Keeping Child in Mind During COVID-19

A framework for working therapeutically with babies, toddlers and preschoolers via online digital platforms

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**Best practice guidance for working therapeutically with babies, toddlers and pre-schoolers via online digital platforms**

This document provides guidance on parent-infant video therapy with babies, toddlers and preschoolers during the particularly challenging circumstances presented by the COVID-19 Pandemic.

The Early Years Programme at the Anna Freud Centre has developed an overarching framework for understanding the key practical and clinical challenges in relation to remote parent-infant work during these exceptional circumstances. Drawing on common ground best practice points released from multiple Psychotherapy and Psychology associations (i.e. The UK Council for Psychotherapy, British Psychoanalytic Council, British Association for Counseling and psychotherapy, British Psychological Society and the Association of Child Psychotherapists) and the Anna Freud Centre’s own clinical expertise on adapting treatments to the crisis, we suggest a number of practical and clinical considerations for working therapeutically with new and existing families of babies, toddlers and preschoolers, where COVID-19 restrictions have forced to move to online or technologically mediated delivery of interventions.

The framework includes practical considerations on preparing for video therapy, clinical considerations before each video session, guidance on planning video therapy with families, adapting clinical practice to the challenging circumstances and regularly checking-in with families for how things are going.

Please note, this guidance document will need to be adapted to the specific needs, capacity and circumstances of the individual family you are working with, particularly considering their developmental age and stage. Furthermore, as this is a novel way of working, this framework will require updates in light of new discoveries and progress.

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| 1. **Practical considerations in getting yourself set-up to start video therapy**
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| * **Work from a private and confidential space.** We recommend ensuring that the space from home you work from is private, un-interrupted and where possible free from loud noise. For example, headphones can help manage interference from background noise. To ensure this, it may involve asking others in your space to respect your privacy by doing things like turning on entertainment in another room or listening to something on headphones. If the required confidentiality is not possible from home, then it is not advisable to conduct video sessions and other alternatives such as phone sessions may be advisable instead.
* **Replicate face-to-face environment.** We advise that the space you conduct video therapy from replicates where possible the environment that would be typically used for therapy in a face-to-face setting. *When working with children under five, typically this involves sitting on the floor surrounded by toys. It may be worth thinking about how to create a sense of continuity, perhaps by conducting video therapy on the floor with some familiar toys and finding ways to position the computer so that this is possible.*
* **Meet in the same place.** We advise you to conduct the therapy in the same place chosen for each family. This will also help to create a sense of continuity with face-to-face work, since in-person meetings typically would have occurred in the same consultation space. This will also require dressing as you normally would if you were to meet in person.

* **Lighting and background.** Best practice points on technical consideration suggest avoiding any lighting directly behind you and closing curtains and blinds in the room. If the video platform is permitting, perhaps blur the background or chose a specific image/picture for the background (e.g. Zoom allows this). If you decide to keep your home background in view, you may consider choosing a part of your home which you are happy to show beyond your shoulders. We recommend that you also take into account the family’s needs and personality. With some families it is better to choose a more neutral/professional background, for example bookshelves. With others there is less need, and they experience a sense of familiarity even when they see the kitchen of the windows of the therapists’ home.
* **Familiarity with video platform**. Ensure you are familiar with the digital video platform you are using and understand its functionality. For this, practicing using it with family or friends may help you to feel confident and prepared. *When working with children under five, it may be particularly helpful to use the whiteboard feature to draw pictures, or to share your screen to show trigger pictures or videos – this requires familiarizing yourself with these features.*
* **Managing disturbance from other devices.** Turn off or put to sleep all devices other than the one you are using to make the call, including watches, laptops, and other phones. If using a smartphone or computer, do your best to quit from all programs other than the one we are using and turn off all notifications if you can. It is best to leave your hands free by using headphones.
* **Insurance.** Ensure to check that your professional insurance plan covers video therapy.
* **Information governance.** Familiarize yourself with the updated [NHSX guidance](https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance) on information governance considering COVID-19 and ensure that your planned practice is GDPR compliant (see [Catherine Knibbs – Privacy 4](https://medium.com/%40catherineknibbs/what-are-the-issues-to-consider-working-online-with-children-young-people-during-covid-19-66cd53254d58) for helpful advice on this matter).
* **Supervision.** With the increased sickness, staff redeployment and furloughing, ensure that you are still able to access regular clinical supervision in relation to your video work.
* For further practical considerations on communication method and video software visit the [BPS guideline](https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Effective%20therapy%20via%20video%20-%20top%20tips.pdf) on conducting effective therapy via video.
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| 1. **Clinical considerations in preparing yourself for therapy within a digital platform and best practice points in preparing yourself prior to each session**
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| * **Acknowledging the impact that the current situation has on us as an individual.** We are all constantly exposed to distressing news, however deeply we may attempt to shut it out from ourselves. Further, there are a number of issues relating to Covid-19 which may affect us directly, namely mortality, possible loss, feeling a sense of lack of control, social vs personal responsibility, etc. It is not possible to empty ourselves entirely of these private worries before contact with our patients. However, each of us has resources and techniques to listen to ourselves, bear our emotions and anxieties, and steady ourselves within. We need to do this self-steadying before each session. If, however, you feel that your ability to calm your mind is slipping, for whatever reason, please do not hold a session. It may be time to look focus on looking after yourself and getting support to do so.
* **Pre- and post-session preparation.** Its important to consciously settle yourself before a video session so that your voice is soothing and calm. It may help to monitor your emotional temperature, ensuring that it is neither too hot nor too cold but in the appropriate warm mentalizing range to connect with the family. To further help your sense of connectedness we recommend you do something with your curiosity by finding that space inside you where you can attend to the other and get to a point where you will know you are more regulated, which everyone has their own way of monitoring. For example, it is recommended that you leave yourself an additional 15-minutes both before and after the session for a walk, either by going outside and doing something such as going around the block (if you are comfortable doing so) or, if staying inside, wandering around your place. If there is no way to take a walk it makes sense to do some simple stretching. It is not a good idea to leave another remote meeting or call or activity requiring focused attention (either work or play) and then immediately calling in to start the session. You will need some time to get ready for the work we are about to do. Similarly, after the session is over-take 15 minutes to do the same thing before diving into the next activity. This will give time for the session to resonate before jumping back into whatever you have next.
* **Supervision.** We recommend using group and individual supervision as a safe space where your thoughts, fears and own anxieties can be held during this time. Further, in adapting to this new way of working it may initially indicate a need for more frequent supervision. Here you may also safely explore your feelings and beliefs about using video therapy and self-regulate your own difficulties with the changes such as the worries for families’ mental health, irritation with the option of discontinuing face-to-face psychotherapy, or guilt at the idea of not being available enough.

We also recommend that you keeping in contact with colleagues also via other more informal means (e.g. phone, Whatsapp etc.) to support each other.  |
| 1. **Practical and clinical considerations in planning therapy within a digital platform with the family**
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| **Give thought with the family to what will best anchor you and them:*** *Preparation.* First, we recommend not rushing to start the video therapy until the proper preparatory and practical arrangements are in place and you have reviewed the suitability of this form of treatment together with the family on a case-by-case basis.
* *Using telephone contact to transition to video therapy.* The preparatory conversation may be easiest held in a telephone conversation as families differ in their responses to the idea of meeting their therapist on a digital platform. Indeed, many families will have difficulties in accepting digital psychotherapy, the prospect of which might be experienced as rather anxiety provoking, intrusive or uncomfortable. As such, initial discussions about this via telephone may support the transition. For this, there will need to be discussions with family about the implications of digital delivery at the outset and a clear plan for when you will speak (for isolated caregivers/parents a clear schedule will be especially important to help them know you are holding them in mind).
* *Keeping the child in mind during preparation.* In discussing the implications of digital delivery, we recommend holding the baby/toddler/preschooler in mind from the outset, by also discussing how they might experience this differently and the type of measures you can take to address these changes (for example, consider having shorter sessions which are match the attention needs and span of the child, or how to talk to the child to prepare them for the video format). This way, the child will be involved from the beginning and their experience will be inherent to the co-production and planning of the session.
* *Keeping in regular contact.* Isolation is endemic to social distancing policies, so now more than ever there is the need to keep connected to the families you work with, so they feel held. Consider staying in contact between video therapy sessions with shorter telephone calls or via text/WhatsApp messages. Given this and the shorter attention spans of children under 5, you may also wish to consider shorter, but more regular sessions and/or regular planned breaks within a session.
* *Helping families create a safe space.*In preparing families for video therapy you may offer suggestions for how to create a therapeutic space, safe and protected from interference. Of course, having a private, distraction-free room is best, but even in this case it can be suggested to use headphones and a microphone, and maybe some background music, so reducing the risk others listen. Alternatively, sessions can be conducted over smartphone in the open, for example a private garden, the parking lot or one’s car. Small as they may sound, these suggestions may help many families to accept and practice therapy even after initial reluctance.
* *Assessing whether general family support is preferable to therapeutic intervention***.** Be open to the idea that video-therapy will not suitable be for all families as some for various reasons will not manage transitioning to video therapy sessions (for example if confidentiality cannot be assured from other members of the household). For these families, it may be very important that an ongoing relationship is maintained, and this could be just keeping in touch, so that they have a chance to speak at less frequent but nevertheless regular intervals. Here, you may consider whether working by telephone, WhatsApp, text or even email may be possible. Families can thus be reassured that you are still there and keeping them in mind. In this situation, it may then be necessary to renegotiate therapeutic goals to provide general family support as opposed to a more therapeutic intervention. it may be possible to leave the door open, so that once the difficult business of managing daily life has settled down a bit, patients can come back to therapy.

**Therapeutic contract for video therapy:*** In preparing with the family for video therapy, we recommend you discuss expectations with the parent/carer and set-up a specific therapeutic contract for video therapy. This may include reference to the following:
	1. Consideration of whether you can still work on the therapeutic goals you have previously agreed or whether they need adapting.
	2. Agreement on where sessions could take place in the house so that they are in a safe and confidential space, which could include considerations of the following:
		+ 1. Can this be the same place each session?
			2. Will the space be private from being overheard by others?
			3. Can we agree that nobody will be in the room if they are not involved in the therapy?
			4. If there is a TV, is it ok for that to be turned off?
	3. Discussion of how you would like to manage the situation if siblings or other family members unpredictably enter the room.
	4. Discussion of what you would like to do if the parent and/or baby/toddler/preschooler becomes distressed or the session must be ended for an unplanned reason.
	5. Discussion of how you would like to manage technical difficulties. This should include an alternative telephone number to contact the parent/carer if the video link does not work (i.e. a clear back-up plan if technology fails).
	6. An understanding that the psychologist convenes the sessions, invites the parent and family to attend at a specified time, and that video contact between sessions will not be possible. For this there should be clarification that for appointments, you will send families a unique, secure hyperlink to activate each session thus avoiding out of session contact on the chosen digital platform.
	7. An understanding that parents/carers must not record any part of the session.
	8. Clarification that any safeguarding concerns will be managed in the usual way; be mindful that video may reveal risks that might have been unknown before, including poor living conditions, behaviour of other family members etc.
	9. An understanding that therapeutic material will be kept separate from business communications such as arranging appointments or managing cancellations.
	10. Clarify any feelings of psychological distance and beliefs about video therapy (e.g. whether it can work, be effective, support the therapeutic relationship; this may be especially important if starting up with a new family).
	11. Discussion of how babies may cause disruptions with the camera (which may test the patience of adults) and how to use this as an opportunity to introduce playfulness, exploration of stress triggers and boundary setting.
* *Creating a safe space.* For some families this will be a therapeutic task in itself (e.g. if they have issues on boundaries, setting rules, trusting other family members to respect their space). This may therefore also be a goal to set in the short term as part of the new therapeutic contract for video therapy.
* *Asking feedback on remote working.* In any case, asking parents for feedback about how they experience the therapist in this new environment is crucial. This is also an opportunity to step in to the child’s experience and wonder, explore how they may be finding this new video format.
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| 1. **Adapting clinical practice**
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| **Assessment** * When conducting an assessment, ask questions about family life as specific to the impact of home confinement, social distancing, financial implications of employment changes or caring responsibilities, personal or family sickness associated with COVID-19.
* It can be very helpful to ask a parent to describe the daily routine of their child (ideally through their eyes) before and after the pandemic, to understand the degree of change. Particular emphasis should be placed on people, places and activities.
* Explore parents own anxiety related to COVID-19 and assess any changes to their mental health as a result.
* There are further considerations if you consider taking on new clients, so it might be wise to delay this to find out more about assessing suitability for video therapy.
* Raise the bar on what we normally consider psychopathology. Reactions of distress, such as rage, anxiety, fear, guilt, obsession, emotion and behaviour dysregulation, though transitory, are to a certain extent normal during a crisis. This is also the case for the child, who may start to display a range of common reactions, which in other times we may otherwise consider more problematic (e.g. temper tantrums, losing potty training and clinging to caregiver etc.).

**Intervention** *Focus on the ‘here and now’.* * We suggest refraining from therapeutic interventions that arouse anxiety and challenge our patient’s coping mechanisms. As such, we recommend staying and discussing with families how to cope in the ‘here and now’ of their daily lives. In times of high stress, the short-term focus should be on containment and stress management. Stress is triggering, particularly for parents who have suffered trauma. This is not the time to process trauma which will be highly arousing and potentially disempowering, but rather the time to focus on safety, self-efficacy, identification of vulnerabilities and resources, and tactics that promote sustainability.
* As mentioned above, working on therapeutic goals that bring up the past may be arouse too much anxiety for parents during this time. As such we recommend you avoid actively enquiring how current times may trigger feelings from parents/caregivers’ own past or how for example specific memories or felt experiences from the parental past are brought up in response to COVID-19.
* Coping in the present - everyday life can be discussed and explored as one of the revised goals of the new therapeutic contract, which during this time precedes the need for working on previous psychotherapy goals. Helping parents with this goal may involve mitigating stress responses and assisting them in developing skills for coping and helping their children cope with distress arising from the current situation.
* The following are important aspects of therapy:
	+ Establishing a sense of safety: facilitate grounding and self-regulation
	+ Psychoeducation: acknowledging with accurate information how the current situation affects parents and their children under 5 (see below for further information). Here it may be helpful to review coping mechanisms found to be useful for addressing emotional, physical, mental and social aspects of a crises.
	+ Identify vulnerabilities: monitor immediate and anticipated vulnerabilities and risks for parent and child.
	+ Sustainability: help parent come up with short-term strategies and routines for emotional sustenance for themselves and their child (see below for further information).
* Overall, we recommend starting from where the parent is at in their current daily life and most importantly taking cues from the parent as to where they want to pitch and what feels safe for them to bring to the video therapy session.
* Important to acknowledge that the parent and child may curious about where the therapist is during the video therapy. Let them know that they are free to ask and feedback on their experience of this new therapy format.
* Important to note that the remote aspect of the therapy may, at least in part, transform it into an advice-giving relationship. Undoubtably this will form part of the treatment. However, it is important to have a conversation with the parent about how much of the therapy will be comprised of this – where you acknowledge that it is an important part of the therapy but also how will you manage to incorporate other, more reflective aspects into it.

*Discussing COVID-19 and its impacts with children under 5.* * Support parents in acknowledging how their baby or toddler may sense changes in their parents/caregivers’ stress levels, and how they signal their awareness through changes in their actions and behaviours. Encourage parents/caregivers to wonder with you about their infants/children may be asking for help to comfort uneasiness and confusion they are feeling but can’t understand.
* Help parent/caregiver consider ways to comfort, nurture, and soothe their child. Offer anticipatory guidance about changes/behaviours they might notice in their little ones and help them put behaviour into context and acknowledge how hard it may be for them to retain patience when they are stressed and anxious.
* Support parents/carers in managing the onslaught of advice in the public sphere related to childhood and parenting in the pandemic by choosing 1-2 relevant, evidence-based resources that you can share with them (for an example, see top tips in the [Zero-To-Three](https://www.zerotothree.org/resources/3210-tips-for-families-coronavirus) website).
* Explore if and how parents/carers have explained COVID-19 to their child – and support them with this process in a way that is honest and age-appropriate, without provoking fear. Initially, this may involve exploring parents own experiences of distress and loss to enable them to have these discussions and respond to their child’s question, particularly those which may be a trigger for feelings of anxiety and stress (e.g. “How long will this last?”).
* Within the child’s developmental understanding, explore the child’s visual representations and meaning making related to the virus. Consider (co-)developing a story, ideally a visual one that portrays the virus as non-menacing, using markers and/or metaphors that might be familiar to them, i.e. the virus is like a cold or the flu (show a cartoon picture of a virus if possible), it flies through the air in coughs/sneezes and hands, it can make some people very poorly so it is hard to breath, most people get better with some rest and medicine (see an example of a [child friendly explanation of coronavirus](https://www.tes.com/teaching-resource/child-friendly-explanation-of-coronavirus-by-manuela-molina-12267168?fbclid=IwAR30OldeKpwGNSFynZ3qprt1HQUv9OoseKd5xdioUjHRAmLGrlRIaFRw0x4)).
* Share with parents/carers some of the common reactions their child may display as a result of the impact of the changes and losses induced by the pandemic, including: frequent crying, difficulty staying still, problems falling asleep and staying asleep, nightmares, clinging to caregivers, fears of being alone, whining behaviour, increased temper tantrums.
* Support parent/carers in responding to any expected developmental regressions, for example, losing their toilet training, wanting to go back to drinking from a bottle, talking like a much younger child and have speech difficulties.
* Here it will be important to raise the bar for what we consider psychopathology, as common child reactions of distress (outlined in the point above) are to a certain extent normal during the current crisis. We therefore recommend you helping the parent understand that their child’s suffering is mostly unavoidable. This can help to open up a conversation on how to address these child behaviours.
* Encourage parents/carers to create new routines in the context of the pandemic, by keeping regular mealtimes and bedtimes, setting a daily time to do activities such as playing games together, reading to them, or singing songs together, which will all contribute to the child’s sense of stability.
* Validate the fears and worries of parents/caregivers to co-regulate and help them feel calmer. Important to normalize parents’ feelings ­­­and to be reminded they are not alone in this. This may involve also normalizing the present feelings that the current situation is triggering (for example, feelings of helplessness, loss of control, anger or frustration, or bodily vulnerability). Also, remind them that self-care will give them the energy to care for their loved ones. Acknowledge the disparity in access to COVID-19 testing and the undue burden many of our families will face, either through job loss or being expected to work and risk their own health and find ways to care for their children safely.
* Note how experiencing fears for their own and their loved ones health is understandable, that to be worried about the future of the economy is reasonable, how to behave with a certain degree of obsessions is adaptive (e.g. hand hygiene) or that unexpected losses of temper are to be expected in confinement. Where sharing is appropriate, the clinician may provide examples of witnessing the same experiences and noting this is part of what the humanity is experiencing now. This is aimed at reducing feelings of self-shaming, self-criticism stigma, or guilt for one’s own weaknesses. Self-disclosure is unique in this aspect. Above all, it is one of the most powerful interventions and in this moment becomes even more necessary. Therapists may need to strategically disclose moments of their own personal vulnerability during the outbreak
* Strategize with parents/caregivers about how to create time for play or do it during the visit. For example, you could have the parent position the phone so that you can “observe” and “share” in their interactions. A young child might want to show you things in the home. Playing peek-a-boo with a baby can help the parent/caregiver and baby practice managing the loss of your physical presence.

*Parent-child and play therapy.* * Support parent’s to step into the world of their child under 5, and consider how they might be experiencing (as thoughts, feelings, wishes, desires), what this may be like for their under 5 and help the parent consider any changes to their child’s environment or in their own stress levels or availability – and how they might be communicating any needs for comfort or reassurance to the child.
* It is important to support parents in having a reflective, observational stance towards their child. Remote working may cause parents to shift from their own reflective and observational stance to relying more on the you, the therapist, as the expert who has all the answers. Despite this, there is a need now more than ever for parents to strengthen their reflective stance and tolerate multiplicities of understanding.
* Helping parents be curious and reflective of their child may require layered modelling on our part; by demonstrating particular curiosity of the parent’s inner world we aim to help them become curious of their child’s inner experience. Perhaps it may require some boundary setting wherein you establish with parents that for the first part of the session you can discuss issues occurring exclusively for them and that for the remaining duration you will focus together on the child’s experience. This will create some structure and containment which will also help the parent to feel safe and not lose track of the child’s experience. Think in advance about some of the techniques you might use with the parent to step into the child’s world.
* Be mindful of the parent’s wellbeing and mental state, which may be harder when you are not in the room and may be harder to talk about if their child is present. It may be useful to consider having a mix of parent only and parent child session to manage this. It may be that COVID-19 itself, the environmental changes or the emotions associated with them are triggering conscious or unconscious memories or feelings from the parent’s past (i.e. feeling vulnerable, trapped or controlled). Video therapy is an opportunity to offer that parent compassion to nurture their inner child but also to support them in modelling compassionate responses to the difficult feelings that their baby, toddler or young child may be communicating to them.
* Setting up and supporting play interactions via video can be challenging. As mentioned previously, having some eye catching and novel toys can be helpful to focus the attention of children under 5 on the screen. You may also wish to ask them to bring their favorite toys to the session so they can show them to you during your session. Consider how you will work creatively when you cannot interact with the child through play or drawing, i.e. via screen sharing trigger media, singing songs, or playing games.
* Consider the use of games such as ‘peekaboo’ to help children process loss. This may also be helpful for you to play with them yourself, so they are able to adjust to the lack of your physical presence
* Focus on any repetitive play in sessions as this may be an enactment of the child to process their uncertainty and loss, children may repeat over and over again what they have heard and understand about the pandemic to take it all in.
* If it is not possible to facilitate play in the video session, it may be helpful to set up play inter-actions between sessions that you could discuss with the parents at your next session, or ask them to video the play – so you could review the video material together (see below on video feedback approaches via a video platform).
* You could facilitate play activities during the session by using activities from the open access play manual [‘*Watch me play’*](https://tavistockandportman.nhs.uk/care-and-treatment/our-clinical-services/first-step/watch-me-play-supporting-babies-and-young-children-care/).It is freelyavailable from the Tavistock and Portman trust that has been designed as an intervention to promote child-led play in order to enhance relationships and inform child-centred care planning. This manual may provide helpful for example in providing parent with a play task during the call which they can do with the child alone and then report back to the psychotherapist during the call on how it went.
* It is important to stay with the here and now of our patients’ daily lives. Often this gives opportunity to mentalize experience – think about what happens in the course of their self-isolation with baby, give name and normalize affects where it is the case. We do not regard a flood of speech regarding the seemingly mundane as ‘non-analytic’ or defensive in these circumstances.
* Pressure of speech on the part of the parent/s can make it difficult to connect with the baby in the session. We need to hold in mind how the baby may be experiencing the parent’s anxieties and burdens and ease thinking about their baby into the parent’s preoccupation.
* Digital working also complicates our ability to really include the baby in the moment through interactions and play. When the family and screen are on the floor the baby and therapist can see each other. Babies respond in various ways to a screen, but often seem to register our physical non-presence in an anxious way. Tracking the baby as much as possible will enable you to pick up expressions of interest in the baby. When the family is not on the floor the baby may be physically absent from your screen and may have to rely on mentalizing him/her with the parent.
* Within the session we need to think with the parents not only their upsets and fears but also how they rally themselves. This, in Anna Freudian terms, would be working with ego strengths – their coping abilities. For example, a parent describes being driven mad by a situation. It is not sufficient to explore how/why they got into that state – i.e. the triggers to the stress response, but also how they got out of that state of mind – i.e. more resilient aspects of their functioning.
* We suggest refraining from therapeutic interventions that arouse anxiety and challenge our patient’s coping mechanisms. It is important to remember that you are operating with reduced information about your patients’ responses to your interventions. You are limited to the frame of the screen and miss many of the nonverbal cues that normally inform us about ‘how’ our intervention has been experienced by the other. Therapeutic focus is therefore recommended to be on self-regulation, overcoming distress or exploration of opportunities for building healthy parts and pursuing autonomy, exploration and expanding the healthy self.

*Video-feedback work** One of the most straightforward ways to do video-feedback remotely involves live recording video sessions, and then showing this back to parents via sharing your screen with them – so you will need a platform that has these functionalities.
* To initiate video-feedback work with a family, it will be helpful to understand whether the family have a device (which could be a phone or tablet) that they could record themselves on interacting with their baby, in addition to any device they are using to complete the video session with you. They may also wish to identify some key toys to use as part of play activities you may wish to record.
* Once this is in place, ask them to position the laptop/phone/device somewhere where you will be able to see what they are doing and can get as clear a view as possible, of both their face and their baby/ toddler’s face – this may be a low table/a chair or on the floor
* When they are ready, verbally give the instructions of the play task, asking them to use their own resources/toys to do so, and then record the video session while they are doing the task.
* To feed back on the recorded clip, share your screen with the parent so they can see the videos playing. They should still be able to see your face on the screen at the same time, so you can make eye contact with each other and they can see your facial expressions and vice versa. This will help you to pick up on any cues as to how engaged the parent is, what parts they are enjoying, which parts are they struggling to watch, how they are reacting to specific types of message and the feedback generally.

*Group work** A first response to working remotely may be to cancel all group work – but the majority of group may still be possible over a video platform. Continuing with a parent only group will be the most-straight forward option.
* An alternative could be to have parents and babies/toddlers join meeting on video platform and for the clinician to set an activity (example playing with child in a particular way as discussed during the group session) and ask parents to do it with their children in real-time. Once each parent-child has carried out their play activity they could return to the therapist in on the video call and report back to everyone in the group on how it went and discuss/reflect together.
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| 1. **Reviewing with the family how things are going**

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| * + Start all sessions by checking in with parents/carers about any changes in the child or family situation. If there are new issues, then these may need to be the focus of the video session in order to create safety and containment. This should be done at the start of every session due to the fast-changing nature of the current situation.
* Like in all therapeutic work, check in with the family around how they are experiencing the video-therapy, whether they feel they are able to engage with it in a meaningful way, and whether they feel safe and contained when working in this way.
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