Anna Freud National Centre for Children and Families

The PPIP Society

Covid-19: suggestions for practice of psychotherapy with parents and infants via digital video platforms

These guidelines have been developed over this short period by clinical and training staff practicing parent infant psychotherapy at the Anna Freud Centre. We have considered the unique issues that can arise when working with babies and their families via video platforms, during a period of heightened societal and personal stress. **Our key preoccupation is how to create and sustain a safe space for therapy** in the digital frame.

With a systemic-relational view of PIP work, we have particularly thought about how we ourselves may feel, think, worry about – and thus what we bring to the session in terms of our own internal states. We assume that, to some degree, we are also hyper-aroused and need to take care, therefore, in relation to therapist-generated impingements, their impact, and repair.
Please pick and choose from these ideas for each family you work with, at different times, and according to your own state of mind at any given time.

1. Discussing therapy within a digital platform with the family

The preparatory conversation may be easiest held in a telephone conversation as families differ in their responses to the idea of meeting their therapist on a digital platform.

One of the key issues that arise is that of where the therapy can take place to **ensure privacy and confidentiality**. Within your home, it is important to have a closed and distraction free area that can replicate the metaphorical constancy of a consulting room.
From your patients' point of view, ensuring a confidential setting may be problematic – depending, for example, on how many people are sharing their physical space, presence of other members of the family, etc.
If either you or your patients are not able to ensure a private space for confidential work, it is probably best to agree to move from a therapeutic contract to one of

supportive contact, if wanted by the family. This would be characterized by a 'checking in' and 'touching base' stance – to listen and support, perhaps by telephone.

It can be important to talk to the family about how the imagine they will feel with this new arrangement. Some patients may have very mixed feelings about allowing you as a 'cameraperson' into their residence – it can feel intrusive, shaming, dismembered. Others may have a lot of experience of using digital platforms e.g. to keep in contact with distant family, and feel relatively confident.
Give thought with the family to **what will best anchor you and them in a PIP state of mind**. For example, if you habitually sit with your patients on the floor, it be helpful to suggest this to the family so that even via the video you are all in your familiar positions and at the level of the baby. We have found that the babies may cause disruptions with the camera (indeed this may test the patience of the adults), but can also introduce opportunities for playfulness, exploration of stress triggers, boundary setting.

Familiarise yourself with operating the system you are using and suggest to the family that they do the same. This may ease some the anxiety about the 'something new' and 'will it work for me?'.

The following are further guidelines from the BPS which you may wish to adopt or adapt:

Before starting video therapy, discuss expectations with the parent/carer, and set up a specific therapeutic contract for video therapy. This could include reference to the following:

- Consideration of whether you can still work on the therapeutic goals you have previously agreed or whether these need adapting
- Agreement on where sessions could take place in the house
- Can this be the same place each session?
- Will the space be private from being overheard by others?
- Can we agree that nobody will be in the room if they are not involved in the therapy?
- If there is a TV, is it ok for that to be turned off?
- Discussion of how you would like to manage the situation if siblings or other family members unpredictably enter the room.
- Discussion of what you would like to do if the parent and/or baby/toddler/preschooler becomes distressed or the session has to be ended for an unplanned reason
- Discussion of how you would like to manage technical difficulties. This should include an alternative telephone number to contact the parent/carer if the video link does not work
- An understanding that the psychologist convenes the sessions, invites the parent and family to attend at a specified time, and that video contact between sessions will not be possible.
- An understanding that parents/carers must not record any part of the session.
- Clarification that any safeguarding concerns will be managed in the usual way; be mindful that video may reveal risks that might have been unknown before, including poor living conditions, behaviour of other family members etc.

When setting up appointments, send families a unique, secure hyperlink to activate each session, to avoid out of session contact.

2. Preparing yourself before each session

We are all constantly exposed to distressing news, however deeply we choose to shut ourselves off from it. Furthermore, there are many primary issues with which we are confronted by Covid-19 – mortality, possible loss, out-of-controlledness, social vs personal responsibility, etc. It is not possible to empty ourselves entirely of these private worries before contact with our patients. However, each of us has resources and techniques to listen to ourselves, bear our emotions and anxieties, and steady ourselves within. We need to do this self-steadying before each session. You will know you are in a balanced state through your breathing, the muscular tension around you mouth, feeling relaxed in your shoulders.

If, however, you feel that your ability to calm your mind is slipping, for whatever reason, please do not hold a session. It may be possible to reschedule with the family and it may be time to focus on looking after yourself and getting support to do so.

3. Adapting clinical practice

We are guided at this time, in this situation, by the question of how to best contribute to our patients' well-being as they get through their day/s. To this end, we have found that

a) It is important to stay with the here and now of our patients' daily lives. Often this gives opportunity to mentalize experience – think about what happens in the course of their self-isolation with baby, give name and normalize affects where it is the case. We do not regard a flood of speech regarding the seemingly mundane as 'nonanalytic' or defensive in these circumstances.
b) Pressure of speech on the part of the parent/s can make it difficult to access the baby in the session. We need to hold in mind how the baby may be experiencing the parent's anxieties and burdens and ease thinking about their baby into the parent's preoccupation.
c) Digital working also complicates our ability to really include the baby in the moment through interactions and play. When the family and screen are on the floor the baby and therapist can see each other. Babies respond in various ways to a screen, but often seem to register our physical non-presence in an anxious way. Tracking the baby as much as possible will enable you to pick up expressions of interest in the baby which you can capitalize on to represent their inner world. When the family is not on the floor the baby may be physically absent from your screen and you may have to rely on mentalizing him/her with the parent.
d) Within the session we need to think with the parents not only their upsets and fears but also how they rally themselves. This, in Anna Freudian terms, would be working with ego strengths – their coping abilities. For example, a parent describes being driven mad by a situation. It is not sufficient to explore how/why they got into that state – i.e. the triggers to the stress response, but also how they got *out* of that state of mind – i.e. more resilient aspects of their functioning.

e) We suggest refraining from therapeutic interventions that arouse anxiety and challenge our patient's coping mechanisms. It is important to remember that you are operating with reduced information about your patients' responses to your interventions. You are limited to the frame of the screen and miss many of the nonverbal cues that normally inform us about 'how' our intervention has been experienced by the other.

We quote from Gillian Isaacs Russell, Ph.D., NCPsyA
On screen, the view of the face without the whole body is closer than in-person connection and distracting. It is two-dimensional. The loss of many subtle non-verbal cues means that we have to work so much harder to perceive the whole communication.
This is loss of a sense of presence, a core neuropsychological phenomenon stemming from an organism's capacity to locate itself in an external world according to the action it can do in it. For humans these actions specifically include the person's capacity--even potential capacity-- to interact with another person in a shared external environment. The sense of presence enables the nervous system to recognize that one is in an environment that is outside one's self and not just a product of one's inner world (i.e. being awake, not dreaming). Presence is not the same thing as emotional engagement, absorption or the degree of technological immersion.
When communication via technology "works," it is because we have an illusion of this sense of presence. But the illusion cannot be consistently maintained. We lose the illusion of shared embodied presence when we have to narrow our focus and concentrate hard. That is why working with technology is so tiring. It is more difficult to get to those moments of evenly-suspended attention, reverie, relaxed communication.

f) Flexibility, in these circumstances, means going the extra mile in reaching out to a vulnerable baby and parents, and engaging with the network to ensure they receive professional support and containment to keep safe. It may also mean that if you 'meet' at a prearranged time, and the family is too much turmoil to engage, you call a short time later if you can, and hold the session then. Sometime a full session cannot be managed but a shorter holding meeting is helpful. Our approach is to use your clinical judgement to assess what the family can make use of at any point in time and work with that, even if it feels that the usual analytic frame is being somewhat flexed.

Risk

Stress inevitably increases overall risk in already vulnerable population and stressors are multiplying in families e.g. with the prolonged social isolation and increasing unemployment. We also need to be alert to covert issues, such as domestic violence or reliance on alcohol/substances, which may become more pervasive under stress

Assessing risk is more complicated for the therapist if not brought as a concern by the parent, whether about themselves or about their baby; again, this is because you are missing so many of the nonverbal cues to which you have access when physically together. As much as possible, these are now issues you may need to initiate conversation about and probe verbally. Contact with the network around the family has

never been more important.

We ourselves are also at risk: from the outside through potential illness and loss of close others, in the consulting room through traumatic contagion and psychic exhaustion. Risk seems to sit heavily with the therapist in this online period, when so many of the health and community resources are hard to access, and can make other work more difficult. Moreover, for those working within organisations and teams, our ordinary contact with colleagues – often an important source of support – is no longer built into our working lives.
We think it is very important to organize a professional community around you and maintain regular contact with them. Supervision during this period is central, as you well know, but maybe not enough. We advocate for 'communities – online'.

We wish you all the very best.