Telemental health for child trauma treatment during and post-COVID-19: Limitations and considerations

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ABSTRACT

The ongoing COVID-19 pandemic has led to unprecedented disruptions and stress in the lives of children and families internationally. Heightened family stress and turmoil can increase risk for, and exacerbate, child maltreatment. As a result, child maltreatment experts are concerned that there will be an influx of children requiring trauma assessment and treatment during and after COVID-19. As physical distancing measures have been implemented and will likely persist into 2021, organizations providing trauma treatment to children and their families have had to rapidly pivot to telemental health to maintain service delivery with clients. While the benefits of tele-mental health have been identified, including reduced barriers to access, increased cost effec-tiveness, and broad availability of services, there are unique limitations to its implementation within a child maltreatment population, such as challenges with attention and emotion regulation skills, difficulties identifying dissociative symptoms, and increased time with perpetrators of abuse due to shelter in place orders. These limitations are exacerbated for children and families who are most marginalized and facing the highest levels of social and economic barriers. Lack of access to reliable technology, lack of a private or confidential space for sessions, and reluctance to process trauma in the absence of a safe environment, are all barriers to conducting effective trauma treatment over telemental health. This article discusses both the benefits and barriers to telemental health in a child maltreatment population and offers considerations for child trauma service provision, program development, and policy during and post the COVID-19 pandemic.

1. Introduction

The novel coronavirus (COVID-19) has led to unprecedented disruptions in the lives of children and families. To mitigate the spread of COVID-19, public health measures such as mandatory quarantine, shelter in place orders, work from home rules, and the shutdown of services such as daycares, schools, libraries, and community centers, have been imposed. The "pandemic paradox" refers to how these public health measures, intended to keep children and families medically safe during the pandemic, put children living in families characterized by violence and maltreatment at increased risk (Bradbury-Jones & Isham, 2020). Indeed, experts hypothesize

that economic strain (e.g., job loss) and increased psychological stress in children and caregivers (Cooke, Eirich, Racine, & Madigan, 2020; Racine, Cooke et al., 2020), coupled with isolation from supports that can buffer families from COVID-19 risk, will likely lead to increased exposure to child maltreatment and domestic violence during the COVID-19 pandemic ((Humphreys, Myint, & Zeanah, 2020)Usher, Bhullar, Durkin, Gyamfi, & Jackson, 2020). Increased negative coping behaviors by parents and caregivers, such as alcohol use, also have the potential to increase exposure to family violence (Choenni, Hammink, & van de Mheen, 2017).

Although it is notoriously difficult to capture research data or evidence to substantiate increases in child maltreatment and family violence during crises, media reports have indicated that rates of women accessing domestic violence shelters during COVID-19 have increased (Taub, 2020) and calls to child distress hotlines have increased by over 60 % (Levy, 2020). Yet, preliminary research from a non-peer reviewed report in Canada demonstrated a 33 % decline in child maltreatment reports to child protective services, largely attributed to reductions in reports from school personnel who are typically a primary source of child maltreatment reports (Royer, Noel, Lafortune, & Collin-Vézina, 2020). Taken together, despite challenges in measurement and reporting, increased exposure to child maltreatment and related forms of family violence during COVID-19 are likely to occur, pointing to an increased need for trauma treatment and support for children and youth.

2. Child-trauma treatment via telemental health during COVID-19

As many as 36 % of children who are exposed to child maltreatment develop severe post-traumatic stress symptoms that may require trauma treatment (Ackerman, Newton, McPherson, Jones, & Dykman, 1998). Over the last two decades, the research evidence for the effectiveness of trauma-focused interventions for children who have been exposed to maltreatment and other related forms of family violence has increased considerably. Evidence from meta-analyses demonstrate that individual, group, and parenting-based interventions offered in-person are associated with reductions in post-traumatic stress symptoms and child behavior problems for children exposed to maltreatment (Fraser et al., 2013; Macdonald et al., 2016; Romano, Weegar, Gallitto, Zak, & Saini, 2019). Child trauma treatment is offered in children's mental health centers, hospitals, and child trauma centers around the world (Cohen, Mannarino, & Deblinger, 2012). Anecdotal evidence from services that provide child trauma treatment indicate that referrals and waitlist times have increased since the onset of COVID-19 (Jackson, 2020). Not only is there an increased need for services, but agencies have had to rapidly pivot to offering services remotely using telemental health. Telemental health refers to the use of audio and video technology to administer psychological or therapeutic interventions through a secure and encrypted internet connection (Jones et al., 2014). With the potential for physical distancing measures to persist during the course of the COVID-19 pandemic, children's mental health centers are likely to primarily offer telemental health services well into 2021.

While there is an emerging body of evidence for the effectiveness of trauma-focused treatment for children and adolescents who have been exposed to maltreatment and related forms of family violence, research on the use of these modalities via telemental health is sparse (Jones et al., 2014). For example, none of the trauma-focused interventions for maltreated children evaluated in a large review in 2013 were provided remotely via telemental health (Fraser et al., 2013) and only one study in a large-scale review was provided over a web-based platform that was accessed outside the professional setting (Macdonald et al., 2016). Together, these examples highlight a large gap in the literature when it comes to the implementation of trauma services for children via telemental health. Thus, it is important to consider the potential benefits and limitations to its implementation, which will be reviewed below. We will also offer considerations for child trauma service provision and program development both during, and post-COVID-19.

3. Benefits to child-trauma treatment via telemental health

Over the last decade, with the increased access and availability of technology around the world, an emerging body of research has evaluated the efficacy of implementing psychosocial interventions for mental illness more broadly, via telemental health. Telemental health has been shown to be as effective in treating children's general mental health difficulties when compared to in-person treatment (Gloff, LeNoue, Novins, & Myers, 2015). Indeed, evidence-based mental health interventions over the telephone have been shown to be effective for children with behavior problems and anxiety (McGrath et al., 2011). Telemental health has also been shown to reduce barriers to treatment access (e.g., transportation; Nelson, Cain, & Sharp, 2017). However, as mentioned above, research on the efficacy of trauma treatment via telemental health is in its infancy. A recent pilot study of 15 children demonstrated that Trauma-Focused Cognitive Behavior Therapy (TF-CBT), a gold standard evidence-based treatment for addressing post-traumatic stress symptoms in children and adolescents (Cohen, Mannarino, & Iyengar, 2011), offered via telemental health, was effective in reducing post-traumatic stress symptoms at rates comparable to in-person therapy (Stewart, Orengo-Aguayo, Cohen, Mannarino, & de Arellano, 2017). There is also evidence to suggest that TF-CBT treatment delivered via telemental health may reduce rates of treatment drop out (Stewart, Orengo-Aguayo, Cohen et al., 2017), which has historically been a challenge in the child trauma-treatment literature (Ormhaug & Jensen, 2018).

Another treatment modality that is used to reduce behavior problems in young children exposed to maltreatment (Timmer, Urquiza, Zebell, & McGrath, 2005) that has shown preliminary evidence to support its use via telemental health is Parent-Child Interaction Therapy (PCIT) (Comer et al., 2015). Although not specifically conducted with maltreated children, a randomized trial that compared the delivery of PCIT via the internet to delivery in the clinic for children 3–5 years of age with behavior problems showed that both treatment modalities led to reductions in child symptoms as well as high levels of positive parental engagement, treatment retention, and treatment satisfaction (Comer et al., 2017). Parents who participated in the internet-delivered PCIT program also reported less barriers to accessing treatment (Comer et al., 2017).

Additional benefits to child trauma treatment offered via telemental health include increased access to treatment for children and

families in remote communities, reduced travel costs for families (i.e., transportation, time off work), increased clinical capacity for the agency, and increased likelihood of treatment attendance (Jones et al., 2014). During COVID-19, the most significant benefit of telemental health services is the ability to provide child trauma-treatment services despite shelter-in-place orders and physical distancing requirements. Telemental health also has the potential to increase efficiencies in the delivery of child trauma treatment as there is some evidence for increased treatment attendance, which could lead to shorter treatment duration and therefore increased clinical capacity for therapists (Leigh, Cruz, & Mallios, 2009; Pignatiello et al., 2011). Taken together, emerging research suggests that providing child trauma treatment via telemental health is a viable option, that may offer benefits to the patient and therapist. However, additional research is needed to further elucidate the benefits of trauma-based telemental health and to determine when, and for whom, it is most beneficial.

4. Limitations of child-trauma treatment via telemental health

For the large part, prior to the COVID-19 pandemic, telemental health services in the field of child trauma treatment were limited. While guidelines for implementing child trauma treatment services via telemental health existed (Jones et al., 2014), very few agencies implemented trauma-based telemental health services. However, in the face of COVID-19 and physical distancing rules, many agencies were required to transition from in-person trauma-treatment to telemental health trauma-treatment. It is important to consider the limitations of telemental health that clinicians and service providers are encountering during COVID-19 in order to inform long-term service delivery and preparedness for future health crises or natural disasters. Limitations to providing child trauma treatment via telemental health during COVID-19 fall into two broad categories: physical limitations and therapeutic limitations.

Physical limitations refer to challenges in access to reliable technology and confidential space in order to adequately participate in trauma treatment. Successful telemental health services necessitate access to a reliable internet connection and a technological device with adequate audio and video capabilities. Although 82 % of households in the United States have an internet connected device in their home (Ryan & Lewis, 2017), the access and reliability of these devices, particularly in more socioeconomically disadvantaged homes, is not guaranteed. Indeed, one trial examining the effectiveness of trauma-focused CBT for children provided laptops or iPads with an internet connection to participating families who needed them (Stewart, Orengo-Aguayo, Cohen et al., 2017). Most children's mental health agencies do not have the financial resources to provide this technology, leading to access barriers for those who are socioeconomically disadvantaged.

Another physical limitation is access to a confidential and safe space in which to conduct therapy sessions. It is recommended that therapy sessions be conducted in a self-contained room with a door, that is ideally not the child's bedroom. For low income families where space is restricted, children may not have access to a private space, particularly during a pandemic when other family members are home. Thus, it is possible that client confidentiality could be compromised, and steps to mitigate this risk should be reviewed and repeatedly evaluated with the client to negate this possibility. Client confidentiality is particularly important during the pandemic as this may be one of the only opportunities for a child to disclose maltreatment, particularly in the face of reduced reporting by school personnel or other adults in the child's life (Collin-Vézina, Brend, and Beeman, 2020). Child trauma therapists would be most well-positioned for addressing these reports. Previous research using TF-CBT via telemental health has been conducted in schools, which addresses this limitation (Stewart, Orengo-Aguayo, Cohen et al., 2017; Stewart, Orengo-Aguayo, Gilmore, & de Arellano, 2017). Access to physical space for therapy sessions outside the home are more limited during health crises, especially during COVID-19 when many school districts are closed or have limited capacity for accommodating additional requests while navigating COVID-19 restrictions. Another physical limitation is that there is currently a lack of evidence on the optimal platform for delivering child trauma interventions given the variability in privacy requirements and legislation across jurisdictions. Indeed, privacy has been identified as limitation for the offering of telemental health services in children and youth (Golberstein, Wen, & Miller, 2020). Taken together, physical limitations to telemental health are exacerbated for children and families who are most marginalized and facing the highest levels of social and economic barriers (Zhai, 2020). Thus, it is critical to consider and, if possible, address these barriers in the provision of child trauma treatment.

There are also therapeutic limitations to telemental health, including challenges assessing and treating severe clinical presentations and challenges in identifying dissociative behaviors. Children and adolescents with maltreatment histories who often present with severe emotion regulation difficulties or challenges sustaining attention may particularly struggle during telemental health sessions (Comer & Myers, 2016). Previous research opted to offer in-person treatment to children who endorsed significant suicidal ideation, exhibited serious externalizing behaviors, or were under the age of 7 years, rather than telemental health services (Stewart, Orengo-Aguayo, Cohen et al., 2017). Given that 51 % of children accessing child trauma treatment demonstrate physical aggression and 34 % endorse current self-harm or suicidal thoughts (Racine, Dimitripoulos et al., 2020), the clinical presentation of some children who have been maltreated may not be conducive to telemental health services. Specifically, clinicians may struggle to engage children with more severe attentional difficulties or behavioral outbursts. As a result of social isolation and increased time with a perpetrating family member, trauma symptoms presentations may also be exacerbated during COVID-19, making therapeutic intervention more challenging.

Client safety when providing telemental health services outside of clinically supervised settings (i.e. in the client's home) is an important consideration and may also present as a limitation when offering telemental health to maltreated children and adolescents. The potential for safety concerns to arise (i.e., harm to self or an abrupt disconnection), particularly given the risk profile of maltreated children, necessitate the consideration of safety when providing these services. A systematic review of the literature on the safety of providing telemental health services outside of the clinically supervised setting has largely demonstrated that safety plans and protocols can be effectively used for telemental health services with adults (Luxton, Sirotin, & Mishkind, 2010). However, there are

limited studies comparing the safety of clinic-based treatment with telemental health outside of clinically supervised settings for children and adolescents (Kramer & Luxton, 2016). Thus, there is currently a narrow understanding of whether safety protocols can be effectively used when providing telemental health to children and adolescents in their homes. It is paramount for clinicians to be mindful of safety concerns and to have safety plans and protocols in place when providing mental health interventions to children and adolescents who have a history of maltreatment.

Another therapeutic concern is the clinical challenge of assessing patient affect, particularly dissociation, via telemental health. Dissociation typically includes separating oneself from reality and is a common symptom in children who have been maltreated (Collin-Vézina & Hebert, 2005; Macfie, Cicchetti, & Toth, 2001). Dissociation is especially likely to occur when discussing or narrating a traumatic experience, a core component of many trauma treatments. tFor example, in TF-CBT, the trauma narrative is an imaginal exposure where the child is encouraged to experience negative feelings associated with the traumatic event in the context of the support of a clinician (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). Both technological limitations (i.e., lack of dual monitors to view the narrative and the child's face) as well as increased difficulty in interpreting child affect over video make identifying and addressing dissociation particularly challenging. These therapeutic challenges, specific to the child maltreatment context, highlight the importance of considering how telemental health services may impact service access and provision to the most challenging and severe clinical cases.

5. Implications and considerations for service provision

The benefits of delivering child trauma treatment via telemental health will not be equally experienced by all children. Pilot work evaluating the effectiveness of child trauma treatment via telemental health occurred under ideal conditions– with adequate technology, private and confidential spaces, and with clients who were deemed a priori to be appropriate for telemental health services. During COVID-19, many clinicians, programs, and organizations have not transitioned to telemental health under similar conditions. Thus, it is critical for program management and administration to recognize existing barriers and, as much as possible, provide services that can address these barriers.

Not all child trauma treatment cases will be appropriate for telemental health. As outlined by Comer and Myers, the implementation of telemental health must consider "when, under what circumstance, and for whom" telemental health services are most appropriate (2016). Adequate assessment that includes questions about barriers to treatment access as well as availability and reliability of technology in the home to determine which children will benefit from and be able to engage in trauma treatment via telemental health is critical (Simms, Gibson, & O'Donnell, 2011). The risks and benefits of telemental health will need to be weighed for each client. In some cases, services may need to safely continue in a socially distanced manner and in others trauma treatment may need to transition to supportive counselling over the phone until physical and therapeutic barriers to treatment have been addressed. Methods for triaging cases and determining which children need in-person trauma treatment versus those who would likely benefit from telemental health are needed. Innovative assessment approaches that include determining appropriateness for telemental health services as well as offering different pathways of care depending on the client's presenting needs will promote equitable access to child trauma treatment.

As the evidence base for providing trauma-therapy via telehealth grows, clinicians may find it helpful to engage in communities of practice, to regularly consult with colleagues, and access resources on teletherapy provided by professional organizations, as well as preliminary non-peer reviewed reports that have been made available to guide clinical practice during the COVID-19 pandemic (Briere, Lanktree, & Escott, 2020).

Finally, given the possibility that telemental health with children and adolescents may be one of the only opportunities for a child to disclose maltreatment, trauma-informed trainings for how to handle and address these disclosures in the context of telemental health should be prioritized. Trauma informed approaches to care include a strengths-based framework that acknowledges the impact of trauma, as well as the imperative to provide services and develop policies that value six core principles: (i) Trustworthiness and transparency; (ii) Safety; (iii) Peer support; (iv) Collaboration & mutuality; (v) Empowerment and choice; and (vi) Cultural, historical and gender issues (Substance Abuse & Mental Health Services Administration, 2014). For example, a trauma-informed approach to telemental health would acknowledge and respond to children's disclosures of past and ongoing maltreatment and avoid practices that induce further harm (Sweeney & Taggart, 2018; Sweeney et al., 2019). It would also take into consideration social inequalities and poverty-related issues to improve access to telemental health services to all children in need and would consider culturally adapting treatment material and improving flexibility in service delivery (Collin-Vézina, Brend, & Beeman, 2020). Although evidence for the impact of trauma-informed care on service provision and patient outcomes remains limited, providing trauma treatment to children and adolescents that reduces the potential for re-traumatization and empowers children to engage in treatment are part of competent clinical practice is necessary (Racine, Killam, & Madigan, 2020)

6. Conclusion

Telemental health is an innovative approach to providing child trauma treatment during and after the COVID-19 pandemic. However,there are likely inequalities with regards to the children who can access these services. We argue here that there are both physical and therapeutic limitations that may impede children and adolescents from accessing or fully engaging in telemental health trauma treatment. Careful consideration must be made in identifying whether telemental health services are appropriate for a child and their family. Valid and reliable assessment tools for determining which children and adolescents are most suitable for telemental health are needed. As child trauma treatment services re-open and begin to address their long waitlist of clients, it will be important to

prioritize and triage cases that would benefit most from in-person treatment, while providing telemental health services to those who will benefit. Additional research examining the implementation of child trauma treatment using telemental health is needed to inform practice and program development going forward.

Declaration of Competing Interest

The authors report no declarations of interest.

Acknowledgements

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