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Division of
Clinical Psychology
Faculty of Perinatal Psychology

BEST PRACTICE GUIDANCE

Working therapeutically with parents and their infants during pregnancy and postpartum using remote delivery platforms

INTRODUCTION AND PURPOSE

The use of telehealth interventions, such as telephone and online audio-visual platforms, has increased across the health and social care system in recent years. There is a substantial evidence base demonstrating that remote and blended forms of delivering psychological interventions are as safe, effective, and acceptable as face-to-face treatment for a number of presenting problems, including depression, post-traumatic stress disorder (PTSD), social phobia and panic (Karyotaki et al. 2018a; Karyotaki et al. 2018b; Kuester et al. 2016; Lewis et al., 2018; Spek et al. 2007), across a range of treatment modalities, such as Cognitive Behavioural Therapy (Carlbring et al. 2018), Interpersonal Therapy (Donker et al. 2013), Acceptance and Commitment Therapy (Lappalainen et al. 2014), Psychodynamic Therapy (Johansson et al. 2017), Self-Compassion Focussed approaches (Kelman et al., 2018; Krieger et al. 2019); and parenting interventions (Sanders et al. 2012). Recently, clinical trials of transdiagnostic treatments and treatments for personality disorder delivered via the internet are also underway (Weisel et al. 2018; Zanarini et al. 2018). Studies of remote delivery of both adult mental health and parent-infant dyadic treatments with perinatal populations have similarly found it is an effective and acceptable delivery format (Danaher et al. 2013; Forsell et al. 2017; Kelman et al. 2018; Kersting et al. 2013; Milgrom et al. 2016; O'Mahen et al. 2014). Critically, there is evidence that remote delivery is as effective as face-to-face delivery formats (Carlbring et al. 2018) and that the working alliance between clients and psychologists is strong in both remote and face-to-face delivery formats (Preschl et al. 2011).

The Covid-19 pandemic has sharply accelerated the need to deliver psychological services remotely. This guidance addresses the practical and clinical challenges of working remotely with parents during pregnancy and the first two years post-birth. We have written this guidance to be inclusive of mothers, fathers, co-parents and other primary care-givers of infants/toddlers. We hope that this guidance supports clinicians to embrace and develop skills in delivering technologically-mediated psychological interventions. This guidance has been written for applied psychologists, and it is intended to be useful to other psychological practitioners and psychotherapists working in perinatal and parent-infant mental health services. Our aim is to help applied psychologists consider some of the unique issues of working with pregnant women and the primary care-givers of 0–2 year olds and it should complement local policies. Whilst there is a current focus on using online video platforms,

we have written this guidance to include other forms of remote working (e.g. telephone, text, email) that may supplement or be used instead of online video platforms.

Remote working can enhance access, but may not do so equally for all individuals. Many mothers, fathers and infants that use our services may not have affordable access to the internet and/ or a device to enable the use of online video platforms. They may not have data for their phone. Psychological interventions will need to be tailored to the unique context of each individual/family and the resources that they have access too. Where relevant, normalise these circumstances, but also do not assume that this will necessarily be the case for all clients with low incomes or complex social/living situations. Engagement with treatment can improve with remote delivery, but it is still the case that individuals with complex life situations may often require active outreach from the clinician in order to maintain adherence to the treatment. It may be useful to know that studies of low-income women have found that, on average, 5–20 calls (or texts) were needed between sessions to keep women engaged with treatment (Miranda et al. 2003; O'Mahen et al. 2013). Women experienced this outreach as helpful and a sign that the therapist cared about them. Therefore, this guidance will need to be adapted to the specific needs, capacity and circumstances of each individual parent/family.

This guidance discusses specific considerations for working with pregnant women and primary care-givers of 0–2 year olds. It covers the breadth of direct interventions that perinatal and parent-infant psychologists are trained to deliver, including individual, couple, group, and dyadic (parent-infant) interventions. It will complement therapy specific guidance (e.g. Cognitive Behaviour Therapy CBT, Video Interaction Guidance VIG, Circle of Security CoS, Eye Movement Desensitisation Reprocessing EMDR), helping to provide an additional 'perinatal lens'. The BPS Resource Paper '[Effective therapy via video: top tips](#)' should be used in conjunction with this guidance.

PSYCHOLOGICAL ASSESSMENT ACROSS THERAPEUTIC MODALITIES AND MODE OF DELIVERY

- Assess the suitability of a telehealth intervention for the individual or family before completing the psychological assessment. It is important to consider the individual/family preference of mode of intervention delivery (e.g. telephone, online audio-visual platforms, email, online chat forums), as well as their access to technology (e.g. devices, internet access, data allowance) and their skills in using the different technologies.
- Familiarise yourself with the telehealth platform you will use prior to engaging in the appointment with your client. In the case of online video delivery, do you know what to do if the connection becomes poor? If you or the client cannot be heard? If you are conducting a family or group session, do you know how to manage multiple participants across the platform? Test the system before the session. Allow extra time at the beginning of a session to set up the technology appropriately and agree with the client how you will proceed if you get cut off or can no longer see or hear one another properly.
- Before conducting a psychological assessment take account of the waiting time to intervention and the depth of information asked of the individual/family. Covid-19 related threat and instability may mean that for some parents, it may not be appropriate to complete an in-depth assessment of their trauma history and experiences of being parented without timely access to support and intervention. If it is likely that the parent/family will have to wait some time for psychological treatment to commence, conduct a briefer assessment focusing on current difficulties/symptoms and agree to revisit the more emotive topics when therapeutic containment can be provided. When working in a multidisciplinary team, psychological assessment could inform containment/

stabilisation sessions offered by other staff, including the impact of Covid-19 and the client's response to this impact. Consider conducting a 'getting to know you' pre-assessment session where you can practice using the technology together and the different settings/functions (e.g. if using an online audio-visual platform consider with the family/individual if they prefer to view their own as well your face). This session should include discussing a clear plan for what will happen if the technology stops working (e.g. how/when contact will be re-established, if necessary, what safeguarding procedures will be followed if the presenting concerns include risk).

- Have a pre-prepared written therapy contract that can be adapted to the specific needs of the parent/family that includes both the usual contracting details discussed during an initial assessment and technology-related clinical and information governance issues. Provide a written copy of this contract as soon as possible following the first initial meeting. This could be emailed, texted via secure links, or where possible, sent via letter. It may also be provided via online links.
- Agree clear expectations for who will be in the room during the session and discuss why this is important.
- Discuss with the parent/family if it is helpful have a code word that could be used if someone else in the household enters the room and the session needs to be terminated for confidentiality or safety reasons. Agree in the contract with the individual the processes that will be followed if the code word is used to ensure safety and help manage risk.
- Consider with the parent/family when the timing of sessions best suits the infant's routines, particularly where the infant will be present and/or part of the session. Consider when it would and wouldn't be helpful to terminate sessions and reschedule, for example if the infant or older children have needs that cannot be met by another care-giver. Convey to the parent the normalcy of sessions getting interrupted.
- Where the parent has other small children, if feasible support them to think about how to ask for parental or other carer support in looking after other children (e.g. if possible, have the child in a separate room or location).
 - If the child/infant must be nearby, consider how signals of infant distress will be managed during the session (when to pause and intervene or not). Think through how to manage the parent's feelings and responses should these situations arise.
 - If there is no one available to care for the infant/children during session, think through with the parent about other children's needs and how these might be managed (e.g. for small children, plan to have a few activities and some small snacks available). Some children will need supervision during the call and/or may find parental absence from the room they are in a signal that they should search for and stay with the parent. Consider how this might be managed. If the parent needs to stay in the same room as the children, plan for where the parent can be, and if they can arrange technology to allow for some privacy (e.g. headphones, parent sits in back of room whilst children watch a television program).
- Explore the impact of the COVID-19 pandemic on the parent's/infant's daily life, family routines and psychological functioning. Ask questions about parent's and infant's responses and coping mechanisms to COVID-19 and their specific context (e.g. home confinement, key worker status, social distancing, caring responsibilities, financial and employment changes, illness of significant others etc.).
- Allow time and space to empathise with, validate, and normalise the parent's/family's experiences of loss, grief, or trauma reactions to being pregnant, giving birth, and raising a young infant during the Covid-19 pandemic. Changes to antenatal appointments and birth

plans, being unable to access usual sources of support, and being unable to introduce the new baby to family members and friends during Covid-19 is very challenging and distressing. For some parents, psychological interventions will need to be adapted to allow for space to consider the impact of Covid-19.

- Explore with the parent/family their social and professional support network during Covid-19. Early on in the intervention, make a self-care and support plan that the parent/family can access if needed following sessions.
- Ensure systems for the collection of routine psychometric questionnaire assessments comply with local information governance guidance during Covid-19.
- Delivering tele-health interventions can be tiring for individuals and therapists alike. Consider an extended assessment period that includes shorter sessions. This could help build the therapeutic alliance and ensure that the necessary information is acquired whilst giving the individual/family space to ask questions and build trust in you and in this new way of working.
- Consider the potential impact of stress responses (e.g. anger, anxiety, fear, guilt, etc.) on existing mental health problems and how these may also impact on the parent-infant relationship (e.g. may become overwhelmed more easily because of lowered threshold to stress). Work with the parent to make a plan that recognises what their individual responses to stress are and identify ways to help limit distress and address any possible safeguarding concerns.

INDIVIDUAL PSYCHOLOGICAL THERAPY DURING THE PERINATAL PERIOD

- Where possible, core skills and competencies should remain similar during telehealth delivered psychological interventions as those for face-to-face sessions. There is an extensive research base on remote delivery of interventions, indicating the full range of interventions is effective and acceptable.
- Across therapeutic modalities, sessions should have a clear structure, with an agreed upon agenda for the session with good time keeping.
- If the infant or older children cannot be cared for by another adult during the session, explore with the parent their views, anxieties and fears about engaging in sessions with children present. As is the case with face-to-face interventions, it may not be appropriate to work on past traumas and/or to discuss certain topics with the infant/children in the room.
- Consider how you will manage situations where a parent may feel unsafe in their own home (e.g. domestic abuse).
- Consider how you will help the parent manage times when they become distressed during sessions. Extending the early phase of the psychological intervention to include the teaching and practice of emotion regulation/stabilisation skills could be helpful at these times.
- To help build and nurture the therapeutic relationship consider using texts/emails between sessions offering words of encouragement and letting the parent/family know that you are thinking of them. This can be helpful in reducing DNAs that are attributed to parents losing track of what day it is during lockdown.
- Take advantage of the ability to share your screen with clients if your mode of delivery allows. For example, you can work jointly on a formulation with a client in session and email it to them afterwards. You may also be able to share videos or images to support your clinical intervention.

- At each session, check who is in the house and their location. Adjust your session to ensure safety and confidentiality.
- Remote working can present benefits. For example, it may be more straightforward for partners or family members to join a session to support the clinical work, where this may have otherwise not been feasible.
- Clients may ask to record a session for their own purposes. Consider what you or your trust's policy is about this and under what conditions this might be permitted.
 - Consider where recording sessions may at times be therapeutic. For example, you may help a client to record parts of the session (e.g. an imagery exercise, or a loop tape exercise with OCD).
 - Consider practising online recording prior to the actual recording portion of treatment.
- If working with pregnant women, work collaboratively with maternity and mental health services to ensure that the woman's psychological needs are considered in the birth plan. This is especially important during the Covid-19 pandemic when the presence of birthing partners and father's/family members on the postnatal wards is restricted.
- Similar to all therapeutic work, explore how families are experiencing remote therapy. Consider checking with them about both the benefits and barriers they may experience with remote treatment, including whether they can meaningfully engage with it, find it easier or less intrusive, and their levels of perceived safety and containment with this type of work.

WORKING REMOTELY WITH TRAUMA DURING THE PERINATAL PERIOD

It is possible to work with PTSD via remote delivery platforms. A recent meta-analysis of I-CBT interventions indicated that there is preliminary evidence that this is effective (Kuester et al. 2016; Lewis et al., 2018). Many studies conducted to date appear to rely on adaptations to guided self-help rather than a more direct transfer of formulation-driven trauma focused treatment to remote delivery (e.g. trauma focused CBT or EMDR). There are no studies available which examine remote therapy for PTSD in the perinatal period. Of note, a recent systematic review of treatment for PTSD in pregnancy (Baas et al., 2020) found 13 reports across different types of trauma-focused intervention. Most of the studies were case series, the authors noted poor methodological quality, but no adverse events. They conclude that intervention for PTSD in pregnancy is important due to the potential impact of PTSD on the baby. All interventions in this review appear to have been delivered face to face, so adaptation to remote delivery format will be needed.

Additional care needs to be taken when working with PTSD in this period due to initial exacerbation of symptoms and potential exacerbation of risks in some cases. In particular, it is important to take into account how these relate to the baby as well as the mother and the time scales of pregnancy and the postnatal period. During this time there can be a significant lack of sleep and this may have a detrimental impact on emotional regulation and ability to process the trauma. During the peak of the Covid-19 pandemic, high levels of uncertainty and perceived threat may have made it difficult to create the psychological safety necessary for PTSD treatment. With the peak over, whilst ongoing concerns and safety measures in relation to Covid-19 continue, it is likely that for many, sufficient sense of psychological safety can be created and it will be important to provide a trauma-focused intervention. Individual decisions will need to be made about the relative costs and benefits of providing this remotely or face to face, taking into account the likely risks of coronavirus transmission and the steps that can be taken to mitigate this (e.g.

social distancing, PPE), the feasibility of safely and effectively adapting the intervention to online delivery and personal preferences of the client. In relation to complex PTSD in particular, some authors (e.g. Cloitre et al., 2012) promote the use of an initial phase of stabilisation in therapy: this is likely to be particularly relevant if therapy commences close to the estimated date of delivery or if there is a high level of perceived threat due to Covid-19. If it is not considered appropriate to undertake trauma focused work, then use stabilisation strategies, with a view to progressing to trauma focused work as soon as it is feasible.

Treatment decisions should always be personalised and weigh up the advantage and disadvantages of undertaking treatment at that given moment for the parent and their baby. In both trauma-focused CBT (TF-CBT) and EMDR, imaginal reliving components typically begin early in treatment and are powerful parts of the treatment associated with improvement from post-traumatic stress disorder (PTSD). These can often be conducted remotely. Before undertaking reliving components, however, assess the woman's preferences and readiness for treatment. Clinicians should aim to treat clients with a history of trauma exposure within a 'window of tolerance' (Ogden et al., 2006)

- Consider using the NESSI-R¹ acronym to help determine the woman's readiness for trauma focussed re-living.
 - **N**umber of previous traumas (single versus multiple)
 - **E**motional Dysregulation
 - **S**ocial Support (consider in reverse)
 - **S**tability of living situation (consider in reverse)
 - **I**nvolvement with Social Services
 - **R**isk to self or others, risk of dissociation

Women with more significant complications (i.e. from NESSI-R acronym) may require a phase of stabilisation and will require more time and support to complete reliving components in PTSD treatments during the perinatal period.

When conducting treatments remotely, consider raising the threshold for engaging in reliving treatment components (i.e. based on the NESSI-R profile factors).

- Consider the stage of pregnancy/postnatal the woman is in. If you are planning to undertake imaginal reliving components, it is generally advisable to do so if you can complete the reliving *prior to delivery*. This approach will help to ensure that the process of engaging in reliving is not interrupted by the birth of the baby. This is especially important when the woman has significant factors as identified using the NESSI-R acronym.
- Be alert to new triggers of trauma memories and its correlates that may emerge in the postnatal period (e.g. the gender of the child or the experience of childbirth or breast feeding for women with a history of childhood physical and sexual abuse; particular aspects of the childbirth experience that trigger feelings of being powerless and out of control both physically and psychologically; the impact of sleep deprivation and social isolation on emotion regulation and usual coping mechanisms and social support).

¹ NESSI-R is an acronym derived in the context of this guidance, which was considered to provide a useful shorthand: it has not been tested or validated.

- Consider how remote delivery may affect responses to dissociation, should this occur. Be sure to:
 - Allow extra time to assess for the possibility of dissociation
 - Spend time developing grounding strategies with all clients prior to engaging in reliving strategies, especially if there is a history of dissociation or significant complicating factors use the NESSI-R acronym.
 - Think through where the client would like to conduct reliving sessions. Some individuals may not want to do these sessions in their home, or may want to think about the space in their home where they do them. Consider other alternatives (e.g. out in the garden, in their parked car, etc).
 - If the client is not comfortable with conducting the sessions in the house, give them the ability to discontinue reliving portions of the treatment.
 - If the client is comfortable, ask whether it would be possible to involve another person in the house, in case of dissociation during a reliving session (i.e. alert other person when session is taking place. With permission, ask to have the other person's mobile number so you can call/text that individual to come and assist should dissociation occur. Review steps to take in case of dissociation with both the client and supporting other, prior to sessions taking place.
- Consider spending extra time on stabilisation strategies for women nearing the end of pregnancy, and/or with significant complicating factors using the NESSI-R acronym.
- The Oxford Centre for Anxiety Disorders and Trauma (OxCADAT) recommend narrative approaches for TF-CBT when conducting the reliving portions of treatment where dissociation is an issue. Also consider narrative approaches where the parent has significant complication factors in line with the NESSI-R acronym and/or there are multiple distractors in the home environment (e.g. baby, other children, cramped living quarters).
 - You may request that the narrative is completed outside of treatment and then brought back at a subsequent session to share and reflect upon.
 - When using narrative approaches, it can be helpful to use the 'share screen' function and ask the client to read it aloud.
- Try to conduct sessions where the client will have an opportunity afterwards to do something calming and/or soothing (with or without the baby/other children present)

WORKING WITH COUPLES AND FAMILIES DURING THE PERINATAL PERIOD

- Try and obtain both parents' email addresses to send out the links to join the session to ensure that they both feel equally considered in therapy. Ideally all communication about the therapy would be sent to both members of the couple.
- When you first start working with a couple/family, it will be useful to have a discussion about where in their house they will do the sessions and what device they are going to use to connect.
- Consider childcare and who will be looking after the infant during the session. It may be worth thinking about scheduling a session for naptimes or whether as a service you can offer evening appointments.

- If the baby is likely to need attending to during the session agree about how you are going to manage this. Make it clear that you will wait for both parents to be present before continuing with the session.
- Agree how situations will be managed if one member of the couple becomes distressed and wishes to end the session.
- It is helpful if they can connect from a laptop/computer/tablet to ensure that they are both in screen. If couples or the family cannot meet together from the same physical location, it can also be useful to have different members join via phones/computers from separate locations. This can enhance adherence to treatment.
- Lighting can also be an issue, you may need to ask parents to move so that you can clearly see everyone's faces. If one of the couple has moved off screen let them know.
- You may need to be more directive than you would in face-to-face sessions about where the couple sit so it can be useful to get permission for this at the outset. This may also involve the couple/family having to sit very closely together during the session which can be challenging to maintain if there is discord. If there is too much discord it can be useful to have both individuals call on their devices and link them in a 3-way call.
- You may need to be more directive in questioning than you would in face-to-face sessions as subtle cues around who you are directing a question to (e.g. by looking at them) are likely to be missed online. Therefore, you may need to be more clear about who you are directing a question or reflection to. You may also need to suggest they talk to each other where appropriate as the default may be to turn to you on their screen.
- Think together about how you are going to manage taking turns speaking, perhaps getting permission to interrupt the session if people are speaking over each other.
- Leave sufficient time at the end of the session to manage discord or distress. Hold in mind that you are leaving them in their home environment so modelling how to repair discord in session can be very powerful. You may also need to think with them about what they are going to do directly after a session (e.g. if it has been a particularly emotive session does one of them need some space on their own).

PARENT-INFANT INTERVENTIONS

- At the start of a new dyadic intervention, core skills and competencies should remain similar to those for face-to-face interventions; these include a clear introduction, establishment of relevant expertise, clear information sharing and confidentiality policy, a positive and non-judgemental attitude and contract of treatment to establish both the client's and therapist's expectations of the process. Consider setting a clear agenda, which can potentially be shared with the parent prior to the session. See the [Anna Freud Centre guide](#) for more detailed guidance.
- Overall, it is helpful to start the remote intervention thinking where the parent is at in their daily life and ask them what feels safest and most helpful for them to bring into the remote session. It can be very helpful to ask a parent to describe the daily routine of their baby (ideally through their baby's eyes) before and after the pandemic, to understand the degree of change. Particular emphasis could be placed on people, places and activities.
- 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 baby is present. It may be useful to consider having a mix of parent only and parent child sessions to manage this. It may be that COVID-19

itself, the environmental changes or the emotions associated with them are triggering challenging feelings such as of vulnerability, being trapped or controlled. Video therapy is an opportunity to offer that parent compassion but also to support them in modelling compassionate responses to the difficult feelings that their baby may be communicating to them.

- Video therapy will not be possible for all families for the aforementioned privacy and accessibility reasons. When video therapy is not possible, it may be inevitable, at least in part, that the therapeutic sessions are converted into something that is more focused on family support and advice-giving. Consider acknowledging and discussing any modifications to the therapeutic process with the parent, following a collaborative approach.
- In the therapeutic work, support parents to step into the world of their baby, and consider how they might be experiencing (as thoughts, feelings, wishes, desires) any changes to their environment or in their parent's stress levels or availability – and how they might be communicating any needs for comfort or reassurance to them.
- To directly include babies in parent-infant work when working remotely, video therapy is the main option available.
- Setting up and supporting parent-infant intervention via video can be challenging, but it is possible. When choosing the space in your home to conduct video therapy, try to replicate where possible the environment you would typically use for therapy in a face to face setting. When working with babies under 12 months, this is typically done sitting on the floor surrounded by some toys. So ideally you would want to have some familiar toys, but also some eye catching and novel toys to help focus the attention of baby on the screen set. Try to think about how you would position your computer so this might be possible.
- Consider how you will work creatively when you cannot interact with the child through play such as through singing songs or playing games.
- If it is not possible to facilitate play in the video session, it may be helpful to set up play interactions 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.

In summary, some of the adaptations you may consider for parent-child dyadic therapy, include:

- Agree on goals for therapy: think with the parent if you can focus on the same therapeutic goals you had previously agreed or whether you need to adapt them.
- Ensure a sense of safety is established, by facilitating grounding and self-regulation. Consider when it may be helpful to have a parent-infant session and when it may be helpful to see the parent alone.
- Identify vulnerabilities: think of any immediate and anticipated vulnerabilities and risks for both the parent and the child and monitor them regularly.
- Psychoeducation: use accurate information to inform the parents how the current situation affects them and their children. Consider reviewing the coping strategies that parents had previously found helpful for coping with the mental, emotional, physical and social aspects of a crisis.
- Encourage mentalisation: support the parent to step into the world of their baby, and consider how they might be experiencing (as thoughts, feelings, wishes, desires) any changes to their environment or in their parent's stress levels.
- Play work: try and replicate any play work you would do in a face to face setting by sitting on the floor surrounded by some toys.

- Sustainability: support the parent with identifying short-term strategies and skills (such as through play) to sustain emotionally both themselves and their relationship with their baby.

GROUP-DELIVERED INTERVENTIONS DURING THE PERINATAL PERIOD

- Have at least two facilitators when delivering online groups. Having two facilitators will help share the increased cognitive load of delivering online interventions and provide a safety net should the internet connection for one of the facilitators stop working.
- Prior to conducting the first group, ensure that you and your co-facilitator are familiar with the technology you will be employing, especially how to manage multiple group participants entering and exiting the session throughout the session (e.g. because of technical problems).
- Particular consideration needs to be given to online safety. Use the functions of the platform that you are using e.g. password protected meetings, meeting room/waiting room function, some platforms give the option to lock the meeting once everyone has joined.
- Agree with your cofacilitator and group members the process in case there is a problem, e.g. if someone from outside the group joins the session.
- Ensure both facilitators have administration rights on the online platform and ensure that the meeting is locked and online safety procedures have been followed.
- Agree the contract for the group delivered intervention before starting session 1 and ensure that all group members have agreed and signed up to the contract. Provide a written copy of the contract ahead of session 1. The contract should include confidentiality (e.g. no recording of sessions, disclosing other parent's names/personal details), creating a safe and comfortable meeting space (information governance related etc), boundaries, attendance and punctuality, processes for managing distress and risk, expectations for attendance and engagement in out of session practice. A reminder of the ground rules can be posted on the Chat as a reminder at the beginning of each session.
- Online groups may become more challenging as infants become mobile but parent-infant interventions could still be possible. Consider having reduced attendee numbers if delivering group-delivered dyadic interventions with mobile infants/toddlers.
- Reduce the duration of each session and correspondingly reduce the content. Providing psychological therapy via online audio-visual platforms and the telephone can be very tiring for parents and facilitators – 90 minute sessions may be a helpful maximum length. It is important to consider the impact of pregnancy and infant routines too.
- Invite a smaller number of participants to the group delivered intervention. It is important for all attendees to feel heard and to have a space to contribute and for reflection. A maximum of eight attendees may be a useful guide.
- Consider using pre-recorded segments of the intervention where you lead through a given exercise (e.g. a mindfulness script or relaxation exercise) and then facilitate live reflection following the viewing of the recording. This can help reduce the cognitive load on the facilitator(s) and enable facilitators to observe parents' engagement in and responses to the exercise.
- When running groups with parent-infant dyads, consider setting up play interactions between sessions that are discussed with the parents at your next group session.

- Some online platforms have break-out rooms. Familiarise yourself with the different functions of the online platform that you are using and consider using breakout rooms where smaller groups of participants can complete a given exercise or practise a particular technique together. Once finished, parents and children can return to the ‘main’ room with the therapist and discuss/reflect with the group on how it went.
- If delivering an on-line group-delivered dyadic intervention, consider recreating the therapeutic space that mirrors the environment that you would be working in if the intervention was delivered face-to-face (e.g. sat on the floor on floor mats, similar objects and lighting etc).
- Consider setting up a video call with parents and their babies and plan an activity they can do (in a ‘break out’ room); for example, they may play with the child in a particular way as previously discussed in the group session. When the activity ends, parents and babies may return to the ‘main’ room with the therapist and provide some feedback and reflections to the group on how it went.
- Consider what psychological input or support will follow the intervention. When attending group delivered interventions face to face, it is common for attendees to make friends and to be a source of support for each other following the group. Consider facilitating online peer-led support groups following the psychological intervention to enable parents to connect with others in similar situations. This may mitigate any perception of lost opportunities associated with giving birth and raising young children during COVID-19 (e.g. social isolation, family/friends not being able to meet the new baby, being unable to attend baby groups and meet other mothers).

THERAPIST SELF-CARE AND STAFF SUPPORT

- Delivering interventions remotely places different demands on therapists compared to working face to face. For many, this is a new way of working, but it is rapidly becoming more familiar.
- The transitional moments of coming in to and leaving the therapy room, which are often used as a less formal way to begin and end the connection with a client, are missing. Processing is focused on audio and visual information without the ‘felt sense’ of being in a room with someone – and often with their baby. This requires intense concentration and can be experienced as physically and psychologically tiring. It can be more difficult to pick up non-verbal cues, which may impact on the therapist’s ability to respond sensitively and pace the discussion. In particular, it may be harder to connect emotionally with a client in order to find the psychological space that will facilitate change for them. Psychological therapists may find that they have to work hard to keep clients engaged and focused and will be repeatedly adapting their approach to the remote delivery format.
- At the same time, there are also benefits of telehealth interventions. These may include improved engagement and attendance, as there is no need to travel and also takes overall less time out of an individual’s day to attend. Some clients find telehealth approaches less stigmatising and/or easier to keep private (when this is something they value). Some clients can find it easier to disclose distressing or shameful information in this format.

The following suggestions may help to adapt and moderate the impact of transitioning to remote delivery of therapies

- During the initial months of delivering telehealth interventions consider increasing the frequency of supervision to support reflection and learning.
- Consider developing peer support networks to support reflection and learning.

- Ensure that there is clear policy and guidance that includes remote delivery and also supports decision-making about when and how to work remotely and when to see face to face.
- Observe your limits and boundaries. Because delivering interventions remotely can be psychologically and physically taxing, consider a reduced caseload and reduced number of sessions per day.
- Pay particular attention to your own self-care strategies. Taking regular breaks (e.g. every hour) and planning gaps in between sessions can be helpful. Ensuring enough rest and sleep continue to be very important.
- Each clinician will have different contexts that will affect how and whether they are able to implement remote delivery approaches (e.g. home situation, availability of a quiet room, having own children at home, likelihood of interruptions).
- Take account of your own personal responses to telehealth approaches. This may include personal preferences for how and where you conduct interventions, and familiarity/liking of technology. For those conducting telehealth approaches in their own homes, it can be important with some clinical presentations to attempt to create separation between your clinical work and your home/living space. Some clinicians, for example, have found it useful to conduct difficult or challenging work outside their home (e.g. in their garden shed, their car, etc). Some therapists may consider that delivering psychological interventions from home is not appropriate given their circumstances.

In summary, remote delivery of psychological assessment and therapy has become a necessary reality in the context of the Covid-19 pandemic. The guidance given in this document will support this being done in a safe and effective way. When used thoughtfully, there can be benefits to using technology to support the flexible delivery of interventions. Having the capacity for remote delivery of therapies adds to the different options available and will help to ensure ongoing access to psychological input for women and their families in the perinatal period at a time when it is particularly needed.

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