Children's Health Care

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/hchc20

Understanding the benefits of child-parent psychotherapy delivered via telehealth during the COVID-19 pandemic

Nailah Gallego Clemmons, Erica Coates & Alison McLeod

To cite this article: Nailah Gallego Clemmons, Erica Coates & Alison McLeod (2024) Understanding the benefits of child-parent psychotherapy delivered via telehealth during the COVID-19 pandemic, Children's Health Care, 53:1, 41-59, DOI: 10.1080/02739615.2023.2179489

To link to this article: https://doi.org/10.1080/02739615.2023.2179489

CHILDREN'S HEALTH CARE
2024, VOL. 53, NO. 1, 41–59
https://doi.org/10.1080/02739615.2023.2179489

Taylor & Francis
Taylor & Francis Group

Understanding the benefits of child-parent psychotherapy delivered via telehealth during the COVID-19 pandemic

Nailah Gallego Clemmons[a], Erica Coates[b], and Alison McLeod[c]

[a]Department of Pediatrics, Children's National Hospital, Washington, DC, USA; [b]Department of Psychiatry, Georgetown University Medical Center, Washington, DC, USA; [c]Department of Psychology, Georgetown University, Washington, DC, USA

ABSTRACT

African American families have been disproportionately affected by the pandemic. Child-parent psychotherapy (CPP) was developed as a dyadic, attachment-based, in-person intervention for parents with young children who have experienced trauma that promotes secure attachment between the parent and child. This case series study evaluates the acceptability of telehealth delivery of CPP by four providers to five African American parent-child dyads during the COVID-19 pandemic. Findings revealed that both parents and providers were overall satisfied with the use of telehealth for CPP delivery during the pandemic. The virtual delivery of CPP led to perceived beneficial outcomes for families who experienced trauma and additional stressors during the pandemic. Although the virtual delivery of CPP had its drawbacks, it decreased accessibility barriers such as time and distance. This finding lends support to the acceptability of telehealth delivery of CPP for under-resourced African American families and their providers as well as offers recommendations for improving the virtual delivery of CPP.

Introduction

The COVID-19 pandemic led to a sudden change in children's environments, making them highly vulnerable to mental health problems. Pandemic-related school closures left 1.5 billion children out of school in 2020 (Karboul, 2020). School closures can be especially harmful for children with preexisting mental health issues as they disrupt established routines and can impact a child's access to mental health resources (Lee, 2020). The life-altering changes brought on by the pandemic threatened the well-being of children, and studies have shown that children who have experienced a pandemic are at risk for developing depression and anxiety (Imran, Zeshan, & Pervaiz, 2020; Loades et al., 2020). This can be due to increased feelings of helplessness and isolation, disruption in routine, and heightened child and parent stress levels (Meherali et al., 2021). Their lack of fully understanding the pandemic and the burden of

CONTACT Erica Coates Erica.Coates@georgetown.edu Georgetown University Medical Center, 2115 Wisconsin Ave NW, Washington, DC 20007

dealing with the stress or sickness of family members also makes children especially vulnerable to psychological distress (Fegert, Vitiello, Plener, & Clemens, 2020; Imran, Zeshan, & Pervaiz, 2020).

The measures taken for disease containment such as stay at home orders disrupted family and community networks by limiting access to basic services usually provided through the community and placing restrictions on extended family's ability to help with the care of children (CDC, 2020; Meherali et al., 2021). The fluctuating economy and concerning unemployment rates put even more stress on families, especially pre-pandemic low-income families (On Budget & Priorities, 2022; Rodrigues, Silva, & Franco, 2021). With economic hardships and social isolation comes increased risk for domestic violence and violence against children (Imran, Zeshan, & Pervaiz, 2020; Peterman et al., 2020; Usher, Bhullar, Durkin, Gyamfi, & Jackson, 2020). This heightens the risk of the COVID-19 pandemic being a traumatic experience for children, posing mental health risks particularly for those from under-resourced families and those with preexisting mental health issues (Fegert, Vitiello, Plener, & Clemens, 2020; Lee, 2020).

Child-parent psychotherapy (CPP) is a dyadic attachment-based intervention developed for families with young children who have experienced trauma that promotes secure attachment relationships between the parent and child (Guild, Toth, Handley, Rogosch, & Cicchetti, 2017). CPP is an effective therapy to improve the psychological well-being of children who have experienced traumatic and stressful events (Ghosh, Harris, Van Horn, & Lieberman, 2011). After a comprehensive assessment with the parent individually and together with the child in which the history of trauma, child's development, and child behaviors are assessed, the therapist facilitates and interprets play behaviors between the parent and child in the following sessions while working to understand and modify problem behaviors and engaging the parent and child in developing a cohesive joint narrative surrounding the trauma (Lieberman, Van Horn, & Ippen, 2005). CPP has been used with families with young children who have experienced trauma related to violence, death, abuse, neglect, parent separation, or parent substance abuse (Willheim, 2013). The objectives of CPP include encouraging normal child development, strengthening parent-child relationships, helping resolve trauma-related symptoms of the child, and increasing the child's capacity to respond to threats (Willheim, 2013). While the intended goal is to reduce the number of post-traumatic stress disorder symptoms, depressive symptoms, and behavioral problems in children, CPP has also been shown to improve parent's psychological functioning (Ghosh, Harris, Van Horn, & Lieberman, 2011; Hagan et al., 2017; Lieberman, Van Horn, & Ippen, 2005). CPP was developed for in-person delivery (Lindsay et al., 2015), and to our knowledge, no formal guidance on the virtual delivery of CPP exists. However, growing research indicates that mental health interventions delivered via telehealth are effective

and associated with more participation in sessions, improved psychological health, and higher satisfaction with treatment (Barnett et al., 2021; Chi & Demiris, 2015; Fogarty et al., 2022; Lindsay et al., 2015; McLean et al., 2021).

There is limited research on CPP use with African American families (Weiner, Schneider, & Lyons, 2009). Existing studies that discuss working with diverse populations advocate for the providers to have cultural competence when treating patients but there are no studies that include assessments of the acceptability of CPP for specific populations or the development of culturally sensitive adaptations to CPP (Weiner, Schneider, & Lyons, 2009). More broadly, studies have found that African American families are more likely than Caucasian families to drop out of trauma-focused therapy (Fraynt et al., 2014; Sprang et al., 2013). Another study revealed that early termination of outpatient child therapy was more likely to occur in those of lower socioeconomic status and from minoritized families and single parent families (Kazdin, Holland, & Crowley, 1997). parents' barriers to completing child therapy include obstacles with transportation, perceptions of therapy being irrelevant, and poor relationships with therapists (Kazdin, Holland, & Crowley, 1997). When families remain in treatment, specifically in underserved communities, child-parent based therapies have been proved to be successful (Lyon & Budd, 2010).

Virtual delivery of CPP may be beneficial in treating under-resourced African American families who have been traumatized by the pandemic and systemic racism. Utilizing telehealth decreases costs, expands availability of services, and relieves barriers of time and distance to reach underserved populations (Burke et al., 2015). While there is no formal documentation of how CPP treatment should be translated to virtual delivery, existing guidance recommends incorporating potential traumas and stressors associated with the COVID-19 pandemic into the CPP virtual treatment (Osofsky, Keyes, Trigg, Dickson, & Mamon, 2020). Further recommendations included explicit opportunities to take breaks during emotionally intense moments, using digital media for narrative construction, and providers' synchronous play with the child to form connections (Davis et al., 2021). One study on virtual CPP during the pandemic showed that increased accessibility and creativity led participants to derive the expected benefits, but issues with safety and confidentiality were found as well as conflicts with working from home and connectivity issues (Fogarty et al., 2022). Other findings show that clinicians' flexibility and adaptability is imperative to contend with the complexities and distractions of virtual CPP sessions and that clinicians who were able to build a trusting therapeutic atmosphere and participate in responsive interactions found success in virtual delivery of CPP; the challenges of virtual delivery of CPP included therapeutic relationship formation, distraction of parent and child, and issues with finding safe spaces to discuss traumatic events (Davis et al., 2021). However, these studies did not specifically explore the experiences

of under-resourced African American families participating in virtual CPP, and it is important to assess the effectiveness of virtual CPP with African American families given the disproportionate negative impact of the pandemic on African American families and historically higher rates of attrition in parent-child therapy.

Current study

It is critical to understand how CPP was utilized during the pandemic via telehealth for treatment of under-resourced African American families, which is lacking in the literature, in order to improve mental well-being for young children and their parents. The current study will contribute to the virtual CPP literature by obtaining reflections from African American participants, as well as the treatment providers, regarding their experiences. The purpose of this phenomenological case series study is to assess the acceptability of telehealth delivery of CPP with African American families of low-socioeconomic status who have experienced trauma and received treatment during the COVID-19 pandemic.

Methods

Participants

Five African American female parents (aged 35–51; $M = 42$, SD = 7.04) with preschool aged children ($M = 5.2$, SD = 1.10) exposed to trauma (domestic violence, neglect, parental substance use, community violence, attachment issues, and parent separation) who received virtual CPP from 2020–2021 participated in semi-structured interviews, See Table 1. Their four CPP providers (psychiatrist, mental health counselor, and clinical psychologists) participated in the semi-structured interviews, 50% of the providers were African American and 50% were Caucasian. One provider served as a therapist for two families, leading to a discrepancy in the number of providers (4) to parents (5).

Procedure and measures

The case series study obtained full IRB approval. Families and providers who engaged in CPP during the COVID-19 pandemic were recruited from organizations which serve predominantly African American families of low socioeconomic status in Washington, DC to provide support to children who are at risk for developing mental health concerns. Flyers were provided to parents to gauge their interest in participating in the research, and their contact information was provided to the study team. The study was then further explained to the parent over the telephone, and electronic consent was obtained through

Table 1. Sample characteristics.

	Sample	
Baseline Characteristics	n	%
Parent		
Race/Ethnicity		
African American	4	80%
African American/Hispanic	1	20%
Age ($M = 42$, SD = 7.04)		
35–49	4	80%
50+	1	20%
Gender		
Female	5	100%
Child		
Age ($M = 5.2$, SD = 1.10)		
4–6	5	100%
Provider		
Race/Ethnicity		
African American	2	50%
Caucasian	2	50%
Age		
25–34	2	50%
35–49	2	50%
Gender		
Female	4	100%
Type of Provider		
Psychiatrist	1	25%
Clinical Psychologist	2	50%
Mental Health Counselor	1	25%

DocuSign. Parents received $50 compensation for participating in the study. Semi-structured interviews were conducted separately with each parent and their CPP providers via a recorded Zoom video call lasting approximately 30–60 minutes. CPP providers were interviewed twice if they provided therapy to multiple families participating in the study. Parents and providers were asked questions about their experiences during the COVID-19 pandemic, telehealth therapy sessions, and the strengths, weaknesses, and acceptability of using a virtual platform. See Table 2 for the primary interview questions relevant to the current study.

Data analysis

The data from the transcripts were analyzed using a thematic analysis framework outlined by Braun and Clarke (2006). Thematic analysis allows themes and sub-themes to be assessed from qualitative data through coding. The recorded interviews were transcribed and manually coded using the interview questions. The first author reviewed transcripts to familiarize herself with the data and then generated codes from reflective notes on participants' experiences. The first author worked in close consultation with the second author regarding the themes and subthemes generated. Parents' and providers' perceptions of telehealth delivery of CPP during the COVID-19 pandemic were assessed, including satisfaction level, advantages and disadvantages of this

Table 2. Interview questions for parents and providers.

Parents	Providers
How were you supported by your CPP provider?	Tell me about the family you worked with including demographics such as age and gender of parent(s) and child, parent's occupation, and family status. Does the parent have any mental or physical health issues?
When was CPP started and when did the therapy end?	When was the CPP started and when did the therapy end?
How did the COVID-19 pandemic impact your therapy sessions?	What was the family's trauma exposure that required CPP?
Tell me about the virtual delivery of CPP. What device did you use? What application was used for virtual delivery?	Tell me about the virtual delivery of CPP. What device did the parent use? What application was used for virtual delivery?
Were there any difficulties with internet access or connection?	Were there any difficulties with internet access or connection?
What worked well? What did not work well? Is there anything you would have changed?	How did the COVID-19 pandemic impact CPP? Were modifications made to CPP in response to the COVID-19 pandemic? How did you support the family during this time?
When the therapy sessions became virtual, do you feel like you were still able to identify and connect with your therapist?	How has the family progressed through each stage of CPP?
Do you believe the virtual sessions still positively impacted you and your child's relationship?	Have you seen an increase in compliance with the use of tele-therapy?
Were you satisfied with tele-therapy? Why or why not?	Was the family satisfied with tele-therapy? Why or why not? Were you satisfied with tele-therapy? Why or why not?
Would you recommend the virtual therapy sessions to other parents?	What worked well? What did not work well? What lessons did you learn? What changes will you incorporate during your next session?

delivery method, and recommendations for future practice. Subthemes were then identified based on parents' and providers' perceptions and reflections of virtual CPP; excerpts were then highlighted to support each subtheme.

Results

After reviewing parent and provider data using thematic analysis, subthemes were identified for the following themes: advantages of virtual CPP, challenges of virtual CPP, positive impacts of therapy, recommendations for future virtual therapy (see Table 3 for a summary of themes). Overall, all five parents stated that they would recommend virtual CPP to other parents, and all four CPP providers believed there were benefits to virtual therapy. Sample quotes are provided for contextual support of common findings.

Advantages of virtual CPP

Flexibility

Parents and providers both highlighted how virtual CPP, compared to in-person CPP, provided more flexibility. With the COVID-19 pandemic resulting in remote learning for students throughout the study period, parents and providers juggled working from home and caring for their children during the

Table 3. Parent and provider reflections of virtual CPP during the pandemic.

Themes	Subthemes	Supporting Quotes
Advantages of virtual CPP	Flexibility	*Parents*: "What worked well was the flexibility and scheduling and being able to have sessions during the day, which tended to work better" "It was easy to coordinate my schedule to work around it" "If something came up and we needed to switch around the meeting time, it was just a lot easier to do that"
		Providers: "More flexibility to accommodate her schedule around the pandemic and all that entailed with supporting her son, with her work"
	Accessibility	*Parents*: "The virtual allows you to commit and be there, no matter what phone, tablet, wherever" "It was more easier for me to commit to" "…Because of the transportation, because of the time, and because I still have other children"
		Providers: "Even though there were different challenges, with it being virtual I think access kind of trumps all like getting the family in the room, is the most important piece after that then we can actually do the work." "…And with this mom, I don't know if I ever would have gotten her in the office" "You know, I think it should always have a place in our system because it really provides access to people that would not access our services"
	Video conferencing	*Parents*: "I felt a connection, just as strong as if I would have met them in person" "I was still able to see her, so I felt her presence" "It still gave that personalization to it because with the face to face" "It was better than a phone call"
		Providers: n/a
Challenges of virtual CPP	Technology issues	*Parents*: "There was times where I would have a signal that wasn't so great and would need to switch from one to the other" "I did experience a lot of internet issues in the beginning, but now I'm pretty much fine with my internet" "Sometimes my connection would be a little wonky" "When I got the tablet, I had to figure out how to download the app"
		Providers: "I would have a signal that wasn't so great" "We would have connectivity issues or the call may drop" "I wasn't able to see her on the tablet"
	Limited child engagement	*Parents*: n/a
		Providers: "Having a child in or out of screen vs if it was CPP in the office, the child, most likely would be there, most of the time" "It seemed even harder to interact with the child" "The child would be like playing with the friend somewhere else" "I would see just snippets of her son for a lot of our sessions" "I never felt like I got to know him well"
	Material availability	*Parents*: n/a
		Providers: "It was a little bit of a struggle with having the right toys and things like that, because I was relying on the family to have their own toys" "The times where [the child] joined our sessions, it's a lot harder to do some of the dramatic play that would be a part of CPP"
	Prolonged therapy	*Parents*: n/a
		Providers: "I think you have to spend a little bit more time building a rapport and building that relationship virtually" "I didn't want to dive too deeply into things with the son in earshot"
	Limited view/space	*Parents*: n/a
		Providers: "Being able to get a full picture of the affective response and being able to really see a full picture of the child-parent interaction" "So much of it is dyadic and kids move a lot. it's hard to capture that all on the screen"

(*Continued*)

Table 3. (Continued).

Themes	Subthemes	Supporting Quotes
Positive impacts of therapy	Improvement in parent-child relationships	*Parents*: "I think a certain level of talking with my therapist, of her helping me understand . . . (my son) to kind of help him make sense of the world." "One thing I've learned . . . you got to be understanding to that need of how to reach them (children) as well." *Providers*: "She's definitely more confident in her parenting skills, she feels more competent and more able to regulate herself to then help... her son regulate because he was dealing with a lot... big emotions" "Both of them really felt like they improved a lot throughout therapy. And then, it was a really big benefit for the family."
	Support during time of isolation	*Parents*: "Because I don't get to talk to my friends, talking to my provider was really like someone who I can like trust with everything, she made me feel comfortable and safe" "It just kind of gave me a venue, in a time of being isolated, to virtually talk about what was going on in the world." "It was probably a lifeline for a lot of people" *Providers*: "I think, providing validation, providing empathy, really working on honing that empowerment piece was probably the way in which I supported her"
	Coping during the pandemic	*Parents*: "They've been here just to help support me and help me think things through" "Helped me navigate to know I'm doing my best" "Helped me center myself, calm my thoughts, think rationally, and just work through my feelings" "Us both being in the pandemic, that was another level of something that we shared and she could relate to a few stressors" *Providers*: "Talking about the impacts of the pandemic were central... how to work around some of the obstacles like what does virtual schooling look like... how to balance mom's role now as an educator essentially and as a parent" "Working on more recently how with things opening... how do we get out into public and have socialization in a way that feels comfortable for her"
Recommendations for virtual CPP	Increasing child engagement and view	*Parents*: n/a *Providers*: "Having an intentional way to bring the child in helped keep it CPP focused" "Setting standards from the beginning, if it's going to be the parent and child in each session" "The expectation of how important it is to see both of them and their interactions" "Setting the expectation about the child's involvement and when sessions are more appropriate for just the parent" "Prepping of the space"
	Material availability	*Parents*: n/a *Providers*: "I'll try to find a way to like send certain materials to families" "I mailed them some toys through Amazon"
	Technological support	*Parents*: n/a *Providers*: "A better go to person where if you had to troubleshoot some of those things that arose" "It's good to have a plan B, that you can either talk by phone or you can text to try and troubleshoot"

school day. Parents made the following illustrative comments in support of this theme: "What worked well was the flexibility and scheduling and being able to have sessions during the day, which tended to work better," and "if something came up and we needed to switch around the meeting time, it was just a lot easier to do that." Providers shared similar sentiments regarding increased flexibility. For example, a provider shared that virtual therapy

allowed "more flexibility to accommodate [her patient's] schedule around the pandemic and all that it entailed with supporting her son, with her work."

Accessibility

Both parents and providers commented that virtual therapy allowed for easier access to services. A parent shared how the virtual sessions increased her attendance in therapy: "The virtual [therapy] allows you to commit and be there, no matter what – phone, tablet, wherever." Another parent shared how virtual sessions allowed for easier access to appointments, ". . .because of the transportation, because of the time, and because I still have other children." In addition, a provider shared her uncertainty of a parent attending therapy if sessions were in-person ". . .and with this mom, I don't know if I ever would have gotten her in the office." Another provider spoke highly about the increase in access stating that "even though there were different challenges with it being virtual, I think access kind of trumps all like getting the family in the room is the most important piece; after that, then we can actually do the work."

Video conferencing

Many parents were satisfied with being able to connect with their providers through video conferencing. One parent shared, "I was still able to see her, so I felt her presence." Another mother said "I felt a connection, just as strong as if I would have met them [the provider] in person." Other parents highlighted that "it still gave that personalization to it because of the face to face" and that "it was better than a phone call."

Challenges of virtual CPP

Technology issues

Parents and providers used the following applications to conduct therapy sessions: Zoom, Google Meets, and Microsoft Teams. Both parents and providers expressed concerns with technological issues with either the application, connectivity, or issues with the devices used (phone, tablet, or computer). Parents primarily had difficulty with the internet or connectivity stating "I would have a signal that wasn't so great" and "I did experience a lot of internet issues in the beginning." Providers expressed challenges with "connectivity issues or the call may drop" and being unable "to see her on the tablet."

Limited child engagement

While the virtual platform allowed for easier accessibility, it led to a decrease in child involvement. This challenge was particularly expressed by providers when it was time to transition to a different stage of CPP that required the presence of both the parent and child. Providers shared the following concerns

in regard to child availability: "Having a child in or out of screen versus if it was CPP in the office, the child, most likely would be there, most of the time," "it seemed even harder to interact with the child," "the child would be like playing with the friend somewhere else," "I would see just snippets of her son for a lot of our sessions," and "I never felt like I got to know him [the child] well." These challenges were encountered when children were visiting family members, when the therapy sessions took place at the parent's workplace, or when children were in a different room in the home.

Material availability

In preparation for the sessions with the child, providers use toys to help children show how they think and feel through play. Because of the virtual sessions, one provider felt "it was a little bit of a struggle with having the right toys and things like that, because I was relying on the family to have their own toys." Another provider shared "the times where [the child] joined our sessions, it's a lot harder to do some of the dramatic play that would be a part of CPP."

Prolonged therapy

The overall duration of the therapy was prolonged because of the transition to virtual therapy. While the length of in-person CPP varies, typically averaging 1 year in duration, most parents in this study were in therapy for at least 1.5 years. One provider stated "I think you have to spend a little bit more time building a rapport and building that relationship virtually." Another provider expressed difficulty in discussing the family's history, experiences, needs, and challenges with virtual CPP, saying "I didn't want to dive too deeply into things with the son in earshot."

Limited view

While the virtual therapy allowed for the provider to view parent-child interactions in their homes, parents ultimately had control of the camera limiting what the provider could view on the screen. One provider expressed difficulty with "being able to get a full picture of the affective response and being able to really see a full picture of the child-parent interaction." While another provider shared that "so much of it is dyadic and kids move a lot... it's hard to capture that all on the screen."

Positive impacts of virtual CPP

Improvement in parent-child relationships

While there were challenges that arose, parents and providers believed there were positive impacts of virtual therapy when it came to strengthening the parent-child relationship. One mother highlighted the positive impact saying, "I think a certain

level of talking with my therapist, of her helping me understand . . . [my son] to kind of help him make sense of the world." Another parent shared what she learned from therapy: "You got to be understanding to that need of how to reach them [children] as well." One provider believed the mother she worked with was "definitely more confident in her parenting skills, she feels more competent and more able to regulate herself to then help her son regulate, because he was dealing with a lot of big emotions." Another provider witnessed how the therapy helped the parent and child commenting, "both of them really felt like they improved a lot throughout therapy. And then, it was a really big benefit for the family."

Support during time of isolation

Parents felt very supported by their providers during times of isolation during the COVID-19 pandemic. One parent shared: "Because I don't get to talk to my friends, talking to my provider was really like someone who I can trust with everything, she made me feel comfortable and safe." Another parent said, "it just kind of gave me a venue, in a time of being isolated, to virtually talk about what was going on in the world" and that "[virtual therapy] was probably a lifeline for a lot of people." Providers equally felt like they were playing a supportive role in families' lives, stating "I think, providing validation, providing empathy, really working on honing that empowerment piece was probably the way in which I supported her."

Coping during the pandemic

Families also believed they were able to cope well during the pandemic with the help of their provider. One parent who dealt with a close loved one becoming seriously ill due to COVID-19 shared the following: "They've been here just to help support me and help me think things through" and "helped me center myself, calm my thoughts, think rationally, and just work through my feelings." That same parent felt like "us both being in the pandemic, that was another level of something that we shared, and she could relate to a few stressors." One provider believed "talking about the impacts of the pandemic were central... how to work around some of the obstacles like what does virtual schooling look like... how to balance mom's role now as an educator essentially and as a parent." Another provider who worked with a parent with PTSD discussed their recent focus in therapy: "[We're] working on more recently, how with things opening... how do we get out into the public and have socialization in a way that feels comfortable for her."

Recommendations for future virtual CPP

Increasing child engagement and view

Providers identified ways to improve future virtual CPP sessions. One recommendation that was consistent across providers was creating expectations for

parents. When it came to child engagement, providers said what worked was "having an intentional way to bring the child in helped keep it CPP focused" and "setting standards from the beginning that it's going to be the parent and child in each session." Given that the parent controls the camera, discussing "how important it is to see both of them [parent and child] and their interactions." Lastly, "setting the expectation about the child's involvement and when sessions are more appropriate for just the parent" and "prepping of the space and kind of parameters to make sure that it would work."

Material availability

Another suggestion was to have materials readily available for families at the start of the virtual CPP for the dyadic play sessions. Next time, one provider said they would "try to find a way to send certain materials to families." Another provider proposed "mailing them some toys through Amazon."

Technological support

Lastly, providers shared the need for better technological support when utilizing virtual therapy. Providers were able to overcome some obstacles they faced with technological issues such as using different platforms to video conference. A recommendation was to have "a better go-to person where if you had to troubleshoot some of those things that arose," for instance an IT specialist to easily contact to help resolve technological issues. Another suggestion was "to have a plan B, that you can either talk by phone or you can text [the parent] to try and troubleshoot."

Discussion

In this case series study, we evaluated the acceptability of the telehealth delivery of CPP with African American families of low-socioeconomic status who have experienced trauma and received treatment during the COVID-19 pandemic. We found that both parents and providers were overall satisfied with the use of telehealth for CPP delivery. Both parents and providers were in support of the use of virtual therapy because it provided more flexibility with scheduling, easy accessibility to therapy, and the ability to have face to face contact virtually. The results of this study support previous findings of telemedicine overcoming barriers of distance and time to reach underserved populations (Burke et al., 2015). These findings are in alignment with the prior literature in which telemedicine continued to provide good quality care, while also resulting in beneficial outcomes such as increased participation and improved quality of life (Burgoyne & Cohn, 2020; Demiris, Oliver, Wittenberg-Lyles, & Washington, 2011; Lindsay et al., 2015). In alignment with the objectives of CPP (Willheim, 2013), parents reported strengthening

their relationships with their children and receiving help to cope with the isolation and added stressors that presented during the COVID-19 pandemic.

Despite the overall positive outcomes, the virtual platform did have its drawbacks, particularly from the providers' perspectives, including technological issues, child and material availability, prolonged therapy, and limited field of view. These challenges are consistent with difficulties psychologists have identified when treating patients remotely during the pandemic (American Psychological Association, 2020), as well as therapists who treat children and families virtually (Burgoyne & Cohn, 2020; Davis et al., 2021; Fogarty et al., 2022). During CPP treatment, the provider must attend closely to the parent and child's interactions and emotional responses during each session. The dyadic play sessions, which require the presence of the child and appropriate toys, allows for the parent and child to engage in enjoyable interactions while also allowing the child to communicate their feelings, beliefs, and worries (Willheim, 2013). With this in mind, it makes sense that the providers' perceived disadvantages of virtual CPP were obstacles in providing the most effective treatment and caused an extension of the typical duration for treatment. Notably, parents did not mention any specific challenges of virtual CPP.

Although providers experienced some challenges with facilitating virtual CPP, their recommendations to set expectations, send relevant toys to families, and have technological support available would improve virtual administration of CPP in the future. These suggestions are in alignment with a recent study in which family therapists recommended establishing expectations, positioning the camera so the whole room is seen to allow the child to move freely, and ensuring both the child and therapist had toys to facilitate parallel play (Burgoyne & Cohn, 2020; Davis et al., 2021; Fogarty et al., 2022).

Given that study findings mirror previous research on virtual CPP, it provides support for limited racial differences in CPP treatment (Weiner, Schneider, & Lyons, 2009). However, study findings highlighted the importance of accessibility and receipt of toys for the successful delivery of virtual CPP, particularly for under-resourced families. The disproportionate mental health effects of the pandemic on African American mothers specifically underlines the relevance of the findings of this study, such as the ability of virtual CPP to remain a source of support for African American parents as they navigate higher levels of stress, psychological distress, and trauma (Snowden & Snowden, 2021). Additionally, our finding that virtual delivery of CPP was associated with prolonged treatment was a unique finding in the literature on virtual CPP. This could be a result of the racial composition of our sample as institutional racism has led to greater instances of trauma and race-related stress such as the disproportionate negative effects of the pandemic on African Americans; therefore, providers that followed existing guidance to incorporate trauma associated with the COVID-19 pandemic into treatment may have needed more time to treat African American

families as there are heightened levels of distress for this population and a need for an incredibly a trusting connection to discuss race-related stressors.

Recommendations for virtual delivery of CPP

As providers outlined in their responses, parents' and providers' recommendations for delivering CPP in a virtual format directly address the issues they experienced throughout the course of their treatment. The strengths discussed by parents and providers of virtual CPP emphasized its flexibility during the pandemic, stressing the importance of adapting to changes in scheduling and the need for parents to support children and work from home. It is also especially important for providers to have their video conferencing on and to encourage families to do the same whenever possible, as it was reported to contribute to forming a connection with the provider. This can be challenging as internet connectivity issues can arise, but providers and families can adapt by exploring the use of different virtual platforms, finding alternative times or methods of conducting the session (phone, text) when issues occur. Providers also discussed the need for improved technological support and suggested having someone to contact such as an IT specialist; providers may also find it helpful to learn from other providers who are experienced with solving common telehealth technology issues.

Keeping the child engaged during a session was also a challenge, and providers recommended early collaboration and communication with the parent about the expectations of therapy, such as the importance of the child's involvement in sessions and the visibility of the parent and child, their interactions, and their dyadic play. Providers should also discuss strategies to avoid distraction during the session with the parent, such as removing nonessential toys and being in a comfortable but controlled environment. Providers also suggested having materials for the child's play sessions available for families at the beginning of virtual CPP. Families may require a longer duration of treatment of virtual CPP than they would in-person due to challenges in building a virtual relationship with the provider, so it is recommended that providers adjust treatment to accommodate each family's needs. Additionally, providers are able to utilize the virtual format to observe natural child behaviors and the parent-child relationship in their home environment, allowing them to work with parents to address problem behaviors occurring at home. Providers should also be prepared for the need for a longer duration of treatment as the virtual platform may slow initial connection with the patient.

Limitations

Although the present study had multiple strengths, there are also notable limitations including homogeneity of the sample, sample size, and

retrospective reports. First, the study population was homogenous, our intended population was African American families of low socioeconomic status who participated in CPP. We sought to gain perspectives from this population given that historically and presently, barriers have prevented African Americans from completing mental health treatment. Second, due to the need for a corresponding pair of patients and providers,' and the desire to provide quality results that are useful in assessing the acceptability of CPP for African American families during the pandemic, the sample size for our case series study was small for providers ($N = 4$) and parents ($N = 5$). While this is a small sample, it allowed extensive reflection, analysis, and attention to each transcript which led to high quality data derived from interviews. Many researchers suggest sample sizes ranging from 5 to 50 (Dworkin, 2012), and for phenomenological studies such as this one, the recommendation of 5–25 is sufficient for quality data collection (Creswell, 1998). Despite the small sample size, a major strength of the study is that it included perspectives from both parents and providers regarding the acceptability of virtual CPP.

Third, clinical measures were unavailable to determine the effectiveness of telehealth delivery on reducing parents' and children's mental health symptoms and strengthening parent-child relationship quality. Given the retrospective design of the study, there was no standardization or requirement of measures for the therapist to use during the course of treatment for the research team to analyze. Fourth, social desirability bias may have affected the results of the study as parents did not provide any specific examples of challenges to virtual CPP or suggested recommendations for improvement; however, providers did share their reflections in those areas. Fifth, specific questions assessing cultural considerations in the virtual delivery of CPP were not included in the interview, this would have provided valuable insight as our intended population was African American families. Future research should include a larger sample size and obtain quantitative data with the use of clinical measures, as well as data on the cultural acceptability of virtual delivery with African American families.

Implications for practice

This study provides preliminary support that CPP delivered via telehealth would be beneficial to treat African American families in the future, as both parents and providers were overall satisfied by this method in the current study. In regards to implications for practice, we recommend continuing to offer the option of virtual CPP delivery as this mitigates barriers of time and distance for under-resourced African American families. This delivery was proven to be helpful during the COVID-19 pandemic, and should continue to be an option for families to expand accessibility and availability of mental health treatment. With the use of telehealth, the parent is in a unique position

to help create a space that would be optimal to provide CPP, and it is the provider's role to give appropriate instructions, set expectations, and potentially provide materials, particularly for under-resourced families, to aid in facilitating a successful therapy experience. Lastly, it is important to implement a continuous feedback model to help optimize virtual CPP provided to families.

Conclusion

African Americans have been disproportionately affected by pandemic-related stressors including job loss, deaths, and COVID-19 infections. Additionally, family dynamics during the COVID-19 pandemic were altered by stay at home orders and increased isolation for parents and children. The pandemic was a critical time to utilize CPP via telehealth for mental health treatment of African American families in order to strengthen the parent-child relationship and improve mental well-being in parents and their young children. In this study, we assessed various perspectives of parents and providers involved in virtual CPP during the COVID-19 pandemic. Using a phenomenological approach, parents' and providers' perceptions of telehealth delivery of CPP during the COVID-19 pandemic were assessed, including satisfaction level, advantages, and disadvantages of this delivery method. The virtual delivery of CPP led to perceived beneficial outcomes for African American families who previously experienced trauma and additional stressors during the pandemic. Although the virtual delivery of CPP had its drawbacks (e.g., connectivity issues and limited child engagement), it decreased barriers such as time and distance, making therapy more accessible to African American families. Providers also recommended strategies to improve the virtual delivery of CPP with under-resourced African American families in the future which included establishing expectations early on, sending materials to families for play sessions, and having technological support readily available. Overall, these findings provide preliminary evidence for the acceptability of telehealth delivery of CPP by under-resourced African American families to reduce barriers to receiving mental health treatment.

Acknowledgments

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under award UA6MC32492, the Life Course Intervention Research Network. The information, content and/or conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Disclosure statement

This study was approved by Georgetown University's Institutional Review Board under protocol number GU-HRP-503. Informed consent was given by all individual participants included in the study. All procedures performed in this study were in accordance with the ethical standards of APA ethical standards, Georgetown University Institutional Review Board ethical standards, and with the 1964 Helsinki declaration and its later amendments. We have no known conflicts of relationships or interests to disclose. The datasets generated and/or analyzed during the current study are not publicly available but are available from the corresponding author upon reasonable request.

Funding

The work was supported by the Health Resources and Services Administration [UA6MC32492].

References

American Psychological Association. (2020, June 5). *Psychologists embrace telehealth to prevent the spread of COVID-19*. APA Services. https://www.apaservices.org/practice/legal/technology/psychologists-embrace-telehealth

Barnett, M. L., Sigal, M., Rosas, Y. G., Corcoran, F., Rastogi, M., & Jent, J. F. (2021). Therapist experiences and attitudes about implementing internet-delivered parent-child interaction therapy during COVID-19. *Cognitive and Behavioral Practice*, *28*(4), 630–641. doi:10.1016/j.cbpra.2021.03.005

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. doi:10.1191/1478088706qp063oa

Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process*, *59*(3), 974–988. doi:10.1111/famp.12589

Burke, B. L., Hall, R. W., the SECTION ON TELEHEALTH CARE, Dehnel, P. J., Alexander, J. J., Bell, D. M. … the SECTION ON TELEHEALTH CARE. (2015). Telemedicine: Pediatric applications. *Pediatrics*, *136*(1), e293–308. doi:10.1542/peds.2015-1517

CDC. (2020, March 30). *Stay Home DC | coronavirus*. Coronavirus DC. https://coronavirus.dc.gov/stayhome

Chi, N. -C., & Demiris, G. (2015). A systematic review of telehealth tools and interventions to support family caregivers. *Journal of Telemedicine and Telecare*, *21*(1), 37–44. doi:10.1177/1357633X14562734

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, Calif: Sage Publications.

Davis, A. E., Saad, G., Williams, D., Wortham, W., Perry, D., Aron, E. … Biel, M. G. (2021). Clinician perspectives on adapting evidence-based mental health treatment for infants and toddlers during COVID-19. *Perspectives in Infant Mental Health*. https://perspectives.waimh.org/2021/05/14/clinician-perspectives-on-adapting-evidence-based-mental-health-treatment-for-infants-and-toddlers-during-covid-19/

Demiris, G., Oliver, D. P., Wittenberg-Lyles, E., & Washington, K. (2011). Use of videophones to deliver a cognitive-behavioural therapy to hospice caregivers. *Journal of Telemedicine and Telecare*, *17*(3), 142–145. doi:10.1258/jtt.2010.100503

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of Sexual Behavior*, *41*(6), 1319–1320. doi:10.1007/s10508-012-0016-6

Fegert, J. M., Vitiello, B., Plener, P. L., & Clemens, V. (2020). Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: A narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child and Adolescent Psychiatry and Mental Health*, *14*(1), 20. doi:10.1186/s13034-020-00329-3

Fogarty, A., Savopoulos, P., Seymour, M., Cox, A., Williams, K., Petrie, S. . . . Giallo, R. (2022). Providing therapeutic services to women and children who have experienced intimate partner violence during the COVID-19 pandemic: Challenges and learnings. *Child Abuse & Neglect*, *130*, 105365. doi:10.1016/j.chiabu.2021.105365

Fraynt, R., Ross, L., Baker, B. L., Rystad, I., Lee, J., & Briggs, E. C. (2014). Predictors of treatment engagement in ethnically diverse, urban children receiving treatment for trauma exposure: predictors of treatment engagement. *Journal of Traumatic Stress*, *27*(1), 66–73. doi:10.1002/jts.21889

Ghosh, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse & Neglect*, *35*(7), 504–513. doi:10.1016/j.chiabu.2011.03.009

Guild, D. J., Toth, S. L., Handley, E. D., Rogosch, F. A., & Cicchetti, D. (2017). Attachment security mediates the longitudinal association between child–parent psychotherapy and peer relations for toddlers of depressed mothers. *Development and Psychopathology*, *29*(2), 587–600. doi:10.1017/S0954579417000207

Hagan, M. J., Browne, D. T., Sulik, M., Ippen, C. G., Bush, N., & Lieberman, A. F. (2017). Parent and child trauma symptoms during child-parent psychotherapy: A prospective cohort study of dyadic change: Treatment-related dyadic change in posttraumatic stress symptoms. *Journal of Traumatic Stress*, *30*(6), 690–697. doi:10.1002/jts.22240

Imran, N., Zeshan, M., & Pervaiz, Z. (2020). Mental health considerations for children & adolescents in COVID-19 Pandemic. *Pakistan Journal of Medical Sciences*, *36*(COVID19–S4), 36(COVID19–S4. doi:10.12669/pjms.36.COVID19-S4.2759

Karboul, A. (2020, December 4). *COVID-19 put 1.6 billion children out of school. Here's how to upgrade education post-pandemic*. World Economic Forum. https://www.weforum.org/agenda/2020/12/covid19-education-innovation-outcomes/

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, *65*(3), 453–463. doi:10.1037/0022-006X.65.3.453

Lee, J. (2020). Mental health effects of school closures during COVID-19. *The Lancet Child & Adolescent Health*, *4*(6), 421. doi:10.1016/S2352-4642(20)30109-7

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry*, *44*(12), 1241–1248. doi:10.1097/01.chi.0000181047.59702.58

Lindsay, J. A., Kauth, M. R., Hudson, S., Martin, L. A., Ramsey, D. J., Daily, L., & Rader, J. (2015). Implementation of video telehealth to improve access to evidence-based psychotherapy for posttraumatic stress disorder. *Telemedicine and E-Health*, *21*(6), 467–472. doi:10.1089/tmj.2014.0114

Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A. . . . Crawley, E. (2020). Rapid systematic review: the impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(11), 1218–1239.e3. doi:10.1016/j.jaac.2020.05.009

Lyon, A. R., & Budd, K. S. (2010). A community mental health implementation of Parent–Child Interaction Therapy (PCIT). *Journal of Child and Family Studies*, *19*(5), 654–668. doi:10.1007/s10826-010-9353-z

McLean, S. A., Booth, A. T., Schnabel, A., Wright, B. J., Painter, F. L., & McIntosh, J. E. (2021). Exploring the efficacy of telehealth for family therapy through systematic, meta-analytic, and qualitative evidence. *Clinical Child and Family Psychology Review*, *24*(2), 244–266. doi:10.1007/s10567-020-00340-2

Meherali, S., Punjani, N., Louie-Poon, S., Abdul Rahim, K., Das, J. K., Salam, R. A., & Lassi, Z. S. (2021). Mental health of children and adolescents amidst COVID-19 and past pandemics: A rapid systematic review. *International Journal of Environmental Research and Public Health*, *18*(7), Article 7. doi:10.3390/ijerph18073432.

on Budget, C., & Priorities, P. (2022, February 10). *Tracking the COVID-19 Economy's Effects on Food, Housing, and Employment Hardships*. Center on Budget and Policy Priorities. https://www.cbpp.org/research/poverty-and-inequality/tracking-the-covid-19-economys-effects-on-food-housing-and

Osofsky, J. D., Keyes, A. W., Trigg, A. B., Dickson, A. B., & Mamon, L. Y. (2020). Telehealth during COVID-19: Advantages, challenges, and barriers across zero to three programs. *Zero to Three*, *41*(2), 45–53.

Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., Oertelt-Prigione, S., & Van Gelder, N. (2020). *Pandemics and violence against women and children* (Vol. 528, pp. 1–45). Washington, DC: Center for Global Development.

Rodrigues, M., Silva, R., & Franco, M. (2021). COVID-19: Financial stress and well-being in families. *Journal of Family Issues*, 0192513X2110570. doi:10.1177/0192513X211057009

Snowden, L. R., & Snowden, J. M. (2021). Coronavirus trauma and African Americans' mental health: Seizing opportunities for transformational change. *International Journal of Environmental Research and Public Health*, *18*(7), 3568. doi:10.3390/ijerph18073568

Sprang, G., Craig, C. D., Clark, J. J., Vergon, K., Tindall, M. S., Cohen, J., & Gurwitch, R. (2013). Factors affecting the completion of trauma-focused treatments: What can make a difference? Traumatology (Tallahassee Fla), *19*(1), 28–40. doi:10.1177/1534765612445931

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N., & Jackson, D. (2020). Family violence and COVID-19: Increased vulnerability and reduced options for support. *International Journal of Mental Health Nursing*, *29*(4), 549–552. doi:10.1111/inm.12735

Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review*, *31*(11), 1199–1205. doi:10.1016/j.childyouth.2009.08.013

Willheim, E. (2013). Dyadic psychotherapy with infants and young children. *Child and Adolescent Psychiatric Clinics of North America*, *22*(2), 215–239. doi:10.1016/j.chc.2013.01.003