationally. Notably, when assessing pre-ABC to post-ABC parent sensitivity change in community implementation settings, the effect size for this improvement is large, and similar to what has been seen in previous research trials (Perrone et al., 2020; Roben et al., 2017).

**Adapting ABC to Telehealth Delivery**

The researchers were confident in transitioning from an in-person model into a telehealth model for several reasons: ABC has identified in-the-moment commenting as the program’s active ingredient (Caron et al., 2018), and has an established method of tracking, training, and maintaining fidelity (Caron
As part of the fidelity monitoring process, parent coaches received weekly supervision and fidelity feedback. These supervision meetings served as opportunities to discuss any needed adaptations to administering outcome assessments and delivering intervention sessions. Parent coaches were quickly able to adapt to making in-the-moment comments when transitioning from in-person sessions to telehealth sessions (Caron et al., 2021), and were able to maintain frequent and high quality in-the-moment comments while delivering ABC through telehealth (Roben Kipp et al., 2021). Telehealth allowed parent coaches to continue working with families in their everyday environments, even though the weekly meetings were virtual rather than through in-person home visiting. Visits did not count as an ABC session if they were conducted without the use of video.

Notably, feasibility of measuring pre/post parent sensitivity change via telehealth was relatively straightforward, given that parent coaches serving families through local agencies were already administering observational parent behavior change measures for the purposes of program evaluation as part of previously established guidelines on data collection in community settings during ABC training. Regular fidelity monitoring and coding observational parent–child interactions pre- and post-ABC are aspects of ABC implementation that are both relatively rare among community implementation of ongoing early intervention programs.

Given the importance of parental sensitivity in determining key child outcomes, and the increasing need for high-quality virtual home visiting services, it was imperative to maintain positive changes in parental sensitivity through the new partially or fully telehealth modality. This paper examines pre- and post-ABC parental sensitivity from families who were already receiving or set to receive ABC in community settings from a local provider. COVID-19 created a natural experiment, wherein some ABC cases moved from in-person to telehealth as a result of local “stay-at-home” ordinances, leading ABC to be delivered in a hybrid in-person/telehealth format; new cases referred to ABC during this time period were provided services in a fully virtual space (TeleABC). These families were referred to ABC through their local agencies and were not enrolled in a research study. Families were not randomly assigned to conditions, nor could we feasibly or ethically compare to a “no-treatment” group, so we cannot make causal inferences about the mode of ABC delivery. However, ABC developers have already established that using an observational pre-/post-ABC parent behavior assessment that is coded in community settings is feasible and shows significant positive change in parental sensitivity (Roben et al., 2017). In this paper, we aimed to establish that an observational parent behavior assessment is both feasible to implement and that parent behavior change persists when assessments and/or intervention sessions are delivered through telehealth. Thus, the goal of this paper was to assess whether ABC delivered either partially or fully through telehealth resulted in improvements in parental sensitivity from pre- to post-intervention. We hypothesized that parents would improve in sensitivity from pre- to post-intervention.

Method

Participants

Families receiving ABC. A total of 70 families were included in this sample. All families were receiving ABC through community implementation sites in the United States (US), representing 27 community agencies across 10 states. The community agencies varied widely, but most provide prevention or intervention services to families experiencing early adversity, including local early intervention services, mental health services, foster parent training, and agencies involved with child protective services. Specific reason for referrals and family demographic data were not available, but families were eligible for ABC if the child was between 6–24 months (ABC-Infant) or 25–48 months (ABC-Toddler) and had experienced any type of early adversity.

Data from participating families were included in the dataset because families completed the ABC program as well as a post-intervention sensitivity assessment between June and December 2020. This represents a convenience sample during the COVID-19 crisis, and all families were included if they completed a post-ABC sensitivity assessment during this time period and had completed a pre-ABC sensitivity assessment prior to beginning the program. When compared to families who completed only the pre-ABC sensitivity assessment during this time period, there were no statistically significant differences in any of the parental behavior measures between those who completed a post-ABC assessment and those who did not. Forty-three of the families received ABC entirely virtually through TeleABC, with both pre- and post-sensitivity assessments and all 10 intervention sessions delivered remotely. Twenty-seven of the families began ABC in-person but switched to telehealth as a result of the COVID-19 pandemic’s heightened safety concerns and decrease in face-to-face visits, thus receiving a hybrid model of the program. Families who received a hybrid model of ABC all participated in the initial (pre-ABC) sensitivity assessment in-person, had an average of 4.45 ($SD = 2.56$) out of 10 ABC sessions in-person (range = 1–9), and completed the post-ABC sensitivity assessment virtually.

Sensitivity assessment data came both from families who participated in ABC-Infant ($n = 40$) and ABC-Toddler ($n = 30$): the two models have significant overlap in content and both use in-the-moment commenting to address parent behaviors and focus on improving parental sensitivity. Additionally, the sensitivity assessment is scored for the same indicators of parental sensitivity for both versions of the model. Enrollment in ABC-Infant versus ABC-Toddler was not associated with statistically significant differences in parental sensitivity outcomes.
Parent coaches. Thirty-nine parent coaches, representing 27 community agencies in 10 US states, collected the pre-/post-sensitivity assessment data and implemented the ABC program with families. Parent coaches primarily identified as female (97%, n = 38; 3%, n = 1 identified as male). The majority of parent coaches identified as White (59%, n = 23), with substantial percentages identifying at Latino/a (15%, n = 6) and Black (10%, n = 4), and 15% chose not to report race (n = 6). Sixty-four percent of parent coaches had completed some Masters-level education (n = 3) or a Master’s degree (n = 22), while 13% had a Bachelors-level education (n = 5), 3% had a Doctoral-level education (n = 1), and 21% did not report their education level (n = 8). All of the coaches included in this sample were actively in training in the ABC model and receiving ongoing clinical and fidelity supervision on a weekly basis. Coaches in this study generally represented the larger cohort of parent coaches who are either actively in training or who are certified in ABC.

Procedure

Parent behavior measure: Sensitivity assessment. Before and after ABC implementation, parent coaches administer a 9-minute sensitivity assessment, based on the National Institute of Child Health and Development Observational Recording of the Caregiving Environment (ORCE; NICHD Early Child Care Research Network, 1996). In this assessment, parents are asked to interact with the target child participating in ABC using a standardized set of toys. When ABC is conducted in-person, parent coaches bring a standardized set of toys (e.g., stacking cups or rings, rattle, squeaky toy) to families’ homes for this assessment.

Ensuring that the assessment was administered in a standardized way via telehealth included some challenges. Even with telehealth service delivery, some agencies were able to drop off or mail the standardized set of toys to parents’ homes. However, this was not an option for many agencies and parent coaches. Thus, the ABC developer team identified toys and materials that were suitable equivalents to the set of toys typically used in the assessment. For example, if parents did not have a rattle at home, parent coaches could ask a parent to place a set of keys or small items in a plastic storage container, thus mimicking a rattle. If parents did not have any toys or materials that were determined to be equivalent to the original set of toys, parents were asked to choose “three toys you and your child typically play with.” An amendment addressing potential challenges to virtual sensitivity assessment collection and description of alternate toys was made to the original set of assessment instructions and distributed to parent coaches as they were planning assessments via telehealth. Additionally, parent coaches planned the sensitivity assessment with their ABC clinical supervisor to ensure that the assessments would be codable.

Parent coaches often integrated collection of the sensitivity assessment as part of an intake session which was used to introduce families to the ABC model and help parents learn how to integrate the videoconferencing software into weekly sessions. Assessment of technology and internet availability for telehealth sessions was typically completed at this intake session. Some participating agencies were able to offer devices or hotspots for sessions, whereas others did not have the resources to share this assistance, and thus parent coaches worked with each individual family to assess and plan for telehealth capability. Parent coaches spent some time in this meeting giving individual instruction and troubleshooting with parents about where to place their device so that the parent coach would have the best view of both the parent and the child for the assessment, a key element to ensure accurate coding, as well as placement for subsequent ABC sessions so the parent coach would be able to give detailed, specific in-the-moment comments.

Measure

Sensitivity assessment coding. ABC program evaluation coders at the University of Delaware, unaware of implementation site and assessment timing, score parents on separate Likert scales of 1 to 5 for following the lead (e.g., child taps two rings together and a parent also taps two rings together), intrusiveness (e.g., parent takes a rattle and shakes it in their child’s face), and positive regard (e.g., parent smiles toward child). The ideal outcome is for a parent to score highly (5) on following the lead and positive regard, and to receive a low score (1) for intrusiveness.

The sensitivity assessments were coded by seven undergraduate or post-baccalaureate research assistants who were unaware of the timing (i.e., pre- or post-intervention) of the assessment. Before they were considered to be reliable, coders underwent an intensive month-long training in the coding process, where they learned to identify the key behaviors captured in the assessment (i.e., following the lead, intrusiveness, positive regard) and practiced assigning scores to the parent behaviors. They then independently completed a set of 10 “test” videos that were scored for reliability. To become reliable, coders needed to reach agreement with a master coder on at least 80% of the scores.

In this sample, 44 of the 140 sensitivity assessments were double-coded to ensure accuracy across coders. Reliability was good across scales, with one-way random effects single-measure Intraclass Correlation Coefficients of 0.74 for following the lead, 0.61 for intrusiveness, and 0.73 for positive regard. The data were originally collected for program evaluation purposes and are considered to be exempt by the University of Delaware Institutional Review Board.

Analytic Plan

The analytic plan was to analyze each subset of data (TeleABC only and hybrid ABC) using paired-samples t-tests with 43 pre-ABC observational sensitivity assessments paired with 43 post-ABC observational sensitivity assessments for the TeleABC only group and 27 pre-ABC observational sensitivity
assessments paired with 27 post-ABC observational sensitivity assessments for the hybrid ABC group. Each sensitivity assessment includes three outcome scores (following the lead, intrusiveness, and delight). We hypothesized that following the lead and delight would increase from pre-ABC to post-ABC, and intrusiveness would decrease from pre-ABC to post-ABC, across both the TeleABC only and hybrid ABC subgroups.

For the analysis to have 80% power to detect a moderate effect size of 0.5, with a significance level of .05, 27 participants were required in each set of paired samples (Durlak, 2009; Lakens, 2013). The final subsamples both met this requirement. Effect size was based on previous ABC implementation analyses, which have found moderate-to-large effect sizes in pre- to post-ABC parental sensitivity change (Caron et al., 2018; Roben et al., 2017, 2021).

**Results**

**TeleABC Only**

For families who had received ABC entirely via telehealth (n = 43), paired samples t-tests were conducted to compare parent behaviors from pre- to post-TeleABC. There was a significant increase in following the lead from pre- (M = 3.35, SD = 1.25) to post-TeleABC (M = 3.93, SD = 1.01), t(42)= 2.90, p < .01, as well as a significant decrease in intrusiveness from pre- (M = 1.81, SD = .96) to post-TeleABC (M = 1.47, SD = .83), t (42)= 2.15, p < .05. The increase in positive regard from pre- (M = 3.98, SD = 1.10) to post-TeleABC (M = 4.30, SD = .83) was not significant, t (42)= 1.71 p > .05 (See Figure 1).

For TeleABC, the effect size for the paired-samples repeated measures design (using Hedges’s g to account for small sample size) was moderate for following the lead (g = .50), small for intrusiveness (g = .37), and small for positive regard (g = .32).

**Hybrid In-Person/Telehealth Sessions**

For families who had initially received ABC in-person but switched to telehealth, receiving a hybrid version of ABC (n = 27), paired samples t-tests showed a significant increase in following the lead from pre- (M = 2.81, SD = 1.18) to post-hybrid ABC (M = 4.15, SD = .82), t (26)= 5.89, p < .001, as well as a significant decrease in intrusiveness from pre- (M = 2.41, SD = 1.53) to post-hybrid ABC (M = 1.48, SD = .70), t (26)= 3.34, p < .01. The increase in positive regard from pre- (M = 3.81, SD = 1.11) to post-hybrid ABC (M = 4.19, SD = 1.11) was not significant, t (26)= 1.66 p > .05 (See Figure 2).

For hybrid ABC, the effect size for the paired-samples repeated measures design (using Hedges’s g to account for small sample size) was large for following the lead (g = 1.26), large for intrusiveness (g = .71), and small for positive regard (g = .38).

Thus, when ABC was delivered through a telehealth format, regardless of whether parents received ABC fully virtually (TeleABC) or through a combination of in-person and virtual sessions (hybrid), they showed improved sensitivity from pre- to post-ABC (see Table 1).

**Discussion**

Parents showed significant improvements from pre- to post-intervention in following the lead and intrusiveness, whether considering parents who received telehealth for any of their sessions, or considering only those who received exclusively telehealth sessions. These findings suggest that ABC’s brief, targeted intervention can be implemented successfully through telehealth. The transition to telehealth needed to be rapid and responsive to the developing concerns regarding COVID-19. ABC’s identification of an active ingredient (in-the-moment commenting) and precise weekly measurement and supervision of this active ingredient facilitated the

![Figure 1. Sensitivity change from pre- to post-ABC for families who received TeleABC only. Note. This figure represents families who received TeleABC fully (n=43), the assessments and all intervention sessions were conducted virtually. Significance of t-test results indicated by asterisks: ***p < .001, **p < .01, *p <.05.](image)
Meaningfully, these results are not based on parent report of behavior change. Observational assessments of change were possible, even through the virtual connection. These observations represent ecologically valid and unbiased measures of parent sensitivity that have been demonstrated to serve as a mechanism for positive child outcomes (Garnett et al., 2020; Lind et al., 2020; Raby et al., 2018). One major strength of these results is that the assessment of parental sensitivity is administered virtually, often with parent-supplied materials. While it was challenging to move quickly to telehealth, these findings are a testament to both parent coaches and families investing in this work. Home visiting did not stop during this time, and parent coaches and families worked hard to collaborate on ways to continue services in a high-quality way.

Though parental stress was not directly assessed, it is heartening to continue to see significant improvement in parental sensitivity within the context of several overlapping national crises. Such results are especially important given sensitive caregiving can serve to mitigate the effects of trauma and adversity as well as promote resiliency in babies and young children (Julian et al., 2018).

Limitations and Future Directions

One limitation of these data is that it can be challenging to conduct the sensitivity assessments virtually. Parent coaches often had to give parents considerable feedback about how to adjust their device so that both the parent and the child could be seen clearly in the video. Some homes were less conducive to this technological setup, both in terms of space (e.g., finding a place to set up the camera that was far enough from the dyad to capture the full interaction) and technology (e.g., lagging and inconsistent internet connections). The sensitivity assessment is also designed to be coded for dyadic interactions, and often when collected virtually it was difficult to record the dyad apart from other family members. Siblings were often at home and needed to be attended to during this time period, making it logistically difficult to exclude them from the interaction. Additionally, demographic information about families and reasons for referrals were not available.

Another limitation is that families were not randomly assigned to condition, but received either a hybrid version of in-person and telehealth or a fully virtual TeleABC based on conditions and timing of the COVID-19 pandemic. Due to the lack of randomization and the fact that the TeleABC and

Table 1. Summary of t-Test Results, Comparing Means and SD for Observations of Parental Sensitivity from Pre-ABC to Post-ABC.

|                        | Following the Lead | Intrusiveness | Positive Regard |
|------------------------|--------------------|---------------|-----------------|
|                        | Pre | Post           | Pre | Post          | Pre | Post             |
| TeleABC (n=43)         | 3.35 (1.25) | 3.93 (1.01)**  | 1.81 (.96)  | 1.47 (.83)*  | 3.98 (1.10) | 4.30 (0.83)      |
| Hybrid (n=27)          | 2.81 (1.18) | 4.15 (.82)***  | 2.41 (1.53) | 1.48 (.70)*** | 3.81 (1.11) | 4.19 (1.11)      |

Note. Comparing changes in means and standard deviations of following the lead, intrusiveness, and positive regard from Pre- to Post-ABC. TeleABC refers to families who received the intervention fully in the virtual setting, hybrid refers to families who received the intervention partially in-person and partially in the virtual setting. Significance of t-test results indicated by asterisks: ***p < .001, **p < .01, *p < .05.

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hybrid groups differed in parental sensitivity at baseline, the two conditions could not be compared to one another or to a no-treatment group. One future direction is to study telehealth delivery of ABC outside the context of a pandemic, with randomization to type of service and more control over the implementation of the service modality.

These preliminary results demonstrate significant improvements in parent sensitivity through a brief, targeted telehealth program raise many questions for the field of home visiting prevention and intervention programs. Home visiting is designed to serve those for whom accessibility of services can be challenging (Peacock et al., 2013). The pandemic made access to services challenging for all families, but many eligible families were not being reached before the pandemic (National Home Visiting Resource Center, 2020).

It is critical that telehealth adaptations such as ABC’s be studied in prospective, randomized trials using intent-to-treat analyses to determine the environments and individuals for whom TeleABC or a hybrid in-person/telehealth mode works, or for whom in-person ABC is preferred. Though the hybrid in-person/telehealth mode of delivery occurred out of necessity and had a relatively small sample size, the positive changes in parent behavior and strong effect sizes justify a next step in exploring the possibility of a hybrid mode of delivery as a model for the future. There may be differential benefits for some families across all three delivery options for various reasons. Some geographical areas may not support the infrastructure needed for internet-based services due to existing digital divides, and thus in-person services may be of necessity (Hall & Bierman, 2015; Racine et al., 2020). Alternatively, some agencies that deliver ABC are in rural areas where staff time and transportation costs contribute to a high cost-per-family when delivering 10 in-person home visits for ABC. For instance, in Kansas, one ABC parent coach covers 19 counties and often drives 2 hrs each direction to complete a one-hour ABC session with a family. Her work could be made much more efficient if several or all of the sessions could happen via telehealth.

In addition, some families and parent coaches may be better fit for telehealth services than others. Factors related to the working alliance or family openness to change could be impacted by the mode of service delivery (Norwood et al., 2018). Given family engagement has been identified as being crucial to home visiting success (Guastaferro et al., 2020), flexibility in mode of service delivery may be warranted to meet families where they are. Some families and parent coaches may feel more comfortable with at least periodic in-person connection to build rapport. Thus, either an in-person or hybrid service delivery option may be a strong fit. To note, the hybrid option could serve as a cost-saving measure for local agencies while still allowing the opportunity for parent coaches to have some in-person rapport building opportunities. Alternatively, other families and parent coaches may feel more comfortable engaging in services virtually. Randomized trials would permit the development of best practices regarding telehealth.

Conclusion

The COVID-19 pandemic has had a critical impact nationally, and worldwide, with significant effects on young children and their families (Cameron et al., 2020; Russell et al., 2020). In the United States, the field of home visiting had to adapt quickly to a telehealth approach, and during this rapid and unprecedented shift, both home visitors and families worked hard to maintain high-quality services, all while facing immense stress themselves. The current study found that ABC effectively increased parental sensitivity in both a fully telehealth and in-person/telehealth approach. This increase is particularly important, given that sensitivity is a protective factor against the experience of early adversity for young children (Sroufe, 2005).

Although the transition to telehealth is not without challenges, ABC maintained positive changes in parental sensitivity for several reasons. First, ABC is a targeted, precise, and standardized intervention, with clear and focused guidelines for each session, thus serving as a blueprint that coaches could take to sessions as they pivoted from in-person to telehealth service delivery. ABC also has a consistent and rigorous method for monitoring and maintaining fidelity to the intervention, which was continued during this time (Roben Kipp et al., 2021). Finally, members of the ABC treatment developer team, ABC parent coaches, and families involved in services stayed committed to maintaining service delivery and ensuring that services were provided in a high-quality manner.

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Notes

1. There are no specified education or experience requirements to be an ABC supervisor. ABC supervisors come from a diverse set of vocational backgrounds, such as past certified parent coaches, undergraduate or graduate students in psychology, licensed psychologists, and those with Doctoral or Master’s degrees in psychology or a related field such as social work. Clinical
supervisors are trained alongside certified ABC clinical supervisors for the year-long certification cycle of a group of parent coaches in training, with a process that moves from observation to application with intensive monitoring and feedback. Fidelity supervisors are trained to reliability in ABC coding, then trained in supervision procedures and practices. Some individuals are trained in both types of supervision. Both clinical and fidelity supervisors engage in regular consultation with the team of ABC developers and are either employed by or directly trained by the developer team to ensure fidelity and adherence to the model.

2. As with ABC supervisors, there is no educational requirement for ABC parent coaches. However, before being trained, all parent coaches must participate in a screening interview to determine fit for implementing the model. The screening interview includes elements assessing openness to attachment experience and initial skill at making in-the-moment comments and is predictive of parent coach fidelity to the ABC model (for more details, see Caron et al., 2018).

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