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Perspectives in Infant Mental Health

The Voices of COVID-19

Professional Publication of the World Association for Infant Mental Health

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From Desk of the President of WAIMH

By
Campbell Paul, Melbourne, Australia

Associate Professor, President of WAIMH

As we approach the end of the year 2020, it is important to look back and reflect upon what has been an exceptional year of stress and anxiety with the impact of the COVID-19 worldwide pandemic. The pandemic causing severe illness and death of so many has impacted the health, relationships, and well-being of infants and parents. Restrictions have been placed upon family and professional supports and services for mothers, babies, and fathers. Whole communities are experiencing job loss, financial insecurity, and social upheaval. This means we must build our information base and be even more insistent and creative in how we advocate for the needs of the infant within the family. Colleagues from the UK, USA, Poland, Turkey, the Netherlands, and Australia have initiated one of several surveys on the impact of the pandemic upon children 0 to 4 years. Colleagues from the Queensland Children's Hospital, Australia, are taking the lead in this project (https://www.childrens.health.qld.gov.au/covid-19-unmasked/). We welcome news of other projects looking at the impact of the pandemic on infants and families.

This year was to have been 40 years since the first Congress in Cascais, Portugal, but now our Congress will be June 23-27, 2021 in Brisbane, Australia. Each Congress, held in a different country, has had its own unique features, and the Brisbane Congress will be no exception.

This congress will be a "hybrid" one, with an innovative mixture of in-person, COVID-19-safe presentations in Brisbane, and live virtual symposia and presentations through online media. In addition, most events will be video-recorded, and congress participants will be able to view these for some time after the event and exchange ideas and comment through "chat". This means that effectively everybody has ready access to the work of their colleagues, as you will have an opportunity to review most of the sessions at your leisure. We will have a rich cultural and arts program, and sessions particularly pertinent to Oceania and Asia.
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WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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The new crises in mental health present challenges for all world governments and there are public policy changes that must be addressed to meet the needs of all our babies. Infants' rights must be identified and upheld.

We will have plenty of opportunities for people across the world to meet in small groups through zoom to discuss the plenary, symposia, and other presentations, and meet with some of the thought leaders in our field. Our important prominent plenary speakers include Prof. Helen Milroy from the University of Western Australia who will share crucial understandings about the resilience of Australian Aboriginal cultures in supporting infants and young children within families and community. There is more news about the plenary and other speakers on the Congress website. With the amazing revolution in opportunity for us to meet in real-time using virtual media, we anticipate an even larger number of people participating in the Congress than those who attended in person the Congress in Rome.

Please take care and keep safe, care well for yourselves, your families, and colleagues in these troubled times. We look forward to seeing you in person or in virtual reality in June next year.

WAIMH Executive Director Corner

Dear colleagues and friends,

The year 2020 is nearing its end and there have been a lot of memes going around expressing the wish that the whole year could be cancelled or erased. This issue of Perspectives is about one of the major reasons for people wishing for this, the Covid-19 pandemic. For those of us working with infants and their families in different parts of the world the year has meant increased worrying. Prolonged or repeated lockdowns of communities and cities have meant complete loss or at least reduced accessibility of services for the families in both health care and social services, and we know how harmful that can be for the wellbeing of our client families. At the same time worries concerning the health of our own families and ourselves have been in our minds all this time, and the worry for our colleagues working in the different occupations where social distancing is not possible. As many of you may remember, I live in Finland which in all the memes is the country with serious, silent people who like to keep at least 2 meters distance from one another. So this year may perhaps have been a bit easier for us Finns concerning instructions of social distancing, as it is not our custom to kiss friends hello or goodbye, and even hugging each other is a new custom that youngsters have adopted far more easily than earlier generations. Yet, even for us the necessity of not meeting our relatives and friends has started taking its toll. The most painful issue for us, too, has been not being able to see our elderly relatives for fear of infecting them, and particularly grandchildren not being able to visit grandparents for longer periods of time. Luckily there is now good news coming in from different countries concerning the development and effect of new vaccines against the Covid-19, but it will still take a while before the pandemic is over.

In Finland the recommendation for wearing protective masks in offices and public spaces was not issued until this autumn. Slowly but steadily the number of adults wearing masks in public has increased and questions concerning young children's reactions to this have been raised here too. Just this morning I read in our local newspaper a plea from an early educator to allow the staff in day care centers to work without face-covering masks. In this issue of Perspectives you will also find a paper discussing the possible effect of adult mask-wearing on infants and young children. It is hard to reconcile the need to prevent the Covid-19 virus from spreading with the need of young children to see us showing emotions with our facial expressions. How then should we advise parents in this difficult situation? One thing we can tell parents is that if no one in the family is ill with the virus, masks at home are not needed. Parents could also be encouraged to increase the time they are in face-to-face interaction with their infants and young children, and leave smart phones and other gadgets alone until children have gone to bed. Having said that, there is one thing where computers and online connections can be of use. Our president Campbell Paul has mentioned in many of his talks how infants and young children can be engaged in interaction via video connection in remote clinical sessions. Maybe we could encourage grandparents, aunts, uncles, cousins and other close adults to spend some time weekly in interaction with infants and young children. It is amazing what we can do these days with our smart phones, tablets and computers. I myself was lucky to have a lovely experience of exchanging recorded voice messages with my four-year-old grandson which was really heartwarming in its simplicity. I also saw a lovely video of my nephew's newborn son (I am a four-time great aunt as well), and was able to reassure the parents that the funny sounds he made in his sleep meant that he was dreaming and that there was nothing wrong with the baby. A little thing for me, but a big question for the new parents.

I have often talked about how we all need support and reassurance, no matter whether we are old or young, experienced or new to things. In these times with so many uncertainties about the future, I believe we need each other's support even more. And since we cannot meet and touch each other as much as we would like to, let us send a nice message to, call or videocall our near ones and encourage the parents to reach out as well in all the ways they can. Let's make all this technology work for the good of us all, and particularly for our young ones.

My warmest wishes to all of you,

Kaija

The Voices of COVID-19 Perspectives in Infant Mental Health Special Issue: From the Editors

By Maree Foley (Switzerland), Holly Brophy-Herb (USA), Jane Barlow (UK), Patricia O'Rourke (Australia), Jody Todd Manly (USA), Azhar AbuAli (UAE), Salisha Maharaj (South Africa), and Chaya Kulkarni (Canada)

We welcome you all to this winter (2020) special issue: The Voices of COVID-19 WAIMH *Perspectives in Infant Mental Health*. We wanted to take this opportunity to acknowledge every baby across the globe, and to strengthen our resolve to be actively engaged in ensuring that every baby is seen, protected, and provided with nurturing care, along with their families and their communities. We also wanted to take this opportunity to acknowledge all infant and early childhood mental health professionals who are working relentlessly with, and on behalf of, babies and their families amidst this COVID-19 pandemic.

Early in 2020, in response to COVID-19 and the emerging voices of families with infants, early childhood mental health practitioners, and researchers, a tiered initiative with three unique but inter-related platforms was developed as a collaboration between the *Infant Mental Health Journal* and WAIMH *Perspectives in Infant Mental Health*. The initiative, "*Infant and Early Childhood Mental Health in the Context of the COVID-19 Pandemic*", is led by Holly Brophy-Herb (Editor of the Infant Mental Health Journal), Jane Barlow (Guest Editor), and Maree Foley (Editor of WAIMH Perspectives in Infant Mental Health).

This special issue of WAIMH Perspectives in Infant Mental Health, represents the culmination of our efforts for Platform 1: The Voices of COVID-19 WAIMH Perspectives in Infant Mental Health. At the outset, the goals of this platform were to:

1. Capture some of the experiences of individuals, families, and practitioners of meeting and working together with the shared purpose of supporting, promoting, and protecting the mental health of babies during this global COVID-19 pandemic.
2. Make these learnings from these experiences immediately available to WAIMH and our allied WAIMH community; and
3. Identify emerging themes that could inform future empirical COVID-19 infant and early childhood mental health research.

Furthermore, given that many of us are in virtual connection but not able to meet in person, we asked authors to keep in view both the baby in the families that are the focus of their paper, and you the reader. Our hope in doing this was to bring each reader as close as possible to the infants and families that the authors present to us - as if we were together in the same room, sharing experiences, and learning from each other.

Work on this special issue began in July and we are delighted to now share with you a series of papers. We begin the series with two research papers that focus on pregnancy and birthing.

The first is a paper from colleagues in Portugal: *COVID-19 and Mental Health in Pregnancy: A Cross-sectional Study on Depression, Anxiety, and Stress among Portuguese Pregnant Women* (Pedro Rafael Figueiredo, Joana Mesquita Reis, Francisca Padez Vieira, Patrícia Lopes, Maria João Nascimento, Cristina Marques, Pedro Caldeira da Silva). The next paper is from colleagues in Chile, entitled *Birth during the Coronavirus Pandemic: "When fear is the uninvited guest"* (Macarena Romero, Catalina Sievereson, Marcia Olhaberry, Carolina Honorato, and Trinidad Tagle). The focus then turns to a paper on shared pleasure by a colleague in South Africa, Anusha Lachman entitled: Shared Pleasure in the Time of COVID 19 – The Importance of the Shared Smile for Babies in a World of Masked Faces. We then feature a paper that is oriented towards the care of the practitioner, written by colleagues in the USA, Margaret Holmberg and Heidi Maderia, entitled: *Helping the Helpers. Relationships During the Pandemic: "Good Morning, Margaret" "Good Morning, Heidi"*.

The next group of papers, from colleagues in the USA and Portugal, are clustered around the theme of telemedicine and telehealth: *A necessary Telemedicine Intervention for a Pre-Schooler with Anxiety during COVID-19: A Clinical Reflection* (Miller Shivers, USA); *When the Screen becomes a Playground: A Dyadic Therapy Program's Transition to Telehealth during COVID-19* (Hillary Mayers, USA); *Symbolic Play using Telehealth: A Brief Case Study during the COVID-19 Pandemic* (Martha Alverez, USA); *COVID-19 Confinement and Babies: Video-Call-Based Developmental and Mental Health Approach* (Christina Halpern, Mariana Alves, Sandra Pires, Pedro Caldeira de Silva, Portugal); and *Clinician Perspectives on Adapting Evidence-Based Mental Health Treatment for Infants and Toddlers during COVID-19* (Annie E. Davis, Dorinda Williams, Whitney Wortham, Deborah F. Perry, Emily Aron, Audrey Neff, and Matthew G. Biel, USA).

We then present two papers that focus on early childcare during COVID-19. First, a paper by a colleague in the USA: *The Classrooms that Never Closed: Stories of Essential Early Childhood Practitioners* (Candace Barriteau Phaire). The second paper, also by colleagues in the USA, is entitled: *Bolstering Social-Emotional Development in 0-3 Childcare During a World Pandemic: Balancing Physical Health and Safety with Emotional Well-Being* (Katherine A. Lingras, Krista Mrozinski,

Anna Clavin, Arielle Handevidt, Lauren Moberg, Cari Michaels, Mary Mischke, Tracy Schreifels, and Michele Fallon).

The impact of COVID-19 and necessary adaptations to group programmes are presented next. First a paper with colleagues from Israel and the USA: *"Co-Relation" Groups - Virtual support groups for Israeli parents. Understanding the messiness and repairs of relationships between parents and young children during COVID-19: A case study* (Gilad Amshalom, Miri Bar-Halpern, Tamar Lev-Ran Galai, Dana Lahav-Meir, and Ed Tronick). The second paper in this set is by colleagues in Australia, *Infants at a Distance: Adaptation of the Building Early Attachment and Resilience (BEAR) program during COVID-19 for Online Virtual Delivery* (Louise Newman, Vesna Newman-Morris, Angela Komiti, Beth Gammell, Alice Braden, and Sarah-Pia Carron).

Our next step in this initiative is to turn our focus towards goal three of this first platform: To identify an emerging research agenda for understanding and responding to the impact of COVID-19 on the mental health of babies in their families and communities. This emergent agenda will be primarily constructed from each paper published in this special issue and papers from Platform 2 in this initiative (see below). This overarching research agenda paper will be published on the WAIMH website in early-mid 2021.

As noted above, *Perspectives in Infant Mental Health* and the *Infant Mental Health Journal* are collaborating in a multi-tiered approach to address infant and early childhood mental health in the context of the COVID-19 pandemic. Platform 2, the next step in the response to the pandemic, involves a special section of papers in the *Infant Mental Health Journal* designed to address research findings in the immediate context of the pandemic. The call for a special section of papers was issued in Summer 2019 and abstract submissions were received in December 2020. Invitations for full manuscripts will be issued in January 2021 with manuscripts due in the spring and publication expected by fall 2021. There is also the possibility of Platform 3 that would consist of a special issue of the *Infant Mental Health Journal* focused fully on research that examines the impact of the pandemic on infant and early childhood mental health, including how the field can respond most efficiently and effectively in the face of similar crises in the future. Collectively, the multi-tiered collaboration between WAIMH *Perspectives in Infant Mental Health* and the *Infant Mental Health Journal* is designed to amplify the voices and needs of infants, young children, and their families during this global crisis and inform innovative, applied practices to support them, and to promote their development and well-being.

Finally, we would like to acknowledge the support of the WAIMH Board and the WAIMH office in the creation of this issue and are delighted to feature messages from WAIMH President Campbell Paul and WAIMH Executive Director Kaija Puura. We finish this issue with news from the engine room of WAIMH, the WAIMH Office in Tampere, Finland, with Minna Sorsa and Sari Miettinen at the helm.

Covid-19 and Mental Health in Pregnancy: A Cross-sectional Study on Depression, Anxiety, and Stress among Portuguese Pregnant women

By Pedro Rafael Figueiredo[1], Joana Mesquita Reis[2,3], Francisca Padez Vieira[2], Patrícia Lopes[3], Maria João Nascimento[3], Cristina Marques[2], Pedro Caldeira da Silva[2,3]

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Introduction

Coronavirus disease (COVID-19) is an infectious disease, declared by the World Health Organization (WHO) as a pandemic on March 2020. By September 2020, there were more than 30 million confirmed cases spread beyond 180 countries and territories around the world (WHO, 2020). In this context, several measures were adopted by national authorities to limit the global transmission of disease. Collective control measures were introduced that included specific recommendations for risk groups, including pregnant women (CDC, 2020).

In Portugal, during the COVID-19 state of emergency lockdown (active from 18th March to 2nd May 2020), healthcare resources were reorganized in response to the pandemic, involving the reallocation of services and the suspension of non-urgent medical activities. In this context, Portuguese pregnant women had prenatal appointments, routine exams and ultrasounds cancelled, and companions were no longer allowed during labour and postpartum. For women who tested positive for COVID-19, protective measures initially recommended no skin-to-skin contact between the mother and the baby, wastage of all breastmilk and separation between infected mothers and the newborns (DGS, 2020). These measures were intended to mitigate the spread of the disease but might have had a possible negative impact on the mental health of this vulnerable population.

Mental health problems, including depression and anxiety disorders, are relatively common among women of reproductive age, affecting nearly one in every five individuals (Charlson et al., 2019; Kendig et al., 2017). During the perinatal period, evidence suggests that the global prevalence of these mental disorders may increase up to 25%, with relevant morbidity features experienced by the mother throughout the pregnancy and the post-partum period, especially amid stressful or traumatic events (Howard et al., 2014; Howard et al., 2018). Accordingly, perinatal depression is now considered one of the most common medical complications of pregnancy reaching 10-15% of incidence (Woody, Ferrari, Siskind, Whiteford, & Harris, 2017).

A recent meta-analysis suggests an overall prevalence of any anxiety disorder during the perinatal period of more than 15% (Dennis, Falah-Hassani, & Shiri, 2017). When left untreated, these conditions are possibly linked to obstetric complications (i.e. preterm birth and low birth weight) (Accortt, Cheadle, & Schetter, 2015; Becker, Weinberger, Chandy, & Schmukler, 2016) and early child development difficulties, including emotional problems, insecure attachment, and low levels of cognitive development (Herba, Glover, Ramchandani, & Rondon, 2016; Pearlstein, 2015).

Despite the current knowledge on psychiatric disorders during pregnancy, less is known about the true impact of a global pandemic like COVID-19 on the mental health of pregnant women. In the present study, we aimed to determine the incidence of depression, anxiety, and stress among a Portuguese sample of pregnant women, during the national state of emergency lockdown. This study also aimed to obtain a holistic view about the risk factors, as well as the maternal characteristics associated with this phenomenon.

Methods

Study Design and Sample

This study presents data from a cross-sectional study performed among Portuguese pregnant women who completed an online self-report questionnaire between 25th April and 30th April 2020. Eligibility criteria included pregnant women aged more than 18 years, who were living in Portugal, and who agreed to take part on the study after completing an informed consent.

An online questionnaire, stored via Google Forms (Google, 2020), was developed by the research team members, and took approximately 10 minutes to complete. We used a self-explanatory questionnaire which did not depend on additional information or support in order to be

completed online (Portugese and English versions available upon request).

A total of 1750 women participated in the current study. Those who did not fully complete the questionnaire or refused to give consent were automatically excluded. By joining in the completion of the questionnaire, participants understood that all the information obtained would be strictly confidential, with guarantee of anonymity and data protection on future publications on the topic. In the end, participants were given advice to seek medical support if needed and a contact line of our hospital department (including phone number and email) was also provided.

The study protocol was approved by the ethics committee of Hospital Dona Estefania – Centro Hospitalar Universitário de Lisboa Central in Lisbon (reference number: INV80-872/2020).

Study Measures

Edinburgh Postnatal Depression Scale – EPDS: The EPDS is a 10-item self-report questionnaire, extensively used as a screening scale for perinatal depression (Bergink et al., 2011; Cox, Holden, & Sagovsky, 1987). A cut-off of 13 is generally used, with higher scores denoting more symptomatology.

Depression, Anxiety and Stress Scale – DASS-21: The DASS-21 is a 21-item self-report questionnaire divided in three subscales of 7-items designed to measure the emotional states of depression, anxiety and stress (Lovibond & Lovibond, 1995). The DASS-21 and EPDS were both adapted and validated for Portuguese (Areias, Kumar, Barros, & Figueiredo, 1996; José L. Pais-Ribeiro, 2004).

Sociodemographic characteristics: Data was obtained on age, place of residency, marital status, household, highest qualification, and current employment status.

Pregnancy data: Participants were asked to give information regarding the gestational age, impact of COVID-19 on medical vigilance, and family support.

Medical history: Medically relevant issues were requested, such as past and/or current psychiatric disorders.

Stress factors associated with COVID-19: Pregnant women were asked to rate fear of contamination and/or transmission of the disease, fear of early separation from the baby after birth, and fear of not being permitted to breastfeed due to COVID-19 safety measures.

Table 1. Prevalence of depression, anxiety and stress symptoms reported by DASS 21.

	Depression	Anxiety	Stress
Normal	73,4% (n=1247)	55,4% (n=941)	62,2% (n=1056)
Mild	13,1% (n=222)	20,8% (n=20,8%)	15,6% (n=265)
Moderate	9,2% (n=156)	12,4% (n=12,4%)	13% (n=220)
Severe	2,5% (n=42)	5,7% (n=97)	6,5% (n=110)
Extremely severe	1,8% (n=31)	5,7% (n=97)	2,8% (n=47)

Statistical analysis

Quantitative data analysis was performed using Statistical Product and Service Solutions (SPSS) software version 25.0 (IBM, 2017). The significance level chosen corresponds to a p-value of ≤ 0.05. The mean and standard deviation were used to describe quantitative variables. Percentage and proportions were performed to describe the variables and study measures were rearranged into categories.

The association between categorical variables were tested using the Chi-square test or the Fisher's exact test; comparisons between continuous variables were done using a two-sample t-test or the non-parametric Wilcoxon rank sum test (when the data is not normally distributed). By using electronic data capture that required participants to provide responses, there was very little missing data in the analysis variables.

Results

A total of 1750 women participated in the current study. Of these, 52 were excluded since they were not living in Portugal during lockdown. A final sample of 1698 women was obtained. The average age of the participants was 31.89 years (SD 4.334; min. 19 years; max. 49 years). The majority of women had a high school (20.7%) or university educational level (76%). Within the population covered by this study, 90.5% were working before the pandemic. Of those, 46.4% suspended their professional activity, 23.6% were transferred to teleworking and only 3.2% remained at their usual place of work. The current pregnancy was reported to be the first one in 58.4% of our sample.

Most women were in the third trimester of pregnancy (61.1%) and only 8.1% were in the first trimester. In 81.2 % the current pregnancy was being supervised by an obstetrician and in 18.2% by the general practitioner. Regarding the psychiatric history, only 6.6% were currently being followed up in psychiatry or psychology consultations and 30.3% reported having been in the past. Of the 63.1% who answered that they had no previous follow up in mental health appointments, 14% said they feel they needed it at that moment. In our sample, 26% of pregnant women reported symptoms of depression (according to both used scales); 45% symptoms of anxiety and 38% symptoms of stress (Table 1).

The prevalence of depressive and anxious symptoms was higher in pregnant women in the third trimester (Table 2). Participants were also divided according to the place of residency revealing that higher rates of depression and anxiety symptomatology were encountered in Algarve, Alentejo, Madeira, and Azores Islands regions.

Table 2. Prevalence of depressive and anxiety symptoms by stage of pregnancy.

Stage of pregnancy	EPDS		DASS-21 (Anxiety)	
	No symptoms	Symptoms	No symptoms	Symptoms
1st T	78,8% (n=108)	21,2% (n=29)	58,4% (n=80)	41,6% (n=57)
2nd T	79,6% (n=417)	20,4% (n=107)	62,4% (n=327)	37,6% (n=197)
3rd T	70,1% (n=727)	29,9% (n=310)	51,4% (n=534)	48,5% (n=503)

The vast majority of participants (86.4%), reported that the pandemic situation was related to a subjective feeling of higher anxiety and concerns about the current pregnancy. Circa 80% women considered that the current pandemic situation had a negative impact on the surveillance of their pregnancy, mainly due to a postponement of scheduled appointments (41%), impossibility or difficulty in scheduling new appointments (27%), cancellation or postponement of ultrasounds (16%) or, due the impossibility of being accompanied by any family member to medical appointments (72%). Lack of support at this stage of their life was reported by 43% of women.

Due to the current pandemic, 7.4% did the laboratory test to SARS COV 2 and 0.3% (n=5) had been diagnosed as infected with COVID-19. All pregnant women that had been infected had developed only mild symptoms. In our sample, 48.1 % of the pregnant women reported high fear of contracting the virus and 82.3% mentioned they felt afraid of the possibility of passing the infection to the newborn. Other concerns were related to the possible absence of a partner or another family member during labour or postpartum (moderate to high concern in 92.8%), impossibility of skin-to-skin contact (moderate to high concern in 93.8%), initial seclusion of the newborn (moderate to high concern in 93.4%) and, possible implications in breastfeeding (moderate to high concern in 88.8%).

Discussion

This cross-sectional study revealed a significant increase in depression, anxiety, and stress-associated symptoms, presented by Portuguese pregnant women during the national state of emergency lockdown. A large group of 1698 participants from the general population in Portugal were assessed by the EPDS and DASS-21. These results contrast with previous international studies that reported lower prevalence rates of depression and anxiety during pregnancy (Howard et al., 2014).

A large majority of the participants reported that the pandemic situation was related to a subjective feeling of higher anxiety and related concerns over the course of pregnancy. In our sample, around half of the pregnant women reported being very much afraid of contracting the virus and more than 80% described has being very much afraid of possibly spread the infection to the newborn. Other concerns were related to the anticipated absence of a companion during labour, impossibility of skin-to-skin contact, initial seclusion of the newborn, and possible negative implications in breastfeeding.

Although the protective measures applied by national health authorities were designed to safeguard mothers and babies from the COVID-19 disease, we argue that they may have led to a negative impact on the mental health of this population. In fact, previous studies established associations between worry, trauma and conflict settings, and mental health issues during pregnancy (Charlson et al., 2019; Erickson, Julian, & Muzik, 2019; Mourady et al., 2017).

According to the place of residency, higher rates of symptomatology were encountered in regions with lower socioeconomic status and fewer mental health resources available in the community.

Other aspects related to the pandemic lockdown such as social distancing and lack of family support, may also have contributed to the escalation of psychiatric symptoms. Similarly, restricted access to mental health services may have been even more intense during the pandemic, limiting early detection and intervention in these pregnant women.

If present in the antenatal period and if not treated, mental disorders (such as depression and anxiety) tend to persist during postpartum and may affect both the mother and the development of the infant (Grace, Evindar, & Stewart, 2003; Herba, 2014). These results emphasise the need for:

1. More extensive antenatal screening in this population.
2. The importance of implementing additional mental health resources in the community, and
3. Rapid referral to specialized units (when indicated).

Participants were divided in three groups according to their stage of pregnancy with higher prevalence of depressive and anxiety symptoms found during the last trimester. This finding is in line with previous literature reports (Biaggi, Conroy, Pawlby, & Pariante, 2016; Marchesi, Bertoni, & Maggini, 2009). During this stage, pregnant women normally experience fear and concerns regarding child birth and tend to request the presence of a close companion during labour with a positive impact on their psychological well-being (Ip, 2000). Since this possibility was initially not allowed by the health authorities, we argued that these circumstances also contributed to these findings.

A strong feature of this study is that the EPDS and DASS-21 are self-completed screening tools that are well validated for Portuguese, making them suitable for use during pregnancy in our population. Despite the fact that these questionnaires do not make a clinical diagnosis, they do investigate a number of symptoms experienced by each participant, providing more comparable results. Other strengths of this study are the large sample size and information on many maternal characteristics throughout pregnancy.

A limitation may be the fact that it was limited in time and most participants were from Greater Lisbon area, limiting the generalization of our findings. Finally, response bias may exist if the nonrespondents were either too depressed or anxious to respond or, not at all interested in this survey due to the lack of symptomatology. These factors should be taken in consideration by future studies.

The main results of this study were initially disclosed in several Portuguese media platforms (i.e. television, radio, newspapers), right after the state of emergency lockdown. Given the widespread access to this information, we believe that our work contributed to a significant change in the national paradigm regarding safety control measures for COVID-19 in pregnancy. In fact, the following official guidelines conducted by national authorities started to focus on the importance of periodic mental health assessments as part of pregnancy surveillance routine, as well as the mandatory presence of a companion during delivery, when indicated.

In order to better understand the true impact of these measures in this population, we are currently conducting a study focused on COVID-19 related effects during the postpartum period. With this study, we strongly believe that mental health awareness in our country was enhanced, providing useful frameworks for decision-makers and also reducing social stigma and discrimination around mental illness.

Conclusion

A cross sectional study was conducted to evaluate the presence of depression, anxiety and stress symptoms in Portuguese pregnant women during the pandemic lockdown. We found a significant increased rate of symptomatology in all stages of pregnancy with a reported subjective feeling of psychiatric symptoms due to COVID-19 and related concerns. The current analysis does not provide definite diagnoses but these results should not discourage the implementation

of additional mental health resources specially focused on pregnancy, in order to help the mothers the future of their babies.

Conflicts of Interests

The authors have no conflicts of interest with regard to the current work.

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Birth during the Coronavirus Pandemic: "When fear is the uninvited guest"

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The anonymous participant research data presented in this article, is part of a major study: "Learning about parenting experiences with children and unborn babies during the Coronavirus (COVID-19) pandemic in Chile", led by Dr. Marcia Olhaberry.

Pregnancy and birth are transforming experiences for both parents and the newborn, typically requiring adjustments and challenges at both an individual and family level (Epifanio, Genna, Luca, Roccella, & Grutta, 2015; Stern, Bruschweiler-Stern, & Freeland, 1998). During pregnancy and birth, the mother experiences physical, biological, psychological, and relational changes (Carmona et al., 2019; Olza et al., 2020), that favor the baby's development while requiring specific care and support from a third party, frequently the partner or father. Both parents must guarantee the baby's survival, development, and mental health while undergoing this normative crisis and balancing their life roles (Epifano et al., 2015; Stern et al., 1998). Considering how sensitive these processes are to the environment and the parents' role in preparing the baby's arrival (Olza et al., 2020), there is a potential risk that life demands may exceed the individual, interpersonal and contextual resources available in the triad. This could generate negative consequences for the parents and the baby (Baldwin & Kelly, 2015; Paulson & Basemore, 2010).

Currently, the coronavirus pandemic and its related health measures have triggered high levels of fear in pregnant and puerperal women and their partners, due to the perceived vulnerability, and the risk of contracting the virus and its consequences (Rashidi, Fakari, & Simbar, 2020). Although fear is an emotion that leads to protective and caring behaviours in dangerous situations, when it is activated for a significant amount of time during pregnancy, labor, and peripartum, it can lead to negative consequences (Olza, 2017). In the mother, it has been linked with anxiety and depression (Fontein-Kuipers et al., 2014), as well as attachment issues (Monk, Spicer & Champagne, 2012). In the baby, a neurotoxic effect from long-term stress has been described, which interferes with the later emotional management skills, learning, and posterior executive functions (Nelson, 2020).

Studies conducted during the pandemic on parents going through the peripartum period, describe concerns, fears, stress, and symptoms at different levels. Concerning infection and childbirth, anxiety related to the risk of death has been reported. Also, the following concerns have been identified:

- Protocols during delivery and newborn care.
- Mothers fear being unaccompanied during check-ups and labor.
- Increased frequency on requests for c-sections.
- Induced labor.
- A higher number of deliveries at home without the necessary assistance.
- Fear of exposition to toxic effects of disinfection products.
- Early mother-baby separation after birth and
- Difficulties to start breastfeeding (Rashidi et. al. 2020).

There are also medical risks described linked to lock down and the lack of sun, physical activity, and vitamin D, such as a higher risk of thromboembolism and a rise in the mothers' and family stress (WHO, 2020). At a psychological level, recent studies describe an increase in anxious and depressive symptoms on pregnant women in isolation and/or with decreased social contact, even considering symptomatology before the pandemic, as well as an increase in gender violence during pregnancy and birth (Davenport, Meyer, Meah, Strynadka, & Khurana, 2020; WHO, 2020).

Fortunately, preliminary findings from scientific research on the effects of coronavirus during pregnancy and peripartum show a minimal probability of vertical transmission, low risk for virus-related complications in pregnant women and fast remission, as well as low impact on the development of the unborn baby (Chen et al., 2020; Khalil et al., 2020). However, due to the lack of knowledge about the virus and its consequences to date, and to the physical and inmunitary changes that take place during pregnancy, expecting mothers have been considered, with their babies, a risk group (Allotey et al., 2020; OMS, 2020a).

Suggestions from the WHO for the care of pregnant and puerperal women are the same as for the general population and emphasize that both breastfeeding and

skin-to-skin contact should be prioritized due to the lack of evidence of transmission through breastfeeding (OMS, 2020b). The fostering of these practices bolsters the role that nursing and skin-to-skin contact have in nurturing: physiological regulation, sleep quality, health, development, and mortality risk reduction in babies. In turn, these elements, trigger the creation of new neural circuits in the mother for the care and protection of the baby (Bergman, 2014).

Despite all of the above, the protocols and guidelines suggested by different governments in some European and Latin American countries can vary greatly between each other. Moreover, the enforcement of these protocols depends on each particular establishment and location, generating important differences between the recommendation and what is being practiced.

Unfortunately, with the intention of controlling infection, professionals have made their own decisions based on limitations within their healthcare centers and fear. These measures include interruption of partner support during pregnancy check-ups and delivery, over-operated labors and restrictions in parents visiting hospitalized premature babies (GCABA, 2020; Martínez-Pérez et al., 2020; Minsal, 2020; Minsalud Colombia, 2020; Ministerio Sanidad España; Sadler, Leiva & Olza, 2020).

Before COVID-19, evidence had shown a considerable reduction of mortality at birth due to the medical advances and the assistance of professionals during pregnancy and labor (OMS, 2019). Nevertheless, the fear and uncertainty associated with COVID-19, increased speculation of death and disease, which in some cases impacted decisions and procedures during pregnancy and delivery. Furthermore, the concerns and uncertainties linked to COVID-19 that intimidate the parents and their babies also affect the healthcare professionals that assist the deliveries, who may change their professional behaviour. This could lead to increased medicalisation, and imposed interventions of greater control that are not necessarily in line with the available information (O´Connell, Crowther, Ravaldi & Homer, 2020; Wilson et al., 2020). All of that could have negative effects during the birthing process, in the mothers' and babies' mental health, and in the creation of a secure attachment, which may reduce the mother's participation in her own experience of labor (Horsch, Lalor & Downe, 2020; Olza et al., 2020).

Evidence shows that overvaluing medical procedures at the expense of natural and instinctive processes of birthing can result in negative experiences in childbirth for the mother and the baby (Olza et al., 2020). Studies indicate that, depending on the characteristics of the mother, these experiences could lead to post-traumatic stress disorder (Dekel, Stuebe & Dishy, 2017). Common risk factors to developing PTSD have been described to include factors such as first-time mothers, preterm labors, c-section, and early separation of the mother from her newborn (Olza et al., 2014). Such factors could even impact the future reproductive life plan of the mother (Gottvall & Waldenström, 2002), the breastfeeding process, and the initial interaction of the mother and the baby as it reduces the enjoyment and increases the unpleasant emotions within this relationship (Beck & Casavant, 2019).

As mentioned above, pregnancy, delivery, and puerperium are processes of large physical, biological, and psychological vulnerability for both parents and the baby. These subjective experiences cause deep and lasting changes at a neurobiological, psychological, and relational level, that could leave a long-lasting and permanent mark, and that could impact on the infant's brain structure with the risk of later psychopathology (Carmona et al., 2019). In the current context of the pandemic where the real risks of death and disease have increased, the levels of individual and family stress, and especially, the feeling of uncertainty are growing; particularly in the risk groups that include pregnant and puerperal women and newborns.

Guidelines must have clear information based on current scientific research so that they safeguard the processes of pregnancy and childbirth. In this scenario pregnancy and after birth care and protocols must promote and guarantee mother and child contact, allowing that the mother deploys her competencies in relation to the health and wellbeing of the baby (Olza et al., 2020).

A study carried out in Chile about COVID-19 and its impact on early parenthood had almost 300 pregnant women participating (Olhaberry et al., 2020). They reported fear and worries about the idea of getting infected, of isolation, not having company during checkups and delivery, and the possibility of being separated from their newborn should they have a positive PCR test. For example:

> I fear that whilst going for a checkup I could get infected…
>
> Isolation... you already know you are going to be alone during the first months after your baby is born, but now, also 3 months before! It makes it so much harder to prepare for postpartum.
>
> Going alone to the routine checkups and exams, not being able to share your pregnancy with your loved ones…

> Knowing the baby is going to be born whilst in the peak of the pandemic and that if either you or your husband have a positive PCR they won't let you see your newborn for 14 days...
>
> Not knowing who will assist you during labor, if I will have company, what protocols will be enforced at the moment, and especially the fear of me or my husband getting infected before or after my daughter is born.

In the same study, these women also reported worries concerning their motherhood in isolation and to the future relationship with their children:

> I will be avoiding physical contact of my baby with the outside world until all of this is completely over …
>
> More fear and apprehension during upbringing my child…
>
> I think this might trigger an overprotectiveness in me...

Practice guidelines from local governments, should be based on scientific evidence and be promoted and enforced correctly so that in addition to avoiding new infections they protect parents and newborns. It cannot be forgotten that pregnancy, childbirth, and puerperium are periods highly vulnerable and sensitive for both parents and the baby. Decisions made should facilitate and promote contact with other significant caregivers in the presence of a positive COVID-19 test in the mother. The support of the father, or other significant figures, to the mother-baby dyad, should always be allowed, acknowledging the importance of early bonding for future development and mental health.

Healthcare providers should also be guaranteed safe working conditions, that allow them to assist adequately pregnancies and birthing. Currently, the challenge is to protect ourselves from coronavirus at the time proper conditions of peripartum are safeguarded, this means, not to forget the need for contact, closeness, and emotional availability of the parent towards their newborn and their own emotional needs.

Key ideas for the clinical practice

1. Pregnant women are a special group that requires specific considerations in clinical practice. During a highly-sensitive environment period, they need attention in mental health that takes into account their particular needs and characteristics.
2. Fear can have a strong influence on the development of mother and child mental health and in the child's' later development that needs to be acknowledged.
3. There is a need to create guidelines based on evidence, that are respectful of the needs and the mother-child bond during pregnancy.

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Shared Pleasure in the Time of COVID 19: The Importance of the Shared Smile for Babies in a World of Masked Faces

By Anusha Lachman, Department of Psychiatry, Stellenbosch University, Cape Town South Africa

As South Africa prepares for the winter to arrive and with it, the increased risk of COVID-19 infections, the economic toll of a continued lockdown meant that despite this risk, there had to be an easing of the harsh strict lockdown to allow for some salvage and restoration of livelihoods. As parents resume work, domestic helpers in the informal sector doubling up as the nannies also return to work. Part of the relaxing of the lockdown in South Africa is accompanied by the compulsory wearing of face masks in all public places, including places of work, and during the utilization of overcrowded public transport services where social distancing is virtually impossible. As such, the domestic nannies travel amid high-risk environments to enter homes in the leafy suburbs to help with the essential service of childminding. The level of risk to these adults is high as South Africa has a disproportionate burden of respiratory disease (Tuberculosis), immuno suppression (HIV and related infections), and psychosocial adversities. Whatever little protection can be offered, needs to be adhered to as the population braces for the inevitable surge of the Coronavirus infections.

While face masks have clear benefits in reducing transmission of the virus, the impact this has on social engagement remains to be seen. As adults, we adapt. We rely on verbal cues, re-adjust our gestures, and incorporate the mask as part of the new normal. For children, the mask is reframed as their "super-power" to protect themselves and is integrated fairly easily into the routine of wearing it on the playground, at school, and as part of a safer peer interaction.

But what about the babies? The Center for Disease Control (CDC) does not recommend the use of face masks in infants under 2 years of age - however, they make no clear statement on the use of masks by external caregivers providing the care but who themselves are at risk prior to entering the home. The fear and uncertainty around infection is palpable amongst professionals and parents alike. A colleague sent me the following message:

> I return to work soon leaving my four-month-old boy with his lovely responsive nanny. She is choosing to wear a mask in the house. I have explained that the mask mostly protects others from her and that I am happy for her to not wear it in the home, but she feels more comfortable with it on. However, as the primary person interacting with the baby, her entire face except for the eyes is not visible. I am concerned about his development with this "semi blank face" caring for him. Is it enough for him to just see the nanny's eyes and hear her voice? What are your thoughts?

This made me wonder. What does the science and our understanding of what babies need in those early few months tell us? Will the mask cause more harm than benefit to the baby? How do we assess the risk before we can offer advice?

The ability to detect and focus on faces is a fundamental prerequisite for developing social skills. Immediately after birth, babies are attracted to moving objects and show preferences to face-like stimuli over other objects (Johnson, Dziurawiec, Ellis, & Morton, 1991). The attraction for faces continues to develop over the next year of life, with the focus on faces allowing for infants to learn social-environmental cues and interactions with them (Baron-Cohen, 1994; Gliga & Csibra, 2007).

From as early as two months of age, infants demonstrate skills like eye contact and facial expressions as part of social communication (Stern, 2018; Trevarthen & Aitken, 2001). During episodes of mutual gaze, the mother and infant engage in spontaneous facial and vocal communications that may elicit a positive effect on both mother and infant (Lavelli & Fogel, 2005). Such highly arousing, face-to-face interactions allow the infant to be exposed to high levels of social and cognitive information (Feldman, 2007; Schore, 2005).

For the next four to six months, shared smiles with caregivers are considered the high point of face-to-

face interactions (Weinberg & Tronick 1994). Smiles help organize social and emotional exchanges, providing the parent with the feeling that they are in touch with and have "doing well", by their baby (Spitz, 1949; Sroufe & Waters, 1976).

Infant smiles communicate joy and elicit positive emotional responses and interactions with adults (Bowlby, 1982). As in adults and children, infant smiles involving cheek raising along with the raised orbicularis occuli (eyelid muscles) and zygomaticus muscles are called "Duchenne Smiles" which tend to occur during emotionally positive smiles (Bolzani-Dinehart et al., 2005; Ekman, Davidson & Friesen, 1990; Fogel, Hsu, Shapiro, Nelson-Goens, & Secrist, 2006). Infants engage in smiles involving cheek raising when they are being smiled at by their mothers (Messinger, Fogel, & Dickson, 2001).

As development progresses, infants alternate their attention and smiles from their caregivers to objects in the environment (Rochat, 2001). These smiles progress when they use gestures, vocal stimuli, and eye contact to attract their caregivers to their own actions and their environment (Messinger & Fogel, 1998). While young infants observe and mimic the facial expressions of their mothers, the mothers in turn monitor and emphasize their infant's emotional expressions allowing babies to almost "fine-tune" their expressions (Gergely & Watson, 1999; Holodynski & Friedlmeier, 2006). This interactional exchange allows for the enhancement of their emotional displays and by inference their social development.

Young infants' social expectations and sense of self-efficacy are formed within their interactions with their caregivers. In a study of contingent smiles between 4-month old babies interacting with their mothers, Mcquaid, Bibok, and Carpendale (2009) showed that mothers' contingent smiles during an interactive engagement accounted for unique variance in infant social bids during a still-face phase beyond that which could be accounted for simply by the frequency of mother and infant smiles during the interactive phase. In face-to-face interactions, infants are more likely to smile when they are gazing at their mothers and when their mothers are also smiling back at them (Messinger et al., 2001; Weinberg & Tronick 1994). In a Brazilian cohort of mothers and young infants, there was a strong association between mothers' behaviors and their babies' smiles, emphasizing the importance of affective interactions in early development (Mendes et al., 2014).

The simultaneous sharing of a smile with synchronized direct gaze contact between mother and infant is hypothesized to be a marker of high-intensity positive affectivity and is referred to as a "Shared Pleasure (SP)" moment (Puura et al., 2002; Puura et al., 2019). SP is interesting in that it has been shown to correlate with attachment security (Mäntymaa et al., 2015), is highly malleable in the first year of life (Varpula, 2014), and maybe a possible marker of adequate parent-infant interaction (Puura et al., 2019). Its absence has been associated with maternal mental illness (Lachman et al., 2019; Varpula, 2014). Based on findings from Puura et al. (2019) in Finland, dyads who were best able to read each other's positive cues and respond to them, were more likely to experience mutual positive affects.

So if babies aren't able to see their caregivers' smiles how do they mimic it? How do they engage in the highly arousing, positive affective interaction if they are essentially faced with a blank screen? If we know babies need to engage face-to-face with their caregivers in the first few months of life, what happens when the caregiver needs to wear a mask?

For the Still Face Experiment, Tronick (2003) hypothesized that face-to-face interactions are co-created by an ongoing moment-to-moment dynamic process that generates unique interactive exchanges between the infant and its mother. The infants first engage in a normal interaction followed by a phase in which they have to cope with a stressful interaction—the "still face" (SF) where the mother freezes and becomes vocally and gesturally unresponsive. In response to this manipulation, infants typically react with less eye contact, express negative affect, and may lose postural control. Following the SF there is a reunion episode, where the positive affect recovers but not fully to the observed initial baseline level.

A review by Mesman, IJzendoorn, & Bakermans-Kranenburg (2009) suggested that the SF effect may also be due to the break-in typical social interaction. The responsiveness of the parent plays an important role in affect regulation, and the type of stress expressed by infants appears to be related to the breakdown in the expected communication within that dyad (Melinder, Forbes, Tronick, Fikke, & Gredebäck, 2010). This suggests that when infants expect a specific relational response from the mother or caregiver (such as a playful smile or expression) and this expected connection is not present (or interrupted in this case by the presence of a masked barrier), it could theoretically result in increased stress reactions. Melinder et al. (2010) further showed that the SF manipulation is perceived as a more dramatic experience for infants who relate to their mothers than for infants who relate to a stranger. Many South African infants are co-reared by a nanny employed as a domestic worker in the family home—as such the presence of the nanny in this situation is less that of a stranger and more closely resembles that of the primary caregiver. Does this mean the baby is more likely to protest and experience this new masked interaction as a stressful response to their normal expected interactions?

Perhaps timing is key?

As development progresses, emotional expressions increase in complexity and coordination. While in the first few months we recognize the reciprocal dyadic synchronous interactions as key to the infant's imitation of expressions, from around four months of age and beyond, communication changes. Social and emotional competencies become increasingly necessary for further relationships, and the type of maternal interaction at this stage is critical (Feldman, 2007; Little & Carter, 2005).

Early experiences have great potential to shape the trajectory of the developing brain and the long-term development of children. The World Health Organization's Nurturing Care Framework reminds us that in situations of unrelenting psychosocial adversity and stress, responsive and attentive nurturing care may be the key modifiable risk factor to protect babies against the negative effects of adversity.

As restrictions on close face-to-face contact in the time of COVID-19 force us to re-examine our instinctive social behaviours, maybe it is time for us to refocus and adapt how we provide responsive caregiving. Before children even learn to speak, engagement, and affection between them and caregivers are expressed through cuddling, eye contact, gestures, and of course smiles. Part of this responsive caregiving also includes observing and responding to infants' attempts to connect with the

world. Perhaps part of the new normal in a masked world needs to be an increased and more deliberate effort to notice and attentively respond to attempts by the infant to communicate. This would include more focussed and attuned responses to gestures, sounds, movements, and non-verbal interactions to help create and reinforce a mutually enjoyable interaction.

But for the really young infant, there likely can be no substitute for an authentic direct gaze with a synchronized shared smile. Regardless of the context, we all still smile in the same language.

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Helping the Helpers. Relationships During the Pandemic: "Good Morning, Margaret" "Good Morning, Heidi"

By Margaret Holmberg, PhD, IMH-E® (USA) and Heidi Maderia, MS, IMH-E® (USA)

Connecticut Association for Infant mental Health (USA)

Amid a global pandemic, with increased cases of COVID-19 reported everywhere every day, with rates climbing, with calls out seeking health care workers to come to hospitals and medical centers, with the news reporting outbreaks in every part of the world, and death, the Connecticut Association for Infant Mental Health (CT-AIMH) considered:

What do infant mental health professionals and leaders need during this time?

And thus, begins another day with Zoom meetings galore, masks on when out, 6 feet apart when nearing others, and wondering when it will all end, when will the vaccine come, when will we return to something near normal.

The following suggestion was one that was shared as the CT-AIMH worked to maintain relationships through virtual experiences and opportunities for our members and our Infant Early Childhood Mental Health (IECMH) community.

What do we,

those good infant mental health folks,

do

while we wait,

while we wonder,

and while we listen?

You could try starting your day with," Good morning, (your name)"

and if you can,

place your hand on your heart and add,

"I love you (your name).

To begin our work during these unprecedented times, in March, our Executive Director and Board of Directors posted a *Letter of Hope* to our members on the CT-AIMH website. This letter was followed by a list of categorized resources for use by our professionals in infant and early childhood mental health and set the stage for more 'personal' ways to reach out and relate.

APRIL 2020

In Connecticut, the CT-AIMH Executive Director (ED) presented to the Board of Directors (BOD) the possibility of creating opportunities to meet on a daily basis with our members. "Every day???" "That's too much", said some. Nevertheless, we went ahead and posted an invitation to our members to join us at noon, Monday – Friday (every business day), for 45 minutes, for the entire month of April. We called it: "Help for the Helpers".

Why every day? We wanted to be as available as possible to hold our members during this time when everything about their current way of working was changing. CT-AIMH wanted to hear what the infant mental health workforce was experiencing, to offer ways to cope, to provide a space to share resources, to create manageable professional development opportunities and to provide some time for joy. We knew everyone could not come to every session. We wanted to maintain our relationship with our members by being available as frequently as possible and at a predictable time.

The topics and facilitators were the same for each particular day of the week, but the content and participants varied. For example: Monday's facilitator remained the same for each Monday, and the focus for Monday's group remained the same throughout the month, but attendees were not bound by that. Attendees could choose to attend Monday and Thursday one week, and then Wednesday and Friday the following week.

On Monday we invited conversation with each person having the opportunity to share how she/he was staying connected with families, how folks were coping (both families and providers), and how the Association could support or help with connections needed. Our BOD member, Margaret Holmberg, IMH-E®, led this group. Frequently people shared that they were staying connected via phone or internet and that families were eager to talk. Some commented that families liked this form of 'visiting', while others voiced concern about not being able to see the child in-person, missing their energy or tone. Providers seemed to have their own resources and routines that were helping them cope (walking, baking, meditating, singing, staying connected with family). Many were coupled with the added responsibility of having their own children at home as their new co-workers, as schools closed. They were also mindful of the families they were serving now, having multiple children of all ages at home, and needing to consider providing resources/activities for those older children.

On Tuesday we focused on mindfulness and self-care. Videos and articles about mindfulness featuring "*Palouse Mindfulness"* were shared, along with different mindfulness meditations, art activities, poetry and more. Here is one example: Take a pencil, draw some squiggly lines. Now take some crayons or colored pencils and color in the enclosed areas. Now write the names of those who have a meaningful relationship to you in the colored spaces.

This group was facilitated by our Executive Director, Heidi Maderia, IMH-E®. With a consistent facilitator, we learned that what you practice makes you stronger, and practicing together, alongside others, helps everyone feel like they are capable of setting aside time to practice slowing down. Mindfulness is the practice of paying attention to the present moment (attention), on purpose (intention), without judgement (attitude). This is great infant mental health advice, as well as good self-care advice. Many spoke about their need to stay connected to others (co-workers, extended family, or friends). This topic was requested to continue.

On Wednesday we held a professional development opportunity where we listened to chapters from Michael Trout's book, *This Hallowed Ground – Four Decades in Infant Mental Health* (2017). Michael Trout is a clinician, an author, and a leader. He was the founding president for both the Michigan and the International Associations for Infant Mental Health, a charter member of the Infant Mental Health Journal Board, and an early leader for WAIMH in the US. He has been in the infant mental health field since 1968. Michael's powerful voice resonated passionately with all who joined us. The discussion for this group was led by our Endorsement® Coordinator, Heather Bonitz-Moore, IMH-E®. This professional development opportunity was also one of the days that was requested that we continue.

On Thursday we introduced people to the Padlet. A Padlet had been created and was housed on the CT-AIMH website, where many COVID-19 related resources for providers, families, and parents were posted. This could be added to and viewed in real time. Our Board member, and co-chair of the Promotion and Education Committee, Jennifer Vendetti, lead this session and was an inspiration for all of us. We posted Alexander Smith McCall's (2020) poem, "*A poem for Trouble Times*", from his book, *In a Time of Distance*. Remember McCall's dinner speech to us during the 2014 Congress in Edinburgh?

> And then, with the unexpected upon us,
> We look at one another with a sort of surprise;
>
> How could things possibly turn out this way
> When we are so competent, so pleased
> With the elaborate systems we've created — (McCall, 2020)

Friday was a no talk day. It was strictly a movement and dance party. Children were invited to participate, and together we all moved, danced, and sang to music that was provided by our ED. "Everything in the universe has rhythm, everything dances" (Angelou, 2020).

MAY 2020

May was a month of planning and working to convert many of our highly valued Infant Mental Health (IMH) training series onto a virtual platform. The first series to be offered virtually was offered in Spanish, for a cohort of family childcare providers who did not want their training to stop because of the virus. This was our first virtual pilot and was very positively received. We did need to offer orientation/support for "how-to" Zoom to be sure participants were comfortable accessing and using the new on-line platform.

Next, we moved on, to plan for the monumental task of converting our 8-day IMH training series, into a virtual event. There were many lessons to learn from others, as we listened to the comments about Zoom fatigue, the difficulty in offering trainings in the afternoon. We wondered how we could effectively engage participants in a training about the value of "relationships", virtually?

We finally were able to arrive at a model that we could start using. The model blended the use of live lectures, used

Squiggly Art Example. Published with author permission to use.

the poll and chat functions, and created small discussion groups. These groups not only held the same participants throughout the entire series, but also employed facilitated discussion group leaders that were assigned to the same group, for the entire series. Working on maintaining relationship within the restrictions of an online delivery system, was new to us.

JUNE 2020

And then came June. Not only were we still under the COVID thumb, but we also came to our knees confronting the inequality not only in health care but also in our justice system and throughout our communities. Where is infant mental health? How can it help?

Heidi continued to lead weekly sessions called Mindfulness Mondays. Again, we invited clinicians and supervisors to join the professional development Wednesdays to listen to Michael Trout describe his clinical work of 40 years. This audio book is available from MI-AIMH store. Listening to Michael Trout read his casework is both provocative and compelling, inviting us to listen and wonder about the complexity and power of relationship-based practice to heal and transform. We highly recommend this activity for all, but particularly for clinicians.

We sponsored an on-line book launching of *The Power of Discord: Why the Ups and Downs of Relationships Are the Secret to Building Intimacy, Resilience, and Trust* with authors psychologist, Ed Tronick, and pediatrician, Claudia M. Gold (2020). They describe how disruption and repair are necessary for growth. We discussed whether this applied to our US racial status as well as infant and parent relationships. This virtual opportunity was available to our Alliance colleagues, as well as our Connecticut members, and friends.

We also held a virtual film screening of one episode of the 5-part documentary, *The Raising of America: Early Childhood and the Future of our Nation* (2017). This film focused on looking at our current childcare system and policies that affect children and families. It also focused on the value that our country currently places on the early years of childhood versus the significance of investing in policies that support the Early Childhood Education workforce, communities, children and families, for the ultimate success of our society.

These June sessions were co-sponsored by the *Connecticut Office of Early Childhood*, and our audience expanded beyond our members, to all professionals working with very young children and their families.

Finally, to help our workforce, who might have more time to put their portfolios together and to begin the process for Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® we offered an online Endorsement® orientation facilitated by the Endorsement Coordinator. The focus was on how to get started and was an introduction to our website, with a step-by-step video on how to navigate applying for membership. This was followed by another step-by-step video on how to apply for Endorsement®. Feedback from this pilot led us to decide it would be a good use of the Endorsement Coordinator's time to offer a similar introduction on a regular basis, on a set day/time each month.

JULY and ongoing 2020

CT-AIMH began the month by creating a statement of solidarity, declaring our continued commitment to stand together with our black colleagues, friends, families, and communities. Then CT-AIMH's Diversity, Equity, and Inclusion Committee, that formed out of our 2-year focus on Diversity, Equity, Inclusion, and Implicit Bias, met for the first time.

CT-AIMH is determined to ensure that opportunities for relationship building, connection, and professional growth are not going to end just because the world is experiencing such BIG life altering events. Instead, we are working to create shared experiences for all.

To slow down,

pay attention,

and turn toward all the feelings that might be coming up while learning

some new way

of staying in relationship.

At the same time,

we want to hold out hope for the future

with forward movement

and to create space

to celebrate our shared joys,

no matter how small.

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A Necessary Telemedicine Intervention for a Preschooler with Anxiety during COVID-19: A Clinical Reflection

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Infant Mental Health in practice has had to shift in order to meet the needs of families during the COVID-19 pandemic. I work in a large metropolitan city where there were early cases and concerns over the COVID-19 virus, and where the city had strict stay at home orders in place for several months.

As part of the department of psychiatry in a children's hospital (that is part of an academic medical center), parents, infants, and children are typically seen in a clinic with an in-person encounter where rapport and relationships are easily formed to provide the basis of a trusting working relationship. This suddenly was not possible as of March 2020 and still largely continues to this day, as the overwhelming majority of outpatient encounters are virtual.

Adapting from in-clinic to telemedicine

Since the COVID-19 pandemic began, I have had to change the mode of service delivery and relationship building, to one via a video screen where I am connected to a family's home from my home. This is a modality with which I, and my clients, had very little prior experience.

There was a steep learning curve with the technology itself and learning the pragmatics of telemedicine. There were many times when screens would freeze mid-sentence, sessions would get inexplicably disconnected, or families had other difficulties with the telemedicine software. I learned to have the family's telephone number available in case there were any technical difficulties and to expect the unexpected.

The other important lesson was to be flexible. I may not be able to get all my questions answered, as doorbells rang, and daily home life interrupted (at the client's home and my own home).

After some trial and error, I established a system of general assessment that seemed to work:

1. I had an initial session with parent(s) to learn their concerns and the child's history.
2. Then, I had a second session where I observed the infant/child play at home as they typically would. Sometimes this 50-minute play session felt long but allowing it that length of time ended up providing rich information.
3. Then, for preschool-aged children, I would begin the third session with a 15-minute tea party with me and the child. The child could tailor this tea party to their likes (such as a race car tea party or a unicorn tea party).
4. Then provide assessment impressions to the parent at the end of this session.

I found this assessment method via telemedicine gave me a thorough understanding of the child with their family and also helped to establish rapport with the parents and the child/children, in an otherwise awkward modality.

By the time intervention began, the parents and the child seemed more at ease with the video communication and me, and our treatment could begin.

I had a few months of adjustment to the video platform when I met Sonja (pseudonym) and her family.

Meet Sonja (4 years old) and her parents

Sonja's mother and father sought an evaluation for their 4-year-old daughter due to concerns of limited engagement in her daycare setting. She would alternate between periods of not responding to and being withdrawn from her teachers to being upset and frustrated very quickly. Sonja generally interacted well with peers at daycare but tended to want to control the play and would become upset if peers did not comply. She also wanted to be in charge of how her parents played with her at home by telling them what to do, what to say, and in what tone of voice to speak. She would become quite upset if her parents did not comply with her wishes and demands. She could be particular and would only watch TV shows, not movies, and only certain episodes of TV shows. If an unfavored episode came on the TV she would cover her ears and come to parents shaking.

Sonja was described as very-creative and engaged in elaborate imaginary play quite often. Sonja's parents recounted a time when she created a family band to perform in front of an audience of her stuffed animals. When

it came time for the performance, Sonja seemed to get stage fright in front of the stuffed animals and wrecked the entire set-up, and dismantled the band. She was very articulate and could express her feelings well, so her parents were puzzled as to the extreme frustration and upset she would display at home.

Sonja's mother and father indicated that they both had histories of anxiety and still struggled somewhat with symptoms themselves. They recounted stories and incidents from their childhoods that reminded them of Sonja's behavior and wondered whether Sonja had anxiety too? They questioned whether the way they intervened and parented Sonja could be exacerbating her symptoms.

As COVID-19 began, it necessitated that Sonja would need to attend her daycare via a video screen. It became commonplace in our area for preschools to offer the remainder of the school year virtually. At this time, her parents saw a change in her. Sonja was able to connect to her classmates and teacher via a video platform while she was in the comfort of her home with her younger sister and her parents (who, by this time, were working from home via a video platform themselves). She attended this style of virtual preschool from March 2020 until the summer break began at the end of May 2020. When connected with her teachers and peers via the video, she was animated, engaged, and seemed to be enjoying herself very much.

Her teachers and parents both noted the change in her demeanor. Sonja was suddenly talkative, adding to discussions in the virtual classroom, and asking meaningful questions. She would laugh with her classmates and appeared to be at ease in the environment. This was in contrast to her flat affect and reluctance to speak when attending school in-person.

However, one of her parents had a compromised immune system so the family was not going outside of the home much or connecting with others. Her parents worried about how staying in the home so much during the pandemic would affect Sonja's social abilities and her eventual adjustment back to daycare (now that Sonja had not been connected to daycare for the past several months of summer).

Initial concerns about the usefulness of telemedicine

Her parents also questioned whether telemedicine was feasible with their family and wondered whether they and Sonja could feel connected to a clinician when our interactions were through a video screen.

I too wondered how helpful telemedicine could be for Sonja and her family. Her parents appeared quite anxious about the process, in general, and even more anxious about treatment through a video screen.

I questioned whether I would be able to support the parents and deliver a service to them in a way that could improve symptoms when I could not be physically present with them.

I also wondered how effective my assessment had been of Sonja and worried a bit that I might have missed a key element simply because I could not be present with them.

But, with limited options, the family agreed to try telemedicine to see if symptoms could further improve for Sonja.

Getting started with Sonja and her family via telemedicine

I had to put my reservations aside because the primary focus quickly became Sonja's adjustment to a new school, as decisions had to be made soon. Through the pandemic, the daycare where Sonja had attended full-time since the age of 9 months, first, lost its teachers and then, eventually closed. Her parents felt strongly that Sonja needed to attend school and be in the company of peers to advance her social skills. And they scrambled to find a suitable option for her. Through the recommendation of friends, they decided to enroll Sonja in a particular preschool, five mornings per week but worried about Sonja's ability to adjust to all the change.

Preparing for the video-sessions

I tried to prepare for telemedicine sessions with Sonja, not really knowing what to expect.

I wondered whether Sonja would be reluctant to engage. Would she display negative behavior? How might the parents respond to this and how would we proceed?

I felt that her parents might appreciate a structure to our sessions so they would know what to expect, could prepare themselves and Sonja, and therapy might be more fruitful.

I decided to start our sessions with a greeting to all family members and a check-in with the parents about how things had been going since our prior session. I had then planned to address Sonja directly and attend to what she happened to be doing at the moment and then ease into a discussion with the family about specific issues and strategies.

I prepared for this plan not to work by having a few stuffed animals and figures nearby with which to distract and/or engage Sonja if needed.

I just needed to begin the sessions and see how Sonja reacted while preparing an alternate plan. The planning turned out to be unnecessary.

Telemedicine video sessions with Sonja and her parents

In working with the family, Sonja would look forward to our video sessions. She would have toys set up with which to play and have topics ready to address with the clinician. During one of our first sessions, Sonja stopped playing and asked me directly if she could discuss something with me. She then went on to very articulately express her frustration with her younger sibling and describe how she had "mixed feelings" about loving her sibling and being annoyed by her sibling.

She was also very expressive with her parents during sessions and easily expressed her feelings and explanations for her behavior. It was quite remarkable to observe how articulate and engaged she was, and she continued to be a very active participant in our sessions.

Concerning school, Sonja explained that she was both nervous and excited to start a new school. She was to meet her teacher weeks before school in a park and her entire family was invited to this meeting. Sonja was feeling "scared" about this meeting and wasn't sure she wanted to attend. Her parents worried that the meeting in the park would not go well and then it may be very difficult to get Sonja to attend school.

Because she had been so engaged via video with her daycare and in her sessions with me, we explored using a video screen to help Sonja become accustomed to her new school environment. The school

happened to be social-emotionally minded and agreed to participate and try strategies. So, we established the following sessions, with Sonja's input and approval, for Sonja's adjustment.

First session

Sonja's teacher would meet Sonja via video and Sonja decided they would have a tea party together. This session would be 10-15 minutes in length and leave time for Sonja's parents to connect with the teacher too after the tea party.

Second session

Sonja's teacher would connect with Sonja from the classroom via video for a free play session. Sonja would be able to direct the play if desired and be able to see parts of her classroom while playing with her teacher.

Third session

Sonja's teacher would connect with Sonja from the classroom and give her a tour of the room, the procedures, and the toys. Sonja would determine two toys/games Sonja could play with on her first day and Sonja would be shown and assigned her "job" to help her teacher on the first day.

Fourth session

Sonja and her family would meet her teacher in the park in person. Sonja chose to draw her teacher a picture of the classroom to give to her and to bring a favorite toy of hers to show her teacher. Sonja and her teacher agreed that they would discuss her "job" at the park and they would determine parameters for the job, and her teacher would write down Sonja's duties and give them to Sonja to take home.

Fifth session

Sonja would connect with her teacher via video the morning before her first day of school and the teacher would remind her of the two toys/games she chose to play with and their locations, and remind her of her "job" to help the teacher when she arrives. Sonja would take her paper from the teacher (made at the park) of her "job" duties with her to school on the first day.

All of these sessions took place in the ten days before school was to start. While we had a plan with the teacher and were using video support, we were also planning more typical supportive strategies to help. For example, the family was driving and walking by the school building to familiarize themselves with it, Sonja's parents created a calendar for Sonja so she would know how many days until school was to begin and they established a drop-off ritual for the mornings (Sonja chose to use the same routine that she had used in daycare, two kisses and one hug from her parents).

The video sessions went very well and Sonja appeared to be looking forward to starting school. She was a bit hesitant about the in-person meeting in the park, but she went without incident. Once she got past the initial introduction to the teacher, she was interactive and engaged and even told her teacher all about her therapy sessions to help her.

She was again hesitant on the first morning of school but she reminded herself she could do this (another strategy we used) and of the toys/games she would get to play with, and entered the classroom well after her goodbye ritual with her parents. Sonja continued to do well during school drop-off and was engaged in school. Her teacher noted that she was very eager to interact with her but seemed less comfortable interacting with her peers. Sonja tended to be quiet with her peers and would ask her teacher to play instead.

Sonja's parents now feared that she was now too comfortable with the teacher to the detriment of peer involvement. We quickly pivoted to focus on peer engagement now that Sonja seemed comfortable with her teacher.

We established a plan where her teacher would have a "buddy" for Sonja at school and assign tasks for them to do together to support engagement. Then, we again used Sonja's comfort with video communication to support peer relationships. Her parents established playdates for Sonja once or twice per week with another classmate via a video platform.

In the time of COVID-19, other parents were supportive of this type of playdate and they were easily established. As predicted, Sonja thrived in this video environment and her teacher began to see the benefit in the classroom. Sonja felt more at ease with her peers and would seek them out for play and began interacting with them more and more. Her classmates began playing together at school, with themes they had established on their playdates and they were including other classmates in the play, as well.

Adjusting to the new school environment was definitely aided by the technology that I and Sonja's family grew familiar with during the COVID-19 pandemic. Had the pandemic not forced us into this new environment we may not have known how beneficial it could be for Sonja. Now Sonja is adjusted to school and continuing her relationship building with her peers. She freely engages and expresses herself in our video sessions and we have been able to start to address other behaviors that were of concern to her parents. We may very well find other new and innovative ways to incorporate video technology into our treatment plan as we work together further, as it seemed to greatly benefit Sonja and her family.

Telemedicine insights and questions

Children are adaptable and they may be more amenable to telemedicine delivery modalities than previously considered. COVID-19 forced many practitioners into using telemedicine when they would not have otherwise, and we may well begin to see the unexpected benefits. The focus and fear may have been on the negative aspects and what was different about telemedicine, leaving little space for aspects that might be a benefit. Perhaps using telemedicine strategies with anxious children and their parents, particularly those with social anxiety, will become recognized and accepted as a modality.

Future strategies using telemedicine options for anxious young children and anxious young children with anxious parents, should be explored and studied. The experience of helping Sonja, through helping her parents find ways to calm her anxiety, also helped her parents. It will be important to test this method with other young children with their families and compare its effectiveness to standard interventions.

When the Screen Becomes a Playground: A Dyadic Therapy Program's Transition to Telehealth During COVID-19

By Hillary Mayers, LCSW., Co-founder Chances for Children (CFC) Bronx, New York

Vignette

There are 9 people in the small living room, 2 families, 5 children.

Two of the adults are arguing; the five and six-year-olds are crashing toy cars; the TV is playing at full volume.

Luisa (pseudonym), 3, has one hand over her ears and is tugging on her mother's leg.

"Mami, Mami, my corner! my corner!" she whimpers.

Her mother stops clearing plates from the table, "Que haces, mi hija?"

"My corner Mami!!!" begs Luisa.

Luisa's mother, Flora (pseudonym), after a moment of confusion, remembers.

In a dyadic online video session, Flora, Luisa, and the therapist had created a "cozy corner" with a sheet over a coffee table. Luisa had snuggled in with a book and her favorite stuffed elephant. Absolutely no one was allowed in uninvited. Shortly thereafter, Flora somehow managed to arrange cozy corners for all 5 children.

Finding space for respite during quarantine in a small apartment is a necessity.

Introduction

Our program, Chances for Children - NY (CFC) is a therapeutic program serving families with children, birth to 5, in the South Bronx of New York City. The communities that CFC serves, have been among the hardest hit by the COVID-19 public health pandemic. One of the locations where we provide services is within an Early Head Start and home visiting program. They recently shared these devastating statistics: 70% of their families have been infected with COVID-19; entire families have been or are sick, including children. 100% of families lost their jobs. In all of our sites, families have been without essentials of daily life (food, diapers, formula) and are living in crowded circumstances that make staying at home particularly tense.

As COVID-19 lockdowns have changed New Yorker's lives dramatically and altered routines in every area of functioning, CFC has also changed. As with most other therapeutic organizations, services now take place through a telehealth model using phone, video, and/or text depending on what a family can access. Alterations in both organizational and clinical structures were necessary.

The focus of this paper is to share questions, first thoughts, experiences, and vignettes from this complicated and often confusing transition from dyadic sessions in our offices to the telehealth screen. Though highly disguised case material is presented, it is meant to illustrate different elements of this transition, and not to be confused with caregiver-infant therapy case studies (for discussion of case material pre-COVID-19, please see Mayers & Siegler, 2004; Mayers, 2005).

Organizing the CFC telehealth model

During the first 2 weeks of the lockdown, CFC assessed the needs of clinicians and administration, secured access to encrypted video platforms, and to essential resources that families needed. Regular staff meetings considered both clinical and logistical conundrums while we created new necessary forms and ways to support staff self-care. Fortunately, because CFC is a small organization without layers of bureaucracy, we were able to make changes rapidly and effectively. These have allowed CFC to operate at full capacity through the pandemic.

Under usual conditions, CFC provides dyadic intervention, parent-infant groups, and a tier of intervention for babies and families who have undergone severely traumatic events. In our telehealth model, all families who had begun services before COVID-19

transitioned to telehealth. New referrals were offered telehealth consultation. For example, up to 5 hourly sessions specifically designed to reduce stress, to help establish and maintain daily routines during the pandemic, to provide guidance regarding children's behaviors, and to offer strategies to support their development. Families needing further help became part of our dyadic intervention program. Parent- toddler groups continued, complete with songs, stories, and parent reflection, using an encrypted on-line platform.

Clinical considerations: the infant and family

Many questions challenged us as we considered managing the pandemic and this very new way of working. How can online screen intervention work with infants? What is needed on different levels to address the needs of parents, babies, other family members?

What is happening in the internal and external lives of different families: the pregnant woman, the new mother, the mother with multiple children now confined to home, the dyad who is suddenly reunited during the pandemic after being in foster care, the babies of separated parents who traveled between parents, parents, and babies now caught in multiple bureaucratic systems of child protection and the law?

The clinician

We know that good treatment requires that the therapist remain grounded, present, and steady, despite sessions with little ones that will be unpredictably state dependent, and contexts in which parents are getting sick and in some cases dying. Babies are being born, children are awaiting critical services, neighbors and friends are dying. In the transition to telehealth, many questions arose:

- What of the clinicians who are thrust from in-person, in-office contact to a remote platform with fewer options and many more potential difficulties?
- What does the therapist experience when the screen freezes and important communication is disrupted?
- How does the therapist's frustration affect the client? How competent does the therapist feel with technology?
- How is the therapist's response to her face on the screen, to her external environment, processed?

In short, clinicians are challenged to process new kinds of countertransference at each step of the way. Without readily available supervision and team processing, this would be a nearly impossible task.

The therapeutic alliance

Concerning the therapeutic alliance:

- What happens to the therapeutic alliance when dyadic sessions become meetings on a screen?
- How does the therapeutic encounter change?
- Perhaps the underlying question for all participants is "Will I be/am I safe here?"

According to neuroscientist Porges (2003), there is an adaptive mechanism in the brain that evaluates risk, moving a person toward defense or social communication. The concept that social communication cannot take place without a "felt state of security" makes the sense of safety a prerequisite to effective work (Geller & Porges, 2014).

- Can we create a virtual play space where parent and child can find what they need to understand and manage what is happening in their lives?
- Can the screen become a playground where the dyad can express, channel, and contain confusion?

With these question in mind, and in order to restore or to craft a therapeutic alliance, we must create a safe screen space where a parent can momentarily relax, where the child is freed from focusing on the welfare of caregivers, and where both caregiver and child feel safe enough to explore their own states of mind.

The move from in-person to video sessions: Juanita and Matthew

It is not surprising that the transition from in-person sessions to video was as unpredictable as everything else. Both Juanita (pseudonym) and Matthew (pseudonym) had had over 6 months of in-person sessions before the advent of COVID-19; Juanita for a terrifying trauma history, and Matthew for unmanageable behavior in preschool.

Nevertheless, within their differences, these examples highlight children's remarkable capacities to communicate their immediate concerns.

Juanita, 4, moved easily from in-person sessions to sessions on the screen, exclaiming

> Hello Silvia! I am at home! You are in your house! Me too, I am in your house!
>
> I will show you my bed! Silvia, are you washing your hands?

Here a long history of relational trust with her therapist allowed Juanita to communicate her most salient worry (her safety and the safety of those important to her) despite the strange novelty of the screen experience.

Matthew, nearly 3 1/2, on the other hand, was stony-faced when his therapist greeted him on the screen of his mother's iPhone.

"*Matthew,*" the therapist remarked,

> I see you are thinking. Maybe you are wondering why my face is on the screen. Everything is strange right now, isn't it? We have to stay at home; mommy can't take you to our play space. This is how we are going to see each other for a little while.

Matthew paused, thought, and went to his iPad.

The therapist wondered: Was he looking for the clinician on his iPad instead of his mother's phone?

Was she there too?

As Matthew became more upset, it seemed nothing mom or the clinician said or did could help. He walked out yelling,

> No! I don't care!

The encounter lasted about 2 minutes.

Having put words to Matthew's anger and letting him know that it was okay to be angry with her (and knowing that Matthew was safe in the kitchen with his grandparents) the clinician turned her attention to Matthew's mother.

She understood the most useful intervention would be to lend her support to Matthew's overwhelmed

mother so that she, in turn, could better contain Matthew.

Matthew's mother was an essential worker, struggling with daily frustration, anxiety, and fear. Because of childcare needs, both she and Matthew were confined to her very religious parents' small home where her previously anxious parents were now further panicked by the virus. When not home, she was at work also surrounded by Coronavirus fear. As they spoke, Matthew crept into the room and hugged his mother before leaving once again, letting them know he knew his mother needed help too.

By the second session, Matthew was able to play constructively on the screen with the clinician for forty minutes, building a jail in which Batman was trapped. When the clinician reflected that maybe it feels like we are in jail too, that we want to go out and can't, Matthew broke into the jail exclaiming, *"Break it down! Batman is free!"*

Indeed, at the beginning of the shutdown, many children played about breaking out of confined spaces or being squashed into overstuffed places. Matthew's initial response to the confusion of the changed situation and the intense anxiety that surrounded him was his habitual stubborn, belligerent withdrawal. However, seeing that the clinician had not abandoned his mother or him, and would return reliably every week, he was able to return to productive play with them.

Initiating sessions with new clients

From its inception, the CFC program has tailored dyadic intervention to meet the needs of the individual family (Mayers, Hager-Budny, & Buckner, 2008). This has remained consistent in our work with adolescent parents, community parents, and now in our telehealth interventions. In some families, the COVID-19 pandemic has added new layers of chaos to prior turmoil. For others, it heightened already rigid coping styles.

For clinicians and families alike, the timing and flow of sessions on screen are more unpredictable than usual. Now they are impacted not only by the emotional states of the parent, child, and therapist, but by technology that freezes unexpectedly, creates lags between words spoken and words received, or crashes entirely if a child gets excited and bumps into a screen.

In addition, many families are living in cramped conditions that make finding a private space often impossible. Dialogue and play are often interrupted. Interactions that appear to be private can sometimes reveal any number of onlookers as people outside of the screen view begin to move around.

The disruption of our usual therapeutic frame, along with the security and scaffolding it provides, can leave clinicians feeling unmoored. We have learned the importance of adjusting expectations and not taking too personally when these adjustments may not work. The following two vignettes illustrate different interventions that depended on the need of the family.

Pedro

Our CFC clinician had not met Pedro (pseudonym) (aged 3 and a half) before the COVID-19 shutdown. He had been referred by his pediatrician who could not find any physical cause for Pedro's refusal to use the toilet for bowel movements (although he urinated easily there). Pedro had told his parents he "didn't know how" and was afraid, though he could not explain why. Typical labeling of feelings and behavioral strategies had not worked.

Before the first session, Pedro's mother had set out various toys that Pedro liked and some playdoh that she was able to provide at the therapist's request. Playdoh (especially the homemade very-soft kind) can have a deeply soothing effect on parent and child alike while also providing an outlet for aggressive play that can require full-body engagement and energy.

During this session, Pedro, his mother, and the clinician pushed, pulled, squeezed, smashed, and cut playdoh. After some time, Pedro began to build a house from magnetic blocks. When the clinician asked if there was anything in the house, Pedro replied a kitchen and a bed. She wondered if there was a bathroom in the house.

Yes! said Pedro surprised.

> Help me build a potty Mommy; I will build the shower.

Pedro placed an action figure on the potty.

> Now you build a house Mommy; I will make a tunnel… then we can go between without going outside, right?

Pretty soon playdoh was filling the houses, oozing through windows and doors, flooding the tunnel, and the potties, along with everything else. Action figures were buried, hidden, and found.

In the best of times, life is full of contradictions and confusions for little ones. Inside and outside can have multiple meanings—in my body/outside my body, in my house/outside my house, what can my house/body hold, what fits and what spills, what belongs there and what does not, who is in charge?

Clearly, Pedro had found enough safety in the presence of the therapist and on the playground of the screen to begin to communicate many different worries from fears of leaving the house safely to safely surviving his bowel movements. Here we had a beginning.

Scarlett

Scarlett (pseudonym) at 4 months had just returned to her birth mother, Letitia (pseudonym), from foster care. Letitia, twenty years old and a single mom, had tested positive for marijuana in the hospital. Child protective services had been called and Scarlett was placed in care. Just as Letitia completed the substance abuse program required for the return of her child, sheltering-in-place was mandated. Family courts shut down and processes ground to a halt. As systems struggled to organize, Letitia struggled to maintain contact with her newborn and to establish an identity as Scarlett's mother.

Letitia and Scarlett were referred to CFC by child protective services after Scarlett's return. Here was another program, mandated by a terrifying system that had "snatched her daughter from her," intruding into Letitia's newly created family, just as she was trying to figure out how to keep herself and her baby safe in a neighborhood overwhelmed by COVID-19.

The intervention began via phone as the therapist tried to understand the story of Scarlett and Letitia, from pregnancy through birth, separation, and reunion. In these calls, Letitia and her therapist built an alliance and enough trust for Letitia to let the therapist into her home via video.

For this first session, a solemn Scarlett was placed in a car seat facing the screen. A steady stream of high-pitched chatter served as background while

a disembodied arm appeared on the screen offering Scarlett one toy after another, all of which the baby ignored. Struggling with a myriad of feelings, the therapist (TH), plunged in and began to talk with the baby and her mom.

TH: *Hello Scarlett. I am Hillary. Your mommy has told me so much about you and I am so happy to see you. Mommy wants us to see all the lovely things you have.*

Scarlett is alert to the screen. There is silence as the arm pushes a stuffed rabbit into Scarlett. Scarlett grimaces and turns away.

TH: *You know Scarlett, I would really like to meet your mommy. Do you think you could introduce us?*

L: (giggling) *"Hi Hillary!"*

TH: *THERE you are Mommy. I hear you.*

There is a long pause, and I am struck by how difficult it is to sit with silence on a screen.

TH: *You know, Scarlett, you can see me, and I can see you, but you can't see mommy and I can't see her either!*

Letitia begins to shake a rattle loudly off screen.

TH: *We know she is there though, don't we? We hear her.* (Another long pause.)

TH: *I wonder, Letitia, what do you think it is like for Scarlett to see the toys and hear your sounds and not see you?*

L: *She knows I am here.* (Letitia turns the baby's chair sideways so she and Scarlett can see each other while Letitia remains out of the picture.) *See Scarlett here I am!*

TH: S*carlett saw you, and then she didn't see you, and now she sees you again, just like when she was in foster care. Now you are together.*

At the end of this session, Letitia was able to allow the therapist to see her on the screen. They were able to play together with Scarlett, to reflect on the time it can take to get used to people, toys, and new situations, and this allowed Letitia to slow down her play to Scarlett's pace.

Finally, they were able to reflect on Letitia's need for Hillary to understand firsthand how terribly difficult it is not to be able to see someone important, and Letitia began to share her 4 months of grief.

As Letitia was listened to and heard, she became hopeful that the separation from Scarlett could be repaired and she could indeed become the mother Scarlett needs.

Can telehealth be effective?

Anecdotal findings: Qualitatively, anecdotally, it appears that telehealth can be effective. However, from a more quantitative perspective, it is difficult to know what to measure, how to define success, and what to use as a baseline?

At the simplest level, the absence or reduction of symptoms might be a useful measure. However, as the pandemic continues, new uncertainties surface as communities struggle to figure out how to resume a less sheltered existence. School re-openings bring added stress to families. These stresses are communicated to children and frequently result in renewed symptoms. This makes symptom reduction a less robust indicator of treatment effectiveness.

Usual CFC Assessment measures: Along with some standard assessment instruments, CFC uses pre/post-intervention video recordings of parent-child interactions (blind coded) to assess progress in the dyad. However, during the pandemic video recordings have not been possible given concerns over confidentiality in overcrowded homes and unreliable internet.

A CFC COVID-19 adapted measure to evaluate the effectiveness of telehealth

In an attempt to capture some measurable data, CFC designed three tools:

1. An Exit Survey anonymously completed by families when intervention is complete. This survey assesses a reduction in stress and satisfaction with services received.

2. A Pre-Intervention Questionnaire, given to the parent remotely, assesses a baseline of general stress and stress in the parent-child relationship.

3. A Clinical Session Rating Scale, rated by the clinician after each video session, to assess elements of behavior in the parent, child, and dyad.

As CFC has just begun using these measures, there are no results available yet.

Conclusion

With the ongoing impact of COVID-19 on our communities, our journey into infant-parent telehealth continues. We have learned many lessons, among them that dyadic work can endure, offering critical support to families that reduces isolation, encourages development, and nurtures hope. A great benefit of telehealth has been the scope of its reach, allowing us to reach families who without this option might never have had access to help. The challenges are many: the technology itself, the barrier of the screen which constrains what we see, smell, and touch, the remaking of the therapeutic frame, and of building new, safe alliances virtually. Here we benefitted greatly from the flexible structure of our model that could accommodate changes in delivery while maintaining critical core principles.

We have learned not to be surprised when schedules collapse and know there will be an on-going struggle with the challenge of regaining our own regulation and renewing a reflective stance as the circumstances around us continue to shift. We continue to be surprised that very little ones build relationships with us in just a few minutes on a screen and remember us the next hour. Perhaps most importantly, we are grateful that within the mess and confusion, the remarkable power of play to contain, work through, and resolve difficulties remains astonishing, inspiring, and healing for dyad and clinician alike.

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Symbolic Play using Telehealth: A Brief Case Study during the COVID-19 Pandemic

By Martha Alvarez, LCSW Chances for Children (CFC) Bronx, New York, USA

The globe was impacted by a devastating virus.

Swiftly

This miniscule microorganism passed from soul to soul.

It entered our bodies.

It settled in our lungs, and we could not breathe.

It entered our minds making its way into the deep crevices of our brains reigniting our senses of fear.

Threatening our senses of

Safety.

Forcing us to rethink and reorganize our daily functions.

All the while, as infant mental health professionals,

keeping the baby in their family, in-sight.

As mental health professionals working dyadically one-on-one with families experiencing severe stress, and living in unfamiliar isolation, our team understood the need to maintain a sense of continuity and connection, and we jumped into action, creating a Telehealth model to serve as a vehicle that supports this sense of continuity.

The following is a vignette that illustrates the value of relationship, the importance of symbolic play, the need for flexibility, and the level of resilience in families.

Mary (Pseudonym) and Bobby (Pseudonym) (3 ½ years old)

Before the emergence of COVID-19, Mary began attending *Chances for Children* because she worried about her parenting, frequently asking herself, "Am I a good mother?" She also worried about her son's ability to play with other children and his tendency to isolate himself. Bobby, who will be 4 in October, was timid and had a big imagination. During our initial sessions, Mary would chase Bobby. "Please, can I play with you? Please?" She would repeat this request, trying helplessly to push her way into Bobby's imaginary world of super-heroes and dinosaurs. There was a perceived sense of desperation in Mary.

As our work together progressed, Mary began to understand her son's need for an independent space to be creative. A very useful tool and intervention was *Chances for Children's* use of video and video feedback. This protocol allowed Mary to observe herself and her son and to reflect on those shared moments.

There was a particular video which I will call "the shaving cream experience" that I believe helped move the therapeutic work. The play exercise required shaving cream to be scattered on a large tray, they were given paint brushes and small animal figures and mom and son were asked to paint the animals. They each picked up a brush, Mary asked Bobby, which animal should she pick. Bobby pointed to the dinosaur and they began to play. Sitting side-by-side, they exchanged stories about the dinosaur having a beard, or the bear having funny hair. They hummed silently yet in sync and they sang songs which sometimes Bobby initiated, and at other times, Mary initiated.

They tried to "paint" each other's faces with the shaving cream and laughed. Bobby's acceptance of mom, not as an intrusion but as a fun partner, was very clear in the video. During several video feedback sessions, Mary and I watched, processed, and reflected on their very gentle and enjoyable exchange. It can be concluded that Mary felt more

confident in her skills as a mother and accepted by her son. And so, with the help of our video feedback and conversations, Mary began to approach Bobby's world in a more gentle and introspective way.

Mary's maternal conflicts stemmed from her relationship with her own mother whom she described as distant and uninvolved. As Mary slowly understood, acknowledged, and reflected about her own past, she began to gain confidence in herself as a different sort of parent, a parent who could co-create a different experience with her son.

Suddenly COVID 19 appeared and our working world was turned upside down. We introduced Telehealth as our new way of connecting.

From Face-to-Face Therapy to Telehealth

First session

Bobby was very curious the first time that we connected via WhatsApp. He ONLY wanted us to watch him play, and so we did. If he made a sound or a movement, as in making his car fly, we did the same, following his lead, and mirroring him. Reflecting on this, it seemed that Bobby was recreating the dynamic of our first session together, in which he insisted on playing alone, resisting any approach to join in or insert a separate thought. He seemed to have reverted to an earlier idea that relationships meant being overwhelmed and lost. It was as if he was asking, "Is this video thing safe? Do I have to start all over again from the beginning?"

During this first telehealth session I introduced Ralph, a homemade boy puppet. I did so for two reasons: one to offer a transitional character that was neither inanimate nor alive to reintroduce relationships, and second, because I hoped that Ralph could ease Bobby's transition out of the session, often a difficult task for Bobby. Indeed, Ralph was most helpful!

Using a phone check midweek, Mary and I spoke about that first session. Mary was appreciative that we had connected and surprised at Bobby's level of engagement.

Second session

I became more organized and structured about the sessions.

I began using body-based affect regulation and asked Mary and Bobby if they could scrunch up their faces really tight and then let go. I asked if they could make fists, squeeze them hard, and then let go. Then we breathed in and blew out our breaths together. They participated eagerly.

Then we started to play. Using Magnatiles, Bobby built an elaborate jail with robots trying to get out, a moving symbolization of his/our current circumstances as if we were in jail and wishing to get out. As the robots were trying to escape, the jail collapsed. Normally Bobby would be very upset and tantrum after working so hard on something and having it collapse, but this time, while he displayed minor upset, Mary was able to identify his emotional state and say: "It's ok to be frustrated; we can build another one." And they did.

Photos published with permission by Martha Alvarez.

Subsequent Sessions

Magnatiles became an integral part of our sessions as was Ralph. With great resilience, Bobby quickly accepted our video sessions as a safe way to continue to create stories, make meaning of our current situation, and continuing to build relationships.

In one session, Bobby built a castle with a moat filled with mud and, after a long story of dragons and fights, Ralph fell in the mud. Bobby and his mother "sent" an imaginary rope and tugged the rope to save Ralph. Together, we helped Bobby play out another scene of rescue which helped Bobby gain a much-needed sense of control. We celebrated Ralph's rescue with a silly dance.

During another session where Ralph had not made his appearance yet, Bobby made pretend ice cream with Magnatiles and invited Ralph to share the ice cream with him. Ralph was called in, and I used my Magnatiles to create ice cream also. Bobby and Ralph shared chocolate ice cream with sprinkles, Mom and I joined in with our scoops. On another occasion again using Magnatiles, Bobby made a birthday cake, we sang happy birthday; he blew the candles, cut the cake, and we shared his chocolate cake.

Bobby and Mary remained at home as Bobby stated, "to hide from the virus". They only ventured out to buy groceries or to go to the doctor. Bobby's pre-school offered zoom class encounters every day at 11:00 am. The classes were brief, but they helped Bobby connect with his teacher and classmates.

Midweek Phone Check-In

An important part of this Telehealth intervention was the midweek phone check-in with Mary. During this time, Mary was able to freely share her fears about the virus, how her anxiety rose when Bobby became dysregulated, and how she tried to maintain a sense of calm. Many of our conversations also dealt with her own maternal conflict.

As already stated, Mary experienced her mother as distant and uninvolved. Mary was able to observe her own behavior with her son, which was involved, playful, and engaging, and reflect on her own relationship with her mother which was distant. Mary repeatedly stated that she appreciated our "adult" weekly conversations, as she called them.

I believe our sessions, both in person, and through Telehealth, allowed Mary

to be heard and understood by another adult, providing her with a corrective experience. In the words of Selma Fraiberg et al. (1975), in their renowned article, *Ghosts in the Nursery*:

When the mother's own cries are heard, she will hear her child's cries"

(Fraiberg et al., 1975).

This rang true for Mary and Bobby.

Having been heard and understood, helped Mary become more confident as a parent.

Mary was able to find exactly what she was searching for.

Mary had her experiences as a child with her mother, seen and heard.

Mary more and more began to experience a difference in herself as a mother to Bobby.

Bobby has let her in into his world.

Mary has learned to tolerate and understand that his "No!" is not a rejection of her, but a request for space and independence.

When Bobby needs her, he will call, and she will be there for him.

Mary felt accepted as Bobby's mother.

Reflections and curious outcomes of Telehealth

Our Telehealth sessions bear a resemblance to in-person sessions in that they helped Bobby play out his fears, fantasies, and wishes. However, Bobby's capacity to capture and accept the "remoteness" if you will, of our interactions, in addition to his ability to focus and feel a sense of connectedness via screen, was remarkable. While Mary, initially was much more apprehensive about being on screen, slowly she joined in, and supported Bobby's variety of animated play stories.

A curious outcome of Telehealth in this particular situation was a freer sense of expression for Mary. During our in-person sessions, Mary seemed guarded and less forthcoming. However, Telehealth provided mom a shield of protection that allowed her to share more honestly and deeply, which brought with it a profound sense of introspection and change yielding a more attuned and confident parent.

The consistency of connection which Telehealth provided was critical for this dyad. When I scheduled our *WhatsApp* session at the same hour every week, I was there. Bobby knew that Ms. Martha was going to call, and we were going to connect to play. Mary reported that Bobby would plan what he wanted to play with and prepared what was needed. Just as I kept them in mind, Bobby and Mary were also keeping this encounter in mind. I do believe that having met the family and having had an established and ongoing relationship prior to COVID-19, made the transition to Telehealth easier.

"Virtual" experiences are no substitute for in-person experiences. However, I believe that Telehealth allowed Bobby to practice essential developmental skills. Waiting and taking turns, for example, were constantly in play. While Bobby had difficulty tolerating others initiating play, slowly, Bobby began to accept his mom's, Ralph's, and my needs, to build a Lego tower at a slower pace, for example, or to take turns adding magnatiles to a castle. It was constantly repeated "it's mommy's turn", "its Bobby's turn""It's Ms. Martha's turn", etc. One time, I made Ralph jump the turn, and Bobby said: "it's not your turn Ralph". Bobby then began to internalize this experience and accept it as a norm.

Another curious outcome of our Telehealth sessions was Mary's level of attunement to her son's play themes. A note, our Telehealth sessions were on WhatsApp, we used our phone screen, which was pretty small, and many times I couldn't see all the action. I would ask Mary and she would narrate what was happening, which included action and feelings. This allowed Bobby to hear mom's interpretation of the "story". Bobby would look at mommy and listen intently to her narration, he then would nod in agreement, and continue playing, or disagree with her and mom would correct the narrative. Bobby felt understood by her. This very subtle exchange in this parent-child relationship, helped to strengthen their bond.

Final Reflections

While COVID-19 turned all our worlds upside down, as a clinician, I made adjustments to how I practiced. Tweaking light, sound, backgrounds, ordering toys, and making puppets in order to support this new virtual therapeutic experience became important. Along with, expecting the unexpected, such as, a very-young child's capacity to focus, and understanding a child might only be on screen for 5 minutes, it's okay. As with home visiting programs, being sensitive to and respecting our family's homes, personal space, style, and circumstances. Being cognizant of privacy or the lack of. All this became part of this new way of practicing.

During the COVID-19 quarantine, young children do not have the ability to connect physically with other children. How can all the Bobby's and Lucy's try out their skills of waiting and taking turns, of leading and following, of managing transitions, of separating from mommy, finding her reliably there at the end of the day and saying "Hello!"? It is likely that a backlash of our sheltering-in-place will [1]be that very-young children will have to relearn these important experiences and skills.

I believe that our Telehealth sessions helped to sustain our therapeutic work. There was much progress in Bobby and Mary. Bobby included us in his play, he began to tolerate waiting, he began to label feelings, he began to tolerate and focus during his zoom school classes. Mary reflected on her behavior and felt proud about how responsive and less intrusive she had become.

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COVID-19 Confinement and Babies: Video-Call-Based Developmental and Mental Health Approach

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Introduction

In Portugal, as in many other European countries, the COVID-19 crisis and the nationwide state of emergency, forced families into social confinement. During this period, families were asked to stay home. Gathering in public areas was forbidden. Schools were closed and telework was generally implemented. Commercial establishments were closed except those providing basic needs. Leaving home was authorized for acquiring goods, imperative services, and medical assistance as well as other reasons of extreme need. Short trips for adults and children were allowed for physical activity or walking pets.

These measures had an obvious impact on Portuguese families as well as families all over the world. "Stay home" made a change in daily routines and family ties, for families. "Stay home" meant "adapt and be resilient to get through" but, sometimes, it also meant, "stay safely together, enjoy your children!" Although Portuguese social security provided support for parents to stay home with children under 13 years of age during this period, many families experienced a financial negative impact with a crisis in the labour market, leading to temporary layoffs and unemployment.

The Portuguese National Health Service had no rupture in intensive care units and inpatient services, but ambulatory care changed, and telemedicine was the preferred way of providing non-urgent consultations. During this period there was a significant decrease in Emergency Room visits, most probably due to the fear of contagion in the health services. There was also an excess of mortality per month due to non-covid diseases compared to the monthly average of the past 5 years (2015-2019) (source: Ministry of Health of Portugal).

Our Unit is affiliated with the main Portuguese pediatric hospital in the capital city, Lisboa, which was the center for the COVID crisis. The implementation of the contingency plan to face the crisis resulted in structural changes in the hospital. Consequently, our facilities were needed to install Emergency Room Services. We had to adapt our practice to deal with distance, the fear of families to bring their child to the hospital, and the new dynamics of teamwork that reflected individual responses to stress and fear. Also, we needed to rapidly adapt to using telemedicine and social networks. We kept on providing mental health and developmental services for babies and young children, and their families in a new way. The aim of this article is to describe this experience and show how we dealt with it.

During the first 3 weeks of this period, two infants were admitted to the Emergency Room of the main pediatric hospital in Lisboa, with developmental regression.

Case 1

- A 9-month-old male infant, with no relevant personal or family medical history, showed drowsiness, decreased motor activity, and loss of skills. Namely, absence of response to name, social smile, coos and gurgles or anticipatory gestures, and had not been maintaining circles of communication for the last three days.
- The physical exam was normal. Hematological, biochemical, metabolic, and immunological laboratory studies were normal. RT-PCR SARS-CoV-2 was undetected. Cranial CT scan and MRI were unremarkable.
- During hospitalization, the baby showed persistent avoidance of

eye contact. They also showed fluctuating abnormal engagement and communication behaviors. No treatment was provided.

Case 2

- A 4-month-old female infant, with no relevant personal medical history, showed for the last 2 weeks, periods of irritability and drowsiness, and sporadic chills. There was a maternal family history of epilepsy.
- This was the first child of a healthy and young couple; the mother suffered from two previous abortions (1 fetus diagnosed with trisomy 18).
- The physical exam was normal. Hematological, biochemical, metabolic, and immunological laboratory studies were normal. CSF culture was negative. Blood culture was contaminated. Blood and CSF were negative for neurotropic vírus. RT-PCR SARS-CoV-2 was undetected.
- This infant was treated with antibiotics and antivirals, in the hospital. She clinically improved and was discharged after 7 days. The next day she was readmitted due to drowsiness, restricted response to social interaction, loss of social smile, and lack of interest in toys. Sparse ocular flutter of unknown etiology was observed.
- Laboratory studies were expanded and included tests for toxic substances and metanephrines in urine, serum and urinary catecholamines, and CSF; all were normal. Blood and CSF cultures were negative. Cranial CT scan and MRI were unremarkable. EEG was normal. Chest X-ray and abdominal ultrasound were normal. Ophthalmologic evaluation revealed pseudo-strabismus.
- During the 8 days of hospitalization, without targeted therapy, she gradually improved returning to her previous state.

Post-discharge video-based interventions

After hospital discharge, both babies were followed-up in an Infant and Early Childhood Development and Mental Health Center - Centro de Estudos do Bebé da Criança. Facing strong restrictions due to obligatory social confinement and health services restructuring already mentioned, we set up a video-based methodology for follow-up and treatment.

Methods

- We set up a video-call-based developmental and mental health approach.
- The therapeutic target was on the regulation of the interaction between parents and babies and on the promotion of developmental competencies.
- We approached individual characteristics of the dyad and the triad and follow-up clinical evolution, namely signs of an arrest in the acquisition of developmental competencies or regression, or more subtle fluctuating signs and symptoms.

Legal and regulatory procedures were followed.

The team included a child and adolescent psychiatrist, a neuro-pediatrician, residents, and a mental health nurse. Each member was introduced to the family. They could see the team during the whole session and the setting was the same for all sessions giving a sense of continuity. The team was in the same room, using face masks. For each family case, there was a referral doctor that headed the approach sitting nearer to the camera, with contributions from the others when needed. Residents were observers.

- The first two weekly sessions consisted of an interview with the parents and naturalistic observation of the baby, for 45 minutes.
- Both parents and the baby were always present during observations. In case 2, the family dog was also around.
- The parents were free to choose where they wanted to be seen: one of the families (case 1) set the camera up in a wide and comfortable living room and the other (case 2) set it up in the bedroom, namely on the bed.

The second set of sessions focused on parent-infant interaction regulation and included instructions concerning the setting (toys, camera, the distance between family members to facilitate baby and parents interaction and communication circles) as well as counseling on developmental and behavioral issues.

The evolution of both cases allowed us to make some diagnostic considerations using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood - *Zero to Three (DC:0-5)*, which is a five-axis classification system.

Results

Case 1

The video-based observation was consistent with subtle signs of limited social-emotional responsivity or sustained social attention, namely reduced ability to engage in reciprocal games and to initiate joint attention. A deficit in non-verbal social-communication behavior, by an atypical use of eye contact, was also a concern. However, compared to the hospital stay, the clinical evolution was favorable.

In the first video session, language acquisition was already a strength. He was vocalizing again and understanding mother's speech: when mother said the word "plane", he looked through the window. Some pragmatic competencies, meaning the ability to use and understand some gestures appropriately, were also present. For example, the baby responded to the parents' outstretched arms to change laps. Later, he also followed his parent's pointing gesture and accepted the proposal to move around the room. His favorite toy was a car that he orally explored and repeatedly dropped to the floor. Movement and physical competencies were otherwise fully present.

During the first sessions, the mother was anxiously talking about the whole week's progress. She was also sharing her doubts and concerns about regression using pressured and perseverated speech. As our presence became frequent, she calmed down and took some quiet pauses in her speech. The father was mainly around the child. When needed, to clarify some facts, he interjected with his partner's talk.

During the observations and analyzing the material from the way the parents talked about their worries, we could appreciate no other signs of concern in respect to the quality of caregiver/infant interaction and relationship (except the anxious and overstimulating response already mentioned).

The parents were able to play in a joint format, to propose turn-taking sequences, to show contingent talk, with the presence of motherese. They were pointing to present the external world; they were emotionally attuned and showed affect.

The DC: 0-5

This infant was classified (axis I) as Early Atypical Autism Spectrum Disorder, mild (a Depressive Disorder was dismissed); (axis II) caregiver and infant contributions to the relationship quality was in level 1, well adapt relationships, concern - anxious response and overstimulating; (axis III) despite extensive investigation, no physical health conditions were identified; (axis IV) no psychosocial stressors; (axis V) social-relational and language-social communication developmental competencies are inconsistently present or emerging.

The parents were guided to regulate the interaction:

- They were asked to look for the best physical distance between their son and themselves that would facilitate eye contact.
- To adapt the tone of voice and speech rate and style of commenting.
- To always respond to communicative gestures; and
- Practical suggestions were made to tune-in to the infant's needs and rhythms, and to follow his lead, not overstimulating.

Case 2

Video-based baby observation was indicative of global developmental delay.

When the camera was turned on, the baby was on her mother's lap in front of the camera, on the bed. The baby had a blank expression, sparsely looking at her mother's face. Motor competence of holding head up without support was inconsistently present. Her hands were often open and in her mouth. She was vocalizing poorly. After a small period of time, she began to protest and the mother laid her on the bed, distracting her with a rattle, but she showed no interest.

In another session, the baby was crying, and the father unsuccessfully tried to comfort her by proximity and by touching her face, especially her lips.

In a third session, we were surprised by the interest in the family dog, as the baby was focused on the pet for a couple of minutes.

Although both parents were present during all the sessions, only in the third session did the father let himself be seen on camera. This was important for us as a sign of therapeutic adherence.

The mother was focused on infant symptomatic behavior namely periods of excessive sleepiness that alternated with periods of irritability. Both parents had difficulties in providing comfort for their baby's distress.

Social services were another topic that was present in the mother's speech and the possibility to receive support to move to a bigger house. They lived in a shared house with the father's family.

The DC: 0-5

This baby was classified (axis I) as Global Developmental Delay; (axis II) caregiver and infant contributions to the relationship quality was in level 2, strained relationship; (axis III) extensive genetical investigation is in progress; (axis IV) economical and employment challenges were considered as psychosocial stressors; (axis V) global developmental competencies are not meeting expectations.

Our approach was to:

- Guide the parents to recognize and respond to the infant's emotional needs and signals.
- We also suggested some exercises that could help to improve motor patterns and motor milestones acquisitions.
- Afterward, an approach that focused on the mother-infant relationship was initiated, especially when the mother felt secure to verbalize her suffering with previous pregnancies.
- Further investigations on the genetic etiology of global developmental delay are being performed.

Discussion

We think that this video-based approach provides comprehensive management, allowing early intervention, and taking advantage, even in times of pandemic crisis, of the earliest window of opportunity for brain development and plasticity during the first year of life.

Additionally, this experience raises several questions.

1. To start with, the mandatory confinement and permanent cohabitation, along with the consequent change in family routines, may allow parents to closely observe their babies. Is this an opportunity for families to detect earlier subtle warning signs of abnormal neurodevelopment?
2. The challenge of re-thinking the intervention setting. It was now split into two scenarios (the patients' own home and the hospital) and limited by the camera angles that were dependent on the will of both sides, and not under our control. Taking these differences into account, we respected the family choices, and we made a naturalistic home video observation, during the first sessions.
3. We were able to offer guided interactions, between the parents and their baby. For example, to regulate the distance between the dyad, and follow the lead of the baby, to help the family with joint attention, responsivity to sensory inputs, and the regulation of themselves and their baby.

From the parent's point of view

The setting design was also completely new: doctors were seen on a screen, using face masks that hid facial expressions and altered the tone of voice, thus hindering powerful instruments to signal empathic listening.

Despite these circumstances, parents engaged in a therapeutic relationship. This was evidenced by the way that the families became more comfortable, by letting themselves be seen on the screen, to express their feelings, to show us family dyadic and triadic interactions and living style, in a very rich, zoomed-out effect.

From the hospital team's view

This multidimensional approach and the required sustained attention to the parents words to the baby and to the relationship between the parents and the baby, made us consider that it was advantageous to have more than one observer per session so that all the important elements could be collected, and distractions reduced.

Concluding reflections

- Finally, we realized that access to technology was not a limitation. Families easily accepted this approach and recognized the importance of our regular presence.
- The good acceptance of this video-

based methodology was probably empowered by the massive use of video calls since lockdown started.

- We found this video-based approach useful and not widely disseminated for infant and early childhood mental health services.
- After 45 days of mandatory confinement, we restarted in-person medical appointments for these most critical cases.

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Clinician Perspectives on Adapting Evidence-Based Mental Health Treatment for Infants and Toddlers during COVID-19

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Introduction

The COVID-19 pandemic has presented significant stress for young families across several domains, and in many circumstances has increased the need for therapeutic services to help families cope with a range of emotional and behavioral health concerns. For caregivers, the pandemic has led to new stressors including financial strain due to lost or reduced employment, loss of child care, disruption of professional and parenting responsibilities, and isolation from social supports. The lasting impacts of the pandemic are still unknown, but rapid-cycle data collection, as well as lessons learned from prior disasters, indicate declines in mental health and wellbeing for both young children and their caregivers, with a disproportionate impact on low-income families and people of color (Center for Translational Neuroscience, 2020 a and b; Cluver et al., 2020).

Given the increased stress for parents and young children, there may be a greater need for emotional and behavioral interventions, yet many mental health service providers have been closed or operating at reduced capacity during the pandemic to protect the health of clinicians and families. Many have transitioned to virtual services, which has posed a range of financial and logistical challenges for clinicians and families and simultaneously has yielded creative adaptations by both families and clinicians with unexpected benefits.

This article presents the perspectives of a group of seasoned infant and early childhood mental health clinicians and supervisors from three agencies on the adaptations they made in delivering two evidence-based treatments for young children's mental health. As part of a federal grant funded by the Substance Abuse and Mental Health Services Administration, the Department of Behavioral Health trained and supported clinical teams to offer two dyadic treatments – Parent-Child Interaction Therapy (PCIT) (McNeil & Hembree-Kigin, 2010) and Child-Parent Psychotherapy (CPP) (Lieberman & Van Horn, 2011).

The project focused on increasing access to these therapeutic interventions for urban, low-income Latinx (people of Latin American origin or descent) and African American families with children under the age of six. Families sought these services with a range of presenting concerns, but most commonly to address emotional and behavioral symptoms consistent with reactions to trauma or toxic stress, including externalizing behavior (e.g., aggression, defiance), anxiety, sleep disruption, hyperactivity, withdrawal, and attachment difficulties).

The clinical teams reflected on the adaptations they made to these evidence-based treatments in a series of reflective forums convened by the external evaluators for the system of care grant. Those conversations were recorded, transcribed, and then analyzed as part of this paper. The clinical teams then reviewed the analysis and added additional clinical reflections and lessons learned.

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) is a manualized evidence-based practice designed to treat challenging behaviors among children 2-7. PCIT targets caregivers' attunement and limit-setting with their child to improve both their attachment relationship and child prosocial behavior. PCIT involves dyadic sessions in which the caregiver and child play together while the clinician observes and coaches from behind a one-way mirror. As treatment progresses, caregivers reach mastery criteria in two phases of therapy: Child-Directed Interaction (CDI) in which caregivers engage in dyadic play using new skills (summarized with the acronym PRIDE), and Parent-Directed Interaction (PDI) in which caregivers learn to give effective commands and

follow through with a structured time-out sequence.

Across the two stages, PCIT is highly structured and data-driven, and families are asked to complete weekly homework and questionnaires (McNeil & Hembree-Kigin, 2010). In recent years, PCIT was adapted for a telehealth format ("I-PCIT") (Comer et al., 2015), but in-person treatment was still the norm before the pandemic. Among the clinicians in this sample, there was a wide range of experience implementing PCIT prior to the pandemic: a few clinicians had experience implementing I-PCIT as a supplement to in-person therapy, whereas other clinicians were still completing their formal training in traditional PCIT.

Silver linings. The clinicians observed that PCIT, in comparison with other therapies, may be particularly conducive to a telehealth format. In PCIT's standard format, the therapist is already separated from the family via the one-way mirror and communicating through a bug-in-the-ear device. Hence, it may be less jarring to switch to remote treatment in which they communicate through an earpiece via their respective devices. The clinicians highlighted the potential for some families (with the time and motivation) to attend sessions more frequently and therefore progress through PCIT more quickly. One clinician noted that some families' compliance with homework (daily play sessions) increased because they were home more often. When homework completion did not improve, it created an opportunity to discuss and address barriers to clinical progress other than lack of time, such as caregiver beliefs that playtime may reward challenging behavior or caregivers' discomfort with their own play skills.

Further, facilitating PCIT in a virtual format brings the clinician into the home and provides a more comprehensive picture of the child's behavior. Parent coaching in real-time in the context where the child's behavior occurs may support accelerated skill integration into everyday life. For example, the clinicians noted that they could coach caregivers through moments when siblings disrupt the play, a common issue that cannot be directly addressed in the clinic.

Further, they could individualize the time-out sequence to the spaces available in the home. One clinician described virtually coaching a parent through a child's tantrum at home, a helpful therapeutic opportunity that was unlikely to occur in the clinic because children often exhibit different behavior depending on the context, and have different stimuli at home that can trigger and soothe their dysregulation. Through this experience, the caregiver felt more confident and supported, while also ensuring that they were seen as the clear authority figure because the child was unaware that they were being coached.

One clinician observed that technological challenges, such as disrupted video connection, required additional creativity but could be used as an opportunity. For instance, many parents feel awkward practicing the Child-Directed Interaction (CDI) skill of behavioral descriptions (i.e., narrating the child's play). When in the clinic together, some clinicians would ask parents to "pretend I cannot see what's happening" to help them master this skill; the lapses in the video provided spontaneous opportunities to practice describing the child's play.

Barriers and adaptations. The availability of toys is a major concern because there is specific guidance regarding appropriate toys to use for play in PCIT, and many families did not have the resources to purchase them. In response, the agencies worked to package and distribute PCIT toys to families. One clinician introduced them to families as a way to reinvigorate dyadic play, and noted that "families have been very receptive not just to get a toy but also providing ideas for, this is how you could play with your child using these toys." Other clinicians worked with caregivers to identify objects in the home that could be used for CDI, such as art supplies.

Of note, clinical data collection was reported to be quite challenging via telehealth. The PCIT manual specifies that the caregiver completes a behavior rating scale (the Eyberg Child Behavior Inventory) at each session. Without consistent access to computers, printers, HIPAA-compliant document-sharing platforms, and sufficient session time to complete the questionnaire verbally, the frequency with which these assessments were completed decreased significantly.

Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is an evidence-based intervention for young children (0-5) who experienced traumatic events. CPP is an intensive three-stage treatment in which dyads engage in play and conversation to process trauma, recognize triggers, increase safety, and build their bond. CPP has been rigorously evaluated and shown to improve attachment security and reduce trauma symptoms, behavioral concerns, and maternal distress (Lieberman & Van Horn, 2011). The three phases of CPP are:

1. The Foundational Phase, which includes assessment and engagement;
2. The Core Intervention; and
3. Recapitulation and Termination, with a focus on sustaining gains (Lieberman & Van Horn, 2011).

The clinicians reflected that the adaptability of CPP to a telehealth format was variable depending upon the family and their stage in treatment. As one clinician put it: "I think commensurate with the model itself … it's complicated."

The initial phase of treatment in which the CPP clinician meets primarily with the caregiver was more easily adapted to telehealth. Nevertheless, the clinicians noted that it can be more challenging to be attuned to the caregivers' reactions to discussing trauma via telehealth, and one clinician suggested more explicit invitations for caregivers to take breaks during emotionally intense conversations. Of concern, a clinician noted that there may be unexpected "pop up" visits from children who may overhear upsetting content. A deep, trusting caregiver-clinician bond is foundational to CPP, but relationship formation may be more challenging when treatment is initiated via telehealth.

Silver linings. Play interactions and other creative mechanisms for joining with the family can serve as an inroad for fostering a safe, collaborative, therapeutic space—even amid social distancing. This trusting relationship, in turn, lays the groundwork for rich play, exploration, and meaning-making of relational and emotional themes relevant to dyadic healing. Synchrony in play with a child provides a frame for discussing trauma; while this is more challenging via telehealth, clinicians

shared strategies for facilitating a therapeutic atmosphere and responsive interactions virtually.

One clinician described attempting to play with a child who was racing toy cars; while she did not have a car, she used a staple remover and "he was so gracious in inviting my 'automobile' in, and I kind of matched it on the screen with where the track was and at least I got to be a part of the race." While navigating CPP processes through a screen can be challenging, clinicians who are holding the virtual space may also bear witness to "really beautiful spontaneous gorgeous interactions."

As families completed the Foundational Phase, some clinicians opted to fully employ the technological platform to co-create the trauma narrative with the caregiver and subsequently co-deliver it to the child. One clinician described her efforts to support a caregiver in creating a narrative using a slideshow format to cohesively explain the traumatic event that prompted treatment, including digital content such as family pictures and music to further individualize it.

Barriers and adaptations. Early in treatment, creating a clinical space where confidential information could be shared between the caregiver and clinician can be challenging, especially in small homes and apartments. The clinicians observed that there was "so much to juggle" that they felt depleted of energy after the session and wondered if "the family was picking up on my own anxiety." Dyadic sessions were logistically difficult because the caregiver is trying to both communicate that they are paying attention to the child and also look at the screen whenever the clinician speaks.

One clinician was piloting a hybrid approach using a bug-in-the-ear device (like in PCIT) to talk to caregivers who would then be the conduit to the child. Young children's participation was also noted to be mixed once the novelty of telehealth abated. As an adaptation, one clinician described abbreviating playtime with children because their attention spans were observed to be shorter for interactions on a screen versus in person. In terms of building a relationship with very young children, "that felt experience, it isn't there… are you even really a person if you are just on the screen?"

In terms of appropriate CPP toys (e.g., dolls to represent family members, emergency vehicles), clinicians explored the use of paper dolls as more accessible and inexpensive while still salient enough to depict interpersonal themes. In the absence of therapeutically relevant toys on the family's end, clinicians were able to use their own toys as visuals to help ground children's understanding of the narrative.

CPP is a treatment for trauma and as such requires a feeling of safety; several clinicians shared about working with families to create a fort or set up a tent in which to engage in therapy. One clinician posited that this may "promote this sense of empowerment and self-efficacy for the parent to create a safe cocoon for their child and having that be a co-created process."

Dyadic Treatment via Telehealth: Common Themes Across PCIT and CPP

Despite being very different in their theoretical orientation and specific activities, clinicians noted some common challenges to adapting PCIT and CPP for children under six to a telehealth modality. First, they highlighted the impact of being in the families' homes as opposed to the therapy room. While the therapy room and toys have specific associations with the work of treatment, the family living room, for example, has many other uses and does not prime the child or caregiver for therapy. Similarly, the device used for video conferencing is often used for other activities such as communicating with friends and playing games, and one clinician observed "sometimes it's so informal to be able to access [therapy] virtually that it's not necessarily safeguarded in the same way." Establishing a therapeutic frame can be especially challenging with young children: "I know the clinician has worked with mom on how to bring him into the session and how to prepare him for it, but still, he's three." Further, interruptions from other children and family members are common and can distract from the therapeutic work, such as when siblings join the session or family members enter the room and turn on the television. At the same time, blending therapeutic work into the home setting can present new opportunities – such as observing dyadic behavior in the home setting and in vivo coaching – that can promote the generalization of therapeutic skills. Some families accessed therapy more often and made more rapid progress because the barrier of transportation was removed. While relationship-building can be challenging via telehealth, when done well the increased vulnerability of being in the family's home can also speed up rapport building in some cases.

In addition, both CPP and PCIT require specific types of toys that families may not own. The clinicians shared their efforts to purchase, package, and distribute toys, noting that a one-size-fits-all approach was not realistic given the different treatments, developmental stages, and toys already in the home. It was also challenging to ask families to keep the toys reserved for therapy rather than available throughout the week so they would serve as a cue for therapeutic work.

Logistically, the clinicians recommended a test run with each family to ensure that there were no technological concerns, describing detailed test calls in which the clinician and the family would test their audio and video capacity in different locations of their homes, from different angles, and on different devices. While connectivity issues may happen regardless, this preparation reduced some frustrations and aligned parents and clinicians in a shared effort of preparing for a new form of communication. Of note, some families were unable to continue with their treatment due to limited connectivity, devices, and/or digital literacy.

Conclusions

During the COVID-19 pandemic, families living in low-income communities of color have been particularly hard hit by the negative economic, health, and mental health impacts of the virus. Some of these families were already engaged with mental health clinicians to address emotional and behavioral concerns that they had about their young child. Others reached out to these professionals to get help as the lock-down continued. Clinicians who had been providing Child-Parent Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT) in an east-coast city shared the benefits, challenges, and adaptations to providing these treatments via telehealth.

Overall, benefits to the telehealth format included: the generalization of skills to the child and family's

natural environment; reduced barriers of transportation to sessions; and innovative use of materials, places, and self to boost child regulation and caregiver self-efficacy. Challenges included: lack of therapeutic toys and designated space at home; disruptions and distractions; and maintaining data collection.

Of central importance across both evidence-based practices were clinician flexibility and adaptability. Their roles expanded to include technical support and toy distribution, and sessions often changed in frequency, length, participants, and content. There was marked variability in family and clinician experiences with telehealth based on myriad factors including the families' stage in treatment before the pandemic, type of treatment, clinician training, etc.

While we were not able to say which variables were most salient in predicting a successful outcome, due to the open-ended data collection method used to synthesize the clinicians' experiences, future research in a larger sample should document these patterns. For example, did child age predict the success of telehealth? Nature of presenting problems? The number of caregivers involved or the number of other children in the home? Whether or not the family was directly impacted by COVID-19, either economically or physically?

The key theme in clinician observations seemed to be their creative solutions and genuine commitment to dyadic treatment under unanticipated and complex circumstances. The central story that emerged for both evidence-based practices was the importance of meeting families where they are, being flexible, and building upon strengths. Even as the world recovers from the COVID-19 pandemic, these clinical silver linings may inform and expand treatment modalities for families who have trouble engaging in office-based treatment for reasons unrelated to the pandemic, such as lack of local providers, transportation challenges, or health/mobility concerns.

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The Classrooms That Never Closed: Stories of Essential Early Childhood Practitioners

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Introduction

This article reports the accounts of five early childhood practitioners who remained in their childcare facilities throughout the COVID-19 pandemic. Their respective centers remained open for the young children of essential workers. These practitioners remained committed to young children and their families during the pandemic. The practitioners provide a perspective necessary for contributing to the development of future early childhood methods needed during a crisis or traumatic episodes.

Background

Approximately 76% of children ages three and four in the United States receive education and care from someone other than a parent, for example, "… the majority attend a center-based program defined as preschool, childcare, or Head Start" (National Institute for Early Education Research). However, due to the COVID-19 pandemic, the disease quickly spread and within weeks, forced the closures of businesses, places of worship, and schools; everything except locations deemed essential and necessary for basic survival. Most childcare facilities closed for several months, leaving many parents and/or primary caregivers with few options for their children (The Center for Disease Control and Prevention).

As a global community, we collectively praised essential hospital workers, grocery store employees, transportation workers, and emergency responders during the pandemic.

However, the stories of another group of essential workers have not been as widely shared. Namely, the experiences of early childhood practitioners in childcare facilities that remained open throughout the quarantine period. Early childhood practitioners are essential to the continued growth and development of children and they also support the families of young children (Kleyn & Shaughnessy, 2012). Research suggests that when children receive quality early childcare learning experiences, this contributes toward more success in cognitive and social-emotional development (Espinosa, 2002).

When COVID-19 broke out, several employees in businesses, places of worship, pharmacies, and all emergency response systems needed childcare, as most of their children ordinarily would be in Daycare, Head Start, centers, and or preschools. However, to prevent the further outbreak and spread of COVID-19, most childcare agencies closed indefinitely or until their leadership received guidelines for re-opening. Many sites closed for at least 12 weeks. This left few options for children of essential workers during the pandemic with most of them reporting that they were without childcare (Bipartisan Policy Center, 2020).

Recognizing the need for quality childcare, some private early childhood sites remained open with permission from state agencies, and some were encouraged by state government leaders to support those that could not work from home. As a result of the commitment by essential early childhood faculty and staff, willing to provide support for families during the pandemic, many children of essential workers were able to remain in their childcare facilities, but not without their own challenges.

The early childhood practitioners who shared their workplace experiences

All five practitioners are undergraduate students in a public university in the northeast USA majoring in Early Childhood Studies-Infant/Toddler Mental Health. The author served as their faculty advisor during the COVID-19 pandemic and provided support and development as needed. Each of the five practitioners participated in one-on-one, virtual, semi-structured interviews with the author, allowing for data collection to occur in alignment with the newly revised health and safety protocols.

All of the practitioners are enrolled in a program to become credentialed early childhood professionals to support families of young children and provide opportunities for high-quality infant/toddler and early childhood mental health development. These practitioners also need to be recognized

as essential for maintaining their classroom positions to ensure children of essential workers continue receiving quality childcare while their parents served their communities.

The Voices of Early Childhood Practitioners

Note: All names used in this paper are pseudonyms.

Sarah

Sarah is in her fifth year working at an early childhood center not far from her home. She is the headteacher for the infant room and has several schedules to maintain throughout the day for each child. Before the global pandemic of COVID-19, Sarah's site enrolled at least 60 young children this year, but during the pandemic, enrollment dropped by over 35%. One powerful illustration that Sarah shared, emphasizes the need to find innovative methods for supporting families during a crisis. It is important to understand that traditional approaches will not always apply to every scenario to provide quality care to young children and their families.

> I remember a parent breaking down in tears with me because her daughter always wanted to hug her as soon as she would pick her up because in the beginning of the pandemic, we had to decrease hugs to our kids. It was sad because her mom works in a hospital and cannot give hugs right after work either, so that hurt too. Her mom told us that she always wants to leave work immediately and fears that changing her clothes at work won't keep her from being clean, I guess. She still must walk through the hospital, so she has little choice. Because of her dilemma, our center started working on ways to help her, so we decided to let her leave a change of clothes at our center every day and we let her come in a few minutes before pick up to change in our staff restroom and then go back outside to wait for her daughter and now she gets to hug her mom as soon as we bring her out for dismissal. (Sarah)

Josephina

Josephina is in her ninth year as an early childhood practitioner and seventh year at her current location. She is the lead teacher in the classroom for the two-year-olds and a leader among the faculty at her site. Josephina voiced her desire to do more than just listen to families but to work with her colleagues to develop solutions that could help relieve the anxiety many families face during a crisis.

> I had this overwhelming moment when I was able to almost interpret what this parent needed. I noticed every day at 1 pm, she'd call us frantic, checking to make sure her son wasn't spiking a fever. One day, when she came to pick him up, I just asked her; why at that moment each day did she call. I found out her shift in the Covid unit at the hospital starts at 12:30 and after 30 minutes there, she would just get scared and want to check on him. She was scared about bringing it [COVID-19] home to him; especially because she was on the front lines. That's when I asked my director could we increase our daily communication to parents to include midday reports … and we did. (Josephina)

Suzanne

Suzanne is in her third year as an assistant teacher but also works as a headteacher for infants and three-year-old children. She is also responsible for closing the center every night. Although enrollment experienced a 30% decline during the pandemic, this site was the only one of the five that allowed children of non-essential workers to remain if they were previously enrolled.

Suzanne described several moments when she felt anxious about her ability to provide the usual high-level of care for children and families. She suggested that other practitioners tried to remain positive during challenging situations and described moments that helped her overcome the personal stress of supporting families during the pandemic.

> We recorded temperatures throughout the day in case a child spiked after arrival. When it got really bad, we sent instant messages to families or babysitters to tell them their child's temperature, even if it was normal. Parents really appreciated the extra level of communication; my director wants to keep this and other new methods even when the pandemic is over. These types of changes helped relieve my own stress and anxiety. I needed these kinds of moments. I was getting so stressed out and needed consistency and ways to calm parents down, which calmed me down too. (Suzanne)

Marie

Marie is a first-year assistant teacher for the "woddlers" room (children starting to walk and toddlers). Before the pandemic, Marie's location enrolled 60 children; but during the pandemic, enrollment dropped to only 20 children of essential workers. Marie was the only first-year practitioner interviewed, and she revealed that she was anxious and concerned about several issues, but primarily her ability to provide quality care during a pandemic.

> I had to remind myself constantly to take it one day at a time. I had to give myself grace in everything and say, 'this is my first year and there's a pandemic'. But even if it wasn't a pandemic, I need to just take it step by step. I think a lot of teachers make this mistake and that's why there is so much teacher burnout. I wish we had more advice on

how to deal with the stress so that we can be there for our kids when they need us. (Marie)

Florenze

Florenze is in her 11th year at her childcare site and received a promotion to headteacher four years ago. Prior to the pandemic, there were 75 children enrolled. The enrollment dropped to about 20 during quarantine and only children of essential workers were permitted.

As the practitioner with the most experience, Florenze highlighted the concept of focusing on the verbal and non-verbal cues that families and their children express. She shared examples of her own anxiety about missing such cues but learned how to understand the signals and was able to provide more support for families.

> I learned quickly that I needed to listen more intently to the needs of the parents since this was a traumatizing event for most of them. I paid closer attention and observed some of the children's behaviors changing. That's when I started to put it all together. I learned so much but one of the most important lessons is to listen closely and watch carefully so that you can support your families during traumatizing events and any challenges they're facing. (Florenze)

All of these experiences shared by these early childhood practitioners offer valuable glimpses into their classrooms and given the unprecedented nature of the pandemic, it is critical to listen to these voices.

Caring for Kids During COVID-19: What Common Practices Changed?

While administrators, faculty, and staff at early childhood sites tried to maintain normalcy during the quarantine, all five practitioners shared similar experiences with changes such as adjusted child drop-off procedures and enhanced cleaning protocols. All sites implemented new methods to keep classrooms safe throughout the global pandemic. Table 1 shows the procedure changes that most early childhood sites implemented because of the COVID-19 pandemic.

Several common procedural adjustments were implemented as site directors and instructional leaders learned more about social distance practices for ensuring a safe environment and many will maintain these changes post-pandemic.

Emerging Concepts from Early Childhood Practitioners' Stories

The experiences of the five early childhood practitioners provide an opportunity to understand the concepts they communicated and consider the possible impact on future early childhood educational practices. Across the five interviews, three main themes emerged from the practitioners' account of their experiences:

1. Support for families.
2. The need for consistent clear communication; and
3. Caring for early childhood practitioners.

These themes are identified as a starting point for understanding how to support young children and families when facing a crisis such as the COVID-19, that impacts everyone.

1. Support for Families

The most common theme shared was the need to support families throughout the pandemic and to consider how childcare providers can help families when dealing with critical conditions. Recognizing that a family's challenging situation can impact children's social/emotional development and mental health (Sameroff & Fiese, 2000), it became imperative for early childhood practitioners to become even more

Table 1. Adjustments to Early Childhood Classroom Procedures Due to COVID-19 Pandemic.

Procedures Prior to the Pandemic	Procedures Once Pandemic Was Announced
For arrival, parents walked children into the buildings to sign them in and drop them off for the day.	Parents must remain outside of the building and teachers come to receive students for the day. * Some sites required parents to complete a daily questionnaire upon arrival to identify any health changes or encounters the children may have had since the last time they were at the site.
Teachers did not wear any face coverings.	All faculty and staff are required to wear masks throughout the day while on the premises.
Nap time, meals and small group arrangements were not far apart.	Nap time, meals and any type of group arrangements were distanced (at least 6 feet)
Temperature monitoring occurred when I child felt ill or a staff felt a child may be sick.	Temperature checks completed prior to children's entrance (*and some sites developed procedures to check the temperatures of children throughout the day)
Cleaned toys at the end of the day or after a large project	Toys cleaned multiple times throughout the day and sometimes after each use.

observant. Especially when looking for signs of stress from children and families and providing support with an enhanced level of patience.

One example included children's reactions to staff members at all sites wearing masks throughout the day and recognizing how stressful this became for families. A primary childcare recommendation for sites shared by the Connecticut Office of Early Childhood (2020) was the need for all employees to wear masks while in their sites at all times.

All five practitioners shared that most children at their sites were initially afraid when introduced to their teachers in masks. Children that were ordinarily comfortable at school became visibly tense, scared, and many cried when they transitioned from their parent to a person in a mask. The children found it difficult to recognize the staff member. While it was initially a stressful situation, as one practitioner said,

> …it just took more patience for everyone involved to support the children through the transition. (Marie)

Other practitioners shared games they created to help children and their family transition:

> I decided to make up a peek-a-boo game for the kids when I was wearing my mask and that made it so much easier. (Florenze)

Recognizing that masks may become a permanent fixture in learning facilities, this experience allowed practitioners to plan methods to help children and families adjust to this "new normal."

2. The Need for Consistent Clear Communication

The need to communicate effectively and swiftly with families was another common theme shared. There were rapid, daily, and sometimes hourly adjustments that occurred during the pandemic, and it became necessary to learn and implement alternative methods for communicating with families consistently.

The five practitioners all described the need to revise daily protocols and logs to provide families with the latest information to ensure the safety of each child. Information that many sites typically communicated to families at the end of the day during pick up, was now shared throughout the day.

While research suggests that positive teacher-child relationships in early childhood can enhance a child's academic and peer success in the future (Bakken, Brown & Downing, 2017), this experience highlights the need for families to have successful relationships with their child's teachers as well. It presents the need to develop trusting connections between families and faculty that could further support children's development. Consistent communication helps to build those trusting relationships.

3. Caring for the Caregivers

Given the pressure to be available *every day* for children and families during unpredictable circumstances with little guidance or precedent on how to proceed, all five practitioners recognized that they could experience their own level of stress that would impact their ability to provide quality care.

Often educators are taught to complete lesson plans in advance or have three weeks of activities planned ahead (Cicek & Tok, 2014). However, in the middle of a crisis, there is a need to abandon traditional philosophies and routines to maintain your own physical and mental capacity.

Most of the practitioners shared that receiving protocols or directives from administrators and/or supervisors, that encourage practices on how they might relieve their own stress, helped them enhance their abilities to provide positive care for children while supporting their families through a crisis.

Conclusions

The shared themes highlighted in this article:

1. Illustrate that families and their young children have needs during a crisis and early childhood professionals need to be equipped with the knowledge to support families during traumatizing experiences.
2. Emphasize the need for further professional development for early childhood faculty and staff, to introduce as part of their new long-term plans, ways for maintaining a safe learning environment for young children.
3. The COVID-19 pandemic exposed the dire need to maintain quality early childcare learning environments for children and their families consistently throughout the year.

While there were several lessons learned, the primary understanding is the value of early childhood practitioners and how significant their roles are to support the continued development of children and their families.

Government leaders must help to ensure that early childhood practitioners receive the resources needed to be trained in methods for promoting social-emotional development for children but that they also consider offering supportive services to prevent burnout and fatigue during a crisis such as the COVID-19 pandemic.

The world is grateful to all essential workers—first responders, employees in hospitals, grocery stores, transportation workers, *and* the early childhood faculty and staff in the classrooms that never closed.

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Guidelines for 0-3 Childcare During COVID-19: Balancing Physical Health and Safety with Social Emotional Development

By Katherine A. Lingras (PhD, LP), Krista Mrozinski (MA, LMFT), Anna Clavin (MA, LMFT), Arielle Handevidt (MA, IMH-E®), Lauren Moberg (LMFT, IMH-E®), Cari Michaels (MPH), Mary Mischke (MA. Ed), Tracy Schreifels (MS, LMFT, IMH-E (IV)), Michele Fallon (LICSW, IMH-E(IV)) (USA)

Introduction

Childcare providers are historically undervalued (Tobia, 2020) and are in one of the most underpaid jobs (McClean, 2020), yet are the foundation upon which much of working America is built. The current pandemic has highlighted the extent to which childcare workers are essential (Simonton, 2020) for the functioning of the U.S. economy, and in particular, for working mothers, who historically and currently have taken the brunt of the childcare responsibilities (Cohen & Hsu, 2020; Collins, Landivar, Ruppanner, & Scarborough, 2020; Rhubart, 2020) and associated mental health distress (Miller, 2020). Childcare centers have also struggled to balance financial concerns and best practice care (Covert, 2020). Now, as many employees have returned to work, it is important to consider how to support childcare providers doing this critical work. A key focus must be to provide high-quality care to young children while managing health and safety requirements and limitations of a pandemic. The focus of this article is on supporting the social-emotional health of our youngest children during a time that pushes many of us apart physically.

Above, we share a picture that demonstrates how, even with the most extreme precautions, connection is still possible. Here, we are comforted by the reminder that situations will be different, but care is still present and possible. Childcare providers of young children will naturally have reactions to these differences, and space must be made to tend to those reactions. There is no one correct approach, but rather many ways of balancing physical health and safety needs with social-emotional development. Photo credit: Mary Dossman and Julie Doherty

A note about the current context in the USA

After weeks or months at home and a potentially abrupt disruption for many children and families, returning to childcare may be challenging for young children, their parents/caregivers, and the childcare providers who will be 'holding' their distress during separations. Layered on top of the COVID-19 pandemic context and its related disruptions is the racism pandemic (APA, 2020 in Mills, 2020) that resulted in disproportionate impacts (Martin, 2020) on children and families of color. The murder of George Floyd in Minneapolis (and a long history in the U.S. of previous and subsequent deaths of Black individuals as well as Indigenous individuals and people of color) gave new light to the public health crisis of racism in America (Devakumar et al., 2020). The resulting civil unrest and racial trauma (Comas-Diaz, Hall, & Neville, 2019) that many people of color have and are experiencing creates further concern as families return to or continue to engage in childcare.

As with any stressful life event or adverse childhood experience, parents/caregivers and childcare providers are likely to see normative difficulty with separations, transitions, and rule-following. Children communicate through their behavior and emotions.

This is especially true for the youngest children who do not yet have words to convey their emotional experience. Childcare providers need to be attuned to the possibility of traumatic stress reactions developing in young children (Lingras, Griefer, Sheikh, & Fabre, 2019). Many social-emotional development strategies discussed below will help all children and may be particularly indicated for supporting children experiencing trauma. However, strategies specifically related to identifying and addressing trauma are beyond the scope of this paper. Therefore, we recommend that all childcare providers refamiliarize themselves with possible reactions of young children (Society for the Protection and Care of Children, 2020) and trauma guidelines and resources (e.g. National Child Traumatic Stress Network) in order to meet the needs young children in this moment.

Background

We ask much of childcare providers of young children. They are charged with meeting both physical and mental health (social-emotional) needs during this global pandemic. As societal systems, including childcare, continue to oscillate between "dialing back" and re-opening in the coming months, childcare providers may continue to wrestle with balancing social-emotional needs and physical health and safety recommendations suggested by the Centers for Disease Control and Prevention (CDC, 2020) (i.e. wearing a mask when in public places, keeping a physical distance of 6 feet or more from non-household members, and limiting time in enclosed physical spaces/homes with individuals outside the household).

A note on masks, clear masks, and face shields

As noted above, the CDC recommends the use of masks when in the presence of others outside of one's household. This inherently affects childcare settings, at minimum with respect to guidelines for the adult providers. In order to reduce the potential impact of a covered face, childcare providers may wish to explore using purchased or homemade clear masks that show more of the face (including the mouth and lips) while maintaining the needed properties of standard cloth masks. Some psychologists (McKoy, 2020) and mental health organizations (Florida Association for Infant Mental Health, 2020) have called for the use of these types of masks and face shields in childcare settings to minimize the impact on young children's learning and development (Scott, 2020). These clear masks may be less obtrusive, but are, not surprisingly, more costly. Clear face shields or home-made clear masks may be a lower-cost alternative (see additional resources for the link).

It is important to note, however, that the above options are not the only way to resolve the mask/social-emotional communication dilemma. While hiding a person's lips and parts of facial expression can present a communication barrier and impede social interactions (particularly for children who already struggled with reading facial expression, e.g. children on the Autism Spectrum), many cultures that use face coverings exist and at present no evidence exists to suggest that these children's development is negatively impacted. For instance, although it can look different, the formation of attachment and relationship-building across cultures is well-established; attachment and positive relationships are common in cultures where face-coverings are work for religious or public health purposes, outside of COVID-19 recommendations (e.g. Mesman, Minter, Angnged, Cissé, Salali, & Migliano, 2018; Asanjarani, Abadi, Ghomi, Woundstra & Mesman, 2020; Deater-Deckard, Lansford, Malone, Alampay, Sorbing, et. al, 2011). Additionally, some evidence suggests no impact on facial expression processing with the addition of a mask (Roberson, Kikutani, Doge, Whitaker, & Majid, 2012).

However, wearing a mask is newer for many cultures and communities, and even in cultures where face coverings are practiced, children are still not accustomed to their primary caregivers and/or childcare providers wearing masks in their presence which may be associated with some distress. We also want to acknowledge the difference in childcare for infants and toddlers compared to preschoolers or elementary school children. Masks are not recommended for children under two. As such, infants and toddlers will likely experience their parents/caregivers and childcare providers differently than older children. Older children who are encouraged to wear masks will see adults modeling the same behavior. However, the youngest children have not yet developed the capacity to make meaning of mask-wearing. It is possible that they will instead rely on other cues from parents/caregivers and childcare providers to reassure and reinforce safety and comfort.

The Current Paper

This article is centered on suggestions for childcare providers in balancing the physical and mental healthcare needs of themselves and their young charges. We know circumstances and guidelines change rapidly and frequently. Routine communication about COVID-19 policies and procedures with parents/caregivers and other key stakeholders is essential.

Infant and young children's needs while in childcare or early learning contexts generally reflect basic needs, emotional comfort, and social interaction and learning. We defer to the CDC recommendations for physical health and safety guidelines, which are generally consistent with traditional childcare practice, and will be familiar to childcare providers. While these guidelines provide specific childcare recommendations from a health and safety standpoint, they do not address the social-emotional needs that are so significant for young children. Thus, we provide suggestions for adapting practices to address emotional needs within the current health and safety framework.

In these suggestions, we are guided by the basics of child development and classroom management so that childcare providers have the necessary skills to incorporate these recommendations into their daily schedules. One relevant model is the Zero to Three that uses a Critical Competencies for Infant-Toddler Educators™ (Zero to Three, 2015; Dean, LeMoine, & Mayoral, 2016). This framework represents three areas of need: social-emotional development, cognitive development, and language and literacy development. We use a similar framework here, focusing on the first and third areas, to describe needs and supports in each domain in the context of global pandemic public health recommendations.

Supporting Safety and Basic Needs through Traditional Childcare Best Practices Relationships, Routines, Structure

The CDC's detailed recommendations for childcare providers in caring for basic needs are consistent with existing health and safety regulations for childcare environments. For instance, child development literature has long established that childcare settings with consistent standards for group size, developmentally appropriate surroundings, communication with primary caregivers, familial and culturally responsive supportive networks which encourage best outcomes for infants and toddlers (e.g. Lally, Torres, & Phelps, 2010; Zero to Three, 2015).

Health and safety standards are maintained through relationships and by comprehensive routines. In many senses, the best advice for enforcing new pandemic standards is to go "back to basics". Setting and reinforcing rules helps increase feelings of safety by letting children know what to expect. Using child-directed activities engages children and helps ease transitions. Reinforcing and adhering to (and praising) longstanding standards and practices increases comfort for families and facilitates continued positive relationships between and among children and staff, even during times of stress. In addition:

- *Predictability is key.* Even though the nuances of routines and transitions may change, much will stay the same.

  - Continue to maintain routines similar in timing, order, and activity as much as possible; schedules increase natural rhythms through predictability.

  - Keep infant/toddler environments in order and reinforce rules to increase feelings of safety by letting children know what to expect.

  - Use songs, chimes, or fun sounds to signal positive transitions. Consider using these signals more often than usual, including in infant rooms where verbal explanations may not be as meaningful as consistent sensory-based cues.

  - Address differences in practice/policy by naming them in developmentally appropriate terms. Adults may be required to use standards not recommended for children due to developmental stage, for example, mask-wearing for toddler childcare providers. Because mask-wearing for children under 2 is not recommended, it is important to name and explain these differences, so children understand what they are seeing.

- *Engagement enhances routines*

  - Use increased verbal explanation during basic needs tasks. Support connection with infants and toddlers through verbal prompts and other non-verbal cues such as raised eyebrows, facial expressions, and hand gestures.

  - Build positive connections while wearing masks and/or gloves through exaggerated voice, eyes, touch, and hand movements after sanitizing.

  - Make handwashing and other new rules fun in order to smooth routines that are difficult or time-consuming. For instance, give a child a stamp on their hand that they need to wash off. Increase access to water play with soapy water that can double as extra hygiene maintenance. Sing songs that remind children to wash their hands longer (the ABCs adults are encouraged to sing are particularly relevant for young children!). Use 'airplane arms' or other child-appropriate images to remind children to give space and explain why adults are maintaining distance.

  - Communicate with parents/caregivers about changes in drop-off/pick-up routines. Encourage consistency of transition and basic needs strategies across home and school. Provide resources (Parlakian, 2020) to help parents and caregivers prepare their children. This will ease transitions between home and childcare as well as increase children's sense of predictability across settings.

- *Prepare children for mask-wearing*

  - Explain why people are wearing masks or other protective clothing in a positive and calm manner. Focus on the protective aspect and the use of masks as a kindness practice to reduce fear or othering. For instance, "we wear masks to protect from germs and help keep each other safe."

  - Start with clothing such as bandanas or scarves (especially when asking children to wear masks) that will be more familiar to them.

  - Help children practice wearing a mask and increase exposure to caregiving adults wearing masks. For instance, childcare providers may encourage parents and caregivers to have a "mask day" at home where they and other close family members or friends show off masks so children can become accustomed to seeing familiar adults in masks.

  - Increase exposure to wearing a mask gradually for children (above 2) who are starting to wear masks. Hold the mask, put it near their faces, hold it over their mouths, and ultimately secure the mask around their ears to create distinct steps that children can practice. Consider ear extenders or headbands to reduce physical discomfort that might interfere with mask-wearing or elicit protests.

Supporting Social-Emotional Development Through Relationship-Building

COVID-19 public health guidelines have not only shaped how we keep ourselves and others healthy, it has also changed how we engage in relationship building. Many of our connections are now via virtual platforms and physically distanced interactions. However, this is often not the case for childcare providers and very-young children. Children of this age require close proximity for physical safety and support, emotional connection, and overall learning and development; relationships underlie all of these. Children's early relationships with consistent, competent, and responsive caregivers (including primary caregivers at home and childcare providers) shape the way children see the world and help them learn how to interact within it.

One of the most essential functions of the relationships between caregivers and very-young children is the co-regulation of emotion. This applies to childcare providers' interactions with children as well. Children can only learn how to manage their feelings and reactions in the context of these relationships with significant adults in their world. This creates a paradox in

the time of COVID-19; we are aware of the need to socially distance for safety but there are times when physical contact is necessary to calm a distressed young child.

While we strive for risk reduction, we must continue to be responsive to these most basic needs of young children. When a child requires physical comforting (co-regulation of emotion), appropriate personal protective equipment (PPE) and protocols can balance the need to be responsive to the child with health and safety considerations (for example, hand-washing, changing a gown, etc.). Co-regulation is a basic need in times of a child's significant distress (e.g. at drop-off and separation from a parent). The following suggestions can help to mitigate risk while supporting this need.

Consider spending more time outside to help mitigate risk. Many approaches of early education including the Waldorf and Nature Preschool models encourage extensive outdoor time regardless of weather and serve as helpful guides (e.g. IASWECE Council, 2019; Amico, 2019; Larimore, 2016; Dennis, Wells, & Bishop, 2014). Consistent with child development literature, outside time is suggested to be beneficial to young children in many ways (Tillman, Tobin, Avison, & Gilliland, 2018):

- Consider social distancing both inside and outside the classroom to mitigate risk. Encourage language like "we are giving space to help keep each other safe" to promote positive language rather than fear-based directions. Image-based behavioral reminders such as "airplane arms" can help even very young children concretize, visualize, and remember a more abstract rule.
- Create visuals of peers, parents/caregivers, and childcare providers both with and without masks. This practice will provide reassurance about the caregiver's identity and normalize the use of masks. These steps together can be used regularly and at times of heightened arousal to decrease a child's stress.

  - Childcare providers can print a picture of their smiling face and name and wear it as a necklace/pin on a shirt (or even CDC recommended gowns).

  - Early childhood classrooms frequently display pictures of children's family members; childcare providers can request both masked and unmasked pictures.

  - Early childhood classrooms frequently include pictures of children playing in various learning areas. Consider including pictures of children playing while masked. If these are not available from traditional learning stores, childcare providers can take photographs of children from their own settings for display.

- Promote emotional comfort

  - Stuffed animals may be difficult to clean effectively to a degree needed during the COVID-19 pandemic. Consider dolls or other favorite toys that are plastic or rubber which can provide comfort but be more easily cleaned.

  - Cuddles and physical touch are often used to help infants and young children feel comfort when upset. Wearing gowns may help childcare providers feel protected and safer, which in turn will support the child; if the provider feel safer, the child will also likely feel safer.

  - Rely on auditory cues in addition to visual cues. Humming familiar songs/lullabies can signal comfort and predictability during different parts of a daily routine.

  - Understand and gauge the temperament of infants and toddlers. Young children will communicate their feelings about changes in the environment via potential "fussy" interactions. Childcare providers' abilities to respond allows for the increased insight of the child's needs, especially during times of significant changes such as COVID-19 practices.

- As noted above, building relationships with parents/caregivers around new routines, expectations, and clear communications about policies and practices are central to smooth transitions with children. Providing recommended language and culturally-specific supports for families is even more important when discussing complex and stressful topics such as pandemic protocols.

Supporting Social-Emotional Development through Social Interactions and Intentional Teaching Practices

In the first years of life, children are developing the capacity for basic self-regulation skills by engaging with trusted adults to understand the world around them. Infants begin to learn about faces, preferring and responding to face-to-face interactions with caregivers. Throughout development, we see these skills advance, with increasing social smiling towards and eliciting responses from their primary caregivers and childcare providers.

Very-young children also use adult caregivers as a reference for how to interact with the world around them. This social referencing occurs in all contexts, including home and childcare, and involves looking towards adults for cues as to how to respond in a new environment or when a new person walks in the room. As social referencing becomes more advanced, young children move towards trusted adults and make contact with them to understand unfamiliar people or places. These trusted adults are used to make sense of the world and allow the young child freedom to explore.

Within the context of this rapid development, it is critical to consider the implications of implementing new health and safety practices, such as masks, in a childcare setting.

On the surface, it may seem that masks that hide faces and emotional expression inherently hinder social-emotional development. However, many strategies can mitigate this.

- Physically distant, not socially distant:

  - Even very young children learn social-emotional skills best through interactions with peers and trusted adults. However, with an increase in distancing measures, childcare providers may be hesitant to be in close proximity with children and may need to keep children more physically distant from one another. To balance these competing needs, consider games and activities that do not require as much close proximity or touch.

  - Seat children in a circle so that infants and toddlers are able to face inward and see other children,

even if they are not close enough to physically interact. This will increase interaction and attention to social cues, facial expressions, etc.

- Play games across the circle that involve emotional expression and interactive activities (e.g., rolling a ball which can be disinfected back and forth).

- Enhance social-emotional practices

  - Verbally express your own emotions throughout the day. Stating "you just put a really big smile on my face!" can help a child understand the emotion you are experiencing even if it is partially or fully covered by a mask.

  - Overemphasize gestures using your hands, eyes, and body movements.

  - Use emotional coaching/narration to provide young children with a better understanding of their own emotions. Narrate what you see them doing by making statements like "you are laughing and smiling, you must like it when we play peek-a-boo" is one example.

  - Increase the use of signs or gestures (Goldin-Meadow, 2009) for feelings words to "illustrate" the emotions of young children.

  - Enhance classroom practices related to routines, rules, and transition as described above in 'Basic Needs' to build social-emotional fortitude.

- Emphasize social-emotional and play-based materials and activities

  - Add toys that have faces or emotion blocks that provide opportunities for childcare providers to comment on facial expressions and emotions (see additional resources for links). This can support young children's awareness and attunement to the expressions of others and their own faces.

  - Engage in pretend play with children by allowing dolls or stuffed animals to wear masks or incorporating doctor toys into play areas and simulating a pretend doctor's visit with new safety practices (Parlakian, 2020).

  - Add masks to typical social-emotional classroom materials and games, such as feelings charts, feelings bingo, or matching games (see additional resources for link to examples).

  - If you are wearing a mask, turn it into an activity and a way to get to know children. Activities that allow parents and caregivers to see "behind the mask" can serve to build relationships and/or social-emotional understanding. Consider adapting one like this activity geared towards older children (Stephens, 2020). These types of activities can be done in the childcare setting or as a "take-home" activity that parents complete to help childcare workers learn about their children.

  - Turn mask-wearing into a fun activity. Children can decorate their own cloth masks or masks for parents or siblings. Decorate pictures of masks or people wearing masks to normalize the presence of this new accessory.

  - Add more books about feelings and friendship within the setting. Even for infants, beginning to recognize different 'feeling faces' can help to build a strong social-emotional foundation.

  - Use social stories that help simplify changes in common childcare routines due to COVID-19 (Tuchel, 2020).

Supporting Language Development and Pre-Literacy

Children begin developing language skills beginning at birth through recognizing speech sounds of the language spoken by their primary caregivers. During the first year of life, infants begin communicating through babbling, gesturing towards the things they would like, and speaking their first words. Research has shown that, as these skills develop, infants attend to the mouths of their primary caregivers to learn speech sounds (Lewkowicz & Hansen-Tift, 2012; Tsang, Atagi, & Johnson, 2018). All these skills, in addition to parent-child interactions which support these behaviors early in life, are the foundation for children's later literacy development (e.g. Dodici, Draper, & Peterson, 2003) and occur across environments.

Best practices for language development are again helpful in considering modifications during the pandemic. While many are concerned that young children's language development may be impacted by the wearing of masks, as noted above, there is no evidence that children growing up in countries or cultures where masks or face coverings are worn more regularly have any more difficulty forming relationships or developing language skills (e.g. Roberson, et al., 2012). In fact, many strategies already in common use within childcare settings, such as developmentally appropriate sign language, pictures, and visual prompts, and narration/child-directed play inherently extend beyond facial expressions.

Infants and toddlers also spend time with parents and caregivers at home without masks, which will allow time to practice language development behaviors without face coverings. Therefore, childcare providers can support parents/caregivers by sharing standard strategies for practicing language development at home. As always, the use of books throughout the childcare space promotes language development. Include books that show people's faces to talk about different types of emotions. Books (e.g. Alber, 2020a-c; Chevalier, 2020; Young, 2020), e-books (Ghosh Ippen & Brymer, 2020; Perenyi, 2020; Sedgwick Belgum, 2020) and classroom materials featuring children and adults wearing masks have been created (i.e., Tuchel, 2020; see additional resources for links). These are also important to include in the classroom and will normalize young children's experiences.

Childcare Provider Well-Being

Much like the children, adults were shifted into a new mode of living. As this overnight change catches up with us, it is imperative to note that the same stressors described above have likely taken their toll on a child's grown-ups. Returning to work 'as usual' will not feel 'as usual.' Many of the adaptations described above may feel counter to typical inclinations for interacting with young children. And yet the comfort and ability to have a voice, a belief of what is best for you as well as your setting and the children and families you serve is important. There may be varying perspectives, and changes may be worrisome to staff due to the impact on children, their own well-being, or both.

We know that when adults are stressed, their biological stress response is

aroused (Deater-Deckard, 2004), which can impact the stress level of children in those adults' care (Leerkes, 2016; Meaney et al., 1993). Conversely, when children are distressed and childcare providers cannot soothe them, this creates physiological distress for the adult too (Bornstein et al., 2017). Attempting to communicate with limited visible facial expressions may also feel culturally incongruous or physically exhausting. And the physiological sensation of wearing a mask for several hours a day may require adjustment. Therefore, it is essential that childcare providers have access to a space (and ideally a trained facilitator) to process emotions that arise during this time and to regularly care for their own well-being.

- Take the time to teach your body to wear a mask (HealthcareCareWorkers Hosted, 2020), and consider tips for mask-wearing (Marksowitz, 2020) especially in warmer weather (Levine, 2020). Step away and take breaks to breathe deeply or get a sip of water if you need to re-regulate.
- Make room for self-compassion (Neff, 2020). This starter kit can be a great place to begin (Butler, & McClain-Meeder, 2015).
- Reflective supervision can be helpful for supporting childcare staff wellness needs.
- Join a professional support network and advocate for self-care amongst staff (Goldberg, 2015).

Conclusion

As we look toward the future of childcare as well as an ever-evolving pandemic, we must acknowledge the beauty of each unique childcare setting and the variety of supports for children and their families. We acknowledge that each childcare setting will continue to make decisions based upon the needs of their children, families, staff, and communities using what they know about all areas of a child's development. We hope this guidance provides alternative ways to support difficult decisions. We also acknowledge that the ways in which risks are weighed will vary by individual and context. There is no 'one right way' of navigating these complex and, at times, competing needs. These suggestions can guide conversation and expand practices that support social-emotional development, but they are not intended as definitive answers.

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"Co-Relation" Groups - Virtual support groups for Israeli parents

Understanding the messiness and repairs of relationships between parents and young children during

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Introduction

During the COVID-19 pandemic, parents around the world found themselves dealing with a variety of challenges. Parents of young children had multiple adjustments to navigate: adjusting to the unexpected lack of structure and out-of-home care for their children, planning indoor daily activities, dealing with the financial burden, threat of job loss and income, and the demand of working remotely without support and help. Moreover, the reduction of social contacts and the closure of the social-based educational, recreational, and productive activities has had a severe impact on the emotional and psychological well-being of humans (Provenzi & Tronick, 2020).

A family unit is built upon attachments and relationships. Therefore, a stressful event such as COVID-19, most likely affects the entire family. Due to their cognitive immaturity, younger children may be protected from full psychological exposure to the consequences of COVID-19. However, they may still be vulnerable to a disruption in caregiver functioning, as one of the most important resilience factors for children is their ability to attach to their caregivers (Pine et al., 2005). According to attachment theory (Davis, 2004), at an early age, the parent-child attachment process enhances the child's sense of security in the future. Parents who are both responsive to their children and available to them in dangerous situations, help the children develop internal working models to handle similar situations in the future. The internal working models are based on the caregiver's ability to provide comfort and safety, repair interactive mismatches, and in times of stress will guide the children's behavior and ideas about the safety of the world (Schechter & Willheim, 2009; Tronick & Gold, 2020). Taken together, parents' coping strategies in dire situations may have a dramatic influence on their children's current and future well-being, rendering social support for parents of utmost importance.

While stress and anxiety are inherent to a global pandemic, lack of social support adds another layer of distress. Studies suggest that any form of positive social support is likely to buffer or reverse feelings of perceived isolation or loneliness (Rozenkrantz et al., 2020). Reassurance from other parents, as well as guidance from professionals, can provide parents with resilience during challenging times, nourish their children's wellbeing and mental health, and repair relationships that have been disrupted (Tronick & Gold, 2020). Despite that, today, nine months after the outbreak, there are still limited options for parents of young children to connect virtually or in-person with other parents to discuss their challenges and successes as parents during the pandemic.

In this article, we will describe specific case studies of virtual support groups that were conducted during COVID-19, referred to as *"Co-Relation"* groups. Our hypothesis is that building relationships can be an effective intervention that overcomes the negative effects of social isolation. This assumption was also found to be true in animal and human research on emotional and cognitive well-being (Cacioppo et al., 2015; Cacioppo & Hawkley, 2009; Provenzi and Tronick, 2020). In particular, the reparation of the inevitable mismatches and miscommunications of typical interactions – their messiness - generates a sense of trust and connection to others, increases individuals' coping capacity, and engenders a sense of safety and hope (Tronick, 2006; Tronick & Gold, 2020).

Our focus in this article is on ways that parents and young children can cope with the new reality of isolation, crisis, and uncertainty via support groups. We describe changes to their relationships in the context of personal and environmental change. Finally, we reflect on the theory that the reparation of the "messiness" following being together during a stressful time, may lead to developing new resilience skills.

Methods

Participants

The participants in this study consisted of Israeli parents living in Israel or the United States, who attended the *"Co-Relation"* virtual support groups. The total number of participants was 62. The participants were recruited through social media and by word of mouth. They were assigned to ten groups according to their children's age, specific needs, and commonality, and residence. The demographics of families included middle-class socioeconomic status, 26 female, and one male. Participants' levels of education ranged from high school diplomas to higher education with an academic degree. Children's age varies from 0-6 years: 11 participants had children age 0-12 months, 14 participants had children age 1-3 years, and 12 participants had children age 3-6 years old. Participation rate varied with 51.8% (15) of the participants attending 7-9 group sessions, 25.9% (7) 4-6 group sessions, and 22.2% (6) in 1-3 sessions.

Procedure

"Co-Relation" is an initiative that brought together parents in need of support during COVID-19 together with early childhood professionals. It was aimed to create and build relationships in a time of loneliness and disruption of social and communal connectedness. Additional goals were to create independent parental "communities" that would become a source of support for other families in their own local communities.

Although the groups were unstructured, it was common that participants in all the groups found it helpful to practice coping skills and specific problem-solving in the context of parent coaching and child-parent relationship. Therefore, group leaders practiced an integrative approach using combined techniques that were adapted from evidence-based interventions such as Cognitive Behavioral Therapy (Hoffman et al., 2012), Attachment Theory (Bowlby, 1982), Acceptance and Commitment Therapy (Steven et al., 2011), and Dialectical Behavioral Therapy (Linehan, 1993).

Coping skills included mindfulness, distress tolerance and emotion regulation, grounding techniques, and cognitive re-framing. Additionally, group leaders encouraged the participants to fully engage with one another through emotional processing and personal examples. Thus, the groups were "messy" with a full range of emotions – crying to laughing – and reflection and support.

In addition to the weekly group meeting, all group leaders met once a week to discuss and work through issues raised in the groups. These meetings were essential to make space for related thoughts, feelings, and concerns outside the therapy sessions, as well as to enhance the sense of connection and belonging between leaders. Besides functioning as supervision and reflective meetings, the weekly meetings were essential to identify themes in groups and devise the techniques used accordingly.

Measures

Weekly processing notes of group leaders and post-group surveys

During the weekly group meeting, group leaders took notes regarding specific interventions that were used, areas of struggle, and growth and highlighted specific weekly themes of each group. These weekly processing notes were then used as a data source for this study. An additional source of information was the post-group survey, which participants were asked to complete to gather information about their overall experience. The survey included a demographic questionnaire (children and parent's age, gender, location), the main reason to attend the group, overall satisfaction, and open-ended questions regarding participants' experience and what they gained from participating in the groups.

Using constant comparative analysis (Glaser, 1965), data from the surveys and the processing notes were extracted and analyzed by four group leaders (G.A, M.B, T.L, D.L). As part of the analysis process, specific themes that were common across the surveys, and the weekly processing notes were identified. To reach a consensus about primary themes, the readers analyzed the results separately and compared results via discussion. The main themes that emerged included: Parenting style due to new demands and environmental changes; Emotional distress for both parents and children, Children and parent's emotions regulation, and Loneliness vs. connectedness.

Results

Results were derived first from *weekly processing notes of group leaders* and then from the *post-intervention survey.* The processing notes identified the main themes. They were then used to elaborate on specific participants' experiences. The post-group survey revealed the benefits of the groups for the participants. Hereinafter, we report results from four groups: *The Postpartum Israeli Mothers' group, The general Israeli group, The East Coast/ New immigrants group, and The West Coast group*.

Descriptions of themes extracted from the ***weekly processing notes of group leaders***

The Postpartum Israeli Mothers' group. The group included four women who had given birth during COVID-19. Three of the mothers had their first child, and one mother had her second child. Main themes included the recovery and trauma of delivery, and the physical and mental aspects of breastfeeding, connecting, and bonding with their babies while facing anxiety and loneliness. Shelly (pseudonym) brought up her tendency to get anxious. She reported that the change into motherhood led to distress and triggered old fears from her past: *"My baby is two months old and she is still alive, this is an achievement."*

These feelings, which are typical of women in the postpartum (Bell et al, 2007), were intensified due to quarantine and isolation. Adapting to the new role of being a mother, "The Motherhood Constellation" that was conceptualized by Stern (1995) was also a main narrative during the sessions. According to Stern, a transition occurs: when a baby is born physically, the mother is being born psychologically. She is (re)building new schemas as a woman in the other areas of her life, by making space for her new role and new identity as a mother (Stern, 1995).

For example, Tammy (pseudonym), noted feeling alone and helpless in her new role as a mother: "*It's not the isolation, it's the loneliness*". She disclosed feeling self-conscious and having a fear of missing out. Tammy is a young woman living in Tel-Aviv, who had been her own boss had been going out every night and enjoying a busy urban life. In her new role as a mother, she noticed a sharp change, as her own needs and desires were not the primary focus anymore. She had to take care of another human being, and she could not be as spontaneous as before.

Although it was not planned, one main participant typically became the center of each meeting, disclosing her story and struggles, while the rest of the members provided feedback and validation. It became a circular process, wherein each mother was empowering the other. It was notable that the women in this group were able to put aside their fears from the pandemic and make space for the unique postpartum narrative of each one of them. This speaks to the power of the transition to motherhood and is reminiscent of Winnicott's maternal preoccupation. The group became a platform to share difficulties, to normalize and validate feelings and experiences, and ultimately it led to an intimate connection among participants. Additionally, the group became a source for specific consultations regarding infant care, leading to both emotional and practical support.

The general Israeli group. The group included four mothers and one father of children ages 1-4 years old. All participants lived in Tel-Aviv for at least two years. Main themes included parenting during quarantine, managing daily routine while working from home, and specific themes regarding the social-emotional development of their children. For example, Doron (pseudonym), a father of three, was significantly worried as he noticed changes in his children's behaviors (sleeping, eating, and overall anxiety level): *"Two weeks after the lockdown, the twins started to wake up four to five times a night and crying! I thought they would be happy now that we are all together at home."*

During one of the sessions, Doron mentioned that they don't have an extra room at their apartment to work remotely (both parents continue to work full time during lockdown), so one parent was physically in the room but not available to be with the children. Doron was also worried that the result of the isolation will have long-term effects on his daughter's social development: *"Do you think my daughter will ever want to play outside again with her friends? Yesterday I showed her a picture of her pre-school and she started to scream and threw the picture to the ground."* The other participants shared similar concerns. Another specific theme regarded parents' inability to engage in self-care, due to the lack of emotional availability for their children and lack of regular support from extended family and community.

The parents in this group were strongly attuned to their children's behavioral changes and were stressed and anxious about the results on their socio-emotional development, regardless of the health risk of COVID-19. During group sessions, the leader focused on the importance of their own self-care, which would help them become more regulated and available for their children. Additional focus was psycho-education related to infancy, early development, and mental health.

The East Coast Group/ New immigrants. The group included five mothers of children ages 2-5. Two of the participants recently moved from Israel and had to self-quarantine within a few weeks of arrival. They had no social connections outside of the group. Main themes included parenting during quarantine, and specifically guilt for not being able to enjoy the time with their children, and concerns about the short- and long-term effects of quarantine on children's overall mental health. For example, Maya (pseudonym) reported being quick to anger with her 4-year-old daughter, getting into power struggles and arguments daily, which led to guilt and shame. She reported: *"I feel that I am failing her as a mother and I'm worried that she will forget how to engage and interact with her friends."*

The group discussed Maya's own anxiety and difficulty curving time for herself. The group problem solved about finding times to practice emotion regulation skills and to take space when feeling overwhelmed. The group leader identified ways to increase Maya's daughter's positive behavior by giving her more control during the day and provided psychoeducation about distress tolerance skills for parents and children. In the following week, Maya reported a decrease in overall arguments and being able to enjoy the time together.

Another theme that was brought up in the group included worries about assimilation in a new culture. Efrat (pseudonym), who moved from Israel a few weeks before quarantine, noted: *"I feel guilty for bringing my children here, where they don't know anyone, after promising them so many new exciting adventures. I also feel extremely lonely as there are no opportunities to socialize in the community."* Since the group consisted of new and "old" immigrants, it created a platform of learning from shared experiences, problem-solving and specific skills acquisition of parenting in a different culture.

It is noteworthy that after nine sessions, the group didn't focus on COVID-19 rather themes were related to "life struggles" in general. It is possible that following the support offered by the group, participants began to feel more in control and better able to manage new routines (being out of crisis), which created a space to discuss other problems that were there before COVID-19.

The West Coast group. The group included one couple and three mothers of children aged 1-8 years old. Main themes included an adjustment to changes and demands in parenting during COVID-19, managing daily routine, being overwhelmed, and experiencing emotional flooding, managing stress related to parenthood, and feelings of guilt concerning parental anger.

In this group, despite notable differences between participants regarding beliefs, daily practices related to COVID-19, and personality organization, sessions were characterized by openness, curiosity, and attention amongst group members. Participants found the group to be a place to vent without feeling judged, normalize the daily struggles, as well as get practical skills to help with managing anxiety, anger, and sadness.

For example, one of the participants, Noa (pseudonym) reported a high level of conflict and dysregulation that was amplified by COVID-19. She reported difficulties dealing with the stress, concern about health, uncertainties, balancing work and house demands, and taking care of her children. Noa questioned the quality of her motherhood in comparison to others: *"It seems that other parents are able to see the good, enjoy the time with their kids and are using their creativity, while I am so frustrated and just thinking this*

is all so awful!" Getting support from the group in the last session, Noa reported that the meetings helped her regulate her sense of self-worth and tendency to condemn her motherhood.

Description of themes according to the ***post-group surveys***

Parenting style. Nine parents (32.1%) reported 'seeking parenting counseling' as the main reason for participating in the group, and these were indeed topics that were discussed in the groups. Parents described challenges in adjusting to the new reality, balancing work and kids 24/7, managing daily schedule or routine, and setting priorities: *"The group helped me understand that there is more than one way to be a good parent, and it's ok if things aren't working out the way I planned them."*

Parents also reported positive changes in parenting style following participation in the group: *"I felt better and more confident about my parenting style"; "I got tools to be the parent I was before the quarantine."* Differences between parents from Israel and Israeli parents living in the U.S reflected basic needs: Immigrating Israelis were dealing with a set of different difficulties including lack of support system and an impaired sense of community. These parents seemed to focus more on the parent as an individual who is struggling with managing parenthood and life functioning. The parents living in Israel needed more reminders to attend to their needs, to shift the attention from focusing on the problems with their children to reflect upon themselves. The postpartum women group was exceptional in that sense, focusing on the infant-mother bond and postpartum issues and struggles that were magnified under COVID-19, rather than pure parenting style matters.

Emotional distress. Seven parents (25%) reported seeking emotional support, need for having a safe space to share, vent and express emotional experiences and struggles. These parents noted their children's emotional distress which was related to uncertainties and change in normal life routines: *"The group helped me to survive extremely challenging moments."* In general, the groups from Israel expressed more worries about the children's emotional and social well-being and behavioral issues, along with the absence of child-care arrangements and distancing from grandparents.

Emotion regulation skills. The need to gain new skills for distress tolerance and emotion regulation was central to most of the participants: *"I learned many tools to cope with the challenging situation and reframe situations"; "my perspective shifted to look for and embrace the positive of the situation."* In the survey, parents identified emotion regulation and distress tolerance skills as most helpful. Parents also focused on their role as supporting and regulating their children's emotions as critical to their own well-being and self-efficacy: *"I learned that if I try to identify my child's primary need and not get triggered by his behavior, it might change the outcome."*

Loneliness vs connectedness. Three parents (10.7%) mentioned loneliness as the main reason for their participation. Eight parents (28.6%) reported seeking support from other parents experiencing the same situation: *"It was moving to connect in such a group that was driven by goodwill and motivation to support, it was helpful to meet with other people and share support during this difficult time."* 24 parents (84%) noted that they will want to continue online meetings (even without the group leader). It is imperative to note that loneliness was significantly higher within the post-partum and the new immigrants' groups.

Discussion

The virtual meetings took place late at night when the kids were finally asleep after another stressful and hectic day. In most groups, the first ten minutes were encountered with some degree of shame, tiredness, feeling of hopelessness, and loneliness. All of these emotions, with the setting of a remote group session, created a climate of parental messiness, magnified in the context of COVID-19 and social isolation. For example, some were late to the group because their child was reluctant to fall asleep, others had to leave and come back in the middle because of a crying child that needed to be nursed or put back to sleep.

This dynamic of messiness and clutter was received with great understanding and empathy, perhaps because it simulated daily interaction and dynamics of families with young children. In real life, relationships are not perfectly 'attuned' and 'synchronized', rather are quite 'messy' with frequent, ongoing episodes of mismatches followed by repairs (Tronick, 2017). In our groups, there was messiness between group members and leaders, and mismatches between emotions and thoughts regarding the crisis. Eventually, these miss-synchronized states led to resilience and hope through authentic connectedness. Indeed, seminal developmental studies find that by encountering countless moments of mismatch and repair in our first relationships, we develop a core sense of trust and connectedness, as was shown in the "still-face paradigm" (Tronick, 1978; Tronick E.Z. & Gianino, 1986).

This framework of messiness relationships is supported by the "good-enough mother" concept (Winnicott, 1991), and it was used as an anchor to our parents during the group sessions. This anchor was used to keep their parental ship steady and safe from carrying out to the ocean of uncertainty, messiness, and disruption of their relationship, as the reality changed and became stressful and traumatic.

As described in the results, the main themes varied between the groups. We noticed differences between groups that may underlie these variations and were related to the environment (i.e., lockdown status, rural/urban living), culture (i.e., viewing early childhood education as primarily academic vs socio-emotional) and circumstances (i.e., immigration status, health condition) of each group. We also recognized that while during the group sessions more intimate issues were discussed, in the post-group survey the focus was on the usefulness of the sessions (e.g., coping skills, psycho-educational, the group sessions as a tool of self-regulation).

A common theme that arose across all groups was related to loneliness. However, in the *post-partum group*, as well as the *group of new immigrants*, this theme became the main narrative that led the group. We assume that due to the significant identity change of the participants in both of these groups, their need for a connection from their communities was enhanced, and lack of social support was more prominent.

Stressful events like COVID-19 can damage the quality of existing attachments by adding stress to the parent-child relationship; in some situations, parents who experience distress themselves may be less attuned to their children's needs and less emotionally available. Alternatively, children of parents who are able to

monitor, set limits, encourage skill development, problem-solve, and be positively involved, are more likely to show resilience in the face of stressful events (Forgatch & Ogden as cited by Gewirtz, Forgatch, & Wieling, 2008).

This interaction was evident in the post-group survey; we identified that groups who needed more coaching skills also focused more on children's behavior, particularly the ability to regulate emotions. Emotion regulation moderates the relationship between stress and resilience (Troy & Mauss, 2011). Therefore, it is possible that parents who felt more skillful also noticed an improvement in self-efficacy and an overall sense of control. These findings were particularly evident within the *west coast group* and the *general Israeli group*.

Furthermore, it was clear both from the survey and from group sessions that all parents felt that their parenthood and the sense of capability was evolving and changing through the repeated process of mismatches with their children that followed by reparation (Tronick E.Z. & Gianino, 1986). As they felt more secure in the group setting, the intimacy and the feeling of shared realty helped the group become open to exploring self-efficacy, and then develop motivation for learning and practicing self-regulation and coping skills. Additionally, it led to creating opportunities for co-regulation moments with their children and developing trust and hope in their personal relationships.

The journey that we had with group participants and with our colleagues was humbling, unique, and challenging. There were moments that we had to offer compassion rather than knowledge, and moments that a smile and reassurance built and healed disruptive relationships that were under inevitable messiness. Other situations required specific emotion regulation and distress tolerance skills to help problem solve situations that arose at home. However, the one commonality across all groups was the need to connect with others. This played out in the need of hearing one another, crying, and laughing together, having a weekly hour of being a part of a group and not isolated.

In sum, regardless of personal differences, land of origin, and background, parents during COVID-19 need support. Meeting other parents on a regular basis provided structure to share the burden, learn skills to cope with daily struggles, and most of all, it provided the opportunity to connect. Parents need to be able to "put the oxygen mask on them" first, so they could be available to repair relationships with their children and to co-create hope and resiliency in a time of stress and trauma to their community.

> "I define connection as the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship")Brown, 2010).

Group leaders

Gilad Amshalom is a speech-language pathologist and holds a BA from Haifa University and a Master's degree from Hebrew University (Jerusalem) in infant and early childhood mental health. Gilad joined the Infant-Parent Mental Health Postgraduate Fellowship/Certificate Program at the University of Massachusetts Boston in March 2019. Since December 2018, Gilad has volunteered and now works as an intern at the SPARK Center (Supporting Parents and Resilient Kids) at the Boston Medical Center. At SPARK, Gilad facilitates dyadic interventions with mothers in recovery from substance abuse and their babies. Gilad is a Teaching Fellow in the Harvard graduate school of education, and prior COVID-19 worked as an Infant Mental Health Clinician in the Early Intervention Program in Cambridge, MA.

Dr. Miri Bar-Halpern is the Director of Intensive Outpatient Treatment Services at the Boston Child Study Center and is a Clinical Instructor in Psychology at Harvard Medical School. Dr. Bar-Halpern earned her bachelor's degree at Tel Aviv University and her master's degree and a doctorate in clinical psychology at the University of Hartford. She provides consultation and professional workshops in the United States and Israel about evidence-based treatment to psychiatric hospitals, mental health organizations, and schools. During her graduate studies, Dr. Bar-Halpern trained extensively in implementing evidence-based interventions to treat children, adolescents, and families such as DBT and CBT. Dr. Bar-Halpern has specialized interest in trauma-informed care and has developed treatment manuals, therapy groups, and training seminars on that topic. She has published several chapters and articles about trauma and emotion regulation and is the author of Becoming a Superhero: The Development of a Book for Children Who Have Been Exposed to Terrorist Attacks.

Tamar Levran-Galai is an educational counselor and a CBT therapist who holds a Master's degree from Bar-Ilan University (Ramat-Gan). Tamar is currently an MFT trainee at the Women's clinic counseling center in Los Angeles and enrolled in the clinical psychology Master's program at Antioch University, Los Angeles.

Dana Lahav-Meir is a social worker and holds a BA from Tel Aviv University and a Master's degree from Hebrew University (Jerusalem) in infant and early childhood mental health. Since 2016, Dana has worked for two years in Social Services with families at risk. After finishing her Master's degree in 2018, Dana started working as a parental consultancy therapist and as a child mental health therapist in a Child Development Unit. In parallel, Dana started working as the director of treatment in a rehabilitative daycare center for autistic infants, managing a multi-professional therapeutic team.

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Infants at a Distance during COVID-19: Adaptation of the Building Early Attachment and Resilience (BEAR) Program during COVID-19 for Online/ Virtual Delivery

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Introduction

Experiences of pregnancy and early parenting have been significantly impacted by the global COVID-19 pandemic. Parental anxiety, disruptions to both antenatal care and birth services, and limitations on postnatal support services raise concerns around mental health, infant outcomes, and early parenting. Pregnancy during the pandemic has raised parental concerns about potential harmful effects on foetal development and neonatal outcomes, including concerns around case reports of preterm delivery in COVID-19 positive mothers (Brooks, Weston, & Grenberg, 2020). Central to parental anxieties are experiences of uncertainty as knowledge remains limited, raising existential questions about the future a child may face, given the pandemic's impact on economic and social functioning, and disruption to daily life. Some question their own capacity to protect a vulnerable infant in the face of health and social risk which constitutes a fundamental threat to the parental role (Preis, Mahhaffey, Heisleman, & Lobel, 2020). These anxieties may be contributing to reported decreases in birth rates in some countries as families choose to delay pregnancy.

Importantly, many reports document increased rates of depression and anxiety during pregnancy and the postnatal period during the COVID-19 pandemic (Farrell, Reagu, Mohan, & Elmidany, 2020; Berthelot et al., 2020). High levels of anxiety in pregnancy raise concerns about the impact of stress-related hormones on foetal development and birth with the known association of maternal anxiety with premature delivery and poor neonatal outcomes. Parental anxiety may relate to fears of contracting the virus and fears that this may harm the foetus (Corbett et al., 2020).

In a prospective study of pregnant women during the pandemic, 50% and 47% reported fears of preterm delivery and foetal structural anomalies, respectively (Thapa et al., 2020). These and related findings raise concerns about the impact of anxiety on the development of the attachment relationship in the antenatal period and potentially on the quality of early interaction with the infant who is seen as vulnerable.

For some parents, having conceived an infant during the COVID-19 crisis creates feelings of guilt and anxiety about 'bonding' with the infant in case of poor outcome and loss (Beresic, 2020). These findings raise significant concerns about the mental health of the mother and families during pregnancy, as well as concerns about the impact of maternal stress and mood on foetal development. This increase in distress and psychiatric symptomatology in the antenatal period would, in more normal circumstances, would be the focus of further assessment and intervention aimed at supporting the transition to parenthood, including the development of antenatal attachment, with the addition of postnatal follow-up and support, and a focus on the parent-infant relationship.

The reduction in face-to-face services and usual programs of community-based support during the COVID-19 crisis has contributed to parents experiencing an overall lack of support and social isolation, and many do not have access to their usual extended family support or social networks. In Melbourne, the severe lockdown and lack of movement in the community, has further isolated many vulnerable population groups without traditional family and social support. In turn, this has had specific negative effects on minority cultural groups and those with pre-existing social disadvantage and traumatic experiences, such as asylum seekers and refugees.

The BEAR (Building Early Attachment and Resilience) parent-infant group program described below has been developed to provide infant-parent attachment focussed psychotherapy as a group intervention for parents and families with vulnerability and risk factors, for early parenting difficulties and attachment problems. This is an approach aimed at building parental capacity to reflect on the inner world of the infant and to encourage

emotionally attuned interactions and sensitivity. Offered previously as a face-to-face program, BEAR has been delivered to over 100 mother-infant dyads and is currently being evaluated in terms of longitudinal infant outcome and interactional variables (under review).

A major challenge for clinical infant mental health services is to reach vulnerable and isolated families where a combination of psychological and social factors, impacts parenting capacity and increases the risk of early relational trauma with implications for infant psychosocial, and cognitive development. Whilst there are some examples of online and videoconferencing support groups for parents and infants (Marshall et al., 2020), at the time of writing of this article, we are not aware of reports of therapeutic programs used for high-risk infants which are subject to evaluation.

Anecdotally, there has been an increase in the use of parenting support telephone advice services with a reported increase in calls relating to parenting stress, depression, and issues related to family conflict (PANDA, 2020). In this context, we adapted and implemented the BEAR program maintaining the key components and adding the focus on the current pandemic crisis and its impact on both mental health and early parenting. A key issue was identified as the need to build social support and connection for isolated parents, to share experiences and anxieties raised in this situation, and to contain parental anxiety to allow a place to reflect on the needs of the infant for connection and interaction. These are fundamental elements of infant-parent interventions, now adapted for unusual and challenging circumstances.

Significance of the BEAR Program model

The Building Early Attachment and Resilience (BEAR) program is an accessible therapeutic parent-infant mental health program, specifically designed for vulnerable parents. The BEAR program is based on the extant body of evidence about the critical importance of early care and the quality of the parent-infant attachment relationship for infant neurological, cognitive, emotional, and social development (Russo, Murrough, Han, Charney, & Nestler, 2012). Infant brain growth and emotional development are shaped by early experiences of emotional interaction with the parent and the parent's capacity to support the infant to manage anxiety and self-regulation (Newman, Sivaratnam, & Komiti, 2015).

Importantly, the quality of early emotional interaction and regulation is related to the parent's/caregiver's capacity to think about the inner world of the infant and to read, and respond, to infant affective communication. The tasks of establishing a positive relationship with the infant may be negatively impacted by a broad range of caregiver risk factors including maternal anxiety, depression, mental illness such as psychosis, unresolved issues related to early child abuse and neglect, and psychosocial risks including poor social support, experiences of conflict, and family violence (Schore, 2010).

Early intervention services are central in better identification of vulnerable parents and in the provision of timely treatments for perinatal mental disorders and support for the promotion of sensitive emotional interaction and organisation of the attachment relationship with the infant. Available models support the importance of better recognition of the early risk factors for mental disorders and the specific negative impact of stress and trauma on early brain development (Newman, 2015). Early identification and intervention are crucial given the known developmental sequelae of attachment anxiety and early relational trauma, such as vulnerability in later life to the range of mental health disorders and psychosocial disadvantage (Granqvist et al., 2017; Madigan et al., 2019). Early interventions focused on parenting and parent-child relationship quality to optimise child development and to promote psychological resilience and mental health (Slade et al., 2019) while reducing the economic and social burden of untreated attachment-related disorder, issues across the lifespan (Oates, 2007).

The BEAR program is designed to provide vulnerable parents with increased knowledge and understanding of the emotional and social needs of the infant and an understanding of infant communication (Newman, 2012, 2015, 2019). Parents with risk factors for attachment difficulties, including individuals with complex trauma and/or psychopathology, are supported in developing sensitivity to infant communication and to strengthen their role as an available attachment figure. This involves supporting parents to focus and reflect on the emotional communication of their infant and to build an understanding of their infant's needs, in the relationship. The program addresses parental anxiety, issues related to mood, past trauma, and provides direct clinician-led coaching of interaction with young infants.

The BEAR sessions include three components: (1) Reflection on the parental self, (2) Emotional interaction and building a model of the communication with the infant, and (3) Psychoeducation about attachment and the development of infant's subjectivity. The program is multidisciplinary and aims to provide both developmental and interactional guidance, maternal and child health nurse support, and parent-infant psychotherapy. The group setting provides social support and apprentices for the sharing of experiences. The weekly schedules and modules of the BEAR program are presented in Table 1.

The BEAR program has been adapted and delivered across multiple modalities including in hospital settings working with infants as early as 4-weeks-old, for drug and alcohol using mothers (ABC-WADS program), and as an intensive day community-based program, known as BEAR House. While the majority of the programs are delivered as a 2-hour weekly program, the intensive BEAR House program also includes a maternal and child health component, focused on practical and embodied aspects of parenting such as play, baby massage, information about nutrition, and community engagement (see Table 1 above). Sessions are typically co-facilitated by a psychiatrist/clinical psychologist and maternal and child health nurse/clinician. It is the BEAR House program that was urgently adapted to virtual ACCESS BEAR, due to the necessity in continuing to deliver the service in the face of the COVID-19 pandemic.

Adaptation to ACCESS BEAR during the COVID-19 pandemic: Participant and clinician reflections

In March 2020, a group of 5 mother-infant dyads were attending the community-based BEAR House program delivered face-to-face in Melbourne,

Table 1. Summary of the Building Early Attachment and Resilience (BEAR) program.

Week	Maternal and Child Health Nurse Session (2 hours)	BEAR program Mental Health Clinician (2 hours)
1	Introduction Sleep and settling	Becoming a parent Parenting with feeling
2	Development and Play Newborn Behavioural Observations (NBO, Brazelton Institute, Nugent et al., 2007)	Managing difficult feelings Models of parenting
3	Baby Massage Play	Parental Reflective Capacity Responsive parenting - Part 1 Father/partner - Part 1
4	Growth and Nutrition Community Supports	Responsive parenting - Part 2 Dealing with the past
5	Maintaining Well-being Music and Movement	Being a safe base - Part 1 Father/partner - Part 2
6	Connecting with community	Getting it right Moving towards the future

Australia. The call of the COVID-19 pandemic public health crisis led to the immediate withdrawal of clinical group services which meant that we had to rapidly adapt the BEAR program to ACCESS BEAR to be able to deliver the rest of the program (two sessions) online to these 5 mother-infant dyads. Participant feedback and other data were collected in the context of broader research study protocol resulting in a unique set of insights about qualitative differences regarding online versus face-to-face treatment modalities. In this group of participants, common reflections regarded the positive aspect of ongoing social connectedness during imposed restrictions and social distancing from extended families and early parenting community services.

Participants also reflected on the comfort and the convenience of having the program virtually delivered to their homes which meant that the practical infant care such as feeding, changing, and sleep remained uninterrupted. However, some participants focused on the loss of face-to-face contact. For example, one mother highlighted:

> [it was positive that] we could still have some contact given that at the moment, social distancing would have otherwise made it fairly impossible …though I don't think the online sessions are as good...you know…'cause [facilitator] mentioned that maybe the next group would have to be run entirely online…personally, having experienced both ways of delivery I personally don't think I would've gotten as much out of attending the program if it was just online because a big part of what I enjoyed about the program was actually interaction with the other mothers and babies as well… it's a very warm environment… and umm…also the kind of care … [facilitator]…being in person…there is something really special about the way they provide care… .

Reflections from this group also included grief about the loss of informal conversation during tea breaks and face-to-face contact for babies. Balanced reflections on grief and loss (i.e. not distorted or preoccupying in form) may be seen as an attempt of the psyche to ingrate the environmental changes and to adjust to the parenting role, and the new circumstances under attachment-related stress (Main, 2000). Notwithstanding the sadness of the situation, such reflections may also signify a robust reflective capacity – this hypothesis is to be evaluated in future studies.

The feedback from the next group of 4 mother-infant dyad of participants who completed ACCESS BEAR in its entirety, was largely positive. Program acceptability was high with excellent retention rates. Three of the four dyads (75%) had a 100% attendance rate, and only one dyad missed one session. The mere availability of the program was appreciated as a priority with technical difficulties and saturation of screen time as common themes. The program components targeting emotional interaction and affect co-regulation were remarked and reflected upon, for example, one mother reflected:

> I think it was just getting used to the platform and the technology. But um yeah, I think it worked well. And I, I really appreciated the fact that um the facilitators were really clear about, you know, we didn't need to mute ourselves if our babies were crying, or having, you know, big feelings, like, that was fine. And I think that was actually, really positive, because it's kind of...yeah it helped with that um, you know, getting more comfortable with it as just being a different mechanism to communicating.

The rapid adaptation to ACCESS BEAR has also provided our group of clinicians with techniques needed to deliver the program including experience in successful engagement of families

and infants, online. Some challenges regarding family assessments including safety, deterioration of mental health, including partners and infants, pertained to limitations associated with having the therapeutic frame limited by the screen as one clinician observed, *"it was harder to see the dyad interaction due to the camera - you often only saw one side of the interaction"*. Establishing a plan for each family set the tone about managing issues and participating in this new mode of delivery.

In terms of the content delivery, the clinicians also remarked on the challenge of working with high levels of distress in the context of video technology:

> There was one session about week 3 where a baby cried for the best part of a full hour. We paused the session…it was important for us to stop when babies have big feelings… It was hard for the families to hear, and we did acknowledge that it is hard, but we do need to hear babies even when their feelings are big. It was challenging to be with as a clinician in the face-to-face sessions we would have helped the mother take a break and help the infant to organise themselves with the mother. It felt a little like we intruded on this mother and infant in a most challenging time for both… we did speak to that mother after the session - it was too hard for her to hear us so she moved away from the camera, although we could hear her infant protesting. It was such a brave mother who allowed us to see her baby struggling - for the other mothers and infants, this moment helped explore that infants are participants in the group and that we need to allow space at times for this.

In terms of infant interaction with the program, the clinicians wondered if the infants were generally more settled at home, due to surprisingly notably fewer episodes of distress and disorganisation. Whilst the babies seemed delighted in the welcoming song each week, their engagement with other babies and the facilitators was reportedly more difficult to gauge. Infant responsiveness and engagement of the mother and of the program, raise important research and clinical considerations. For example, with regards to the objective evaluation of infant mental state, when the infant is at a distance, and when the visibility of the interaction is limited by video.

Both participant and clinician feedback suggest online delivery of ACCESS BEAR is potentially a promising enterprise. It would provide a valuable addition to face-to-face BEAR programs in allowing engagement with difficult to reach and remote populations. However, the differences in the modes of delivery regarding virtual and videoconference use for ACCESS BEAR, including program effectiveness, remain to be evaluated in future studies in terms of infant outcomes, mental health, and the quality of the parent-infant interaction.

Clinical Implications

The above discussed perspectives highlight the importance of the availability of ongoing support and clinical intervention, with regards to challenges associated with emotional aspects of early parenting, for at-risk families during COVID-19. However, the consideration of the assessment of mental state and safety remains of significant importance. The continuation of face-to-face service delivery for most vulnerable families is therefore preferable.

In terms of assessment of infant engagement with online programs, coding principles of attachment-based measures and atypical parental behaviours (e.g., (Tronick & Chon 1989; Lyons-Ruth, Bronfman, & Parsons 1999; Lyons-Ruth & Spielman 2004) are required to be translated from research to practice with more urgency in the context of the current global pandemic.

Screening measures such as the Edinburgh Post Natal Depression Scale (Cox et al., 1997) and the Mother Infant Relationship Scale (Newman-Morris et al., 2020) should be made widely accessible in online formats for the prompt screening of maternal mood, and relationship quality, and used to inform specific engagement with services, and modes of treatment delivery.

Further, the use of video-feedback approaches as methods of intervention, and assessment, or observation, require further research and evaluation in the context of a broader move to the use of online parent-infant psychotherapy service delivery.

Importantly, the integration of screening and relational assessments with online therapeutic interventions allows for monitoring of the longer-term developmental impacts of the pandemic on attachment and infant developmental outcomes.

Conclusion

The established Building Early Attachment and Resilience program (BEAR; Newman, 2012, 2015) was rapidly adapted for distance delivery mode via video technologies (ACCESS BEAR) in response to the urgent clinical need to support parents and infants following the withdrawal of community group programs and home visiting. The ACCESS BEAR program has been piloted and delivered to 9 dyads. Overall, both participant and clinician feedback has been positive with value placed on social connectedness, learning about infant development and interaction, and access to clinical support.
This suggests infant mental health programs developed for vulnerable groups may be well received in online formats. However, empirical research is urgently required to evaluate the effectiveness of the program in terms of infant outcomes, maternal mental health, issues related to assessment and evaluation of mental state, and risk via remote technologies, as well as economic service delivery evaluations. Longitudinal intervention studies evaluating the effectiveness of BEAR programs, including ACCESS BEAR, are underway. More research is required regarding virtual and online delivery of parent-infant programs, including critical discussions and evaluation of the impact of a potential cultural shift to online modes of delivery of psychotherapy more broadly.

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WAIMH Office News: Update of WAIMH Membership

Dear WAIMH members:

The WAIMH membership year is January-December irrespective of when you make the membership payment.

You will be able to make renewals starting 31st December. The first membership renewal letter will be sent December 31, 2020.

There are various ways to renew your WAIMH membership via online payments: You can either choose the autorenewal option or renew the membership manually each year. You can also make a two year payment, which has to be renewed manually every two years.

The fee for the Infant Mental Health Journal (IMHJ) varies, as the publisher Wiley sometimes makes changes. We have now developed a system whereby you need to order IMHJ separately from the WAIMH Store on a yearly basis. Members will be able to order the journal at a highly reduced rate, and you can choose a paper version with online access or an online access option only.

Once you have signed up for or renewed your membership you can go to the WAIMH Store and subscribe to the Infant Mental Health Journal at a reduced rate. Note: New membership applications need first to be approved.

Specially for WAIMH members: the WAIMH online community

You decide who sees your data within the membership platform (the WAIMH membership register is an opportunity for networking!) Please check the visibility of your membership contact info.

You can use the feed, and the platform is an option for you to tell others about your research and events (please note that we suggest that you do not use the membership platform for marketing purposes).

Security note

WAIMH wants to ensure the security of the WAIMH members' data, WAIMH announcements and the website. Due to the large amount of spam email with deceptively real-looking sender's addresses, all personal email addresses have been removed from the WAIMH website. You can contact us via the Contact Us Form.

Please note: WAIMH or WAIMH Board members DO NOT ask for money from members.

Free webinar for WAIMH members

WAIMH members have another webinar available for free at the WAIMH website. The webinar *"Look-ing back, looking forward: Learning from our pioneers as we adapt into the future"* was arranged 8th December in collaboration with The Hospital for Sick Children. The speakers were Hisako Watanabe, Bob Emde, David Oppenheim and Diane Phillipp, with Campbell Paul and Chaya Kulkarni as discussants.

Season's greetings

We at WAIMH Central Office work for you, and hope that WAIMH memberships will run smoothly. If you have any questions, do not hesitate to ask. We want to increase the options of being connected. Have you noticed WAIMH on Facebook, Twitter and YouTube?

During Covid-19 we are fortunate to be able to work from home. But we are well aware that the situation is not so easy for families or our members. We want to send you warm thoughts and our appreciation for your efforts to make the world more baby-friendly. This is a special time in human history, since such large lock-downs have not been experienced in modern times.

Hopefully you will be able to also relax and enjoy, and take care of yourself and your family.

All the best wishes,

Minna and Sari from the WAIMH Central Office