

Relational Lockdown and Relational Trauma[†] in the Time of Coronavirus: A Reflection from a UK Family Therapist

MARK RIVETT*

Like a meteor hitting the earth's surface, 41,698 unexpected deaths have shaken, disturbed, and saddened the core of our nation. This reflection considers the consequences of the coronavirus crisis in the UK with particular reference to the impact on families and on the practice of family therapists. The perspective presented can only be partial because of the fast-changing situation and the limited access to alternative perspectives that are available during this period of relational lockdown. The author provides a systemic understanding of what has happened and what is happening.*

Keywords: Coronavirus; Relational Lockdown; Relational Trauma

Fam Proc x:1–10, 2020

You don't know what you've got Till it's gone. (Mitchell, 1970)

The curious twist in the systemic nature of the individual [man] is that consciousness is, almost of necessity, blinded to the systemic nature of the individual [man] him [or her] self. (Bateson, 1972 : 434)

Clinical vignettes

Prerelational lockdown

The family have arrived to take part in a therapeutically focused family meal with their 15-year-old daughter who has been diagnosed as having an eating disorder.

Therapist: I am wondering how you made the decision about what you were going to bring to eat today?

*CEDAR, University of Exeter, Exeter, UK.

Correspondence concerning this article should be addressed to Mark Rivett, CEDAR, University of Exeter, Washington Singer Building University of Exeter, EX4 4QG Exeter, UK. E-mail: markj.rivett@ntlworld.com.

[†]I am indebted to Sheinberg and Fraenkel (2001) for the phrase "relational trauma" This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

Mother: We knew this was going to be weird and didn't want to make it any harder on her than it need be, so we asked her what she would eat

Therapist: That is interesting. Is this any different than what would normally happen at home?

Mother: Actually, not really. We want to make sure she gets some food inside her and it works better if we ask her first

Therapist: If we think about this eating disorder as almost consuming your daughter, I wonder how effective that strategy has been, do you think, in helping her recover and get healthy?

Postrelational lockdown

The therapy is undertaken via an online package; the family and therapist are both within their own homes. The session is focused on a family meal. Daughter is off screen.

Therapist: How have you decided what to eat together today?

Mother (*band width problems means that her speech slurs and her image freezes as she talks*): We didn't really decide. Our daughter has just got what she wanted to eat

Therapist: That is interesting. How would it have been different if we had run this session in our clinic do you think?

Father: I guess we would have made more effort and planned things better

Therapist: Would that have been harder or easier do you think?

Mother: I think it would have been harder. (*comment made by daughter not audible*)
Don't go!

Daughter apparently leaves the room. Mother follows. Shouting off screen. Father follows.

Therapist (*having failed to turn off the audio*) *mumbles to self: That went well*

The first case of coronavirus death was recorded in the UK in early March 2020. By the writing of this piece, there have been 44, 131 deaths* in which COVID-19 has been noted as a cause of death (Wikipedia, 2020). The majority of those who have died have had "pre-existing health conditions," are over 60 years of age, and men. Like most health conditions, the prevalence of fatality with COVID-19 mirrors social and financial disadvantage. Further, there is evidence that being from a minority ethnic population increases risk of death even when socio-economic disadvantage is considered. At the start of this pandemic, the UK Prime Minister, Boris Johnson, warned the nation (four nations: England, Wales, Scotland, and Northern Ireland) that families "will lose their loved ones before their time" (BBC, 2020a). I doubt that when he said this, anyone understood that those loved ones would be isolated during their final hours. This includes elderly relatives in care homes as well as young babies and children, alone, during their last moments of life. Nor did the nation understand that the consequence of "Stay home, Protect the NHS, Save lives" (the UK Government strapline) would be vast economic turmoil leading, possibly, to an extra 1.4 million unemployed citizens (Independent, 2020a); further deaths from the shutdown of all other health services (BBC, 2020b); vulnerable individuals (children and adults) being exposed to abusive interactions during lockdown (Guardian, 2020a); a potential rise in mental health conditions (through isolation, trauma, and the reduction in routine services; Independent, 2020b); a significant loss of learning within all levels of education; and

*By the time this piece is read, the number will be higher

eye-watering levels of national debt unprecedented outside of a world war situation. It would be fair to repeat the hyperboles of the politicians: never has a stable, Western, democratic nation had to withstand such a cataclysm outside of a world war; the last of which is now three generations in the past.

The ramifications of this cataclysm echo in system after system within our country. As I am writing this, the country is taking its first gradual steps out of lockdown and most of us expect the future to resemble a science fiction story in which the survivors emerge from a bunker to view a devastated landscape (Forster, 1928). The enormity of the rebuilding task is beyond both imagination and comprehension. Work, recreation, family life, and social interactions will all be different. The economic ramifications quite probably mean a generation of young people being underemployed. Small businesses have never seemed so vulnerable while the hospitality and tourism industries appear to have suffered the same catastrophe as large-scale manufacturing did in the UK in the 1980s.

This piece will seek to provide some thoughts about the effects of this crisis both on families and on the practice of family therapy in the UK. Many of my comments will be similar to those of colleagues around Europe although we have yet to hear from those who worked through the coronavirus “tsunami” in Northern Italy which seriously incapacitated their health system. Almost syntonic with the times, the evidence that will be drawn upon is, of necessity, less robust and reliable than that provided in most academic papers. Undoubtedly, a plethora of research will shortly emerge from more traditional sources, but here I will have to rely on news published on the human creation that has sustained us through these times of coronavirus: the Internet. The fullness of time will let us know if this evidence is substantiated or proves to be “false news.”

THE PROFESSIONAL, THE PERSONAL, THE LIFE CYCLE, AND FAMILIES

The day before the emergency was declared, my wife broke her wrist. We were due to attend the International Family Therapy Association Conference in Basel, Switzerland but, as it was canceled, chose to do some walking on the Cornish coast. She slipped and heard the crack.

Therefore, throughout the crisis, we have been coping with our own personal crisis, clearly nowhere near as traumatic as the suffering of others around us. But still, it has catapulted us into a family pattern well documented by family therapists (Altschuler, 1997; Rolland, 2018) in which we “hunkered down” and a relatively equal partnership became one where one partner was dependent on the other. We both fear that, in the years to come, this “first fall” might stand out in significance because of what was happening around us at the time.

I have chosen to call these times “relational lockdown” not to imply that there is no human connection happening. After all, systems practitioners know that it is impossible *not* to be in some sort of relationship. To a systemic sensibility, isolation is simply another form of relational context. Rather, I have used this phrase because what has happened has radically affected both the forms and breadth of relating. It has both “pressed the pause button” and added intensity. It is also worth noting that such a process is profoundly contrary to everything that constitutes “being human” (Harari, 2011). We are a social species (curiously, coronavirus is a social virus). This has defined our whole evolution. Having said that a kind of relational paradox has been unfolding. On the one hand, families have made great efforts to remain in contact with extended family members. In terms of staying connected to adult children and older family members, online programs have mushroomed in popularity (Business Insider, 2020). For instance, my wife and I have weekly Skype calls to our mothers who are in care homes and Zoom calls with our sons who are spread around the globe. But at the same time, the need to set these “meetings”

up, even with various friendship groups, demonstrates what a limited social life we are all living.

There is some evidence that this *family-focused inwardness* has led to more cohesive families (KCL, 2020a; Mirror, 2020). One survey reports that four out of five parents think their family has got closer as a result of lockdown. Social media has been full of advice to parents and children about how to spend their time including playing games, learning, and exercising together. There has also been a surge in “community” orientation with 750,000 people volunteering under a government scheme to help out older citizens and those who are “shielded” from the virus (The Guardian, 2020b). The rhetoric around lockdown therefore seems to be dominated by the concept of the nuclear family. As such, societal challenge has reverted to a narrow view of “family” in which single people, isolated older people, and extended family relationships appear to be marginalized.

But, of course, there has also been a less positive outcome of relational lockdown. The KCL (2020b) survey suggested that almost half the respondents were experiencing high levels of anxiety and depression, almost a fifth were drinking more alcohol and a fifth reported more arguments within their families during this time. Many young people (42% KCL, 2020a) described “really struggling” with the restrictions on their ability to meet friends and partners. Domestic violence support services have seen a rise in referrals (The Guardian, 2020b), and the police have been called to more mental health “incidents” (Independent, 2020b). Contrary to the rosy view about family life becoming more cohesive, while presentations to Accident and Emergency Departments have halved over the lockdown, at least one hospital reports that sibling on sibling injuries have increased by 150% (BBC, 2020d, 2020e).

The relational paradox also seems present in our relationships with other citizens. Despite the recorded rise in community feeling, the virus (and government messages) have often promoted fear. One insidious aspect of “social distancing” (in parks and supermarkets) reinforces the idea that the “other person” might be infectious. To make matters worse, they may be asymptomatic and not suffer the consequences of infecting us!

There are, within the family therapy world, a number of self-evident truths. One is that social calamity always hits the disadvantaged more than the socially privileged. Another is that disadvantages have a compounding effect. So just as those who have “pre-existing health conditions” are more likely to be harder hit by the virus, those families that are already suffering from psychological problems are more likely to be worse affected by lockdown. An unhappy couple relationship is unlikely, after all, to blossom into joy when the couple is together 24/7. Finally, in large part, how a family manages during the lockdown will be related to which stage in the family life cycle they are in (McGoldrick et al, 2016).

The majority of my clinical life is dedicated to working with families in which a young person has an eating disorder. Most of these families are in the “adolescent” phase of the family life cycle. One way of characterizing family treatment for these families is to help them get back on the appropriate developmental trajectory (Eisler et al, 2016; Lock & Le Grange, 2013). In the current situation, the young people are acutely conscious that they *cannot* get back on the appropriate developmental trajectory. Moreover, treatment relies on helping the parental system to be more containing of their young person’s distress. Significant work is done on helping the parents act as a team (even if they are not a couple). In relational lockdown, all the stresses of helping their young person are amplified with no distractions or escapes from the task.

In this clinical situation, myself and my team are constantly having to enquire what our families wish to do: “tread water” during the crisis and delay the challenges of change until we can support them face to face, or manage the consequences of change without the consistent backing of our service. Each option entails aspects of risk that would not have been present but for the lockdown (Independent, 2020a, 2020b, 2020c). One risks the

eating disorder continuing and blighting the young person's development for longer. The other risks an escalating emotional dysregulation that might lead to admission. As a family therapist, this is a very difficult place to inhabit. The experience feels as if I have a hand tied behind my back. The only clinical way it can be managed is to collaborate almost on every statement and every intervention in order to match the family's current capacity. It is too soon to know if there has been a rise in in-patient admissions (pediatric or psychiatric) during this crisis but anecdotal reports suggest that young people might be presenting in more acute situations.

THE HEALTH SYSTEM

The National Health Service (NHS) has a particular place within UK national culture (Welch, 2018). Founded in 1948, almost every citizen has some form of relationship to this "system." At least two popular soap operas (*Casualty* on air 33 years; *Holby City* 21 years) record the ups and downs of working within it. Other series shadow "real life" work within the NHS (*Great Ormond Street*; *24 hours in A&E*). The coronavirus crisis has stimulated this relationship with a national "clap for carers" event occurring every Thursday evening at 8pm and a host of celebrities raising money to help the NHS. "Frontline" NHS workers are given preferential hours in supermarkets, along with the elderly.

Most UK family therapists work within the NHS, often with a "mixed portfolio of employment" including some private work. One survey of UK family therapists found that 80% worked for the NHS (Street & Rivett, 1996). The coronavirus crisis has had a number of impacts on this health system. Firstly, all resources have been temporarily diverted to manage the demand caused by patients with COVID-19 symptoms. This has included the effective closing down of a range of "routine" services including regular screening programs, cancer treatment, and all dentistry. Luckily for us, orthopedic services have remained active. Secondly, NHS staff have been redeployed into areas where the COVID-19 need is high. So, nurses who have worked in mental health services have been asked to work on wards. Some mental health wards have been designated dual wards for psychiatric patients who have COVID-19. Some psychological staff have joined "well-being" teams to offer support to frontline workers. Within mental health services, except in acute psychiatry, face-to-face work has largely been suspended due to the infectiousness of the virus. Most family therapists have therefore had a steep learning curve in the delivery of online therapy (Salivar et al, 2020).

Unfortunately, the NHS, which is excellent at physical crisis management, has very poor IT infrastructure. Equally, it has stringent confidentiality procedures which preclude the use of platforms deemed acceptable by bodies such as the HIPAA. A range of "home-grown" NHS digital platforms exist, each with their own glitches and challenges all made more difficult by the poor Wi-Fi coverage in many hospital sites. The opening "postlock-down" vignette encapsulates the problems we all have faced, at least initially. Nevertheless, many family therapists are now undertaking therapy online and indeed teaching online (all universities have migrated to online platforms BBC, 2020b). Here, crisis has stimulated opportunity. My own team is currently running multifamily groups through an online app, and although the results are positive, they are clearly *not the same* as having the families in the same room. For instance, this kind of multifamily group work (Scholz & Asen, 2009) relies on facilitators using the resources of other families to provide difference and challenge. In online therapy, it is almost impossible to notice the nonverbal changes and the micromovements that in a live situation may be explored to uncover alternative ideas and perspectives.

These clinical developments have precipitated a related crisis in the training of family therapists. Our professional association (AFT, 2020a) has had discussions about how

many hours of online therapy should count toward the professional qualification. To date, no UK family therapy training has integrated “teletherapy” into its curriculum, unlike some US courses (Cravens Pickens et al, 2020). There are widely differing views about this subject. Some teachers are arguing for a figure as high as 50% of the qualifying hours could be online therapy. Others argue for less, asserting that learning to do family therapy is a different training from learning to do online family therapy. The European Family Therapy Association (EFTA, 2020) has also started developing evidence around the use of digital family therapy. This debate is limited by the lack of research into “online family therapy” in contrast to the evidence that our CBT colleagues can draw on (Andersson et al, 2014).

As noted above (Independent, 2020a, 2020b) there are suggestions that after the lockdown, mental health services may be as severely stretched as their physical health colleagues have been during the crisis. It is worth noting that until this crisis, UK health policy had been aiming to reach a funding situation in which “mental health” and “physical health” were funded equally (Gov.UK, 2015). This pandemic seems to have dented that policy, if not made it obsolete.

CULTURAL AND RELATIONAL TRAUMA

Prior to coronavirus, the UK was still grappling with the divisive consequences of the Brexit referendum in 2016. This pandemic has constituted a very different social trauma. Almost certainly, there will be an enquiry into how our government behaved and how the scientific advice did or did not help prevent further deaths. It may be that this enquiry will function in a similar way to the “Truth and Reconciliation Committees” in South Africa. What we can say is that no nation can lose 44,131 of its citizens, with the ripples of each death giving pain to so many loved ones, without experiencing trauma. This trauma is possibly a unique kind of trauma, not one that is reflected in the family therapy literature on trauma itself (Charlés & Nelson, 2019; Coulter, 2013; Figley & Figley 2009; Landau et al 2008; Mendenhall and Berge 2010; Saltzman 2016; Walsh 2007). Most of this literature considers systemic interventions in situations where family members or whole communities have been traumatized by disasters (such as Hurricane Katrina) or acts of war (such as 9/11 or military conflicts). But much of what these authors are describing is similar to the mass upheaval that is occurring during the coronavirus outbreak. Landau et al. (2008) for instance states:

Mass trauma challenges the integrity of a society (and our global community) at multiple levels and exposes us to the bare bones as we struggle to survive, heal, and rebuild which often takes several generations. (2008: 193)

Once more the pandemic introduces a complexity to the concept of “mass trauma.” All of them highlight the role of family and community resources to promote resilience and recovery. This undoubtedly will be the place where family therapists can offer their skills later on. But in the foreseeable future, the isolation of social distancing will surely act to compound the struggle to heal and rebuild. The major UK government message (apart from regular handwashing) is that “we are all in it together.” And yet, it is only by TV and social media that the connections of society are being maintained. In many ways, we have become even more of a “society of the spectacle” as predicted by the Situation Internationalists in the 1960s (Plant 1992). In this case, relational lockdown acts as a kind of barrier to immediate experience, to vivid engagement with each other’s suffering.

The risks of not finding a way of harnessing these family and community resources are noted by all the trauma writers: increased individual and family difficulties; social expression of anger and resentment; and blame being attached to specific populations (often

racial groups). Landau et al (2008) also point out that within a society which is coping with a trauma, there is frequently a process of “transitional conflict” (2008: 196) because different family members; different families; and different sections of society experience the trauma *differently*. This is likely to lead to factionalism and polarized positions rather than a communal ethic of working together. The coronavirus has affected different parts of the UK very differently. The cities have largely been hubs of infection and mortality. Like in other nations, coffins have had to be stored in containers awaiting time for burial. But other parts of the country have been relatively free of infection: leading to signs asking for “city folk to stay away.” There is also evidence that the different nations within the UK are responding to the virus in different ways especially in managing the easing of restrictions. The risk, therefore, is that divisions will not heal but will expand and blame will become the predominant pursuit of influencers, politicians, and journalists. There can be no greater clarion call for systemic thinkers than this.

THE FUTURE OF FAMILY THERAPY PRACTICE IN THE UK

All the trauma writers comment about the possibility of “traumatic growth” arising out of a collective challenge. Walsh states:

traumatic experience often yields remarkable transformation and positive growth. (Walsh 2007 : 208)

The EFTA website also asserts:

most families build family/social resilience out of crises/adversity. (EFTA 2020)

Media commentators (and ecologists) are emphasizing that society “will not go back to the old ways” (BBC 2020c). They cite more working from home, less commuting, more exercising outdoors, and an increase in local holiday making. But systems theory might predict “homeostasis” will be an equal (if not stronger) pull. I think we are all yearning for “things to get back to normal.” It also feels very insensitive to consider positives in this crisis when so many families are losing loved ones and others are losing their livelihoods.

However, there is a general agreement that online working, teaching or providing therapy, is here to stay. Universities are talking about a “blended” curriculum (meaning a mixture of online learning and face to face). The University of Cambridge (BBC 2020b) has already announced that for the 2020–2021 academic year lectures will stay online. Mental health services are talking about the cost savings of online therapy. Families are getting used to receiving services within their own homes and some find it more accessible because of this. It is easy to understand the appeal of online therapy when the alternative (at present) is to offer therapy while all participants are dressed in full PPE (personal protective equipment).

In the UK, debates about training excepted, family therapy has moved online. There are now some excellent guides available about how to “do” online therapy (AFT 2020b; Levy et al 2020). My own favorite “tip” is to have more than one device running for each family so individual reactions can be integrated into the session. Clinicians now need to develop competencies in this mode of intervention, and a range of courses are being set up. But we still do not know whether it is as effective as face-to-face therapy, although Salivar et al (2020) provide some evidence that an online version of integrative behavioral couple therapy is as effective as the “live” version. The examples that we have might imply that this medium could benefit some of the more manualized family therapy models (Levy et al 2020) rather than the more conversational and social constructionist ones. Nor do we know if all the family therapy competencies can be demonstrated in online therapy

(Gehart 2010; Nelson et al 2007; Stanton and Welsh 2011). As a teacher of family therapy, I believe that the “process” skills of our craft (e.g., attending to interactions within sessions) are much harder to evidence in a piece of online therapy.

UK family therapists are also noticing that online therapy does not always work in the same way, as face-to-face therapy. For instance, I have heard of a client who had to sit against the door while talking to her therapist to avoid her children interrupting the session.¹ Not all families have the ability or financial capacity to use online therapy. The Office for National Statistics (2019) believes that 7% of UK households do not have access to the Internet. Recent surveys of online schooling have suggested that up to 700,000 children in the UK do not have stable access to online learning platforms (BBC 2020f). Just as I commented that running online groups was different to running them face to face, some family therapists (and other therapists: Greenberg 2020) are talking about what they miss in providing online therapy. One of the significant “losses” of online therapy is that human *bodies* are not interacting with each other. It is difficult to quantify exactly what this takes away from therapy, but we know that family therapists are conscious about this embodied dimension in their work (Bownas and Fredman 2017; van der Kolk 2015). The lack of embodied presence relates to an idea first proposed by Turkle (2017) that the online world is one in which we are “alone, together”. Petriglieri (2020) has crystallized this experience in his pithy phrase that “it is easier being in each other’s presence, or in each other’s absence, than in the constant presence of each other’s absence.” There may therefore be a further paradox in the way coronavirus is affecting family therapy: the new medium of therapy rather than overcoming isolation (Entis 2020) may in fact be replicating it. For UK family therapists, who have largely retained some team working within their week, the new online world reduces their contact with colleagues in ways that almost certainly will diminish job satisfaction.

LIVING WITH UNCERTAINTY

Throughout the ages, a range of spiritual teachers have exhorted human beings to accept the uncertainties of their lives (Watts 1988). We now seem to be living in an uncertain world. We do not know how many more colleagues, friends, and family members will lose their lives to this virus. In the UK, we sit on a knife’s edge wondering whether we will experience a “second peak” (or even a “third peak”). We cannot know when we will be able, once more, to actually meet our clients and work with them face to face. We cannot predict the unique psychological problems that arise from this virus that will challenge our clinical creativity. But we do know how to help families bear what seems unbearable and to mourn fruitfully.

My wife’s cast came off last week, and the tough pain of recovery is just starting.

REFERENCES

- Altschuler, J. (1997). *Working with chronic illness*. London, UK: Macmillan Press.
- Andersson, G., Cuijpers, P., Carlberg, P., Riper, H., & Hedman, E. (2014). Guided internet-based vs face-to-face cognitive behaviour therapy for psychiatric and somatic disorders: a systematic review and meta-analysis. *World Psychiatry, 13*, 288–295. <https://doi.org/10.1002/wps.20151>
- Association for Family Therapy (2020a). Retrieved May 25, 2020, from <https://www.aft.org.uk/join-AFT/view/COVID-19-Info.html>

¹Many of the examples of practice cited in this reflection come out of conversations with colleagues, in particular Hannah Sherbersky.

- Association for Family Therapy (2020b). Retrieved May 25, 2020, from [https://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/COVID-19/Final%20Guidelines%20for%20remote%20working%20with%20couples%20and%20families\(1\).pdf](https://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/COVID-19/Final%20Guidelines%20for%20remote%20working%20with%20couples%20and%20families(1).pdf)
- Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballantine Books, a division of Random House Inc.
- BBC (2020a). Retrieved May 25, 2020, from <https://www.bbc.co.uk/news/av/uk-51862282/coronavirus-pm-says-more-to-lose-loved-ones-before-their-time>
- BBC (2020b). Retrieved May 25, 2020, from <https://www.bbc.co.uk/news/health-51979654>
- BBC (2020c). Retrieved May 25, 2020, from www.bbc.co.uk/news/uk-52793230
- BBC (2020d). Retrieved May 25, 2020, from <https://www.bbc.co.uk/sounds/play/m000htw2>
- BBC (2020e). Retrieved May 25, 2020, from <https://www.bbc.co.uk/news/education-52732814>
- BBC (2020f). Retrieved May 25, 2020, from <https://www.bbc.co.uk/newsround/53047270>
- Bownas, J., & Fredman, G. (2017). *Working with embodiment in supervision*. Abingdon, Oxon, UK: Routledge.
- Business Insider (2020). Retrieved May 25, 2020, from <https://www.businessinsider.com/zoom-video-everywhere-google-hangouts-skype-2020-3?r=US&IR=T>
- Charlès, L., & Nelson, T. (2019). *Family therapy supervision in extraordinary settings*. New York: Routledge.
- Coulter, S. (2013). Systemic psychotherapy as an intervention for post-traumatic stress syndrome. *Journal of Family Therapy*, 35, 381–406.
- Cravens Pickens, J., Morris, N., & Johnson, D. (2020). The digital divide: couple and family therapy programs' integration of teletherapy training and education. *Journal of Marital and Family Therapy*, 46, 186–200.
- Eisler, I., Simic, M., Blessitt, E., & Dodge, L. (2016). *Maudsley service manual for child and adolescent eating disorders*. London, UK: Kings Health Partners.
- Entis, L. (2020). Retrieved May 25, 2020, from <https://www.msn.com/en-in/lifestyle/in-depth/the-stark-loneliness-of-digital-togetherness/ar-BB14Ekkz>
- European Family Therapy Association (2020). Retrieved May 25, 2020, from <https://www.europeanfamilytherapy.eu/>
- Figley, C., & Figley, K. (2009). Stemming the tide of trauma systemically: the role of family therapy. *The Australian and New Zealand Journal of Family Therapy*, 30, 173–183.
- Forster, E. M. (1928). The machine stops. *The eternal moment and other stories*. (pp. 3–38). London, UK: Sidgwick & Jackson.
- Gehart, D. (2010). *Mastering competencies in family therapy*. Belmont, UK: Brooks/Cole Cengage.
- Gov.UK (2015). Retrieved May 25, 2020, from <https://www.gov.uk/government/news/making-mental-health-as-important-as-physical-health>
- Greenberg, G. (2020). Therapy under lockdown: 'I'm just as terrified as my patients are'. Retrieved May 25, 2020, from <https://www.theguardian.com/society/2020/apr/23/therapy-during-coronavirus-pandemic-lockdown-psyc-hoanalysis-freud>
- Guardian (2020a). Retrieved May 25, 2020, from <https://www.theguardian.com/society/2020/mar/28/lockdowns-world-rise-domestic-violence>
- Guardian (2020b). Retrieved May 25, 2020, from <https://www.theguardian.com/society/2020/may/26/uk-volunteer-ring-coronavirus-crisis-community-lockdown>
- Harari, Y. N. (2011). *Sapiens: a brief history of humankind*. London, UK: Vantage.
- Independent (2020a). Retrieved May 26, 2020, from <https://www.independent.co.uk/news/business/coronavirus-uk-employment-furlough-workers-covid-19-ons-a9521296.html>
- Independent (2020b). Retrieved May 26, 2020, from <https://www.independent.co.uk/news/uk/home-news/coronavirus-suicide-rates-uk-mental-health-support-a9451086.html>
- Independent (2020c). Retrieved May 25, 2020, from <https://www.independent.co.uk/life-style/health-and-families/coronavirus-lockdown-mental-health-impact-royal-college-of-psychiatrists-a9517331.html>
- KCL (2020a). Retrieved May 26, 2020, from <https://www.kcl.ac.uk/news/life-under-lockdown-coronavirus-in-the-uk>
- KCL (2020b). Retrieved May 26, 2020, from <https://www.kcl.ac.uk/news/the-three-groups-reacting-to-life-under-lockdown>
- Landau, J., Mittal, M., & Wieling, E. (2008). Linking human systems: strengthening individuals, families and communities in the wake of mass trauma. *Journal of Marital and Family Therapy*, 34, 193–209.
- Levy, S., Diamond, G., Mason, S., Russon, J., Bouwens, C., Santans, T. et al. (2020). *ABFT via Telehealth & COVID-19*. Retrieved May 26, 2020, from <https://drexel.edu/familyintervention/abft-training-program/overview/>
- Lock, J., & LeGrange, D. (2013). *Treatment manual for anorexia nervosa*. New York: Guilford.
- McGoldrick, M., Preto, N., & Carter, B. (2016). *The expanding family life cycle*. Boston, MA: Pearson.
- Mendenhall, T., & Berge, J. (2010). Family therapists in trauma-response teams: bringing systems thinking into interdisciplinary fieldwork. *Journal of Family Therapy*, 32, 43–57.
- Mirror (2020). Retrieved May 27, 2020, from <https://www.mirror.co.uk/news/uk-news/coronavirus-lockdown-brought-families-closer-21884982>

- Mitchell, J. (1970). *Big Yellow Taxi*. Reprise Records.
- Nelson, T., Chenail, R., Alexander, J., Crane, R., Johnson, S., & Schwallie, L. (2007). The development of core competencies for the practice of marriage and family therapy. *Journal of Marital and Family Therapy, 33*, 417–438.
- Office for National Statistics (2019). Retrieved May 26, 2020, from <https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2019>
- Petriglieri, G. (2020). Retrieved May 26, 2020, from <https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Ftwitter.com%2Fgpetriglieri%2Fstatus%2F1246222551799541763%3Flang%3Den&data=02%7C01%7CM.J.Rivett%40exeter.ac.uk%7Ce9dc937015ab4c7fa34708d8062d042d%7C912a5d77fb984eef321334d8f04a53%7C0%7C0%7C637266137705145058&sdata=VLZ3BEWLvniyqmlNfhhj%2F7LEJgoiMW3en h1QWHWA0ZE%3D&reserved=0>
- Plant, S. (1992). *The most radical gesture*. London, UK: Routledge.
- Rolland, J. (2018). *Helping couples and families navigate illness and disability*. New York: Guilford.
- Salivar, E. G., Rothman, K., Roddy, M., & Doss, B. (2020). Relative cost effectiveness of in-person and internet interventions for relationship distress. *Family Process, 59*, 66–80.
- Saltzman, W. (2016). The FOCUS family resilience program: an innovative family intervention for trauma and loss. *Family Process, 55*, 647–659.
- Scholz, M., & Asen, E. (2009). *Multi-family therapy*. Hove, UK: Routledge.
- Sheinberg, M, and Fraenkel, R. (2011). *The relational trauma of incest*. New York: Guilford.
- Stanton, M., & Welsh, R. (2011). *Specialty competencies in couple and family psychology*. Oxford, UK: Oxford University Press.
- Street, E., & Rivett, M. (1996). Stress and coping in the practice of family therapy: a British survey. *Journal of Family Therapy, 18*, 303–319.
- Turkle, S. (2017). *Alone together*. New York: Basic Books.
- Van der Kolk, B. (2015). *The body keeps the score*. London, UK: Penguin.
- Walsh, F. (2007). Traumatic loss and major disasters: strengthening family and community resilience. *Family Process, 46*, 207–227.
- Watts, A. (1988). *The wisdom of insecurity*. New York: Random House.
- Welch, E. (2018). *The NHS at 70: a living history*. Barnsley, UK: Pen and Sword Books.
- Wikipedia (2020). Retrieved May 26, 2020, from https://en.wikipedia.org/wiki/COVID-19_pandemic_in_the_United_Kingdom