Playing Away the Trauma: Telehealth Practices with Foster Parents and Young Children

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Abstract
Play is the child's primary form of engagement and communication with the external world. Through play therapy, children in foster care can explore their internal conflicts, their past traumatic experiences, and their relationships with caregivers. While telehealth has allowed for greater accessibility for services to families during the COVID-19 pandemic, telehealth has also brought significant challenges to clinicians who practice play therapy with young children in foster care. Caregivers' need for solution-focused interventions, children's limited attention to the screen, clinicians' limited availability to physically contain young children's emotional dysregulation, and clinicians' limited ability to modify the therapeutic setting have been some of the greatest challenges experienced by the authors. This article explores ways to navigate these challenges while also discussing cultural and contextual considerations during the treatment of young children through telehealth. The psychotherapeutic relationship and the space created for the child continue to be regarded as the primary vehicles to help young children explore and resolve their internal conflicts. The authors discuss two case examples referred from child welfare due to young children experiencing physical and emotional trauma. The authors utilized a trauma-informed and culturally sensitive relationship framework by incorporating the young children's respective caregivers in treatment to facilitate the children's exploration and resolution of their traumatic experiences while in foster care. By discussing play themes, symbolism, cultural factors, and the child-caregiver relationship, the authors explore treatment progress and ways to overcome challenging situations brought about by the pandemic and the children's trauma.

Keywords: Child-Parent Psychotherapy, Telehealth, Trauma, Young Children, Welfare System, Culture.

Introduction

At all stages, planning around the child will remain a central topic and we do not expect that to disappear in collaborations that last longer than two years. The presence of reflective narratives and direct relational evaluations, however, demonstrates that the relationship involves more than merely planning. Likewise, the presence of relational remarks and emojis shows that those involved feel free to express their affection.

Instant Messaging enables swift and direct conversations like in face-to-face communication but is less impersonal than most other non-face-to-face communication types. The use of emojis creates an extra meta-communicative layer in the conversations. In our data, no signs of incompatibility of language between BPs and PFPs were found, although sometimes tones of voice differ as shown in table 6. This type of interaction can easily evolve in a more conflictueus interaction, but in our data the BP of the PFP prevent the conversation from going in such direction. We do not see irrelevant and nonsensical messages in our data but did find messaging in late hours. We do not know how the professional foster parents in our study experience this and what kind of rules are set but late hour messaging may be a reason for other professional foster parents to avoid using Instant Messaging to construct relationship with biological parents.

The two cases in this study differ. In the first case, a positive relationship had already been established and there was a smooth, high frequency visiting arrangement in place. This enabled the BP to often start a conversation on Instant Messaging and to reflect on her own position. In the second case, the PFP were more directive and focused more on parental compliance than on deepening the relationship. Future study is necessary to learn more about the conversational patterns in complex child welfare interventions and to give some advice on whether Instant Messaging should or should not be used in highly conflictuous relationships

within foster care.

While Instant Messaging is not a new phenomenon, its communicative advantages have been scarcely evaluated. This study is explorative, and we only analysed two short-term cases. Future study may find out more about the reasons for PFPs to use or avoid Instant Messaging. Future research may shed light on this as well as on the use of Instant Messaging in other types of family interactions such as stepfamilies or kinship care.

Child-Parent Psychotherapy

The inclusion of trauma-informed care has been deemed necessary for the psychological treatment of all individuals (Cohen & Mannarino, 2010). Child-Parent Psychotherapy (CPP) is an evidence-based, relationship-based, trauma-informed treatment that focuses on promoting safety, trust, emotional reciprocity, and understanding between the young child and their caregiver through play interventions (Lieberman, 2004). Play has curative factors and predominates in treatment with young children who use play to learn about themselves, others, and their environment (Gil, 2016; Landreth, 2012). During psychotherapy, play allows the child to work through complex dynamics and traumatic events (Bratton et al., 2009). Through play and an attentive understanding, the clinician allows the child to explore, express, and resolve their emotional disruptions (Raskin & Rogers, 2005; Vliegen, 2009) because the child's play is understood as a reflection of their internal emotions and conflicts that need to be expressed one way or another (Bettelheim, 1987). With the right tools, a caregiver can also begin to interpret these behaviors and take on the role of assisting with emotion recognition and promoting further exploration and healthy development for the young child (Lieberman, 2004).

Following Bowlby's (1982) attachment theory and the seminal work of Selma Fraiberg with her Infant-Parent Psychotherapy (Fraiberg, 1980), CPP treatment is composed of dyadic sessions between the child and their caregiver recognizing this relationship as a vehicle for growth, self-regulation, and recovery (Lieberman et al., 2015). In CPP, the caregiver's ability and availability to interpret their child's play and emotions promote feelings of understanding and connectedness between the child and their caregiver (Ryan & Edge, 2011). As the child shares their experiences with their caregiver, the child invites them into their inner world and together they can co-create new meanings and interpretations of the world, process through unsettling or confusing occurrences in their lives, and re-establish their sense of safety with the caregiver (Diaz & Lieberman, 2010). Addressing the child's emotional needs through the relationship with their primary caregiver has been associated with long-lasting positive outcomes for both the child and the caregiver (Guild et al., 2017; Hagan et al., 2017; Lieberman et al., 2006; Reyes et al., 2017).

The trauma framework instilled in CPP provides the foundation to understand the child, the caregiver, and their relationship (Lieberman et al., 2017). Young children in foster care are rarely provided with an explanation for the reasons they have been separated from their primary attachment figures. The abrupt changes and numerous losses that occur with entry into foster care add to the child's traumatic experiences. "Speaking the unspeakable", openly exploring the child's traumatic history in a caring and understanding way, increases connection and empathy between the caregiver and the child as the child begins to understand what has happened to them (Lieberman, 1991; Lieberman et al., 2015). Through this validation and sense of safety, the caregiver-child relationship promotes healing, repair, and growth for the child (Lieberman and Pawl, 1993).

Foster Parents as Protective Figures

Young children tend to confide in those whom they trust and perceive as protective of them. For children in the foster care system, developing a trustworthy and safe attachment with their caregivers is of utmost importance given that these individuals become their primary caregivers. (Pickover & Brown, 2016). While family relatives are preferred when a child enters foster care (Van Horn et al., 2011), this is not always possible for all young children. Certified foster parents can serve as stable and safe caregivers for young children during their time in foster care (Haugaard & Hazan, 2002). While foster parents enact many of the overall roles of primary attachment figures (e.g., providing food, housing, clothes, and positive attention, etc.), they are also tasked with other roles to support the child's well-being and proper development after traumatic experiences (Farmer & Lippold, 2016). For example, some foster parents have identified their role to be key in promoting the child's sense of belonging, helping the child learn to regulate their emotions, and in advocating for the child's proper health services (Pinto & Luke, 2022).

Incorporating foster parents in the mental health treatment of young children has been shown to increase young children's sense of safety (Chinitz et al., 2017), improve biological parent-child attachments (Danner Touati et al., 2022), and decrease changes in foster care placements (Rock et al., 2015). Foster parents can facilitate growth and self-understanding in the young child by being included in treatment (Heineman, 2008), especially when they receive additional support and direction from clinicians (Hudson et al., 2017). Treatment must also cultivate foster parents' self-reflection, empathy, and self-care as they may also experience vicarious trauma while learning about the child's traumatic experiences (Pickover & Brown. 2016; Noroña and Acker,

2006). This attention to the child, the foster parent, and the relationship can take many forms when utilizing telehealth modalities in treatment.

Telehealth

The use of telehealth has become a common practice in light of the global COVID-19 pandemic since it brought the immediate need for clinicians to transition their psychological services to the virtual world (Madigan et al., 2021). While for some providers this transition was seamless, others accustomed to providing strictly in-person services found significant challenges navigating the learning curve that exists on the path to providing virtual services (Nittas & Von Wyl, 2020). Some practitioners initially experienced a purgatory-like period, anxiously waiting for stay-at-home orders to expire, with hopes of returning to in-person services promptly... only to face the need to acquire telehealth tools a few weeks later (Wosik et al., 2020).

The benefits of providing services through telehealth have been investigated for several years before the COVID-19 pandemic. A recent meta-analysis showed that telehealth with adults has been demonstrated to be beneficial for many psychological problems as compared to receiving no treatment (Bennett et al., 2020). Nelson and Patton (2016) found overall positive outcomes for medication management and brief therapy for children with ADHD using telehealth platforms. Similar positive results have been found in the use of telehealth in providing support to families (Goldstein & Glueck, 2016) and to children with medical conditions (Van Allen et al., 2011; Dimitropoulos et al., 2017). Play therapy via telehealth has also been demonstrated to be a beneficial alternative to in-person sessions (Altvater, 2021). Telehealth has provided the benefit of skipping the commute to an office and the benefit for clinicians to be “invited” to the patients’ homes, which may increase therapeutic connection (Burgoyne & Cohn, 2020). These benefits certainly make treatment more convenient for patients and increase patients’ accessibility to care as long as the family has access to dependable wifi (Connolly et al., 2020; Nelson & Patton, 2016; Dorsey & Topol, 2016).

Despite these positive effects, the sudden change in treatment provision has also brought new and different challenges for clinicians. Anecdotally, nearly every practitioner the authors are aware of faced some difficulties during this transitional time; From improving internet connections to acquiring new software to managing patients’ new anxieties, and ensuring confidentiality, many clinicians struggled with this adjustment. Additionally, some authors have noted that this freedom to engage in treatment outside of an office has also blurred the boundary lines of psychotherapy, as some providers have reported facing patients engaging in other daily activities during their therapy time (Nittas & von Wyl, 2020). Limited resources such as stable internet connection, working phones, and time constraints have also been reported as challenges for telehealth services (Madigan et al., 2021). Privacy concerns may also arise during telehealth as it may be difficult to gauge whether other people in the patients’ vicinity may overhear the work. This may be especially more prevalent when conducting telephone therapy and/or telehealth services to adolescents (Levy et al., 2021) and children (Goldstein & Glueck, 2016; Burgoyne & Cohn, 2020). Telehealth services for young children in the foster care system pose unique challenges and have remained an area where research is limited.

Given that psychotherapy for young children often utilizes toys and activities, providing services via telehealth may add some barriers because clinicians often need to be creative with toys, games, and activities to engage with young patients as a physical playroom may not be available. Other important challenges in working with young children are the limited emotional feedback received through the camera and the limited ability to remain engaged in one activity or in one place (Trub, 2021). While video calls allow clinicians and patients to observe each other, the full range of facial cues and expressions is sometimes lost or misperceived. Similarly, audio reception can also interfere with one’s responses, especially as young children have difficulties verbalizing their feelings. These barriers to online treatment have led providers to rely more heavily on parents and caregivers (Trub, 2021; Burgoyne & Cohn, 2020). However, the role of foster parents may include caring for several other children, which may prevent uninterrupted time for therapy in the home. While some foster parents may have adequate resources for telehealth, some may struggle to have adequate bandwidth or internet data to engage in treatment. For every family, the situations may be different and may require different problem-solving to ensure mental health services, but collaboration, preparation, and compassion go a long way in any treatment relationship.

Even though research has found that relationship-based treatment is especially important and effective for children in foster care (Weiner et al., 2009) and for children who have been adopted (Opiola & Bratton, 2018; Leon et al., 2018), there is limited research regarding telehealth treatment including foster parents and young children. Therefore, to add to the literature on telehealth work with foster parents of young children, the authors present two case vignettes of young children in the foster care system who attended virtual Child-Parent Psychotherapy with their respective foster mothers to address their history of trauma and neglect.

Case Vignettes

The authors present two case vignettes that while they had different traumatic stories, challenges, and strengths, the therapeutic process unfolded in similar ways through the navigation of foster parent-child therapy via telehealth services. The authors begin by presenting the children’s background, to later explore

the challenges associated with setting up telehealth sessions in a trauma-informed framework, and then discuss challenges with psychological interventions through telehealth. The authors also discuss the foster parents' experiences through treatment and explore the cultural and systemic factors that impacted the telehealth treatment for these children while in the foster care system. To maintain confidentiality for the families, all names in these case vignettes were given pseudonyms.

Children's Developmental Background

Patrick's Development

Patrick, a 5-year-old, White, boy, entered the foster care system after experiencing over 4 years of deprivation, neglect, exposure to his parents' illicit drug usage, domestic violence, separation from his father due to incarceration, and ultimately severe injuries caused by a dog in his house. Patrick needed to undergo several surgeries due to his injuries and his parents did not provide comfort or support during such moments, continuing their emotional and physical neglect of this child. Once removed from their care, Patrick's biological parents did not attempt to meaningfully participate in any aspect of their DCFS case plans to provide support, safety, and protection for their child for over 12 months, which led the court to terminate their parental rights freeing Patrick for adoption.

Carley, a White, newly certified single foster parent was called to the hospital to bring Patrick into her home as he was recovering from his injuries. Despite her inexperience in parenting, Carley was patient and determined to have all of Patrick's needs met. A fierce advocate for Patrick and his safety, Carley engaged in weekly CPP treatment with Patrick and one of the authors. Patrick demonstrated significant symptoms of distress as he was an under-socialized child who had experienced severe and multiple forms of trauma. His play was disorganized, he demonstrated aggressive behaviors towards adults which often came out of the blue, he reacted strongly to transitions, had nightmares, and often become emotionally dysregulated; for example, shortly after telling Carley that he loved her, Patrick would punch Carley in the face at times. These behaviors took place at home and school, though the behaviors were more salient at school, with Patrick's aggression also directed towards his peers.

Laura's Development

Laura, an almost 4-year-old, Afro-Caribbean, Spanish-speaking, female entered the child welfare system after experiencing severe leg fractures that required metal plates and surgery. Laura consistently told the police, the medical providers, and DCFS that her mother's boyfriend had been physically abusive for several months. While Laura's mother was somewhat attentive to Laura during this traumatic moment, she also consistently denied that her boyfriend (and father of her unborn child) had been the perpetrator and was unable to provide any other explanation for Laura's injuries. Laura's mother visited Laura regularly and received therapeutic services to increase her protective capacity, which included acknowledging Laura's traumatic experiences, separating from her boyfriend, and preventing further contact between Laura and her perpetrator. However, during any attempts at family reunification, Laura was repeatedly re-exposed to her perpetrator at her mother's home, which would cause her to regress and demonstrate symptoms of trauma. After over two years of attempting to reunify, Laura's mother decided to surrender her parental rights so Laura could be adopted by her foster family who was open to Laura maintaining a stable relationship with her mother without any further exposure to her perpetrator.

When Laura entered foster care, she was placed under the care of the Williams family, a White, monolingual English-speaking, certified foster care family with their biological children. While Laura was raised in a home speaking a dialect of Spanish, she was nonverbal when she entered foster care at almost 4 years of age. However, she was very attentive and quickly learned to communicate in English and her foster parents worked to increase both Laura's and their speaking of Spanish. Given her traumatic experience, Laura initially exhibited motor delays, low frustration tolerance, nightmares, and recurrent emotional outbursts. Laura and her foster mother engaged in weekly CPP sessions via telehealth with one of the authors. Though Laura entered the home as a quiet, scared, and irritable child, the foster family eventually saw that Laura could be a very social and joyful child, who enjoyed being affectionate and playful with others when she felt safe and protected from harm. Concurrently with the online sessions, Laura and her biological mother attended in-person sessions with Dr. Sebastian to support reunification efforts up until Laura's mother surrendered her parental rights.

Setting Up Telehealth Services

Patrick

Telehealth requires more preparation for caregivers and clinicians to think together about the setting, the time, and the toys that are needed to promote an adequate therapeutic space. Since Carley and Patrick were the only ones who lived in the home, they had several spaces available for the telehealth sessions and confidentiality was not an issue. Carley and Dr. Amy Rinner chose to have the telehealth sessions occur in Patrick's bedroom, which would help contain him should he become too emotionally dysregulated and could feel safest. While initially, Carley carried the phone with the camera around while interacting with Patrick, Dr. Amy suggested setting the phone in an elevated location that allowed ample view of the room

and their interaction. While Patrick's bedroom had many toys to utilize in sessions, Patrick was included in choosing what toys to have most readily available, which included a doll house, human figures, and service cars. Including him in the decision helped him express himself and fostered a sense of familiarity and independence. The clinician also ensured that toys were available in the room to utilize when needed for Patrick to play out his traumatic experiences.

Laura
During the initial dyadic session, Mrs. Williams chose to have the sessions early in the morning and in Laura's bedroom so they could have privacy from Mrs. Williams' biological children, who were at school at the time. This allowed the perfect opportunity for Dr. Sebastian to be invited into Laura's world with her foster family and allowed them to explore their dynamics and experiences. Mrs. Williams and Dr. Sebastian also discussed ways to improve video connection and quality by selecting a space where the computer was stable, had a good internet connection, and could show most of the room where they were playing. Laura's room had a variety of her toys (e.g., dolls, doll house, and dressed-up toys) and had enough space to engage in pretend play. This private space also allowed Laura to express her emotions, play freely, and engage joyfully with the camera.

Setting a Trauma Framework Through Telehealth Practice

Patrick
As Child-Parent Psychotherapy emphasizes the exploration of traumatic experiences that may impact the dyad's relationship, one of the initial tasks in treatment was to assess Carley's trauma history and vicarious trauma. While she did not endorse any significant traumatic childhood experiences for herself, Carley endorsed significant PTSD symptoms for Patrick, parental stress, and vicarious trauma as she learned about Patrick's difficult experiences. Initial telehealth individual sessions between Carley and Dr. Amy Rinner focused on validating Carley's experience as a caregiver for Patrick and openly discussing the effects that trauma may have had on Patrick. Carley described a positive and warm perception of Patrick accompanied by a comfortable relationship despite the periods of emotional dysregulation and physical aggression. Carley revealed a strong ability for reflective functioning; to think about Patrick's behaviors and emotions in the context of his history and to understand her emotional reactions to her foster son's behavior. After ensuring that Carley could remain regulated during this process, the initial dyadic sessions involved Dr. Amy and Carley explaining the purpose of the weekly telehealth sessions. Patrick was also invited to talk about his traumatic memories while receiving information about trauma that helped normalized the anger that he had and continued to experience. Invested in Patrick for the long haul, Carley was eager to begin weekly therapy to decrease Patrick's PTSD symptoms and learn skills to help manage his emotional outbursts and decrease her feelings of inadequacy.

The trauma framework was maintained throughout treatment even though it was coming through the screen instead of being physically in the room. Through the camera, Dr. Amy was able to observe the dyadic interactions and was able to guide Carley through narrating Patrick's play, which increased their understanding of the trauma and its effects. Dr. Amy focused on guiding Carley to interpret the play and to trust her relationship with Patrick which provided him with the safety and security to play out his experiences and feelings allowing corrective emotional healing by a validating and emotionally present caregiver. By verbalizing the connection to the past traumatic memories in the present play and by identifying hidden emotions in Patrick, Dr. Amy's presence was still felt through the camera as Carley and Patrick would think about their future together in a safer, stable environment.

Laura
Following the trauma-informed framework of CPP, Dr. Sebastian and Mrs. Williams also first met to assess and explore Mrs. Williams' adverse childhood experiences, her parenting stress, and her relationship with Laura. Mrs. Williams did not endorse experiencing any significant traumatic events as a child and noted some stress over Laura's challenging behaviors but described receiving support from her husband in parenting Laura. She also reported that she and her husband did not know much about Laura's development before her injuries. To instill a trauma framework during the subsequent sessions with Laura, Dr. Sebastian repeatedly utilized the same stuffed animal through the camera to initiate an exploration of Laura's emotions regarding her injuries, her separation from her family, and her previous traumatic and difficult experiences.

During psychotherapy, it became apparent that Laura had experienced many layers of trauma and hardships throughout her young life, but it was also evident that Laura had enormous strengths and resilience. By the time Laura was only two years old, she had experienced significant poverty, had witnessed ongoing domestic disputes between her biological parents, and had emigrated from her home in Central America with her mother, leaving her family behind. During several months and without social or economic support, Laura and her mother wandered through different countries attempting to reach their destination in the U.S. Despite this time filled with food and residential uncertainty, Laura appeared to have a hopeful and cheerful mood that brought her internal peace next to her mother. Once they finally arrived in the U.S., their extended family welcomed them into their home but also introduced them to the man who would become Laura's physical

abuser. Through telehealth, Dr. Sebastian faced the challenge of holding space for Laura to process many of these challenges and traumas while also supporting Mrs. Williams who would learn about her foster child's experiences. Although the clinician and the caregiver may be focused on the trauma that brought the child into foster care and the trauma of the separation from the primary caregiver, if given a safe space to share one's experiences, caregivers often learn of other unknown traumas, some of which are more salient to the child.

Psychological Interventions Through Telehealth

Patrick

Patrick's initial play consistently involved building/creating a home, putting everything in the "right place", and then destroying the home while frequently yelling. Regardless of Patrick's engagement with different types of houses, the play remained the same. This type of repetitive and "stuck" play is known as "traumatic play", where the child exhibits internal pressure to play out their experiencing in a rigid manner without any enjoyment. Patrick needed to set up the house and direct Carley where to place objects to ensure that it was "where it's supposed to be!". As soon as the last piece was set up, Patrick's demeanor would change; he would begin to shout, and dramatically destroy the house, oftentimes to the extent of breaking the toy. As Dr. Amy Rinner watched Patrick destroy houses every week, her comments through the Zoom screen about the chaos Patrick must have felt were seemingly ignored by Patrick. While this could have also happened during in-person sessions, Patrick ignoring the comments was seemingly easier due to the teletherapy element. Dr. Amy also processed Carley's reactions to this repetitive play which was emotionally intense. Carley was a patient caregiver who felt helpless at times, but never chastised Patrick for the destruction of the toys, understanding his need to release his feelings.

After weeks of engaging in this repetitive play, Patrick finally responded to Dr. Amy's wonderings about his feelings. Patrick suddenly announced that he broke the homes because he, just like his old house, felt broken inside. He added that he was scared he would have to return to that home. With the encouragement of Dr. Amy, Carley leaned in and offered quiet comfort and affirmation when Patrick was vulnerable. Patrick's bravery in sharing why he broke the toys every week highlighted the importance of connecting his behaviors with his past traumatic experiences. The willingness of Dr. Amy to speak about Patrick's trauma without shaming him or becoming secretive was felt through the screen and allowed the virtual space to become a safe haven for Patrick to tell his story. This intervention through the screen was strong enough that Carley began to also view Patrick's behaviors in a more compassionate and understanding light. This revelation also allowed Carley to assure Patrick that she would not put him out of her home, and she continued to fight daily to keep him safe, recognizing aloud her role as his protector.

Over time, growing increasingly attached to Carley, who always responded with patience, warmth, and firm boundaries on harmful aggression, Patrick's aggressive behaviors decreased in frequency. Dr. Amy praised Carley's calm demeanor and supportive presence while working with the dyad on regulating techniques and appropriate consequences for Patrick's aggression that was not shaming or grounded in perceived rejection. The virtual space promoted a sense of connection while in their home environment, which allowed Patrick to begin to differentiate between his prior "scary" home environment and his current safe and stable one with Carley's consistent support.

Laura

During the initial telehealth session, Dr. Sebastian told Laura that she "could play with any of her toys and could talk about anything she wanted" with the only rule being that of making sure Dr. Sebastian could see and hear Laura and her caregiver well. Laura was very responsive to these guidelines and began to play out scripts from movies and books while Dr. Sebastian often provided comments on Laura's stories while commenting on Mrs. Williams' engagement with Laura. These interventions seemed to permeate the telehealth screen as Laura began to feel more comfortable in sharing her psychological distress by moving away from retelling fairy tales to describing her own stories including villains who would act abusively towards her characters. Mrs. Williams' attentiveness and engagement also seemed to allow Laura to share more of her thoughts and emotions as treatment progressed.

The characters and stories in Laura's play soon became closer to her previous experiences: instead of a villain from Disney or a scary animal, a "Bad Dad" character was present in most situations. This character allowed Dr. Sebastian to speak directly about the "unspoken" trauma that Laura had experienced. Though it became clear over time that Laura was listening and processing all of Dr. Sebastian's comments, the telehealth modality acted as a barrier at times as the words seemed to dissipate as soon as they were spoken through the screen. For example, at one moment when Dr. Sebastian was yelling out, "She is terrified!", the words echoed silently in the room, while Laura played out a character breaking another character's legs. Perhaps Laura was not yet ready to explore her feelings outwardly. Or perhaps Dr. Sebastian's countertransference from Laura's helplessness made an impact through Zoom, but the truth is that it was difficult at times to feel present in the room. Should they have been physically in the room, Dr. Sebastian would have enacted the feelings of being terrified using one of the characters while describing the situation. However, given the

telehealth modality at the moment, Dr. Sebastian needed to solely focus on verbal expressions spoken for himself or through his stuffed animal proxy.
To overcome the felt distance that telehealth produced, Dr. Sebastian utilized his expressiveness and a stuffed animal to enact some of Laura's emotions and experiences. This allowed Laura to connect through the screen in more meaningful ways. It is also hypothesized that by Laura seeing herself in the camera while showing Dr. Sebastian toys, she was also able to understand her experience more profoundly. For example, after discussing her recovery from the surgery, Laura grabbed a "ballerina" doll and came closer to the screen to show how safe she was now by moving the doll's legs and keeping it close to her chest. Through these behaviors and types of play, it was evident that Laura was not only smiling at the increased connection with Dr. Sebastian and Mrs. Williams but also smiling at the picture of herself being a healthy and safe child who was understood and accepted. The screen made it easier for Laura to disengage when processing but did not prevent her from connecting with Dr. Sebastian when she so desired.

Caregiver Considerations

Patrick

Despite her desire to care and provide for Patrick, Carley felt lost about how to best manage Patrick's emotional dysregulation when he first was placed with her. Carley feared that she was not well-equipped to care for this young child who had "gone through a lot". When treatment began, Dr. Amy Rinner met with Carley individually via Zoom while Patrick was in school to help her better understand Patrick's behaviors, understand the impact of trauma on a young child, and balance her own emotions as a new and single caregiver who was trying to meet all of Patrick's needs while holding down her full-time employment. Though Carley had not experienced significant trauma herself, Carley appeared to demonstrate some signs of vicarious trauma and helplessness. Through Zoom, Dr. Amy provided psychoeducation about trauma in young children and provided a framework to better understand Patrick's behaviors. While affirming Carley's helplessness and care for Patrick, Dr. Amy offered ideas and support on how to respond to difficult situations. Given the initial rapport built with Carley, Dr. Amy was able to help her implement these ideas as they naturally occurred inside her home during telehealth treatment with Patrick.

For example, Dr. Amy and Carley were able to utilize appropriate modeling and descriptions of consequences for Patrick. When Patrick did respond aggressively, Carley was able to consistently implement the timeout procedure she had learned through the individual parent sessions she had with Dr. Amy They also were able to develop specific strategies to be implemented during telehealth visits for when Patrick acted in a dysregulated manner. By explaining the importance of safety and stability, Dr. Amy prompted Carley to set up the room in a way that would promote self-regulation for Patrick while he was being monitored by Dr. Amy through Zoom. This allowed for a safe separation that was planned and understood as a regulation strategy and not abandonment.

With recurrent individual caregiver sessions, Carley's skills and confidence soon grew allowing her to better manage her reactions when listening and understanding Patrick's trauma history. Carley was additionally encouraged to participate in a local resource for foster families that provided education and support for caregivers. Carley was motivated to learn about general foster care circumstances and Patrick's trauma and life history. Telehealth sessions with Dr. Amy allowed Carley to begin utilizing trauma-informed directions and instructions outside of the therapy room, especially at daycare where most of Patrick's behavioral problems occurred. After the judge freed Patrick for adoption, Dr. Amy through telehealth, explained the situation to Patrick and to Carley, which reinforced Patrick's felt safety under the care of Carley. Now Carley could safely reassure Patrick that he would never have to return to the "scary home", and he could stay in her home forever.

Carley's role in telehealth therapy was crucial as she was an active participant by observing Patrick's play, helping him contain his emotions, and making comments that increased a sense of security and understanding. Patrick's felt safety was evident as he would begin each new session by stating his name and his "new last name", which indicated his desire to be adopted by Carley. Patrick knew he was in a safe and loving family who treasured him. Once the adoption occurred, Patrick was no longer demonstrating aggressive behaviors at home or school and knew how to approach transitions as well as an average 5-year-old. A key turning point in Patrick's life was undoubtedly his placement with Carley, who was receptive to helping her foster son express his emotions while keeping him safe in a patient and loving manner. However, without adequate support, Carley may have given up on her ability to adequately support Patrick and be what he needed. The teletherapy provided by Dr. Amy contributed to the relational successes by supporting Carley in her efforts to understand her foster son and gain success in being able to provide for his many needs. Carly was not only able to learn about young children's responses to trauma and local resources for caregivers, but she also learned to become a "therapist's aid" by providing several conditions to increase Patrick's emotional and behavioral regulation outside of the telehealth play therapy sessions.

Laura

During the initial sessions of telehealth therapy, Dr. Sebastian met with Mrs. Williams to explore treatment

goals and treatment process (i.e., the use of play to facilitate Laura's communication). Mrs. Williams in a nervous manner disclosed that she "did not have a great imagination" and had "never played much" with her own children. Even though Mrs. Williams had reportedly not experienced any trauma, she did not have many memories of playing as a child. Through the screen and with a smile, Dr. Sebastian provided a holding space for Mrs. Williams to reconnect with her inner child and explore her expectations of play. During the initial dyadic telehealth sessions, Mrs. Williams was instructed to follow Laura's lead in the play and to "just have fun with her". This quickly allowed Laura to trust her attentive and accepting foster mother while bringing in several themes in her play and finding new toys in the home to fit her narrative, showing an imagination that is not always present in traumatized children and was a sign of Laura's felt safety in this home.

Dr. Sebastian utilized the final 5-10 minutes of each session to discuss Laura's play with Mrs. Williams. This allowed Mrs. Williams to increase her ability to identify Laura's feelings, empathize with Laura's experience, and provide a corrective emotional experience for Laura. These discussions were trifold; while they provided a unique opportunity for Mrs. Williams to understand her foster child's experience, they allowed the dyad to bridge the gaps created by the screen, and they also served to provide updates on Laura's behaviors and the progress of the DCFS case plan. During these conversations, Dr. Sebastian found that using a stuffed toy animal helped Laura to feel at ease while they would explain to her the current state of her case, her treatment, and her safety. Consistency of toys remained a powerful theme on both ends of the camera as well to provide a sense of security and stability for Laura.

Despite some initial hesitations, Mrs. Williams showed great willingness to participate in Laura's pretend play which included several characters who would move around the room and off-screen for a few minutes. During these times of seeming disconnection between Dr. Sebastian and the dyad, Mrs. Williams' warm demeanor and willingness to follow Laura's play filled the emptiness that was occasionally sensed through the screen, especially as Mrs. Williams would narrate the emotions and the actions of the characters. To support their relationship, Dr. Sebastian often reflected on how good it felt for Laura to be understood by her foster mother, which prompted them to openly smile and look at each other.

During one session, a "big bad wolf" killed Laura's doll to which the clinician replied, "She feels she cannot do anything about it! So helpless, she must feel." While this comment did not seem to make an immediate impact, Laura slowly moved behind one of the two dollhouses in the room and slowly pushed the "old house" down making it fall on top of the doll. Mrs. Williams was quick to reflect on how devastating the experience of losing the home was for Laura. Another addition to Laura's play was "Mom's new house." This was relevant in Laura's situation as her birth mother eventually moved to a new home where she had claimed that the "Bad Dad" would not be allowed. During one session, the foster mother noted, "Just like this child, YOU are getting ready for the new house" while Laura was playing with dolls who were going to a new home. Not only was Laura able to share her fear of the house where she was abused, but she also communicated her newfound felt safety and her regained ability to move her healed legs as the therapist and Mrs. Williams narrated Laura's play, drawing connections from her past to the present.

As telehealth treatment continued, Mrs. Williams demonstrated even more attunement to Laura's play and emotions, which led Dr. Sebastian to make fewer remarks and interventions during the sessions because the foster mother was already noting them in the moment, encouraging Laura's regulation, and allowing her to explore her emotions in a healthy manner. The fact that Laura trusted and confided in Mrs. Williams and that Mrs. Williams was able to support Laura's emotional reactions indicated that Dr. Sebastian's virtual presence weekly was no longer needed at this point. The opportunity to see them interact in their home, and in such a natural way, showed that Laura felt safe with Mrs. Williams, and could confide her feelings to her foster mother, who now felt competent in hearing those feelings and helping Laura manage what was coming up for her in the moment. In this case, Mrs. Williams' active participation in Laura's play was crucial in developing a healing, emotionally responsive, secure, protective relationship under a trauma-informed framework.

Cultural Considerations

Patrick

Patrick's early upbringing with his biological parents and his experiences being cared for by Carley had many cultural differences. Carley's socioeconomic status was markedly different from Patrick's biological parents who both had severe substance use disorder and did not have steady income and resources. As a health care worker, Carley emphasized the importance for Patrick of attending regular medical appointments and maintaining a healthy routine. Carley was also able to afford to provide Patrick with consistent and diverse food that promoted his growth and development. She also focused on appropriately utilizing her income to provide for Patrick while attending to his developmental and changing needs through developmentally appropriate toys and by enrolling him in a nurturing preschool that could manage his needs.

During the Winter holidays and given Patrick's theme of playing with houses, Carley added a gingerbread house that was consistent with their shared cultural traditions and beliefs. Should Patrick's biological parents had attempted to remain involved in their son's life, other cultural traditions may have needed to be explored

and honored. However, given that Patrick's parents did not remain in contact with DCFS and Patrick's young age, this allowed Patrick and Carley to develop their own traditions, practices, and beliefs. For example, Carley and Patrick were able to discuss what happens when children lose teeth, what to celebrate during the Winter holidays, and other cultural beliefs. Carley was also tasked with socializing Patrick to learn about her own culture and their community's traditions.

Individual telehealth sessions with Dr. Amy Rinner allowed them to explore Carley and Patrick's community and cultural activities. Given that Carley and Patrick resided in a rural area, approximately 2 hours from the clinic, this distance was a large barrier to receiving many services for Patrick. Without telehealth, this family may have not been able to receive therapeutic services given the numerous weekly appointments that Patrick needed to attend (Occupational Therapy, Physical Therapy, Pediatric checkups, Post-surgical appointments, etc.) in addition to Carley's work schedule. Online resources and online individual caregiver sessions also proved to be especially important for Carley as she was able to process her vicarious trauma, to connect with other caregivers around the country, and to process her changes in identity as a newly single mother of Patrick. The online dyadic session also provided an opportunity for Dr. Amy to catch a glimpse into their lives organically. The authenticity of communications and engagements may have never naturally occurred in an office setting.

Laura

Laura's racial and cultural identities were aspects discussed and explored often throughout treatment. The Williams family was mindful of integrating racially representative dolls in their home while also discussing their differences in skin color with Laura both inside and outside of therapy. Mrs. Williams also independently learned ways to braid Laura's hair, which helped her increase her sense of pride and security. While these interventions were often initiated by Mrs. Williams outside of the therapy hour, they were also part of the therapeutic hour when discussing Laura's toy, Laura's interactions with her caregivers, and Laura's cultural norms and celebrations.

Similarly, Laura's immigration to the U.S. was another aspect for exploration throughout treatment as Dr. Sebastian also communicated with Laura's biological mother to better understand Laura's cultural background and experiences before being placed with the Williams family. Telehealth sessions allowed for these conversations to occur more seamlessly, as they were able to show geographic maps to Laura of her journey and the distance she and her mother had covered. Though they were not fluent in Spanish, the Williams family learned to use some words in Spanish, included several books in Spanish, and enrolled Laura in a pre-K school that provided instructions in Spanish. Throughout the course of telehealth treatment with Mrs. Williams and Laura, Dr. Sebastian's being bilingual opened the door for using interventions in both languages, especially when Laura explored her emotions about her biological mother. The Spanish used allowed Laura to have several ways to express her complex emotions and experiences while increasing Laura's ethnic and racial identity.

Furthermore, Laura's mother did not speak English well and communicated mostly in Spanish with Laura. Given that Laura and her biological mother were also attending in-person dyadic sessions with Dr. Sebastian, the Spanish language served to repair Laura and her biological mother's relationship while increasing Laura's mother's safety capacity. Mrs. Williams also demonstrated being warm, accepting, and supportive of Laura's biological mother despite their language barrier. Through telehealth sessions with Dr. Sebastian, Mrs. Williams learned about ways to learn and honor Laura's biological family's cultural traditions (e.g., surnames, national festivities, religious celebrations, etc.).

Discussion and Conclusion

The global COVID-19 pandemic has brought many difficulties related to providing appropriate care and psychological services to millions of children. These times have been even more challenging for children who are in foster care given their increased exposure to previous trauma, the uncertainty of their permanency, their adjustment to new home environments, and the disruption in their visitations with their biological parents (Singer & Brodzinsky, 2020). Telehealth has been regarded as essential to continue treatment with biological families, foster families, and children during these stressful and uncertain times (Langley et al., 2021).

This article presented two clinical cases to illustrate ways to engage in relationship-focused psychotherapy for young children in the child welfare system using telehealth. While the two children had very culturally different upbringings, they were both under the care of new foster parents after experiencing ongoing abuse, neglect, and instability. Both children shared many similarities in their continued search for security, safety, connection, and growth. Given the ongoing COVID-19 pandemic, both children received psychotherapy via telehealth with their respective foster mothers. This modality proved to be significantly beneficial in assisting these two children and their caregivers and it is hard to imagine how these children and their caregivers would have struggled without the benefit of treatment. As follows, we present a summary and conclusions on several important aspects that were addressed in providing telehealth play psychotherapy with young children.

The first aspect to discuss during online treatment was setting up the telehealth sessions. Given that the sessions were not at the office, the clinicians needed to delineate the importance of being in a private room and of having toys available for the children to express themselves. Emphasizing to the foster mothers the curative factors of play and the power of this "special hour" allowed the clinicians to promote an uninterrupted and growth-promoting space for the children. The fact that these caregivers had stable electronic and technological resources also allowed them to provide a consistent time and space for their foster children. While this may not always be the case, clinicians may need to explore with the foster parents how they will respond to technological problems (poor signal, battery issues, etc.). The clinicians found that by discussing the framework of telehealth and accepting these challenges, the caregivers were also more willing to participate and include themselves in the psychotherapeutic process.

Another aspect of the online sessions was related to setting a trauma framework through telehealth practice. A trauma-informed framework for therapy begins even before the initial session is scheduled by promoting a safe and non-judgmental space where trauma narratives and experiences are openly discussed. During the initial sessions with Laura and Patrick, the clinician provided an honest and empathic explanation of the goals for therapy: to explore their trauma and to feel safer during their time in foster care. Another way to set up the telehealth trauma framework was through the selection of toys available to both young children. While both children's initial play themes seemed to be unrelated to their traumatic experiences, the consistent invitations to explore difficult situations by these clinicians allowed the children to build rapport and trust. This allowed the children to begin utilizing their play to bring to life their internal struggles and experiences in the safety of the relationship with their caregivers and the therapeutic framework. Similarly, the children, with assistance from the caregivers, expanded their use of the toys by utilizing household items and other creative toys when needed. Caregivers can be guided on ways to utilize household items in a more symbolic manner (i.e., using a Tupperware container as a house). As it is not always the case that parents may have all "psychotherapeutic toys" at home, clinicians and agencies may be able to send toys to families' homes or help make toys out of cardboard boxes to send to the families to utilize in session.

Another issue to be discussed is the provision of psychological interventions through telehealth. Coming to a clinical playroom may serve as a signal for the therapist to connect with their inner child and provide a meaningful space to deepen the relationship through play with the client. However, telehealth can result in the clinician feeling "distant" and unable to authentically engage with the children's play through the screen. At times the caregivers and the children may not be in the viewing area of the camera. Sometimes the caregivers may hold the phone with the camera showing the child only. At other times, the child may move to other parts of the room or leave the room, out of the viewing area. In contrast to in-person sessions where the therapist in a non-intrusive way may interact and attend to the family's reactions, these moments during telehealth treatment may make it more difficult to attend to the child and the caregivers' affect and behaviors, especially, for example, when Patrick would become dysregulated and would hide under his blankets. While it may take some time to find a rhythm and to ensure the child's safety, telehealth allows for meaningful moments where caregivers and children can communicate their trust and their security.

During the process of telehealth psychotherapy, the foster parents may have different roles that may vary from situation to situation. One of these caregiver roles is an observer/participant where the foster parent may narrate the behaviors of the child for the therapist to support their relationship and help the child self-regulate. For example, even from afar, Dr. Amy Rinner suggested Carley narrate Patrick's behaviors indicating that he was in need of support and love during those moments when he would become dysregulated. This role allowed Patrick to find his own space under the blanket to self-regulate and then to re-emerge more energized. Another important role is the caregiver as an active play participant. For example, through coaching and explorations, Dr. Sebastian encouraged Mrs. Williams to set aside her emotions and to focus fully on Laura's play with no ulterior motivation aside from being present, attentive, and accepting. Mrs. Williams' immersion in Laura's play during the sessions allowed them to increase their attunement and trust. Finally, as psychotherapy progresses, the foster parent is likely to demonstrate a final role: the one as a co-therapist. By focusing on the children's sense of safety, the children's history, and the children's attachments, the clinicians and the foster parents were able to connect children's current behaviors to past experiences while communicating support, understanding, and love for the child. This allowed them to create new healthy narratives of the children's life events and new possibilities for connecting with others.

A critical aspect to attend to in teletherapy with young foster care children is the needs of the caregiver. In promoting a trauma-informed framework, it is imperative to explore the foster parent's emotional reactions, trauma histories, and discipline practices regularly. Understanding the caregiver's trauma and developmental history helped gauge how vicarious trauma may be impacting caregivers while discussing the children's traumatic experiences (Noroña and Acker, 2006)). Finding a quiet space to be able to share their history may pose some challenges for caregivers who care for multiple children and do not have many breaks. However, the telehealth modality and phone sessions may allow the therapist to emotionally support the caregiver even though they will not be in the same room. Having regular separate caregiver-only sessions helped the caregivers feel supported and heard throughout the process, especially during COVID-19 physical

distance practices and the foster parents' possible isolation (Langley et al., 2021). This also reduced the need for placement changes for the child as the caregivers felt emotionally supported and gained a sense of competency in meeting their foster child's needs.

During the individual telehealth sessions with Carley, Dr. Amy Rinner provided sufficient space for Carley to explore her vicarious trauma and her feelings of helplessness and distress regarding Patrick's behavioral problems. These sessions not only allowed Carley to increase her confidence but also allowed her to connect deeply with Patrick. Similarly, during the end of each session, Dr. Sebastian was able to deepen the connection between Laura and Mrs. Williams by interpreting some of the play's themes. This increased Mrs. Williams' confidence and attunement with Laura. Finally, by humbly accepting the children in their actual living space provided the clinicians with a genuine connection that would not have occurred in our office playroom. The need for individual caregiver sessions often decreases over time as caregivers gain a sense of confidence in their caregiving abilities for a traumatized child and the child's challenging behaviors decrease, but the stress and uncertainty of child welfare cases make offering these sessions on an ongoing basis a critical aspect of successful care.

Finally, even though Laura and Patrick were ethnically and racially different, treatment brought to light important cultural considerations to be addressed in the provision of telehealth psychotherapy. While both children had experienced significant poverty, these children had been socialized and had learned to utilize technology, which may have allowed for a more seamless connection with the clinicians. However, their experiences of poverty before entering foster care appeared in some of the themes of their play. For example, Patrick often broke houses to symbolize his internal feelings and his actual experiences when living with his biological parents, and Laura also often compared her biological mother's house with her foster parents' house.
Another aspect that came up in both vignettes was the importance of exploring cultural practices (celebrations, routines, traditions, etc.) and cultural beliefs. Given that when children enter the foster care system they also enter a new family culture, dyadic psychotherapy with caregivers and children will allow them to explore, make sense of, and adapt to new cultural environments. The therapist plays a critical role in helping all parties acknowledge the differences between the new foster home's culture and the previous family's culture while incorporating an understanding of all cultural values as they impact the child's developing identity.

Limitations

Some limitations exist in the case vignettes presented and in this line of work. First, it is worth mentioning that the foster mothers in these cases were able to go above and beyond to facilitate a safe and therapeutic space for their children with suitable treatment toys, enforced confidentiality, and electronic devices with solid Wi-Fi that limited unnecessary disruptions in the treatment sessions. Another limitation of online play therapy has been the frequent felt "distance" from the patients. Given the need for safe and secure relationships, this distance can potentially disrupt the psychotherapeutic process. However, the inclusion of caregivers, especially for children in the child welfare system, is an effective way to remediate this distance, as the caregiver serves as the secure base to address early and developmental trauma. The vignettes presented in this article exposed two clinical cases where telehealth psychotherapy was successfully implemented with supportive caregivers.

The authors recognize that telehealth may bring a plethora of challenges with children in other situations which may make telehealth and or CPP an ineffective intervention for those individuals and their families. At the outset of psychotherapy, it will be important to assess the child's developmental level and availability to engage with the camera, the caregiver, and the toys presented. The authors have encountered other foster parents who have been unable or unavailable to engage in telehealth psychotherapy sessions with their children. The caregiver's schedule, unstable internet connection, and limited private space have been some of the reasons given. Some caregivers are also uncomfortable with the clinician seeing into their home. For these cases, the authors have found that providing occasional "on-the-go" interventions, guidelines, and support have alleviated some of the stress for the foster parents. Continual check-ins and caregiver support via phone sessions have allowed the children to be supported in a healthy manner while they spend time in foster care. Sometimes these supports have also enabled the building of trust which allows the caregiver to understand that the therapist is not there to judge, but to truly support and telehealth sessions are eventually allowed.

Future Directions

The need for telehealth practices due to quarantines may slow down over time, but telehealth is here to stay (Calkins, 2021; Rosen et al., 2021). Many patients and providers alike have found benefits from telehealth and have stated their likelihood to continue using online treatment in the future (Gentry et al., 2021; Dorsey & Topol, 2016). Getting an understanding of families' appropriate toys and resources for treatment is crucial at the outset of online psychotherapy. Creating clear and agreed-upon boundaries regarding time, space, participants, and location is also essential and was proven to be effective in providing telehealth services to young children. Sometimes families are eligible for grants which will provide cell phones with data packages

for therapeutic use. The authors of this article have worked with several families who were gifted phones specifically for telehealth usage during the COVID-19 pandemic. The widespread use of telehealth also led to clinicians becoming advocates and case managers for families so they could have access to participate adequately in the telehealth process. Certainly, knowing your geographic area and the resources available to families in need is a significant advantage.

Telehealth treatment with biological families for young children in foster care is an area that needs further exploration. Some preliminary research has found that young children cannot create a significant attachment with their caregivers through telehealth, but that attachment can be maintained through telehealth once it was created in person (McClure & Barr, 2017). A multigenerational approach to improve attachment and safety has also been shown to be invaluable (Frame et al., 2015), but there is a dearth of studies addressing the challenges of providing telehealth to biological parents of children in the welfare system. The authors have found that extreme poverty, pervasive mental health conditions, and limited social networks frequently prevent biological parents from successfully engaging in telehealth treatment while attempting to repair their relationship with their young children. While incorporating foster parents and biological parents may create healthy boundaries and relationship models for the children, scarce studies are addressing this model using telehealth. Training in trauma-informed care and attachment-based treatment is needed for professionals working with the foster care population. Gardenhire and colleagues (2019) found that caseworkers, judges, attorneys, and foster parents often do not have the training needed to understand developmental trauma and its impact on young children. There is also a great need for research to continue exploring attachment in culturally diverse populations, especially for those young children in the foster care system. Given their separation from their biological parents, there is a risk for diverse young children to distance themselves from their cultural and ethnic heritage, especially in cross-racial/ethnic foster placements. While past research has reported the efficacy of child-parent psychotherapy with diverse populations (Osofsky et al., 2017; NCTSN, 2008), culturally sensitive interventions are needed to promote cultural understanding between the child and the foster parents, which would enhance the child's cultural identity development. All in all, telehealth remains

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