

From Confinement to Deconfinement:

New Perspectives in Child Psychiatry



Directed by
Sylvie Tordjman
Carmen Schröder
Richard Delorme

From Confinement to Deconfinement: New Perspectives in Child Psychiatry

Directed by
Sylvie Tordjman
Carmen Schröder
Richard Delorme



Conception
[Pôle Nord lab](#)

ACKNOWLEDGEMENTS

We thank Caitriona Pennycook, psychologist and research assistant at the PHUPEA (University Hospital Department of Child and Adolescent Psychiatry, Guillaume Régnier Hospital Center and University of Rennes 1) for her precious contribution to the editing and finalization of the French and English editions of this E-book.

This work was supported by the Guillaume Régnier Hospital Center (France).

Table of contents

I

The 4 Cs of confinement:

Clastration, Compression, Constraint and Contamination

- 2 Clastration
- 6 Compression in time and space
- 9 Constraint
- 10 Contamination
- 11 Refocusing on one-self
- 12 Psychological consequences of confinement: therapeutic perspectives
- 12 From confinement to deconfinement
- 13 Bibliography
- 13 To know more

II

Sleep in confinement

- 15 Dysregulation and desynchronization of sleep-wake rhythms during confinement
- 16 Effect of stress on sleep and effect of sleep on emotional regulation
- 18 Tips to help your child sleep better
- 20 Conclusion
- 20 Bibliography
- 21 To know more

III

Organize school homework time by increasing the child's motivation during confinement

- 23 Organize school homework time ⁽¹⁾
- 27 Increase the child's motivation to work ⁽²⁾
- 30 Maintain your organization and motivation for homework beyond confinement
- 30 Bibliography
- 30 To know more

IV

Perinatal psychiatry during the COVID-19 pandemic

- 31 Consequences of confinement on the general population during the perinatal period
- 33 Consequences for vulnerable people
- 34 Tools for the prevention and therapeutic management of the possible psychological consequences of confinement
- 36 Specific county-based tool
- 36 Telephone interview ^(7,8)
- 37 Update on home visits (HV)
- 37 Prospects for the future (deconfinement phase)
- 37 Bibliography
- 38 To know more

V

Effects of confinement in pandemic times and resources to deal with it in child psychiatry

- 39 Some essentials of the integrative approach to child psychiatry
- 40 Effects of the pandemic and confinement
- 43 Therapeutic proposals
- 46 Perspectives: confinement, finding your own ground
- 46 Bibliography
- 46 To know more

VI

Adolescents in confinement: A specialized telephone platform

- 48 Confinement and its possible consequences
- 49 Objectives of the telephone platform
- 50 Implementation of the telephone platform
- 51 Connection between the telephone platform and the National Education system
- 51 Current experience in confinement
- 52 Bibliography
- 52 To know more

VII

Art therapy in confinement

- 53 Why use art therapy during periods of confinement?
- 54 How to think of art therapy activities conducted at distance?
- 55 Possible tools for maintaining links
- 55 Examples of activities
- 61 And after deconfinement?
- 61 Bibliography
- 61 To know more

VIII

Hypnosis during confinement: Benefits for children, adolescents, parents and caregivers

- 62 The practice of hypnosis
- 63 Benefits of hypnosis during confinement
- 64 Digital tools: a suitable solution
- 64 Tools developed for confinement
- 68 Advantages of hypnosis in teleconsultation after confinement?
- 68 Bibliography
- 69 To know more

IX

EMDR and Telehealth for Children and Adolescents in confinement

- 71 Confinement and psychotrauma
- 71 EMDR for children and adolescents
- 74 Distance makes the heart grow fonder: EMDR and the "Teleclinician"
- 75 Deconfinement and Resilience: anticipating the next moves
- 75 Acknowledgments
- 75 Bibliography
- 76 To know more

X

Conclusions and perspectives: From confinement to deconfinement

- 78 Rethinking the mental health system by integrating remote teleconsultation tools
- 84 Synchronization of physiological rhythms
- 85 Benefits of changing locations
- 85 Role of movement
- 86 The 4 Cs of the 21st century
- 88 To be continued...
- 88 Bibliography
- 88 To know more

I

The 4 Cs of confinement: Clastration, Compression, Constraint and Contamination

Sylvie Tordjman



*Professor of Child Psychiatry, Head of the University Hospital Center for Child and Adolescent Psychiatry (PHUPEA),
Guillaume Régnier Hospital Center and University of Rennes 1 ;
Perception Psychology Laboratory (LPP), CNRS UMR 8242 and University of Paris .
E-Mail : s.tordjman@yahoo.fr , s.tordjman@ch-guillaumeregnier.fr*

It may be useful to recall the definition of the word *confinement* as given in the Littré dictionary, as “the act of re-legating someone to a place.” This definition highlights several dimensions of confinement, namely *clastration* (confinement to the home for fear of social contact) with social isolation; temporo-spatial *compression* (confined space-time), *constraint* (restriction of freedom, reduced mobility) and of course *contamination*, the risk that led to lockdown and related measures. We will explore each of these dimensions in turn in order to understand better the possible psychological consequences of confinement and the responses needed to prevent and treat the effects.

Clastration

In this period of confinement and isolation where social contacts are reduced, it is more important than ever to create and maintain links with others during confinement and then in deconfinement.

To facilitate and enhance social connections, remote communication tools are available and range from simple phone use to video-based conferences. These tools allow rapid and efficient communication and exchange of information. Teleconsultation is a remote medical consultation using information and communication technologies. Teleconsultation requires data security and can be practiced by telephone or video but also by e-mail.

Importance of staying informed

Communication tools are invaluable for both transmitting important information and for verifying and re-establishing certain facts when confronted with false rumors which maintain fear during periods of confinement (<https://www.unicef.org/coronavirus/how-talk-your-child-about-coronavirus-covid-19>). These communication tools offer access to a variety of information, a space for reflection based on exchanges of information, a critical analysis of this information on distancing and a synthesis based on the public health situation (in particular information about COVID-19 as well as the reasons for confinement and its duration may be a source of confusion from some people). Better understanding of the confinement situation (effectiveness, methods, duration, etc.) is likely to help improve its' tolerance. Indeed, several studies have highlighted the key role of information for people in confinement: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

Importance of establishing and maintaining links

Clastration requires developing and supporting social communication, especially for people in confinement. The benefits of building and maintaining links is developed below, both for teams (see box) and for patients and their families (see the following section on telephone platforms). Social ties are essential, regardless of age.

https://translate.google.com/translate?hl=fr&prev=_t&sl=fr&tl=en&u=https://www.who.int/docs/default-source/coronavirus/healthy-parenting/english-tipsheet1-updated.pdf%3Fsfvrsn%3D788a73e3_2

Team links

Sylvie Tordjman, Henry Fagon

Weekly team meetings (by telephone)

The weekly team meetings were maintained by conference calls, for all PHUPEA units (mobile teams, hospital units, National Center for Aid to Children with High Potential, adolescent consultations, medico-psychological centers). After more than a month and a half of conducting meetings in this way, the feedback from professionals was very positive: these weekly telephone meetings made it possible for human and professional links to be maintained between team members, especially for people working from home to hear from and share information with each other. This strengthens the sense of belonging to a team, and increases group cohesion by bringing professionals together around a shared experience, helping them to adapt together to the practice of teleconsultation. This telephone link offers significant support to professionals who may feel alone, isolated or even excluded after days of confinement at home and separated from their colleagues. In particular, this avoids the effects of stigma for COVID+ professionals. We understand better the preventive mental health function for medical staff during confinement: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8 / fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

The weekly telephone meeting facilitates also the maintenance and coordination of continuing care for a family or child. It prevents families from being “overloaded” with a succession of calls by professionals who are teleworking, but also a feeling of abandonment in patients who might be forgotten because of the interruption of face-to-face follow-ups. This weekly meeting enables professionals to review and plan remote follow-up consultations (number of calls per week, etc.) and to assess the evolution of the clinical situation and the need or not for a physical appointment.

Information communication plays a vital role, allowing teams to be reassured, to facilitate organization at the clinical and institutional levels, to imagine what will happen and to make projections in the future. Quality, concise and targeted communication (time limited speaking), was reported by all professionals, as was the quality of communication (active listening, less off-topic discussions, increased concentration). A working framework for these conference calls has become essential for some teams: it is necessary to announce oneself when entering the meeting and listen to others without cutting them off. Many professionals considered the duration of 1 hour for the telephone meeting too short whereas others deemed the duration of 2 hours to be too long as it requires sustained attention. Finally, weekly telephone meetings helped establish a regular process in which professionals could engage, so that these weekly meetings were experienced as a complementary tool to clinical practice and popular experience.



Henry Fagon, Cadre de Santé, PHUPEA

Weekly meetings between teams (telephone and vidéoconference)

Finally, weekly telephone meetings have also been organized between the mobile teams that are part of the AEMP non-profit organization (Association of Mobile Teams in Psychiatry). These meetings were an important source of information about practical facts concerning the highly diverse mobile teams in psychiatry which have had to re-organize to face the lockdown (from simply wearing masks to putting on full protective equipment when meeting families, taking their temperature, etc.). A dynamic experience of sharing and support between teams was further enhanced by sending informative documents, but also photos and humorous videos punctuated by “take care!”

The group identity was also reinforced during these weekly meetings, as described above for the PHUPEA Pole team meetings, and illustrated by the participation and collaboration of the AEMP mobile teams in joint research as well as the collective text to support mobile psychiatry teams focused on the elderly in difficulty due to strict confinement in nursing homes.

The construction and regular maintenance of a telephone link between people and teams, from the same institution or from different institutions, has made it possible to create a relational network that supports individuals in the period of confinement, helping them to face social isolation and build on the resources of each other and the group.



AEMP (Association of Mobile Teams in Psychiatry)

Telephone platforms: communication, collaboration, prevention and care

From the beginning of confinement, telephone platforms were set up to provide opportunities for listening and communication, and to promote prevention (accompaniment, support, early identification of the possible psychological effects of confinement), and therapeutic care (in particular for anxiodepressive disorders, stress and trauma), with remote monitoring by individual or group teleconsultations (with a support group, etc.).

These telephone platforms are part of a social network and show people who are confined that they have not been forgotten: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

Specialized platforms for children and their families are necessary to ensure therapeutic care for vulnerable populations with specific needs who require expertise in the concerned field (from the perinatal period to childhood and adolescence, with support for parenting and families in difficulty).

Regional Perinatal and Adolescent platforms will be described in this book, in chapters IV and VI respectively. The chapters underline the importance of collaborations between front-line professionals, maternity staff and PMI (mother and infant protection) for the Perinatology platform, as well as professionals of the National Education Service for the Adolescents platform (such as teachers in contact with young people for lessons and homework), who take care of children and parents who may be in difficulty.

Other platforms operate as well in the Ille-et-Vilaine county, such as the Families in difficulty platform (coordinated by professionals in child psychiatry trained in family therapy in collaboration with parent support organisations), or platforms for Children exposed to domestic violence that require close links between child psychiatry and front-line professionals (such as pediatricians or the police), outlined here in the box on children exposed indirectly and directly to domestic violence.

Children exposed to domestic violence: Importance of collaboration

Sylvie Tordjman, Martine Balençon

Since the beginning of confinement in France (March 17, 2020), there has been a 32% increase in reports of domestic violence across the country, especially after the first two full weeks of confinement, with a 36% increase in Paris (Le Monde, March 31, 2020). The same trend was observed in Spain (20% increase in reports of marital violence), in Cyprus (30%) and in Brazil (50%): <https://www.theguardian.com/society/2020/mar/28/lockdowns-world-rise-domestic-violence>- world-rise-domestic-violence. In China, the number of women and children mistreated has tripled during confinement, according to messages of appeal for help published on social networks (<http://www.theguardian.com/society/2020/mar/26/warning-over-rise-in-uk-domestic-abuse-cases-linked-to-coronavirus>). Faced with this resurgence of intra-family violence during periods of confinement and social isolation, it is necessary to intervene as soon as possible with suitable support and specialized professionals trained to deal with these problems.

Platform for Children indirectly exposed to domestic violence

This platform was created in 2010, well before confinement, as part of a partnership with the departmental national police of Ille-et-Vilaine (GGD35) and an agreement between the national police, the Prosecutor's Office, and the CRIFEM (mobile team for intra-family crisis care, PHUPEA: university hospital department of psychiatry for child and adolescent, Guillaume Regnier Hospital Center).

CRIFEM's clinical activity is centered on children and adolescents who are exposed to spousal violence (1) and based on an 18-month experience with Steven Marans, Professor in child and adolescent psychiatry at Yale University. Professor Marans has in fact developed a program for children exposed to domestic violence (2), the Child Development-Community Policing (CD-CP), which is based on a partnership between the police and mental health professionals enabling them to intervene early in families where violence occurs. This program coordinated by Professor Marans has been extended to the whole United States.

During confinement, telephone calls relating to intra-family violence increased by 33% according to the figures from GGD35. The exposure of children to intra-family violence (including domestic violence) represents a major societal and public health issue. Indeed, children who have been exposed to such violence constitute a vulnerable population who are at a greater risk of experiencing psychological suffering, developing psychotrauma (<https://www.em-consulte.com/article/1298796/article/psychotraumatisme-de-l-enfant-et-de-l-adolescent>) and subsequently acts of aggression or victimization (3). The effective access to mental health care for these children depends on the reactivity of the "telephone meeting" with the family within 72 hours of the intervention of front-line professionals, such as the National Police. This platform allows these professionals (National police, local police, social services, professionals from the national education service, non-profit associations, etc.) to contact the platform and to communicate the contact information of families or those with parental authority who have signed an agreement form. A family member can also call this platform directly, but this is not often the case. The professionals of CRIFEM contact the family by phone and conduct remotely a psychological evaluation of the child. Decisions concerning access to appropriate care are made based on this evaluation, which can be provided using teleconsultation if necessary.

Platform for children exposed directly to intra-family violence (mistreatment)

During this period of confinement, children living in homes where intra-family violence is present have little opportunity to seek outside help. The calls for help may come through emergency service numbers, such as 911 in USA, 999 in UK and 112 in Europe. Although these services are able to coordinate responses to child protection (reports, etc.), they do not provide a precise diagnosis and adapted therapeutic care. After identifying the situations involving intra-family violence, the caller can be quickly put in touch with professionals (psychiatrist, psychologist, pediatrician, pediatric nurse, therapist) who are trained in clinical approaches to violence enabling remote telephone exchanges and a teleconsultation. For many years now, pediatric teams from Rennes University Hospital (CASED: a unit specialized in children's who are in danger at home) and child psychiatrists from PHUPEA have collaborated on the subject of children in danger and have developed practices in response to related requests. They have acquired expertise through local, regional and national networks. The territorial network is supported by the regional health authority and relies on the referent doctors for child protection in the county, the pediatric hospital teams specializing in violence against children and child psychiatry services.



Doctor Martine Balençon

Pediatrician-forensic pathologist, CASED, CHU Rennes, UMJ Mineurs APHP, Founding President of the French Society of Medico-Legal Pediatrics.

Compression in time and space

Time compression

Time Lost - suspended time

In spite of the diversity of the representations of temporality and the measures which result from them, one can find certain constants present regardless of the choice of the time referential, such as the notion of repeated movements with a stable rhythm which will make it possible to define equal and invariable units of time (<https://www.em-consulte.com/article/1026177/alertePM#AFF0010>). However, during confinement, a distorted perception of time appears: time seems to be suspended. Several factors contribute to the emergence of this “time-suspended bubble.” First, the perception of time depends, at least partially, on capabilities and cognitive processes such as memory, and anticipation with the projection in the future, as well as emotions (4). Thus, the absence of events and therefore of memories of notable events in this “suspended bubble” contributes to the perception of fixed time. A review of the literature (5) shows that the estimation of the passage of time depends on the number of events stored. Moreover, the difficulty to project into the future to represent, for example, the end of the confinement and COVID-19 pandemic promotes the perception of time “without movement” or “stopped time”. This shows the importance of staying informed on the evolution of knowledge and management of the health crisis. In addition, emotions, in particular anxiety (6), produce temporal distortions: <https://doi.org/10.1098/rstb.2009.0013>

Last but not least, the days pass by and ressemble each other without structured daily and weekly experiences. Temporal rhythmicity provided by work outside and rest on the weekend has disappeared. We shift, we desynchronize. The lack of time to go to school or work and a drastic reduction in social activities, both inherent to confinement, lead to a desynchronization of physiological rhythms and a loss of time markers. Several studies report states of confusion in people who are confined: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

As a reminder, physiological rhythms are a common characteristic of living species. Circadian rhythms constitute a complex network of internal biological clocks (cardiac, adrenal, muscular, pancreatic, etc.) allowing both anticipatory and optimal temporal organization and adaptation of biological functions to environmental changes (7). For example, the circadian rhythm

of melatonin (a sleep neurohormone but also involved in the synchronization of internal biological clocks and their peripheral oscillations) makes it possible to adapt to the light/dark cycle by regulating the sleep/wake rhythm. The *zeitgebers* (*time cues*) are external environmental factors which contribute to the synchronization of biological internal clocks (8), such as light (and therefore wake up time) and regular meal times, bedtime/wake-up, social activities (social contact) or physical activities (physical exercise increases body temperature regulated by melatonin) and schedules for going to school or work.



Sculpture of Arman (1985) at Saint-Lazare station entitled “L'heure de tous” (everyone's time)

An entire chapter (Chapter II) is devoted to the desynchronization of sleep-wake rhythms during confinement and the resulting effects, such as insomnia. This desynchronization of physiological rhythms increases with age, for example concerning autonomic nervous system functions (<https://www.em-consulte.com/article/1026177/alertePM#AFF0010>). Therefore, children have a faster heart rate than adults, especially because they are young. Likewise, motor activity and body movements are accelerated in children compared to the elderly. Walking speed even decreases with age. It is not surprising to see children running on the street, adults walking at a brisk pace (but without running) and the elderly advancing slowly (the vision of an old person running down the street would be somewhat surprising...). It is perhaps this acceleration of children's physiological rhythms (such as heart rate) which makes them perceive time going by in slow motion in their environment (things appear to go slowly because there is a mismatch between the individual's physiological rhythm and that of the environment). William James (9) pointed out that the older we get, the more the perceived length of time becomes shorter (especially the days, months and years). We can raise questions about the difficulty of relational synchronicity that can occur between children and adults in the same family living together in confinement!

Time regained

In view of what has just been mentioned, we can only stress the need during confinement to organize events that repeat regularly on a daily and weekly basis, as noted in the box of this chapter for weekly telephone meetings that allow, not only for social links to be maintained, but also to provide a “ritual.” Indeed, organizing one's day with a clear structure during confinement is very important as it provides support as does structuring the time for school homework (see chapter III), but also by respecting zeitgebers, a rhythmicity with identical sequences is reintroduced (for example, meals at fixed times, regular physical exercises: <https://www.familyeducation.com/at-home-learning-resources-for-the-covid-19-outbreak> ; https://www.who.int/docs/default-source/coronavirus/healthy-parenting/english-tip-3-covid-19-parenting.pdf?sfvrsn=492ecf57_6), allowing biological clocks to be resynchronized (especially the sleep-wake rhythm: see the advice for better sleep in chapter II), and to better represent time and temporality.

Spatial compression



The single place

Confinement tends to restrict one's experience to the home. However, each constraining condition corresponds to a different environment which is linked with a different identity.

Each individual has several identities and can be conceived as a plural "subject" who is situated in a family environment (family identity with symbolic and genetic lineage, as well as socio-cultural origins), a socio-emotional environment (social identity with a network of friends), and a school/university/professional environment (pupil/student identity, past, current or future professional identity). However, identity is not limited to belonging to a family, social or professional group. The individual is also part of a societal environment with an identity as a citizen with rights and duties in society (civic identity), a possible identity within a sports association (physical identity which refers to the body) or a religious/humanist community (spiritual identity), or an identity of being a creator recognized for his or her skills (subjective identity with creative potential).

Each place is associated with a different identity and a different point of view. Changing the setting allows the individual to change his or her point of view, to express another identity and to introduce a movement that is both physical and psychic.

One given environment can reveal identities that could never have been expressed in another environmental context. Indeed, changing places and environments make it possible to reveal unsuspected facets of a person's identity, just as the chemical bath in traditional photography makes visible a latent image which could not have appeared otherwise. The change in environments not only reveals latent identities, but also allows new identities to develop in an evolutionary dynamic. The question does not in fact relate to the existence or not of a latent identity and a stable and permanent identity structure of the subject, as we may think in terms of a personality trait. The real issue is how to facilitate, thanks to the changes in places and relational and physical environments, the expression of a plurality of identities allowing the subject to emerge from a fixed monolithic self representation, to then be in motion and to evolve.

Thus, changes of place can bring about changes in perspectives, revealing other identities of the individual, even new identities.

Differentiated spaces

Confinement and the lack of access to a diversity of environments reduces the plurality of a person's identity, or at least its expression. The individual, confined to a single space, risks being exclusively defined through his or her family identity. In addition, if there are problems relating to stress or parenting, few opportunities to escape and low control, there is indeed little "oxygen" and the subject finds him or herself even more compressed. In this context, domestic violence, which tends to occur more frequently, indicates the importance of accompanying the confined family with a particular focus on family dynamics and parenting, as is the case with the aforementioned telephone platform "Families in difficulty : prevention and care" which combines family therapists and parental support associations.

Faced with this single place of residence, it appears essential to (re)introduce a diversity of places with different functions and to refer to the various identities of the individual. Maintaining regular work activity, with the organization at home of an area dedicated to work (associated with a professional identity for the adult and a student identity for the child), is necessary, and is facilitated by telework and the organization of homework for the child (see Chapter III).

Likewise, maintaining social ties by communicating with one's network of friends (social identity) is important to help the individual to break out of isolation and to express his or her social identity, as discussed previously. The Lancet literature review shows clearly that the difficulties experienced by people who are confined are exacerbated by the lack of participation in social activities: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

Playing sports daily during confinement (thirty minutes for adults, 1 hour for children alone, if possible outside the home, enables individuals to take care of their health and also maintain their physical identity: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

<http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov-technical-guidance/stay-physically-active-during-self-quarantine>

The individual or group art therapy activities which can be carried out at home through teleconsultation, can help to induce and recognize one's identity as a creative subject. This theme is developed in Chapter VII.

Finally, creating differentiated spaces during periods of home confinement may not be easy! Space management is necessary, families may require support to help them organize themselves when facing spatial confinement (finding and organizing a work, school, leisure corner, etc.), even when this space is limited: <https://www.familyeducation.com/school-learning/how-to-create-a-learning-space-for-your-child> ; <https://www.familyeducation.com/school/establishing-schedules-curriculum/developing-home-classroom>

In all cases, it is fundamental that one's living space (the home) can be compartmentalized into differentiated areas that are well separated, having differentiated functions in which the plurality of identities can be expressed. This, as we have seen, is much more difficult when everything is brought together and mixed in a single place.

Constraint



The imposed confinement (which may even require people to have an authorization form in order to go beyond a limited perimeter) is a real constraint and restriction of individuals' liberty, including their freedom of movement. Confinement thus represents, in this context, a major constraint which constitutes an obstacle limiting physical contact (the intended purpose) but also the mobility of those confined. Most of the deleterious effects of imposed confinement come from this restriction of freedom, whereas voluntary confinement is associated with less distress and fewer long-term mental health complications ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)). Faced with a restriction of freedom, it is important to offer choices to the confined person, not to keep them locked down passively but to adopt an active stance. This clinical posture is illustrated in Chapter III, which explores the organization of the children's homework during confinement (making the child an actor in his or her own work).

In addition, reduced travel and movement contribute to the stress of confinement and may lead to psychic rigidity. Indeed, physical movement participates in psychic mobility by triggering flexible thinking processes (<https://www.em-consulte.com/article/1026177/alertePM#AFF0010>). William James (9) emphasizes that movement induces change, a process. Research focusing on mirror neurons (10) provides an interesting insight on this topic. Thus, the same brain structures are activated during a movement which is executed and a movement which is observed or imagined. For example, if you ask a person to move by walking or just imagine the movement, the "mental journey" is identical to that of the "physical journey" that would have been accomplished (11). Imagining the journey would therefore have effects similar to those of a real event. It seems possible to reproduce the effects of displacement and physical movement through the imagination. These findings open up interesting perspectives enabling individuals to escape the constraints of confinement thanks to imagination, and thus to "travel."

Reading and music make it possible to initiate these internal journeys (several websites have been available since the start of confinement to listen to concerts: <https://urlz.fr/caRp>). Hypnosis is also an excellent tool to facilitate and accompany these journeys; Chapter VIII is devoted to this topic and includes a section on self-hypnosis.

Contamination



*Dr. Alain Mercuel, Director of department and national referent of mobile teams in Psychiatry-Precarity,
and his resident Caroline Muller:
In full action*

Viral contamination

Confinement was imposed as a health protection measure to reduce the risk of contamination with COVID-19. The fear, anxiety and stress of being infected with or infecting loved ones is a primary concern for people who are confined, especially in pregnant women and those with young children: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)

Regarding home visits, the recommendations of the health authority agency specify that such visits remain possible as a last resort. Professionals and teams in child psychiatry, such as some perinatal mobile teams, continue to go into patient homes. However, on April 9 2020, a court in Lille sentenced a non-profit organization of caregivers that provides home help for lack of personal protective equipment including adequate masks, goggles, gown, gloves and headcovering (complete equipment which is periodically replaced): <https://www.apmnews.com/depeche/162709/349758/une-association-d'aide-a-domicile-condamnee-pour-manque-d-equipement-de-protection-contre-le-covid-19>

In addition, we can raise the question of the impact this equipment has on the therapeutic relationship and alliance. The mask hides facial expressions and the mouth area, which can hamper verbal and non-verbal communication which is essential in psychiatry, and interfere with the consultation context. Masks that allow the mouth area to be seen are currently available for the hearing impaired (and could prove useful in psychiatry): <https://clbritmondiale.com/lifestyle/une-etudiante-fabrique-des-masques-pour-sourds-et-hard-of-hearing/>

The picture below illustrates our questions by clearly showing that the therapeutic relationship in a period of confinement includes: 1) the patient and family, 2) caregivers, and 3) the virus! If the healthcare team may not always have this in mind, the family has not forgotten it. Again, it is important to provide the family with a choice, make the family active in therapeutic management by offering the alternative appointments through teleconsultation. In some cases, this alternative proves impossible (adolescents refusing to communicate by telephone or video call, etc.). However, the confined families tend to be grateful to have a choice, and often seize the opportunity especially as they may often be afraid of being contaminated if they come to the medical center or if a mobile team enters their home. The worry of viral contamination as a result of the mobile team at home is very present! The therapeutic alliance is bidirectional and can only be built on a relationship of trust, without the fear of being contaminated! It is necessary to take this fear into account, to reassure and overcome it by setting up a meeting and consultation framework adapted to patients and caregivers.

Contamination of other spheres

Contamination refers to the infectious nature of COVID-19, but spreads and also extends to the relational, educational and economic spheres which are invaded by the consequences of the COVID-19 epidemic and confinement: fear of being infected by physical and social contacts are present in many people as we have just seen in the context of the therapeutic relationship, school closures which require the educational system to reorganize classes (links maintained at a distance between teachers and pupils) and homework (see chapter III), financial consequences due to the reduction of professional activity during confinement, and in some cases professional inactivity and unemployment.

Refocusing on one-self



During this period of confinement, many articles that have been published recommend that individuals refocus on oneself and sites are even available so that children can practice meditation and yoga:

<https://www.actionforhealthykids.org/activity/exploring-imagination-play-based-yoga/>

<https://www.actionforhealthykids.org/activity/mindfulness-journaling-breathing-and-more/>

This invitation to refocus on oneself is a very positive initiative, but the construction of the “self” can be fragile or not fully achieved in certain vulnerable populations monitored in child psychiatry, especially during the period of perinatality and adolescence, when focusing on oneself can be difficult or even impossible. This book contains chapters that focus on vulnerable populations in confinement, with specific needs and requiring appropriate care, vulnerable population ranging from early childhood (chapter IV) to adolescence (chapter VI), including children with psychological difficulties (children exposed to domestic violence, children who already receive care for mental disorders, etc.: see chapter V). It can be noted that confinement is exacerbated through social isolation, vulnerabilities in families already receiving care from mental health services for pre-existing psychopathological disorders: <https://doi.org/10.31234/osf.io/8svfa>

Developmental psychology provides an interesting perspective on the construction of the *self*. For example, the work of Powell and Spelke (12) has shown that babies, when presented with a video, choose characters integrated into the group rather than those outside the group. The authors interpret this behavior as a manifestation of the social self and group identity, the development of which appears to be very early, from the age of 5 months, and therefore, according to the researchers, can be considered as an archaic process necessary for the survival of the individual. The acquisition of self-awareness involves the distinction between self and the other, with the recognition of the identities of each. Henri Wallon (see <https://doi.org/10.3389/fpsyg.2019.00719>) stresses the importance of the other in the child’s construction of the *self*. René Zazzo’s observations (see <https://doi.org/10.3389/fpsyg.2019.00719>) in typically developing children show that the identification of others precedes the identification of one’s self (recognition of others in the mirror from the age of 8 months and self-recognition in the mirror around the age of 2 regardless of the country and culture). Zazzo’s studies of self-recognition, like Wallon’s, underline the major role of the other in the development of self-awareness. Self awareness is built on the relationship with the other (relational dyad), in behavioral and emotional synchronization and in the gaze of the other. The mother looks at her baby and the baby looks at his or her mother, and the baby sees his or her reflection in the mother’s eyes, like a mirror. But the mirror is distorted and the other, because it is precisely another, does not return an identical image. A baby will interpret his or her own behaviors and emotions, give them meaning according to the baby’s personality, personal history and the resonances they may have provoked in him or her. And it is this meaning, expressed through non-verbal language, words or a simple intonation that the baby notes. A baby will build on this understanding and the representations of the other to develop his or her own representations in an interactive and creative dynamic. The development of self-awareness, with the first stages of the integration of body image and the construction of body self, also involves behavioral imitation of the other. This imitation of the other develops from simple imitation by the newborn, for example the protusion of the tongue, to a more complex imitation in the child when he or she develops (verbal) language. We could hypothesize here that self-awareness is built up in front of the other in imitation of the other with the representation of what is identical, but also in the differentiation of the other with the need for separation.

This reminder of how self-awareness develops and the stages relating to group identity and the identity of others underlines the importance of being able to offer, in our therapeutic care during confinement, group approaches and approaches centered on the relation to the other. Teleconsultation supports the development of self-awareness through group and/or individual therapies (see chapter V on child psychiatry resources to deal with confinement and chapter VII on art therapy).

Psychological consequences of confinement: therapeutic perspectives

Immediate and delayed psychological and psychopathological effects

The psychological and psychopathological effects of confinement most frequently described in the literature (see *The Lancet*: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)) relate to anxiety disorders and stress (acute stress and post-traumatic stress disorder : PTSD). A recent study in China conducted on a population of 1210 people, of which 84.7% were confined at home (between 20 and 24 hours per day), shows moderate to severe disorders concerning anxiety (28.8%), depression (16.5%) and stress (8.1%) (see Wang et al. in <https://doi.org/10.31234/osf.io/8svfa>). For the hospital staff, the experience of confinement is a major predictor of acute stress and PTSD up to 3 years later after the confinement (see *The Lancet* with link above). Length of confinement is an important variable, and the study conducted by Hawryluck showed symptoms of PTSD were greater following 10 days of confinement: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3323345/>

A risk of depression in the immediate aftermath of confinement, but also in a delayed manner (up to 30 months later), is found in the general population and vulnerable population (with a history of psychiatric care) with an increase in depressive disorders (see *L'Encéphale*: <https://doi.org/10.1016/j.encep.2020.04.007>). In the general population, depression rates vary by country, the size of the sample studied and the moment of the assessment: from 16.5% in China (see Wang et al. in <https://doi.org/10.31234/osf.io/8svfa>) to 31.2% in Canada (see Hawryluck et al. In <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3323345/>). Finally, an increase in suicides, reported by a few studies, is also observed, especially in the elderly (see *The Lancet* and *L'Encéphale* with links above).

In children and adolescents, the same psychological and psychopathological effects of confinement are observed as previously reported (anxiodepressive and stress disorders), however they are often discovered indirectly during a general medical consultation for, for example, childhood sleep disturbances (see Chapter II). It must be noted that in children, depressive disorders are more frequently expressed in the form of masked depression through oppositional behavior, hetero-aggressive behavior, tantrums, and/or rage. The box in Chapter III deals specifically with the management of oppositional behaviors and children's tantrums during confinement. In children, the anxiety of contamination and anxiety specific to confinement are frequently manifested through agitation or regressive behaviors, as described in Chapter V. In addition, the problems of domestic violence and the risk of mistreatment of the children, raised in confinement, are also developed in Chapter V. Epidemiological studies are not yet available to properly assess the prevalence of anxiety and depression disorders in children and adolescents who are confined.

Therapeutic approaches

Faced with anxiety and depression-related disorders observed during confinement, it is important to develop therapeutic tools that can be used remotely to help confined people (children and their families) suffering from mental distress. Diverse therapeutic tools and types of psychotherapy are presented in this book: individual or group therapies by teleconsultation, art-therapy, hypnosis, EMDR (hypnosis and EMDR being particularly useful in traumatic situations (<https://doi.org/10.1051/ppsy/201954287>)

The therapeutic care offered here is part of a variety of approaches (psychodynamic, cognitive, systemic, etc.) using tools that must be adapted to the constraints of confinement (remote therapies) and invested by all stakeholders (therapists, children/adolescents, the family). The effectiveness of the therapeutic approach selected depends on the consistency of this approach for both the subject and the therapist (in the context of confinement, available resources, and the uniqueness of each person), and the therapeutic alliance which can then be developed.

From confinement to deconfinement

We hope that this e-book will make it possible to understand better the psychological and psychopathological consequences of confinement, such as its' effects on the synchronization of rhythms and the need to remedy this by (re) structuring time. This objective of this book is also to make readers aware of the existence of vulnerable populations in child psychiatry (from perinatal period to adolescence). Finally, this work illustrates and promotes the emergence of innovative therapeutic practices that can be used remotely during confinement (such as art therapy, hypnosis and EMDR), and even after deconfinement.

Bibliography

1. Charrier, A., Oriol, C., Drenou, A., Fagon, H., & Tordjman, S. (2016). Mise en place d'un dispositif innovant dans la prise en charge des enfants exposés aux violences intrafamiliales: un partenariat entre une équipe mobile de pédopsychiatrie et la Gendarmerie nationale, *Neuropsychiatrie de l'enfance et de l'adolescence*, 64(5), 295-301. [Charrier, A., Oriol, C., Drenou, A., Fagon, H., & Tordjman, S. (2016). Establishment of an innovative device in the care of children exposed to domestic violence: a partnership between a mobile child psychiatry team and the National Gendarmerie, *Neuropsychiatry of childhood and adolescence*, 64 (5), 295 -301]
2. Marans, S., & Berkman, M. (2016). In: Lightburn A, Sessions P., editors. *Police-mental health collaboration on behalf of children exposed to violence: the child development-community policing model*. Oxford: Oxford University Press
3. Adams, C.M. (2006). The consequences of witnessing family violence on children and implications for family counselors. *The Family Journal*, 14(4), 334-341.
4. Tordjman, S. (2011). Time and its representations: at the crossroads between psychoanalysis and neuroscience. *Journal of Physiology Paris*, 105(4-6), 137-148.
5. Friedman, W.J. (1993). Memory for the time of past events. *Psychological Bulletin*, 113(1), 44-66.
6. Mella, N., Conty, L., & Pouthas, V. (2011). The role of physiological arousal in time perception: Psychophysiological evidence from an emotion paradigm. *Brain & Cognition*, 75(2), 182-187.
7. Pevet, P., & Challet, E. (2011). Melatonin: Both master clock output and internal time-giver in the circadian clocks network. *Journal of Physiology-Paris*, 105, 170-182.
8. Wiss, M., & Tordjman, S. (2016). Creating a “social zeitgeber” to synchronize family emotional rhythms: A new therapeutic approach in child and adolescent psychiatry. *Journal of Physiology Paris*, 110(4 Pt B), 480-486.
9. James, W. (1890). *The principles of psychology*. In: Classics in the history of psychology (chapitre XV). <http://psychclassics.yorku.ca/James/Principles/prin15.htm>.
10. Rizzolatti, G., & Arbib, M.A. (1998). Language within our grasp. *Trends in Neurosciences*, 21, 188-194.
11. Decety, J., Jeannerod, M., Germain, M., & Pastene, J. (1991). Vegetative response during imagined movement is proportional to mental effort. *Behavioural Brain Research*, 24, 1-5.
12. Powell, L.J. & Spelke, E.S. (2013). Preverbal infants expect members of social groups to act alike. *Proceedings of the National Academy of Sciences (PNAS)*, E3965-E3972.

To know more

Literature reviews on the psychological and psychopathological effects of confinement:

- Mengin , A., Alle, M., Rolling, J., Ligier, F., Schroder , C., Lalanne, L., et al. (2020). Psychopathological consequences of confinement. <https://doi.org/10.1016/j.encep.2020.04.007>
- Brooks, SK, Webster, RK, Smith, LE, Woodland, L., Wessely, S., Greenberg, N. et al. (2020). The psychological impact of quarantine and how to reduce it: rapid review of the evidence. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)
- Hossain, M., Sultana, A., & Purohit, N. (2020). Mental health outcomes of quarantine and isolation for infection prevention: A systematic umbrella review of the global evidence. <https://doi.org/10.31234/osf.io/dz5v2>
- Inchausti, F., MacBeth, A., Hasson- Ohayon , I., & Dimaggio , G. (2020). Psychological interventions and Covid-19: what we know so far and what we can do . <https://doi.org/10.31234/osf.io/8svfa>

Videos for children, adolescents and adults in confinement

- <https://www.unicef.org/parenting/coronavirus-covid-19-guide-parents>
- <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/videos>

II

Sleep in confinement

Sleep and the sleep-wake rhythms of children and adolescents in periods of confinement linked to the COVID-19 pandemic: Tips for better sleep

Stéphanie Bioulac, Anna Maruani, Richard Delorme, Carmen M. Schroder



Stéphanie Bioulac

*Sleep Clinic, Department of Functional Exploration of the Nervous System, CHU de Bordeaux, Place Amélie Raba-Leon, 33076 Bordeaux, France
USR CNRS 3413 SANPSY, CHU Pellegrin, University of Bordeaux, France*



Anna Maruani

Department of Child and Adolescent Psychiatry, Robert Debré Hospital, Paris, France



Richard Delorme

Department of Child and Adolescent Psychiatry, Robert Debré Hospital, Paris, France



Carmen M. Schroder

Department of Child and Adolescent Psychiatry, Strasbourg University Hospitals, France
CNRS UPR 3212, Institute of Cellular and Integrative Neurosciences, Strasbourg, France

E-Mail: schroderc@unistra.fr

Millions of children and adolescents around the world suffered from sleep disturbances before COVID-19 occurred, and unfortunately, the current pandemic is creating a multitude of new challenges, even for children and adolescents who previously had no sleep-related problems. The confinement linked to the COVID-19 virus can indeed cause significant disturbances in the sleep-wake rhythm, induced by the radical modifications of daily activities and life routines of our children. The stress caused by this pandemic can also affect certain children, adolescents and their families and have consequences on their sleep-wake rhythms. Even if we do not have specific data on the prevalence of sleep disturbances in children relating to confinement, clinical experience and evidence from the literature in the general population suggest that it is a large-scale problem and can have consequences on the emotional management of lockdown and on its psychological impact.



Dysregulation and desynchronization of sleep-wake rhythms during confinement

The 24-hour sleep-wake rhythm is regulated by two distinct processes: the homeostatic process, based on sleep pressure, and the circadian process, orchestrated by the biological clock located at the level of suprachiasmatic nuclei of the anterior hypothalamus. When these two processes interact in an optimal way, they allow for a good quality of vigilance during the day, and a good quality of sleep during the night (1). Synchronizing our sleep-wake rhythm depends on the integration of a number of parameters (*Zeitgebers* or time cues) by the biological clock. The most important time cue in humans is light (exposure to daylight), (2) others include physical activity during the day, meal times and social interactions (1).

During confinement the majority of these key time cues (exposure to light which also depends on the time of getting up in the morning, physical activity, meal schedules, social interaction) can be greatly modified or reduced, inducing disturbances of sleep or sleep-wake rhythm disorders. Additionally, an exposure to some of these *Zeitgebers* at inadequate times of the day (for example, media exposure later the evening) can have a phase delaying effect on the sleep-wake rhythm, comparable to a shift schedule, with difficulties of falling asleep and increased sleepiness during the day (1).



In children, confinement can induce dysregulation or desynchronization of rhythms due to lack of schooling. Indeed, in response to the 2019 coronavirus (Covid-19) pandemic, many countries, first in Asia, then in Europe and finally in the United States, have ordered school closures to prevent contagion. Although necessary, the closing of schools associated with lockdown at home can have extremely negative effects on children's physical and mental health (3,4). Even if there are only a few studies on the specific impact of confinement on children, studies that explored the consequences of periods without school, like weekends and summer holidays, report weight gain during these periods as a result of decreased physical activity, irregular sleep-wake schedules and increased media exposure and screen-time (4). It is likely that lockdown at home will aggravate the negative effects of periods without school.

Brazendale et al. described the "Structured Days Hypothesis" (SDH), a concept based on the need for structured days (such as the school day). This allows for a planned, segmented and supervised organization by adults which plays a role in the overall protection of the child (3). This concept was first described in the context of increasing obesity in the United States where greater increases in weight were noted during the holidays, compared to school periods and on weekends compared to weekdays. According to the SDH, routine and regular planned organization has an impact on the behaviors that regulate hunger and satiety of children (3). This conceptual model is structured around four factors: physical activity, sedentary/screen time, sleep and diet. It is possible to extend this concept to the general health of children in the context of lockdown at home.

Once established, sleep disturbances in children and adolescents also have a significant impact on the quality and quantity of parental sleep, as well as on the overall functioning of the family.

Effect of stress on sleep and effect of sleep on emotional regulation



Based on literature focusing mainly on adults, confinement in the context of the Covid-19 pandemic is an important stress factor that increases the risk of developing symptoms of insomnia or an insomnia disorder if symptoms persist over time (5). Indeed, *insomnia* disorder is defined as difficulty falling asleep, maintaining sleep or waking up early, with a clear impact on the person's daytime functioning (in spite of sufficient opportunity for sleep). These repercussions on daytime functioning can include fatigue or even daytime sleepiness, attention difficulties as well as depression, anxiety or even addiction (6). The diagnosis of *chronic insomnia* disorder is made when these difficulties occur at least 3 times a week for a period of 3 months. A higher prevalence of insomnia disorder has previously been described among subjects in quarantine, related to an increase in stress and anxiety ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8 / fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)).

A reduction in total sleep time associated with stress relating to the pandemic can increase vulnerability to viral infections as well as the risk of developing psychiatric disorders, including addiction (7). Sleep loss can also affect cognitive performance and executive functioning, particularly decision-making; indeed, sleep loss can lead to increased impulsivity and thus have deleterious effects on the individual's social, family and professional life.



For children specifically, stress related to the virus and to the context of lockdown, as well as to parental stress and behavior during this unprecedented situation, can give rise to the onset of sleep-wake rhythm disorders or aggravate existing sleep disorders. In fact, insomnia-type sleep disorders are common in children (with a prevalence that can vary between 25-62% for children and teenagers under 18 years old, depending on the measurement tools used), and have been correlated with emotion regulation disorders and behavioral disturbances (8). The role of sleep in emotion dysregulation is increasingly discussed, in children similar to adults (9). In the context of this pandemic, it is important to point out that insomnia is a significant risk factor for the development of post-traumatic stress disorder (PTSD) ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext)). A recent study on Covid-19 and its impact on adults showed a prevalence rate of PTSD of approximately 7% among Wuhan residents (10). People with better sleep quality and fewer early morning awakenings reported less PTSD symptoms (11). It must be noted that the average post-traumatic stress scores were 4 times higher in children who had experienced a situation of quarantine compared to children who did not experience this situation (12). It will be important going forward to understand better the relationships between the COVID-19 pandemic, confinement, sleep disorders and the emergence of post-traumatic symptoms in children and adolescents.

Tips to help your child sleep better

* The PDF of this brochure can be downloaded here (in French):



<https://www.sfrms-sommeil.org/articles-a-la-une/sommeil-de-l-enfant-en-situation-de-confinement/>

Even if lockdown at home can cause or increase sleep disturbances in your child, this is not inevitable - you can improve it! This is especially important as good sleep will help your child to cope better with stress and anxiety; in addition, it will help strengthen his or her immune system.

Here are some simple and practical tips to improve the sleep-wake rhythm of your child... 24 hours a day.

DURING THE DAY: foster good sleep

Leaving the bed in the morning!

- During confinement, your children may tend to do everything in their beds: schoolwork, reading, eating, sharing via social networks ... but this makes falling asleep at night more difficult.
- Getting enough light, moving and eating regularly!
- These simple measures are essential for the biological clock to regulate our sleep-wake rhythms!
- If permitted, go outside every day, even briefly.
- You can do sports or physical activity every day, even indoors!
- Feeling safe allows your child to relax in the evening!
- Feeling safe allows your child to let go at night. Reassure him or her all the while remaining realistic.
- Ban permanent exposure to news or media that increases anxiety.
- Help your child to manage his or her emotions without sharing yours too much.
- Show that you are protecting yourself - teach your child to do so as well!

IN THE EVENING: prepare your sleep well

Managing screen time!

Limit screen time in the evening, for the whole family, at least 1 or 2 hours before bedtime. This will allow you to discover other activities to share as a family!

Ritualizing!

- Keep the evening routines (stories, hugs, music) or even reinforce them.

Listen to your child's thoughts!

- The evening is the perfect time for complicity.
- Now is not the time to discuss the negative events of the day - this can generate unnecessary stress before going to sleep.

Managing anxiety

- Possibly through practice of soothing strategies (such as relaxation or meditation).

Going to bed at regular times!

- For your teenagers: they are natural evening chronotypes. Choose a slightly later schedule with them, adapted to their natural sleep phase, but keep it regular.

AT NIGHT: making the night suitable for sleep

Respecting the privacy of your child's or your teenager's room!

- It's his or her personal space. To make your child feel comfortable, let him or her organize it the way he or she wants - with your help.

Keeping the room quiet, cool and dark

- Be sure to keep the room temperature around 18-20 degrees Celsius.
- If your child is afraid of the dark: allow a light but with low intensity (open door, nightlight ...), far away from your child's head.

IN THE MORNING: ensuring the proper functioning of the biological clock

Regular get-up times and light exposure!

- This is very important for our biological clock.
- Again, for adolescents: choose a slightly later schedule with them, adapted to their natural sleep phase, but keep it regular.

Do not let your child stay in bed if they have slept badly at night.

To help your child sleep better, help him/her keep a regular sleep-wake rhythm! And most of all, take care of yourself as a parent, as much as you take care of your family!

If, however, your child experiences persisting unusual or severe sleep disturbances, recurrent fears of the illness and death, anger, or separation anxiety, etc ... get in touch with a healthcare professional (your general practitioner, pediatrician or child psychiatrist).

Conclusion

The confinement of the population, especially pediatric populations, can give rise to a negative spiral in which stress and the absence of rhythms and activities during the day can lead to sleep disturbances, which are characterized by both a reduction in total sleep time and a decreased quality of sleep, which in turn weakens emotion regulation in children and their families. Parents, who are also at risk for developing sleep disturbances in this context, should promote behaviors to regulate their child's sleep. It is therefore crucial to support parents by offering strategies promoting children's sleep, such as scheduled times for sleep and waking, and taking into consideration environmental factors (such as light, noise and temperature). A group of academic societies has proposed tips to help families promote good sleep and wake regulation for their children (see box on the previous page).

Bibliography

1. Fuller, P.M., Gooley, J.J., & Saper, C.B. (2006). Neurobiology of the sleep-wake cycle: sleep architecture, circadian regulation, and regulatory feedback. *Journal of Biological Rhythms*, 21 (6), 482-493.
2. Stephenson, K.M., Schroder, C.M., Bertschy, G., & Bourgin, P. (2012). Complex interaction of circadian and non-circadian effects of light on mood: shedding new light on an old story. *Sleep Medicine Reviews*, 16 (5), 445-454.
3. Brazendale, K., Beets, M.W., Weaver, R.G., Pate, R.R., Turner-McGrievy, G.M., Kaczynski, A.T., ... & von Hippel, P.T. (2017). Understanding differences between summer vs. school obesogenic behaviors of children: the structured days hypothesis. *International Journal of Behavioral Nutrition and Physical Activity*, 14 (1), 100.
4. Wang, G., Zhang, Y., Zhao, J., Zhang, J., & Jiang, F. (2020). Mitigate the effects of home confinement on children during the COVID-19 outbreak. *The Lancet*, 395 (10228), 945-947.
5. Altena, E., Micoulaud-Franchi, J.A., Geoffroy, P.A., Sanz-Arigita, E., Bioulac, S., & Philip, P. (2016). The bidirectional relation between emotional reactivity and sleep: From disruption to recovery. *Behavioral Neuroscience*, 130 (3), 336.
6. Morin, C.M., & Benca, R. (2012). Chronic insomnia. *The Lancet*, 379 (9821), 1129-1141.
7. Geoffroy, P.A., Tebeka, S., Blanco, C., Dubertret, C., & Le Strat, Y. (2020). Shorter and longer durations of sleep are associated with an increased twelve-month prevalence of psychiatric and substance use disorders: findings from a nationally representative survey of US adults (NESARC-III). *Journal of Psychiatric Research*.
8. Mindell, J.A., Leichman, E.S., DuMond, C., & Sadeh, A. (2017). Sleep and social-emotional development in infants and toddlers. *Journal of Clinical Child & Adolescent Psychology*, 46 (2), 236-246.
9. Simon, E.B., Oren, N., Sharon, H., Kirschner, A., Goldway, N., Okon-Singer, H., ... & Hendler, T. (2015). Losing neutrality: the neural basis of impaired emotional control without sleep. *Journal of Neuroscience*, 35 (38), 13194-13205.
10. Huang, Y., & Zhao, N. (2020). Generalized anxiety disorder, depressive symptoms and sleep quality during COVID-19 epidemic in China: a web-based cross-sectional survey. *medRxiv*.
11. Liu, N., Zhang, F., Wei, C., Jia, Y., Shang, Z., Sun, L., ... & Liu, W. (2020). Prevalence and predictors of PTSS during COVID-19 Outbreak in China Hardest-hit Areas: Gender differences matter. *Psychiatry Research*, 112921.
12. Sprang, G., & Silman, M. (2013). Posttraumatic stress disorder in parents and youth after health-related disasters. *Disaster Medicine and Public Health Preparedness*, 7 (1), 105-110.

To know more

- The Sleep Council : www.sleepcouncil.org.uk
- The Children's Sleep Charity : www.thechildrenssleepcharity.org.uk
- American Academy of Sleep Medicine COVID-19 resources: <https://aasm.org/covid-19-resources/>
- MindEd UK COVID resources: <https://covid.minded.org.uk/>
- National Sleep Foundation: <https://www.sleepfoundation.org/sleep-topics/children-teens-sleep>
- Sleep Research Society: <https://www.sleepresearchsociety.org/>
- Sleep App: Kids Sleep Dr: <http://kidssleepdr.com/>

For parents:

- Supporting parents of children and young people during lockdown: https://www.publichealth.hscni.net/sites/default/files/2020-04/Supporting%20parents%20of%20Children%20and%20YoungPeople%20during%20lockdown.whsct_.pdf
- 5 tips for a better sleep during lockdown: https://www.youtube.com/watch?time_continue=13&v=mghlks-kHGc&feature=emb_logo

Relaxation and meditation tools for children:

- 7mind: <https://www.7mind.de/en>
- Headspace: <https://www.headspace.com/>
- Cosmic Kids Yoga <https://www.cosmickids.com/>

III

Organize school homework time by increasing the child's motivation during confinement

Chloé Stéphanovitch, Dr Benjamin Landmané, Dr Alexandre Hubert, Pr Richard Delorme



Chloé Stéphanovitch

Neuropsychologist at the Reference Center for Learning Disorders and the Early Childhood Unit of the Medico-Psychological Center for Children (20th arrondissement), Paris.



Dr Benjamin Landmané

Child psychiatrist, Head of Clinic at the Center of Excellence for Neuro-developmental Disorders of Ile de France (InovAND) and in the Child Psychiatry Department, R Debré Hospital, Paris.



Dr Alexandre Hubert

Child psychiatrist, specialist in non-drug therapy, and head physician of the Medico-Psychological Center for Children (20th arrondissement), Paris.



Prof Richard Delorme

*Child psychiatrist, Head of the Centre of Excellence for Neuro-developmental Disorders of Ile de France (InovAND) and head of the Child Psychiatry Department, R Debré Hospital, Paris.
E-Mail: richard.delorme@aphp.fr*

To complete homework in a serene climate, it is necessary to help the child to be organized and give him or her the choice of certain aspects so that the child becomes an “actor” in his or her own work. To achieve this, it is enough to respect a few rules, which are simple and quick to establish.

Organize school homework time ⁽¹⁾

Workspace



It is important to differentiate between workspaces and play spaces. With the child, choose a place dedicated to homework and organize it accordingly, so that this space is practical and conducive to work.

Store school supplies nearby.

Avoid distractors (screens and games must not be accessible or visible).

Learn to manage work time



Help the child get organized

- Each week, create an activity schedule including working hours, then systematically remind the child of homework time a few minutes before.
- When the time is right, ask the child to list aloud the homework he or she has to do, ask him or her about the equipment needed and encourage the child to take it out.

Make the child an actor in his or her work

- Making the child an actor means asking the child what he or she wants to start with, what he or she thinks will take the most amount of time, what the child considers to be the easiest, and prefers to do ... It is important that the child does not assume a passive position in his or her learning.

Foster concentration



Reduce attentional distractors

- There is a clear need to reduce distractors that can disrupt the child's attention, including screens and games!
- BE CAREFUL: some children need to handle an object (pen, anti-stress ball, etc.), to move around in their chair, to shake their legs, to have some background noise... This does not necessarily impact negatively on their concentration, on the contrary. Try it with the child, let him or her move around and see if it has a positive impact on the child's concentration and efficiency.

Manage time



Develop the child's temporal organization

- Our optimal concentration time, whether for an adult or a child, is 20 minutes. Organize homework time as follows: 20 min work/5 min break/20 min work/and so on, until the homework is finished.

Make the child an actor

- Before each lesson, ask the child to estimate the time he or she thinks is needed. It is a very difficult exercise for a child, the relation to time is not the same as that of an adult. Let their guess be inaccurate, time it and at the end, ask the child to assess him or herself: does this correspond to the time they estimated?
- If you encourage the child to do this very regularly, after a few weeks, the child will be able to manage time better.

Promote time management with a timer

- The installation of a timer, an hourglass or a stopwatch can also help children who have trouble settling down to work, those who tend to daydream or those who get discouraged when facing challenges.
- Keep in mind that homework lasts between 30 to 45 minutes in elementary school, 45 minutes to 1.15 hours in middle school and 1.15 to 2 hours in high school.

Help understand the instructions



Help the child get organized

- Teach the child to put in place a routine of questions that will help him or her to develop his or her intellectual autonomy. Systematically ask the child these three questions:
- How many things are you asked to do?
- In what order should you do them?
- Do you know how to do them?

For example, if the child has an exercise on the future tense which consists of locating verbs, circling them in red, then transforming all verbs in the future, ask them these three questions:

- *How many things are you asked to do?*
- Answer: Two, to circle the verbs then put them in the future tense
- *In what order?*
- First I have to find the verbs and then I must put them in the future
- *Do you know how to do them?*
- I can spot verbs, but I forgot my lesson on the future tense. So I'm going to reread my lesson before doing the exercise.

Make the child an actor, so that he or she is less passive in the learning process

- **Ask the child what to do** (to check that he or she has understood correctly), if necessary have the child rephrase it with his or her own words. To answer the three questions above, encourage the child to use a visual strategy, to use color: for example, underline the steps of the instruction in different colors, number the things to do in order.
- *For example, (1) locate the verbs and circle them in red, (2) then transform all the verbs to the future tense.*
- **Encouraging the child to do this work requires him or her to read the instructions to the end**, to break up a long sequence into sub-steps. This also leads the child to understand the instructions and to implement **strategies to work effectively** from the outset.

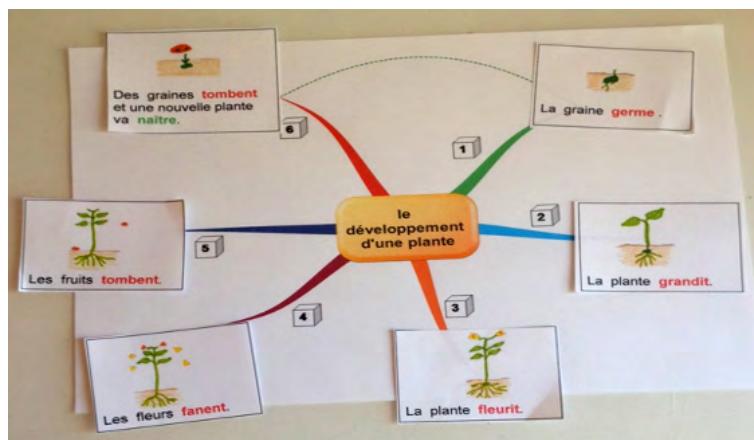
Memorize thanks to all the possible ways of learning



Foster learning through listening skills

- The child reads the lesson aloud (if he or she reads in his or her head, the auditory channel is not activated). The child can also learn the lesson with a musical tune (like learning the alphabet for example).
- The child can record the lesson on a dictaphone and listen to it several times.

Foster learning through movement



Example of a schematic and visual representation of a lesson on plant development

- Let the child learn by moving (shaking, handling a pen, swinging in a chair, walking, etc.). This allows movement of the body to be associated with what one is learning; the integration of information is then more efficient.

Foster learning through visual skills

- It is difficult to learn from a black and white handout. To assimilate the lesson, encourage the child to redesign the material to reflect him or her through writing, using colors, drawing attention to the key phrases and important concepts, making schemas, drawings, and, for the older children, making summary sheets.

Reinforce the concepts covered

• Consolidate learning

It is important to show the value and real-life application of the concepts covered by trying to reuse them in everyday life and during games. It is quite simple for mathematical concepts. For notions relating to spelling and grammar, it is important to be able to spend time reading to the child in the evening if he or she is still at the beginning of the primary school cycle.

Some examples

- **When preparing meals**

Read recipes, convert measurements, use measuring glasses to understand the concepts of weight, volume, etc.

- **During shopping**

Learn to read labels, remind them of the basics of adding or subtracting from the price of the items you are going to buy. You can also provide the child with a small budget for the shopping to do for the family without exceeding the sum.

- **During family walks**

Teach the child to use the map and guide you. Ask him or her to orient the map and explain what he or she sees on the map and what he or she sees in real life. The child can also help you to navigate in the car, for example to find a certain road without using a GPS.

- **When watching a movie and a cartoon**

Locate the continent on which Simba lives, identify animals in a cartoon, ask the child to describe the feelings of the characters, to make a summary of the whole story or of a particular scene.

- **Play educational games**

There are many games that require children to use their memory or other games of strategy (checkers, abalone game), or calculation (Good Pay).

Increase the child's motivation to work ⁽²⁾

Value the child and lead him or her to make a judgment on him- or herself

Praise, Praise

- Even when the child has not successfully completed the exercises, it is **important to value him or her**, congratulate the child, give compliments (on the child's attitude, for example).
- **Learn to associate work and development:** Do not associate homework time with success, but with a pleasant and rewarding work moment. This will also **lower the level of stress** that some children may feel in relation to school performance.
- **Promote the following behaviors:** for example, a calm attitude - attentive listening - getting to work quickly – supplies out - no opposition, etc.

Make the child an actor

- **Ask the child to identify a positive point:** Ask the child to find a positive moment concerning the work of the day. This strengthens **self-confidence**, promotes **the identification of the child's feelings** and ensures that the focus is not merely on academic success (an important point, especially when the child has difficulties in school).
- **The positive point of the day:** It is possible to verbalize, draw, write... Daily progress is the key to success.

Coping with refusal ⁽³⁾

Set up a reward system

The dot chart, also called a token saving chart, is a very important tool to help the child gain autonomy, in particular during confinement. The objective is to reinforce the desired behaviors and to reduce problematic behaviours as much as possible. During this period of confinement, it can be useful to have a few tools to try to value the child, promote his or her autonomy and see him or her happier. If the child tends not to want to get to work, to oppose, to avoid time for homework ... It is possible to set up a **reward/privilege system**, but not just in any way!

- **The implementation of this system:** It is very simple and at the same time very complicated. It is important to consider how the system will be set up. The main mistakes to avoid: too many objectives, too complicated, not functional enough and too oriented towards success. It is the effort that must be valued.
- **For the youngest children,** the system should be run over a day because a week is too long.
- **During this period of confinement,** it is probably more advisable to have a system that restarts each day because the days are long and the child will find it difficult to postpone his or her requests.

Anticipate refusals - use the dot table

Before the work session, inform the child that he will have the right to a reward/privilege if he meets the objectives set. If the child **does not respect the objectives, do not give him or her the expected reward, but do not sanction him or her.**

- **If the instruction is not carried out, we do not give the child a negative point:** we ignore it. We can just say “remember the table (the system).” Repeating or emphasizing the instruction too much can focus attention on the child’s problematic behavior, and there is a paradoxical risk of maintaining the behavior that we just want to see disappear.
- **We don’t change the rules!** If the child demonstrates problematic behavior that is outside the instructions in the table, we do not delete points. If the child shows “silly” behavior, there can be a response related to being silly but not related to the table.
- **It reflects the factors that could explain the failure:** The set point is it too hard? Too vague? Misunderstood? Not attractive enough? Too many?

Focus on achievable objectives (not linked to success but to effort)

- Choose with the child the objectives to be achieved for the work session as well as the reward/privilege.

If refusal turns into major opposition behavior or tantrums: see sidebar

How to manage oppositional behavior and tantrums during confinement?

Emma Barron, Alicia Cohen, Alexandre Hubert, Richard Delorme, Eva Stantiford

The full text can be [downloaded here](#):

Opposition: what is it?

Opposition is a way for children to learn and it is one of the key stages in their development. It is also a way for a child to test the limits or to seek the attention of his or her parents.

These behaviors are likely to be frequent and difficult to manage during the period of strict confinement following COVID-19. It is also a typical process that every parent has to face.

How to handle oppositional behavior during confinement?

- Establish physical and eye contact. It is important to bring yourself to the child's level and make eye contact.
- React in a graduated manner according to the degree of disobedience: for example removing a toy, tablet... for a short and limited period of time (a few minutes) and explaining why.
- Regulate your reaction and maintain it. Avoid the penalties that you do not keep. If you decide to impose a sanction, it must be measured and achievable.

What to do when faced with a fit of rage or anger during the confinement period?

The confinement will lead to an increased intensity for the family. The whole family is under a lot of stress, dealing with frustration. It is therefore possible that your child cannot cope at the moment with the frustrating situations (which are a risk factor to trigger tantrums or rage).

They will therefore have to be managed in the best possible way, in order to preserve family harmony during confinement.

The key message is not to "escalate" during the crisis, in other words to overreact in front of your child.

Some strategies to manage the crisis

- Stay calm in front of your child
- Apply a withdrawal period with the child in another room.
- Prevent the crisis from spreading to the whole family.
- Don't talk too much during the crisis. Your child is overwhelmed by his or her emotions, he or she is not accessible to discussion.
- After the crisis, go over the situation with your child.
- Avoid punishments. Focus on repairing the situation, by allowing your child to repair the damage caused during the crisis.

Is the anger I felt as a parent normal?

You may have felt anger at your child, guilt if you lost control of your behavior during the crisis, but also empathy for your child who is suffering, or even a feeling of discouragement in relation to your role of parents. These emotions can also overlap, you have to accept them.

Managing children's stress - Maintaining good mental and physical health

To succeed in everyday life, and have a healthy child, it is important to take measures to maintain good mental and physical health. The most important ways to help are to make sure that children feel considered, loved and taken care of.

Pay attention and listen

- Most children want to talk about the things that make them anxious or stressed - so let them do it. Accept and tell them it's okay to feel sad, upset, or stressed.

Let them ask questions

- Ask your children what their goals are with regard to learning. Also tell them about your experiences, especially the positive ones. We must start a conversation. What do their friends want to do? It is an important time of exchange which makes school work less artificial and more anchored in everyday life and reality.

Encourage positive activities

- Adults can help children and young people see the positive side of academic success. It is important for children to project themselves into positive projects. This will make them want to be like adults.

Adults can show children and young people how to take care of themselves

- For example, establishing routines, eating healthy, sleeping, exercising during confinement and taking deep breaths to manage stress. If you are in good physical and mental health, you are more likely to be readily available to handle the children in your care.

Maintain your organization and motivation for homework beyond confinement

These measures will be useful beyond confinement. Confinement often allows parents to have a more intimate representation of their child's difficulties in learning. Often the difficulties are mainly reported by the teachers. In fact, teachers often report problems which relate to attention, memory and organization. The child has learned gradually that he or she was incapable and no longer seeks to succeed. Restore the child's confidence. It is the solution for his or her personal success.

Bibliography

1. Weed Phifer, L., Crowder, A., Elsenraat, T., Hull, R. (2019). *CBT toolbox for children and adolescents. Over 200 Worksheets and Exercises for Trauma, ADHD, Autism, Anxiety, Depression & Conduct Disorders*, ISBN: 9781683730750
2. Kazantzis, N., Deane, FP, Ronan, KR, L'Abate, L. (2005). *Using Homework Assignments in Cognitive Behavior Therapy*, ISBN-13: 978-0415947732
3. Lochman, WMJE. (2016). *Oppositional Defiant Disorder and Conduct Disorder in Childhood*, Second Edition, ISBN: 9781118972564

To know more

- General information for families concerning mental health during lockdown and just after: <https://www.debrechilpsychiatry.org/toolbox>
- How to deal with eating impairment during and after the lockdown: <https://www.debrechilpsychiatry.org/post/my-child-snacks-all-day-long-since-the-beginning-of-lockdown-i-can-t-stop-him>

IV

Perinatal psychiatry during the COVID-19 pandemic

Jacques Dayan



*Associate Professor of Child Psychiatry (University of Rennes 1), Unit of Perinatal Psychiatry and Psychology (U3P)
University Hospital Center for Child and Adolescent Psychiatry (PHUPEA), Center Hospitalier Guillaume Régnier (CHGR) and CHU de Rennes;*

1414 Clinical Investigation Center (INSERM); INSERM U1077/EPHE, University of Caen; Vice-President WAIMH-France;

former Associate Professor Kings College (London)

E-Mail: j.dayan@ch-guillaumeregnier.fr

jacques.dayan@univ-rennes1.fr

The current pandemic and confinement can impact pregnancy and the postpartum period. Whereas some of the effects of this situation can be beneficial, most of them increase the psychological risks associated with the perinatal period, in particular the occurrence of anxiety, depression and attachment difficulties. These risks are exacerbated for people who are vulnerable or when the conditions of confinement are stressful. Psychologists and psychiatrists specialized in the perinatal field are best equipped to provide appropriate help and care in this context for this specific population, which is embarking on parenthood.

Consequences of confinement on the general population during the perinatal period

Results from early observational studies have revealed a moderate increase in parental concern. This was particularly the case for vulnerable individuals or individuals confined in situations that render them vulnerable (isolation, poverty, contamination). Chinese studies (excluding perinatal studies) which explored the stress levels of the adult population during confinement found that 15% of adults reported the presence of moderate stress whereas 3 to 5% reported the presence of severe stress. Under ordinary conditions without COVID, approximately 10% of mothers in Europe have a moderate depressive disorder and approximately 5% have a severe disorder (1).

Some stages are particularly vulnerable:



- The period of pregnancy, especially for women with prenatal somatic risks (2)
- Birth and immediate postpartum due to the restrictions imposed by the pandemic: These restrictions can separate the mother from her close circle of support, most importantly from her partner and her own parents, who too can be affected by this separation.



- Parents returning home without their baby in certain cases where the newborn requires intensive care.



Source: <https://www.ch-voiron.fr/presentation/Maternite.html>

- Early and late postpartum when the conditions (overcrowding, isolation with other young children etc.,), including physical conditions, hinder maternal availability and/or the help that is available to the mother.
- Difficulties in being reassured by a professional when the infant presents somatic symptoms and it is difficult to have an appointment with the doctor.

It is uncommon for these causes alone to have lasting negative consequences on the mother-child bond when the mother is supported. <https://www2.hse.ie/wellbeing/child-health/attachment-and-bonding-with-your-baby.html>

https://www.who.int/docs/default-source/coronaviruse/healthy-parenting/english-tipsheet1-updated.pdf?sfvrsn=788a73e3_2

The increase of risks can lead to or contribute to the onset of (1,3):



- relationship disorders (mother-baby, father-baby, within the couple, etc.) or violence (physical, psychological, neglect);
- anxiety disorders, and in rare cases post-traumatic stress disorder (PTSD);
- attachment disorders or psychoaffective and behavioral disorders of the child;
- possible fetal consequences due to prenatal stress, however this is still being debated (4).

This is particularly the case when the following risk factors are added (1):

- Socio-economic factors: overcrowding, financial risk, social isolation;
- Factors linked to COVID-19: being sick yourself or illness of your parents and loved ones, especially in severe forms, Exposure of healthcare professionals to the most devastating consequences of the illness (intensive care or nursing homes for example) as well as the risk of being contaminated or of contaminating relatives;
- Duration or intensity of confinement;
- Previous episodes of domestic violence.

It is important to emphasize that for some families who are not affected by the disease or have unfavorable socio-economic conditions, the early stages of confinement can be experienced as a rather positive experience due to the presence of the spouse and being in close contact with their children.

Consequences for vulnerable people

Confinement is particularly difficult for vulnerable populations as it can contribute to the onset of difficulties or/and aggravate preexisting difficulties.

- This is particularly the case for women (or individuals) who have existing mental health conditions and who are already monitored carefully during their pregnancy, such as people with a history of depression, bipolar disorders or anxiety disorders. The stress related to the confinement and pandemic leaves them more vulnerable and increases the need for security. This support can be provided over the telephone or teleconsultation within certain limits.
- This is also the case for patients with severe chronic pathologies such as schizophrenia who require close support and continuity of care.
- Certain socio-economic conditions (poverty, overcrowding, isolation due to language barriers, financial vulnerability) can exacerbate the psychosocial stress inflicted by confinement and pandemic. Certain mothers therefore require specialized help by services and teams who have received the appropriate training.
- Finally, in cases where the mother and those around her are COVID+, it is particularly important to provide reassurance with clear information and to assure the availability and the maintenance of links with obstetric services.



In these situations, attachment difficulties, anxiety disorders, couple-related difficulties may also arise ...

Although it may offer the opportunity to strengthen family relationships and alleviate work stress, confinement can also increase the domestic workload, increase pre-existing tensions, intensify latent anxiety and prevent the usual reassurance processes that unrestricted socialization allows. The most frequent disorders that result from confinement are an increase in prenatal anxiety and the appearance of postnatal depressive syndromes with more or less difficulties relating to the child. Crying, sadness, exhaustion, physical symptoms, and attachment difficulties are the most common symptoms. Violence can also arise occasionally within the couple. Support by telephone or video-consultation by perinatal specialists allows individuals to be reassured sufficiently by simple advice and also allows therapy to be initiated if necessary, in various forms adapted to the context and the request of the parents or future parents. Telephone or video support throughout pregnancy and into the late postpartum period, offers the possibility to put people in touch with other members of the multidisciplinary team. This support can provide a sense of security that promotes maternal fulfillment.

Tools for the prevention and therapeutic management of the possible psychological consequences of confinement

In this context of COVID-19, several types of care have been developed in different counties and across France.

Ideally the professionals, each having their specific area of competence, are interconnected.

The first consultation with the patient/individual is conducted over the telephone and is then followed by a videoconsultation. The face-to-face benefit/risk analysis requires permanent reflection and evolves in response to the spread of the disease and the individual cases encountered.

Indeed, from the acute period of confinement to progressive deconfinement, the decision-making methods need to be reassessed:

- All consultation services (all disciplines combined) have drastically reduced face-to-face care to decrease the risk of propagating the virus. Almost all specialized full-time mother-baby psychiatric units have closed. However, some mother-baby psychiatric day hospitals remain open under certain specific conditions.
- Midwives remain the professionals the most available for face-to-face meetings. They are also available for consultations over the telephone and can reassure women about hygiene-related measures, the risk of contamination, the possibility of maintaining a serene pregnancy, breastfeeding, etc.
- Experimental networks have been established (pharmacies to deal with domestic violence while preexisting networks have been strengthened)..

In this context, several “tools” have been created in the specific field of perinatal care:



- Telephone platforms for caregivers;
- Telephone platforms for the general population;
- Telephone platform for specialized care (with the proposition of telephone and/or video consultations);
- See links in the section “To find out more.”

Special tools are available and can be used to assess the quality of the assistance that can be provided:

- Use of scales and questionnaires which are simplified for screening, quick to administer, standardized and accepted for use with children with various conditions/difficulties: social withdrawal behavior scale (ADBB) (5) development scale ASQ-3 (6).



- Use of scales and rapid screening questionnaires to measure the mental state of the mother and father (EPDS) (2). <https://www.sciencedirect.com/science/article/abs/pii/S092493389800230>
- Video consultation, sometimes accompanied by a HV (home visit) by a midwife or nurse caregiver which includes a clinical evaluation of the mother’s global functionning. Instruments typically used for face-to-face consultations have been adapted for use during video consultation and can therefore be administered.
- Guides provided to parents

Specific county-based tool

In France, a telephone platform was set up in the Ille-et-Vilaine county to provide initial support and allow for the evaluation of difficulties which occur in the perinatal period, between conception and the first 18 months of the child. This platform is available to all during the day, in particular mothers, fathers and non-psychiatric caregivers.

It is provided by professionals trained in perinatal care with significant clinical experience (child psychiatrist, nurse, psychologist, speech therapist, psychomotor therapist, social worker).

These professionals listen to the request and quickly assess the degree of urgency and severity of the difficulties encountered.

They provide the support and guidance for reaction-related difficulties, temporary concerns or simple inquiries.

If necessary, for specific disorders, the professionals direct the requests towards specialized perinatal units or medico-social services.

The methods of assistance are most often individual (simple listening, guidance, reorientation), sometimes non-specific therapies for combating stress (relaxation, meditation, etc.).

Group care is possible, it is most often focused on general advice such as coping strategies.

Telephone interview^(7,8)



This practice was quite limited before confinement but has developed considerably and become more widespread since the beginning of the pandemic.

- The telephone is a valuable tool which makes it possible to maintain therapeutic relationships, to assess the severity of disorders with an accuracy that is almost equal to face-to-face consultations and to propose medicinal therapy or psychological therapies (it can be used for new patients).
- It is very well accepted by the vast majority of women, especially given that this form of consultation limits the risk of contamination and is therefore reassuring
- However, this modality of consultation is less effective in certain cases, such as those involving language barriers, overcrowdedness and cases where patients have severe disorders or simply refuse to use this mode of consultation.
- The training required for experienced psychiatric practitioners is short. The training for actors outside the field of perinatal psychology is longer.
- The demand for this service is very strong during the confinement period, the number of consultations has increased in all the regions in France for which information is available.
- The duration of the interview is similar to that of ordinary consultations, except for certain women who need reassurance on specific points.
- Initial consultations can be conducted without major technical problems and the telephone does not seem to reduce the quality of communication.

Update on home visits (HV)

Home visits are restricted as much as possible given the risks they involve. HV are only conducted after an evaluation of the benefit/risk ratio based on a multidisciplinary approach. They are limited to specific cases including emergencies that cannot be treated by other means, and situations which pose a serious risk to the mother, the baby or the environment and cannot be treated over the phone.

It is essential that the professionals and patients are provided with adequate means of protection for these home visits: gloves, masks, disinfection by hydroalcoholic gel as discussed in the introductory chapter.

Prospects for the future (deconfinement phase)

The end of confinement increases the risks of the apparition of new stressors:

- Risk of stigmatization of patients or people who were contaminated with COVID-19;
- Professional and financial uncertainty;
- Separation of spouses after a period of close proximity;
- Potentially degraded work or study conditions;
- Family worries or losses;
- Complications relating to the availability of childcare ...

Support and guidance during pregnancy and the postpartum period enable preventive action to be taken and for mothers to be orientated to the appropriate services or professionals.

This support and guidance must therefore be provided for at least several months and adapted in accordance with the evolution of the pandemic, hence the importance of maintaining the option of telephone interviews and teleconsultations.

Bibliography

1. Dayan, J. (2016). *Les baby blues*. Paris. PUF. [Dayan, J. (2016). *Baby blues*. Paris: PUF].
2. Dayan, J., Creveuil, C., Marks, M.N., Conroy, S., Herlicoviez, M., Dreyfus, M., & Tordjman, S. (2006). Prenatal depression, prenatal anxiety, and spontaneous preterm birth: a prospective cohort study among women with early and regular care. *Psychosomatic Medicine*, 68 (6), 938-946.
3. Dayan, J., Creveuil, C., Dreyfus, M., Herlicoviez, M., Baleylete, J.M., & O'Keane, V. (2010). Developmental model of depression applied to prenatal depression: role of present and past life events, past emotional disorders and pregnancy stress. *PloS One*, 5 (9).
4. Graignic-Philippe, R., Dayan, J., Chokron, S., Jacquet, A.Y., & Tordjman, S. (2014). Effects of prenatal stress on fetal and child development: a critical literature review. *Neuroscience & Biobehavioral Reviews*, 43, 137-162.
5. Matthey, S., Guedeney, A., Starakis, N., & Barnett, B. (2005). Assessing the social behavior of infants: Use of the ADBB scale and relationship to mother's mood. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, 26 (5), 442-458.
6. Mackin, R., Fadel, N.B., Feberova, J., Murray, L., Nair, A., Kuehn, S., ... & Daboval, T. (2017). ASQ3 and/or the Bayley- III to support clinicians' decision making. *PloS One*, 12 (2).
7. Dennis, CL, Ravitz, P., Grigoriadis, S., Jovellanos, M., Hodnett, E., Ross, L., & Zupancic, J. (2012). The effect of telephone-based interpersonal psychotherapy for the treatment of postpartum depression: study protocol for a randomized controlled trial. *Trials*, 13 (1), 38.

8. Milani, H. S., Azargashb, E., Beyraghi, N., Defaie, S., & Asbaghi, T. (2015). Effect of telephone-based support on postpartum depression: a randomized controlled trial. *International Journal of Fertility & Sterility*, 9 (2), 247.
9. Dayan, J., & Yoshida, K. (2007). Psychological and pharmacological treatments of mood and anxiety disorders during pregnancy and postpartum. Review and synthesis. *Journal de Gynécologie, Obstétrique et Biologie de la Reproduction*, 36 (6), 530-548. [Dayan, J., & Yoshida, K. (2007). Psychological and pharmacological treatments of mood and anxiety disorders during pregnancy and postpartum. Review and synthesis. *Journal of Gynecology, Obstetrics and Reproductive Biology*, 36 (6), 530-548].

To know more

Scientific works on parenting and therapies for perinatal psychological disorders:

- In English : Stone, S. D., & Menken, A. E. (Eds.). (2008). *Perinatal and postpartum mood disorders: Perspectives and treatment guide for the health care practitioner*. Springer Publishing Company.
- In French : Dayan, J., Andro, G., & Dugnat, M. (2014). *Psychopathology in Parenthood and the Perinatal Period* . Elsevier Masson.

Learned societies websites:

- <https://marcesociety.com>
- <https://waimh.org>

Resource sites:

- Royal College of Obstetricians and Gynaecologists, UK:
<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy>
- Coronavirus and maternal mental health guidance from MMHA:
<https://maternalmentalhealthalliance.org/news/mmha-members-offer-reassurance-amid-coronavirus-outbreak>
- UNICEF:
<https://www.unicef.org/coronavirus/navigating-pregnancy-during-coronavirus-disease-covid-19-pandemic>

Support site:

- http://www.sane.org.uk/what_we_do/support

V

Effects of confinement in pandemic times and resources to deal with it in child psychiatry

Catherine Zittoun



*Psychiatrist, child psychiatrist, Head of Department 75111, GHU Psychiatrie Neurosciences, Paris
E-Mail: catherine.zittoun@ghu-paris.fr*

Valérie Masson-Delmotte, co-chair of the IPCC (intergovernmental group of experts on climate change) argued in 2016 about global warming, indicating that it was important to build a culture of risk reduction for natural disasters, outside of an emergency response situation (1). With the coronavirus pandemic, we have been forced to act urgently to find suitable responses to deal with the psychological effects of the epidemic and confinement.

Some essentials of the integrative approach to child psychiatry

Regardless of endogenous factors, environmental factors contribute to the development of disorders in children. Children are sensitive to the “atmosphere” surrounding them. For example, depressive symptoms in parents can activate anxiety about death in the child; parental anxiety may be translated into restlessness in the child.

Disorders in children are very often a cause of anxiety in parents. This anxiety is perceived by the child and can become part of his or her disorder. Because of their child’s disorder parents may relax limits and rules, which are, however, necessary benchmarks for the child’s psychic construction. In addition, parental anxiety activated by the child’s psychological disorder, may lead the parent to more “confinement” in his or her relationship with the child, unless the parent mobilizes other defense mechanisms, such as the need to control the situation.



Early disorders in the parent-child relationship, or parental psychopathologies can lead to various disorders in children, such as relationship disorders, manifested by clinging to parents, a fusional relationship that excludes all other people. This is part of our daily work as child psychiatrists which was already present before confinement.

Effects of the pandemic and confinement

Clinicians over the last few months have witnessed anxiety in children and their parents that is directly related to the pandemic as well as anxiety that is related to the confinement. In both cases, the impact of anxiety varies according to the context.

Predispositions

Predisposed to melancholy, Alice, 8, clings to the lost “object.” At the beginning of confinement, Alice rarely left her room and cried as she missed her classmates

Father of three boys aged between 2 and 7 years old, two of whom are monitored at our caregiving centers, Mr. M. is afraid of contracting the virus and worries about potentially transmitting it to his children and his wife. He has no symptoms, but anxiety prevails and leads our imagination to cross all boundaries, from state of health to one of disease, from disease to the contamination of others. Mr. M was first alerted to the fragility of his immune system 20 years ago following a bone marrow transplant due to aplastic anemia and again last January when he was hospitalized for asthmatic pneumopathy.

Mr. A is in a precarious position as he does not have official papers which permit him to reside in France. Of Tamil origin, he escaped the anti-Tamil pogroms in Sri Lanka. This devastating experience remains present in his memory. Mr. A. is the head of the family. His wife does not speak French. At the beginning of confinement, his sole focus was to shop for food to ensure that his family did not go hungry. However, the situation echoes his past (out on the street...) and causes great anxiety. Mr. A. never leaves home. There remains only a package of pasta as the sole subsistence for the family.

Symptoms in children and interactive loops

Children are often the last link in the chain. Children experience the anxiety of their parents vicariously and may subsequently suffer from insomnia, be agitated, or express symptoms through their bodies. Being confined, children have no longer the space to express their internal agitation, with the neighbors themselves on their nerves, even relatives try to silence children’s cries and outbursts, and in the end, parents’ screams are fired like cannons towards children’s ears.



Anxiety is easily transferred from one person to another. It can be compared to standing above an abyss, silent and powerless, the individual tries to stay strong and resist falling, succumbing to the anxiety. Parents and children, in this asphyxiating relationship, find themselves struggling like a ship’s crew battling against stormy seas. The knot tightens, one holds the other responsible, abuse draws nearer and nearer. Other pitfalls include being fearful, such as the possible short, medium- and long-term effects observed in children exposed to domestic violence, the rate of which increased during this period of confinement. We have seen, despite hotlines and active support during the COVID-19 epidemic (2), an increase in recent weeks of anxiety-provoking information and fear of what we will find when doors open after confinement.

Regression

We will take the example of a mother and child where the child has just turned four years old and has adopted the behavior of a tyrant. The mother, isolated in France with no support or resources, succumbs to the child’s every wish and demand. Next, we work on developing the child’s autonomy as he showed anorexic tendencies and would only feed himself yoghurt. His mother, who worried about her son’s delay in weight gain, fed him the other foods with a spoon, what he wanted. The last days before the pandemic she began to let go a little on the food issue.



Then the virus arrived, followed by a period of confinement and their situation got worse. Once again, the mother and son sleep in the same bed and the child demands food and then pushes it aside and demands something else, as was the case before. Certain events that occur in an individual's, or a family's life can cause psychological and behavioral regression. The COVID-19 pandemic has proven to be very difficult for many individuals and families, particularly as they are forced to live together 24/7 without interacting with any third party.

Transformations in the perception of time

Transformations in time perception can occur surreptitiously, especially among people experiencing temporary unemployment, and in people working from home as well. Some experience a distortion of time where time seems suspended during this period of confinement. For others time passes very quickly, they do not know how; they feel like time is running out. And time, according to Levinas (3), how and to what extent is a person affected by alterations in temporal markers is a characteristic of each individual.

Regression of learning outcomes

Many fear the academic consequences of confinement and the National Education system is following the matter closely (online content, online work with teachers, audio, video). Remote monitoring of learning can have a positive effect as this intervention of an outside third party (teacher) can oblige pupils to complete homework and therefore help to structure and organize the child or adolescent's day. This can therefore have a positive effect by contributing to temporal anchoring.

But what about families in which parents, for one reason or another, are unable to help children with their homework? The National Education Service have made it clear that they will not take the results obtained by students during confinement into consideration when calculating their final grade for the year. However, this obligation to do homework can be anxiety-provoking within families who are unable to help children with schoolwork and this can therefore be experienced as a source of tension. These important questions are developed in another chapter which is devoted to the organization of children's homework time during confinement.

What state will we be in after confinement? We expect there will be an increase in patients (children, families) presenting traumatic stress. We expect also to see increased dependence on screens and digital platforms. How many parents have given in to letting their child have more screen time in order to have some respite! There may be withdrawal crises when weaning screen habits in children. Some parents may find this too difficult and therefore give up trying.



We are also expecting to have to work on family dynamics. Locked down together day and night, family members rediscover the roles which are naturally assigned to them and whose effects can usually be tempered by the societal interventions of non-family members. Take John's family for example. John is always the bad guy, the devastator, and his little sister a pure angel. John looks physically very much like his dad who used to beat his mom until John's parents separated.

We will remember that each of us carries within us the wise and the wicked, the simple-minded and the shy. It can be noted that everything can vary and that the villain in each of us may remain dormant and can be activated in moments such as confinement.

Some essentials of the use of teleconsultation

Mathieu Thépaut, Tony Brazil, Nicolas Cazenave

Material conditions to ensure better quality for teleconsultation

To benefit as much as possible from teleconsultations, it is above all necessary to have a reliable internet connection, preferably wired (Ethernet/RJ45 cable) and broadband. The characteristics of the video are also important. A computer screen of 15 inches (minimum width display of 30.5 cm for a size 4/3 and 33.2 cm for a screen 16/9) with a resolution of 720p. The webcam resolution should correspond at least to VGA standard (640p × 480p; 0.3 megapixels) and preferably to XGA standard (1024p × 728p; 0.8 megapixels). The audio should be of sufficiently good quality, at least equal to that of a telephone (sampled at least 8 kHz). If the family or the clinician opts to use headphones, the use of a jack is preferable to communication by Bluetooth®. All of these features are often standard on most recent devices. The absence of these features do not need to stop teleconsultations from being proposed, but they ensure that the consultations take place as smoothly as possible.

In some countries, the temporary easing of teleconsultation legislation allows the use of a wider range of two-way video transmission platforms. Most use protocols compatible with the above specifications. Finally, if you can not have access to a videoconference, the telephone interview remains an effective alternative, which may prove to be more suitable with certain children.

The first teleconsultation



At the beginning of the initial teleconsultation, it may be useful to allow time to ensure the quality of the technical conditions. It is also necessary to ensure the confidentiality of the consultation. Is the young person accompanied by a relative or legal guardian? If so, is this presence necessary or beneficial? Will the child or adolescent be disturbed or interrupted during the session? As during face-to-face consultations, it is necessary to demonstrate good listening and attention and guarantee mutual trust, especially given that this is a first contact with the young person.

Limits concerning the use of teleconsultation

Perhaps the biggest barrier to the widespread use of teleconsultations in mental health is the occupational culture of practitioners, some are resistant to technology-mediated clinical interaction. Children and adolescents often seem more open to tele-healthcare than certain medical and paramedical professionals (4) and training may be necessary to help them understand the challenges and rules of good practice for teleconsultation, for the benefit of the young people being monitored.

Therapeutic proposals

We expect that our therapeutic work will increase as the pandemic progresses. But it also depends on what we offer today and what has been put in place since the beginning of confinement to support individuals with disorders and various risks. Since confinement has been imposed, there is evidence for several actions, which are now described.

Exit permits

Taking the necessary precautions, **exit certificates** on an official letterhead and signed by the head of the medical unit, accompanied by recommendations, are issued by email and failing this, given to parents of children with autism in particular, so that parents feel safer during outings with regard to police checks.

Set up parental guidance

The days before confinement, we divided patients and their families, according to the links previously created between each family and certain caregivers. A set of patients and families were assigned to each educator, nurse, therapist, doctor or social worker. Each caregiver provided contact by phone, to ascertain what was happening within each family. Each week, at least, the caregiver contacted the families to obtain an update on the psychological state of the patient, the family dynamics, how the patient was structuring his or her day and the conditions of their confinement (notably, it is not identical to be confined to 100m² or in 20m²). During these telephone exchanges, we reminded everyone of the instructions concerning confinement. The families in greatest difficulty were quickly identified, often those who were already struggling before confinement required increased vigilance from the caregiver team.

Maintain team synthesis meetings

As well as **maintaining weekly team meetings** on a virtual platform, it was necessary to **multiply mini-case reviews** and find together the means to respond.

The role of parents

In some cases, it was possible to continue the work begun with the young person and their family prior to confinement. In other cases, we needed to work with one of the child's parents, who adopted the role of "co-therapist," given the solutions at our disposal during confinement. Just as in face-to-face consultations, it is important to analyze the cause of symptoms, which are rarely exclusively situated on the side of the child.

Family dynamics

During this time of forced confinement, it is particularly important to ask questions in order to better understand family dynamics. Indeed, these dynamics can evolve rapidly depending on how each of the family members, including the parents, experience and cope with confinement.

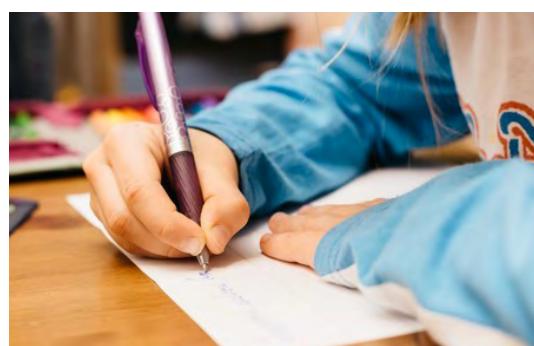
K's father explains how K shouts constantly. He shouts instead of saying yes or no and shouts even at the slightest frustration. The other four family members, who live in a single room, are subject to K's cries. K's distraught father explains that K needs a room for himself and wishes that his children have access to school once again. Last week he brought his children to the school doors but school was closed. The family's circumstances and living conditions will not be able to change immediately, at least not until the end of confinement. And it is better to tell them immediately that the end of confinement is not for tomorrow, rather than to maintain an anxiety-provoking suspense which is not conducive to psychic work (your children will not be able to come to the psycho-medical care center, or only exceptionally, and for a limited time individually). K.'s state of agitation, a child who is usually hyperactive and probably precocious, is proportional to the state of distress and helplessness of his parents. Seeing K. daily, relieving parents of his presence for a few hours would be useless if not to reinforce their passivity.

Mobilize parental resources

It is more important than ever to adopt an active stance to find and mobilize parents' internal resources. After two long telephone interviews involving an interpreter, a social worker and the patient, we develop a better understanding of the causes of anxiety of each parent. It stems from their personal and family histories (attacks, attempted abductions), trauma reactivated by the confinement situation. To help the child and his or her family, it is necessary that each parent has some basic psychological foundations on which to build. At the end of the consultation, recommendations are made to the families to reduce the stress stemming from different sources.

For example, the father is strongly advised not to listen to the news for more than five minutes a day and to go for a walk alone for an hour. It will then be his duty to take care of two of his children while the mother goes for a walk with the third child. Each day, the mother will walk with a different child to ensure that each child benefits from this special encounter. Adherence to and effectiveness of treatment is monitored and evaluated regularly.

Child follow-up and therapy in confinement



While we may often use video platforms in consultations with parents, we try to avoid it in follow-up consultations with individual children in order to prioritize contact through speech. This approach can help to control and limit the child's exposure to screens and can help children to either discover or rediscover the power of words. The unprecedented situation requires other communication channels to be developed. In our center, we have exchanged with some children by e-mail as this act of writing anchors the child and the exposure to narrative writing shows them how writing can be used to make each person's thoughts visible to the other. With teenagers, we have worked on creating newspapers in which each teenager writes and illustrates a story based on their own experience of confinement.

Video therapies

One of our close collaborators, the psychoanalyst Benoit Virole (5) who practices therapies mediated by video games, developed quickly video therapy practices in response to the confinement. This approach identifies some technical elements: "In almost every case, children feel the need to symbolize the distance/digital contact, both to put away the magical unreal effect and to make sure of the real presence of the therapist... The first object or drawing presented by the child at the start of the session symbolizes the child's unconscious experience and condenses its transference statement, the rest of the session is often less intense... It's as if the child has understood the constraints of context and of time of video-therapy and gets straight to the point... We find this in traditional therapies with children, but with less intensity."

Therapeutic groups conducted through secure video transmission platforms

These were quickly developed to ensure the continuity of care in psychological-medical centers and to support children dealing with the isolation imposed by confinement.

The group that has been running for the longest amount of time is composed of a storyteller, two therapists and children. The storyteller chose to explore the adventures of Ulysses. These virtual therapeutic groups reveal a great deal about the problems experienced by these children, the inhibition of one child, the agitation of another, the difficulty of yet another child in establishing his or her place in group, the need for one child to be the center of attention...

Over the hour-long session, the inhibited child gradually became involved and approached the camera. He became empowered to speak out to add a point that the storyteller had omitted in the story. The child revealed a part of his problem by describing an arm wrestling match with the person in position of power. These various aspects can be addressed in the session by the therapist.

This experience of conducting virtual therapeutic groups has highlighted several important guidelines. It is important that the storytelling sessions are relatively short and focus on giving children a more active role. However, given that the members of the group are presented on a digital platform, taking turns to speak is necessary. It is also important that each child is known by at least one of the therapists participating in the group.

Some tools to “deconfine” and soothe one’s body

Our center has been experimenting with the practice of shiatsu with children for several years. This discipline which originated in Japan involves exerting deep pressure on the body, following the path of acupuncture meridians. It helps the person, the child, the patient, especially for those with autism, to perceive the limits of his or her body; it also helps individuals to feel present in the moment and to concentrate. Unable to continue intensive care with particular children with autism, we started giving shiatsu treatment on a digital platform, with the children attending sessions with our shiatsu practitioner. Via a secure system Skype system provided by the hospital, the practitioner guides the parent to give shiatsu to their child. Often mothers, using instinctively the right gesture, applying the right pressure, arrive to channel their child, sometimes more effectively than in a session of traditional shiatsu. They are then able to practice this with their child on a daily basis. For certain children, depending on their age, individual needs and access to digital communication tools, the shiatsu practitioner may choose to conduct relaxation sessions instead. During these sessions, the child or adolescent, guided by the practitioner’s voice, transports him or herself to the place of their dreams and explores this place. Recently a child with autism who attends the day hospital reported having explored all of his or her senses except for smell.

A modeling workshop via a digital platform

Faced with cases requiring immediate therapeutic treatment, especially with children with autism, we are proposing manual-based therapy in order to continue to stimulate the child’s openness to internal and external sensations. Indeed, many children with autism enjoy clay modelling. At the day hospital, they work clay face-to-face with the art therapist. This involves contact with the material and imitation of the art therapist, which is a beneficial experience for many children. And why not use Skype? Last week, we delivered clay to the children’s homes. Next, we will start delivering the clay modelling workshops remotely.

Video messages

Each week two nurses prepare a video to transmit to the children who attend the day hospital but who are confined at home. They have chosen puppets which the patients know well and which they use to communicate. Using the puppets, the nurses who know the children, sing nursery rhymes and name each of the children in the unit. Some of the families have reported that their child has reacted and attempted to interact with the puppets in the videos. Perhaps these means of communication are less threatening for children with autism than direct contact.

Contribution of specialized teachers

As well as working with children in the day hospital, the specialized teachers intervene also with other children in the psychological-medical center. These specialized teachers do not compensate, however, for teachers who have abandoned children with difficulties (lack of computer resources in the family home, too great of a gap in the child’s learning). The intervention of these teachers to support the child’s learning should not increase stress, which is often already significant at home. Rather, it serves as a benchmark to structure school time during confinement and to explore other more playful methods of learning that are suited to the profile of each child, to achieve the objectives set by the school. This involves the specialized teachers making contact with the child’s teacher, establishing a working partnership and perhaps helping them to discover the child’s uniqueness and individual strengths.

Outpatient therapy

In certain cases, efforts to continue patient care and therapy remotely may not be possible due to the absence of internet or a computer in the patient's home. In other cases, it may be too difficult to assure the patient's care from a distance or some families may refuse or ignore requests for care to be provided in this way. In these cases, we send caregivers to the child's home, or outside the home, where we meet with his or her parents - many are too afraid to come to the psycho-medical center. Equipped with some props (a balloon, puppets, books, etc.), without forgetting masks and gloves, we conduct outpatient work on bonding and separation. In many of these situations, it is vital to **provide patients a breath of fresh air, to provide a break thanks to the third party presence of the caregivers.**

Perspectives: confinement, finding your own ground

In some cases, confinement can serve as a trigger to change a situation. Obliging children and their families to adopt a slower pace of life, to give time to raise questions, it frees them from the pressure of having to be maximally productive and efficient. This can lead to greater happiness in children and help them to feel good at home. Parents re-discover the talents of being parents, children the talents of a cook, a handyman, a fashion designer. What if confinement was an opportunity to find oneself. What if this confinement, as it defines the home as a common matrix space, was an opportunity for families to establish new family bonds? However, in families with the most complex problems, it is certain that confinement may have aggravated the situation for parents and children. It is necessary for all families to have equal access to digital equipment and tools.

Bibliography

1. Masson-Delmotte, V.(2016). Climate change, how to respect children's rights? In: Douin (Ed.), *Are we well treated with our children?* Arcueil: John Libbey Eurotext. [Masson-Delmotte, V. (2016). Changement climatique, comment respecter les droits de l'enfant ? In: Douin (Ed.), *Sommes- nous bientraitants avec nos enfants ?* Arcueil: John Libbey Eurotext].
2. Active listening and support lines during the COVID-19 epidemic: Young minds helpline for young people and parents: <https://youngminds.org.uk/find-help/>
3. Levinas, E. (2014). *Time and the other*. Paris: PUF. [Levinas, E. (2014). *Le temps et l'autre*. Paris: PUF.]
4. Schopp, L., Johnstone, B., & Merrell, D. (2000). Telehealth and neuropsychological assessment: new opportunities for psychologists. *Professional Psychology: Research and Practice*, 31 (2), 179-183.
5. Virole, B. (2003). *Good use of video games*. Vanves : Hachette. [Virole, B. (2003). *Du bon usage des jeux vidéos*. Vanves: Hachette].

To know more

Fact sheets and resources for parents and their children, and professionals:

- Family harmony during COVID-19 (WHO): https://www.who.int/docs/default-source/coronaviruse/healthy-parenting/english-covid-19-3-harmony.pdf?sfvrsn=31437c7_2
- Structuring the days (WHO): https://www.who.int/docs/default-source/coronaviruse/healthy-parenting/english-tip-3-covid-19-parenting.pdf?sfvrsn=492ecf57_6
- Supporting parents (WHO): https://www.who.int/docs/default-source/coronaviruse/healthy-parenting/english-tip-5-covid-19-parenting.pdf?sfvrsn=1b3ee706_6
- When we get angry (WHO): https://www.who.int/docs/default-source/coronaviruse/healthy-parenting/english-covid-19-5-anger.pdf?sfvrsn=13ef768e_2

- Supporting Families During COVID-19 (Child Mind Institute): <https://childmind.org/coping-during-covid-19-resources-for-parents>
- Coronavirus guide for parents (UNICEF): <https://www.unicef.org/parenting/coronavirus-covid-19-guide-parents>
- Looking after children and young people during the coronavirus outbreak: <https://www.nhs.uk/oneyou/every-mind-matters/looking-after-children-and-young-people-during-coronavirus-covid-19-outbreak/>
- Unicef : 6 ways parents can support their kids through the coronavirus disease (COVID-19) outbreak: <https://www.unicef.org/coronavirus/6-ways-parents-can-support-their-kids-through-coronavirus-covid-19>

Manage psychological impacts:

- Guidance for parents and carers on supporting children and young people's mental health and wellbeing during the coronavirus pandemic: <https://www.gov.uk/government/publications/covid-19-guidance-on-supporting-children-and-young-peoples-mental-health-and-wellbeing/guidance-for-parents-and-carers-on-supporting-children-and-young-peoples-mental-health-and-wellbeing-during-the-coronavirus-covid-19-outbreak>
- Managing behaviour (WHO): https://www.who.int/docs/default-source/coronaviruse/healthy-parenting/english-tipsheet4-updated.pdf?sfvrsn=9257f2f6_2

How to tell your children and your family about COVID-19:

- Talking about Covid:https://www.who.int/docs/default-source/coronaviruse/healthy-parenting/english-tip-6-covid-19-parenting.pdf?sfvrsn=232558c1_8
- Talking to your children about the coronavirus pandemic: <https://mentalhealth.org.uk/coronavirus/talking-to-children>
- UNICEF: How to talk to your child about coronavirus disease 2019 (COVID-19): <https://www.unicef.org/coronavirus/how-talk-your-child-about-coronavirus-covid-19>
- Resources to explain virus to child and discuss their feelings: https://660919d3-b85b-43c3-a3ad-3de6a9d37099.filesusr.com/ugd/64c685_0a595408de2e4bfcbf1539dcf6ba4b89.pdf
- Comic on Covid 2019: <https://www.npr.org/sections/goatsandsoda/2020/02/28/809580453/just-for-kids-a-comic-exploring-the-new-coronavirus?t=1588164210843>

VI

Adolescents in confinement: A specialized telephone platform

Eric Lehuedé



*Child Psychiatrist, Hospital Practitioner, University Hospital Center for Child and Adolescent Psychiatry (PHUPEA),
Guillaume Régnier Hospital Center, Rennes.*

*Dr. Lehuedé is responsible for the Service for Adolescents and Young Adults of PHUPEA since 1993
and the House of Adolescents in Ille-et-Vilaine since 2006.*

E-Mail: e.lehueude@ch-guillaumeregnier.fr

Why set up a specialized telephone interview platform for adolescents and their families during the period of confinement related to the coronavirus epidemic (COVID-19)? To answer this question, we recall briefly what occurs psychologically during this particular developmental period called adolescence and we try, in parallel, to highlight the risk that confinement can cause or amplify in this population. Finally, we will describe the objectives, organization and operation of a telephone platform.

Confinement and its possible consequences

The process of adolescence is triggered by puberty and the transformations that follow. The forced and irreversible nature of these pubertal changes lead many teenagers to take action to regain control of what they experience. The long moments of apathy alternating with a “need to move” (often presented by the adolescent as imperative) are an illustration of this. Taking **action** thus constitutes a psychic defense which can occupy an important place in the adolescent’s life. Responding to this need to act and to explore their new bodily limits can lead the adolescent to feeling helplessness, which in turn facilitates a certain impulsiveness (3,7).

Besides the irreversible and forced appearance of physical changes, pubertal adolescents encounter bodily differentiation leading to the potential for adult sexuality. That which was not possible earlier due to immaturity becomes possible with adolescence, forcing the teen to modify his or her means of emotional expression with respect to the family and especially the teen’s parents on which adolescents remain dependent materially and emotionally. This situation, experienced often by adolescents as paradoxical, can create emotional **insecurity** pushing for intimacy within the family sphere but also leading adolescents to seek other emotional reassuring benchmarks. Faced with these requirements, many teenagers experience a **threat of rupture** with their childhood world, or even a sense of loss that confronts them with the notion of death. The insecurity linked to the risk of being affected by a disease which can threaten one’s own existence and the lives of those close to the adolescent can exacerbate issues that already are present in the adolescent’s experience and thus accentuate the risk of depression (3,6).

However, adolescence does not just involve puberty-related transformations; these physical changes initiate a whole set of consequences, of psychic and relational reorganizations that take place over time in a more or less harmonious and progressive way. This process should allow the teenager to be **empowered**, to reach adult status and make their own life choices and to assume the consequences.



It is important to consider adolescence as a psycho-emotional maturational process accompanied by a movement of distancing with respect to the parental framework. This process involves a **conflictualization of the parent-child relationship** and the need to develop relationships with individuals outside of the family. Usually it is through peer groups and meeting with other adults that the teenager is able to achieve emotional distance with his or her family. The maturational aspect of this **relational openness** also lies in consolidating the identity that it produces. Furthermore, we cannot neglect the importance of the first romantic relationships that bring to the fore sexual differentiation and the desires of others (2,4).

We can imagine the effects of confinement during which parents and teenagers are in almost permanent contact in a small spaces with, in addition, a drastic limitation of social relations. Confinement introduces the risk of hampering the adolescent's aspirations to live with greater openness and with fewer constraints. The removal of the possibility of these moments spent outside the family sphere, moments that alleviated the tensions between parents and teenagers therefore exacerbates the risk that child-parent conflicts become physically violent.

But above all, the effects of confinement may be experienced by adolescents as an obstacle to building personal and vital change. When this obstacle is considered as impossible to overcome, it can generate a **feeling of being at a dead-end** and this can lead to a depressive tendency or engagement in a liberating act. Another defensive mechanism that can be adopted by the adolescent is a global repression of his or her emotional life in a sort of surface adaptation, of being "reasonable"; the teenager is then at risk of an unforeseeable outburst ranging from an impulsive act, to a depressive collapse or even a psychotic episode (3,5,6).

In a mirror-like way to the psychological development of the teenager, his or her relatives are also usually confronted with the need to revise their position and their relationship with their child. They will have to accept to no longer be the privileged object anymore and to give up projecting their own infantile desires on their child. The difficulties of this can lead to a certain aggressivity, or at least fear concerning a new relationship with their child. In addition, their child's access to bodily and sexual maturity also confronts parents with their own aging, the choices and compromises that they had to make throughout their adult lives and the need to otherwise manage their future (notions of "**parental crisis**" and "living environment crisis") (6,8).

This parental psychic work, marked by renouncing previous patterns spreads over time to cover the different areas of social life that each of the adolescent's parents may encounter. Confinement, by drastically reducing these "down" times, may cause parents to become more aggressive, even depressed, which can cause the adolescent to feel guilt, which is difficult to manage. A **net increase in domestic violence**, in particular, has also been observed since the start of confinement (<https://www.theguardian.com/society/2020/mar/26/warning-over-rise-in-uk-domestic-abuse-cases-linked-to-coronavirus>).

Objectives of the telephone platform

In this context, the specialized telephone platform is a tool that can **serve as a third party** between the adolescent and his or her parents. Telephone exchanges, provided by mental health professionals, introduce some exteriority into the family dynamic that has turned in on itself due to confinement.

Concerning the adolescent, the telephone exchanges aim to help him or her to **emerge from the importance of the moment** and to plan for the possibilities after confinement. But similar to adolescent psychotherapy, it is also necessary to help him or her to stay in touch with the emotional universe of his or her childhood and to maintain a continuity between this past and what he or she is currently experiencing (1,6).

Concerning parents, telephone exchanges aim to support them as parents and to provide **parental guidance**. This guidance can help parents to foster a certain autonomy for their child despite the restrictive rules of confinement (8).



This implies, in any case, to be able to offer at least one telephone exchange of how to build a link to reintroduce temporality and reconnect with the outside world. Based on this link, and as a function of the identified symptoms, a referral to specialized consultations including a telephone follow-up or teleconsultation with a secure hospital system can be organized.

Overall, the main objective is to prevent psychological difficulties from becoming entrenched and hindering the teenager's development and to avoid long-term traumatic effects.

Implementation of the telephone platform

A telephone platform for adolescents must be able to rely on professionals with experience working with adolescents who are able to identify situations involving the risk of mental disorders, suicidal or depressive tendencies as well as auto or hetero-aggressive or even delusional tendencies; all of which confinement can exacerbate.

In France, a county-wide telephone platform was established, coordinated Dr. Eric Lehuédé, child psychiatrist in charge of a Centre for Adolescents in Ille-et-Vilaine and the Service for Adolescents and Young Adults service structures that since 2012 have been integrated to the University Hospital Pole of Child and Adolescent Psychiatry led by the Prof. Sylvie Tordjman). Dr. Lehuédé has been involved in creating and developing these structures since 1993. The population served by these structures consists of teenagers and young adults who are 13-21 years old.

Service professionals for adolescents and young adults are familiar with the specificities of the clinical psychological and psychiatric problems in adolescence. They have all been trained in handling and intervening in suicidal crisis situations. They have experience with familial or parental interview techniques and have been trained in family therapy. Finally, they have a long experience of telephone work with adolescents, parents and other professionals.

In fact, apart from emergency situations in which the adolescent is seen quickly with those accompanying him or her, the first meeting with the psychiatric service takes the form of a telephone consultation with the young person and/or his parents. The objective of this exchange is to briefly assess the situation in order to best adapt the way the healthcare team will welcome the adolescent and his or her family. Experience has indeed shown that the quality of the first meeting largely determines the quality of the patient's investment in subsequent follow-up appointments. Depending on this telephone exchange, the first physical meeting will be carried out either by one or two professionals. It could be a nurse, a social worker, a psychologist and/or a psychiatrist.

With confinement having considerably reduced the number of consultations and the number of new requests, these professionals were quickly available to work on this platform. They will continue to do so for the duration of the confinement period and also during the deconfinement phase.



Furthermore, there are plans to set up a **training process** in the form of certification organized by a specialized agency. Thus, as confinement is lifted, the professionals can return to their normal positions and the newly certified individuals can take over.

In cases where medico-psychological care is required, the adolescent patient and his family can be referred to specialized care teams thanks to the already well-established network of care structures. At a national level in France, the network “Maisons des Adolescents” plays an important role in finding and organizing access to appropriate services.

Connection between the telephone platform and the National Education system

To respect the rules of confinement, many education systems in different countries have put distance education methods in place. In fact, the teachers providing this education are often the only adults to maintain a link with pupils who are confined in their homes.

It has been noted that many teachers identify signs of suffering in their students. Furthermore, every high school and college has a designated **resource person** from the National Education system with whom any teacher can refer to. This referent is a professional of the school establishment: nurse or school doctor, psychologist of National Education system or an educational manager (school director). The referent's role is to confer with the teacher, call the student and parents and/or to contact our telephone platform to discuss the situation. If necessary, the referent can then direct the student and his or her parents to our platform.

This proactive **connection** with National Education is particularly valuable and essential to identify and allow our platform to help adolescents who have psychological difficulties. Furthermore, other platforms exist. There is, in particular, the connection with other specialized telephone platforms, such as one for domestic violence or another concerning perinatality. There are also the usual care services which continue to offer face-to-face consultations when these are essential (psychiatric emergencies, appointment for pre-admission to hospital, etc.). These consultations take all the necessary preventive measures concerning the risks of contagion by COVID-19 (in addition to hand washing and respecting social distances, wearing a mask but also consultation in a special office which is disinfected after each appointment, etc.).

Current experience in confinement

Telephone calls are answered by two professionals: a nurse or an educator receives the call and conducts the phone exchange, while a psychologist or a psychiatrist supervises this exchange. The main reason for this dyad is that the calls received are not usual requests for care and that these callers do not know what to expect from their interlocutor. The callers are often in distress and so there is the interest of proposing a second exchange, with an appointment, which will help a more structured approach to be adopted.

In place for only a few weeks, the platform has received many calls from professionals requesting information (professionals from the education system, educators, assistants social, psychologists, etc.). However, in other cases, it can arise that during the first call it is difficult for the caller to distance him or herself from the current moment and that only guidance based on the rules and objectives of confinement, especially the exceptional exit rules, establishes a sufficient link to propose a new exchange. This second exchange then makes it possible to address questions that could evolve towards possible therapeutic care.



Bibliography

1. Braconnier, A., Chiland, C., & Choquet, M. (2002). *Traiter à l'adolescence: un patient pas comme les autres*. Paris: Masson. [Braconnier, A., Chiland, C., & Choquet, M. (2002). *Dealing with adolescence: a patient not like the others*. Paris : Masson.]
2. Birraux, A. (2013). *L'adolescent face à son corps*. Paris: Albin Michel. [Birraux, A. (2013). *The adolescent facing his body*. Paris: Albin Michel]
3. Gutton, Ph. (2003). Le pubertaire. *Coll. Quadriga*. Paris: PUF. [Gutton, Ph. (2003). Puberty. *Coll. Quadriga*. Paris: PUF.]
4. Jeammet, Ph. (1990). Les destins de la dépendance à l'adolescence. *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 38, 190-199. [Jeammet, Ph. (1990). The fates of addiction in adolescence. *Neuropsychiatry of Childhood and Adolescence*, 38 , 190-199.]
5. Jeammet, Ph. (1994). Les vicissitudes du travail de séparation à l'adolescence. *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 42, 395-402. [Jeammet, Ph. (1994). The vicissitudes of separation work in adolescence. *Neuropsychiatry of Childhood and Adolescence*, 42, 395-402.]
6. Marcelli, D., & Braconnier, A. (2004). Adolescence et psychopathologie. *Coll. Les âges de la vie*. Paris: Masson.] [Marcelli, D., & Braconnier, A. (2004). Adolescence and psychopathology. *Coll. The ages of the life*. Paris : Masson.]
7. Marty, F. (2010). Adolescence et émotions, une affaire de corps. *Enfance et Psy*, 49, 40-52. [Marty, F. (2010). Adolescence and emotions, a matter of the body. *Childhood and Psychology* , 49 , 40-52.]
8. Varga, K. (2008). L'adolescent difficile et ses parents, *Coll. Adolescence et Psychanalyse*, Paris: Editions In Press. [Varga, K. (2008). The difficult adolescent and his parents, *Coll. Adolescence et Psychanalyse*, Paris: Editions In Press.]

To know more

Helplines for young people:

- <https://youngminds.org.uk/find-help/>
- <https://www.giveusashout.org/about-shout/>

Advice for adolescents:

- <https://www.unicef.org/coronavirus/how-teenagers-can-protect-their-mental-health-during-coronavirus-covid-19>
- <https://www.nhs.uk/oneyou/every-mind-matters/looking-after-children-and-young-people-during-coronavirus-covid-19-outbreak/>

Information and videos about COVID-19:

- <https://young.scot/campaigns/national/coronavirus>

VII

Art therapy in confinement

Sandrine Pitarque



*Drama therapist, teacher; co-responsible for the drama therapy specialty
of the Master in artistic creation at the University of Paris; Director and supervisor
E-Mail: sandrine.pitarque @ gmail.com*

Art therapy (1) involves the use of artistic processes and tools for therapeutic purposes. It provides a framework that is both rigorous and creative to support the physical, psychological or social well-being of individuals and groups. The four major forms of art therapy are music therapy, dance-movement therapy, drama therapy and art (visual art) therapy. These forms of art therapy can be combined, as is the case used in video therapy, clown therapy, etc. Art therapists are present in hospitals, most often in child psychiatry, psychiatry, general medicine or rehabilitation services. They are part of multidisciplinary teams (doctors, psychologists, psychomotoricians, speech therapists, nurses). They provide a complementary approach to address self-confidence, imagination, emotions, body awareness, among other examples. They also work in educational and social sectors. Art therapists may use different tools depending on the issues: prevention, socialization, conflict resolution, (re) integration, etc. Finally, art therapies are used for personal development and they provide interesting alternatives to verbal psychotherapy, in particular for children and teenagers by introducing mediation which can facilitate development and strengthening of the therapeutic alliance.

Why use art therapy during periods of confinement?

The main benefits of art therapy during this unprecedented period are as follows:

The use of creativity

Creativity is valuable for both professionals and participants. Creative processes involve psychic processes such as socialization, developing self-esteem and learning. Winnicott (2) noted that the “creativity drive” is a fundamental element of the human psyche.

Resource support

The “detour strategy” (3) offered by art therapies allows the therapist and the participant to put aside, at least momentarily, the main problems (symptoms, traumatic situation) that the individual faces. It encourages people to find or develop their own resources (imaginary, physical). Participants do not only forget their problems during the workshops, but also they develop *casually valuable* additional skills for the long term.

Extending the group

An art therapy group may already exist (art therapy in an institution, for example). In this case, there is the opportunity of extending the group experience throughout confinement. Whereas art therapy practices will need to be transformed, the therapeutic framework must be maintained as much as possible. A group can also be created from scratch at the moment of confinement. Feeling part of a group allows individuals to combat both the harmful effects of loneliness and the possible toxicity of the primary family group with which they are confined.

Reliance on symbols

At an abstract level, symbols are a fundamental element of the connection between people, even without physical presence: the symbolic domain connects people who are separated by physical distance. It is also a fundamental element of psychic development, given that many symbolic events cannot take place during confinement (funerals with all the relatives, family reunions or friends at a birthday, celebration of a birth, for example). Bringing a symbolic dimension to people's suffering can help them to re-establish a link with their history, their community, their culture.

How to think of art therapy activities conducted at distance?

We will describe different possibilities of ensuring care remotely with art therapy, depending on the issues.

Continuing an existing group or individual therapy

Keeping the link, maintaining the group and creative dynamics and providing support during this difficult period are the main reasons to maintain existing art therapy groups, especially in institutions. The first challenge is to ensure that the existing framework is not jeopardized. For example, it was decided not to continue a drama therapy group in adolescent psychiatry with a psychotherapeutic approach (4), where confidentiality is an essential issue; given that the adolescents are confined with their families, the confidentiality of the exchanges may not be protected. The group can be suspended for the entire duration of the confinement period and the link can be maintained individually by the art therapists.

The first issue to be raised is therefore: what is the goal for this group, what are the objectives, and are these consistent with the participants' situation?

If the answer is yes, then it is possible to consider providing art therapy sessions remotely. We can build on the themes developed over the year and tools and technology that have been used previously can be deployed to anchor new activities with established practices. Several examples of activities that can be used with different populations are outlined below.

Creation of a new group or providing new care for individuals

This period may lead to specific requests of care, such as elderly people who are experiencing increased loneliness, or families with teenagers who are suffering. The professionals who identify these issues may request an art therapist to set up a specific individual or group care activity.

It is important to note that establishing an art therapy program requires the presence of a therapist. The therapist's role does not only consist of giving instructions about writing, drawing, using a video or a "resource kit." They are also there to accompany the therapeutic process through engagement in the creative process: receiving the production in response to the activity instructions, listening to it, watching it, possibly commenting on it. This specific support gives meaning to the art-therapeutic approach.

We will now explore the concrete means that are at the disposal of art therapists and how they can engage in creative work with individuals remotely.

Possible tools for maintaining links

The phone

Exchanging over the phone is sometimes the only way to maintain the link with people confined to their homes. It is the communication method most commonly used by healthcare teams to get news from their patients. Phones can also be used by art therapists to give instructions, to obtain the result of a written production, or to improvise an invented dialogue.

For people who cannot exchange over the telephone, therapists can communicate and exchange instructions for activities with the professionals around them (for example, the care unit for patients who have regular treatments, caregivers for people in institutional residences). In these cases, the confidentiality of the exchanges must be ensured.

The smartphone

Smartphones can be used by art therapists to send instructions for various activities and for individuals to send photos and videos of their artistic productions.

Existing social networks

Young people are often very active on online platforms and social networks such as Facebook (page which can be private), Snapchat (photo and video), YouTube (video), tiktok (video and music), Soundcloud (music) and Flickr (photo). These tools have beneficial effects in social and educational settings. However, the use of social networks in settings which use clinical frameworks requires an adjustment, particularly regarding confidentiality of exchanges which is not always assured by these tools.

The art therapist can create a special account or a private page that will allow an individual to interact with each person and/or in a group. Each platform has its specificities which will allow for different uses.

The creation of a blog

A blog specially created for the group will allow content (photos, videos, texts) to be exchanged between group members. It is important that the blog is private so that people outside of the group cannot see the exchanges.

Remote communication applications

Skype and WhatsApp are among the most popular applications for remote communication. Zoom has become very popular since the beginning of confinement. Using a Zoom account, art therapists can easily organize meetings where participants see and hear each other. Such a meeting can be used to conduct a theater workshop for example. There is a recording feature on Zoom but this should not be activated in order to preserve the ephemeral nature of a theatrical mediation workshop. Some of these applications can also be used within the secure computer systems provided by hospitals.

Examples of activities

This section was made possible thanks to the creativity of the art therapists of the association *Je d'Enfant et Adolescent* who were kind enough to share the activities they are experimenting with. Thanks as well to the students of Master 1 Artistic Creation in Dramatherapy of the University of Paris who created and tested various activities described here.

Creation of a blog to maintain the creative dynamic of a group of young people in child psychiatry

Group, creativity, expression and elaboration of what happens to us, projection towards the future

This group initially met once a week with the objective of creating a show together. With the confinement and the cancellation of rehearsals, this was no longer feasible and the project therefore had to be modified. The new objective of the project is for the young people to create a video together and to share it with the teams of caregivers, other patients and families at the end of the year.

The drama therapist, the trainees and the caregivers who have accompanied the group since the start of the year implemented a monitoring program, involving the following actions:

- Creation of a blog and giving access details to group participants;
- Retrieval of the material that had already been proposed by the young people during the various workshops: rap song lyrics, dance videos, song recordings, etc.;
- Regular requests for each patient to share creative ideas relating to the theme;
- Establish and facilitate shared moments for the group via the zoom platform.

Theater workshop for children in foster care via the Zoom platform

Group, creativity, play, expression of emotions

For children in foster care, a daily theater workshop has been set up for the duration of the confinement period. This group gives children the opportunity to speak independently of the rest of the groups and to express their emotions. Furthermore, it enables the supervision staff who take care of these children to have some respite.



Example of a collective figure produced with a group of dramatherapy students (it is not possible to show an image from an art therapy workshop, for ethical reasons. All images provided are from art therapy training or exchanges between colleagues)

Many games are possible such as combat at distance, conferences in grommelo (imaginary language) with a translator, mirror, conductor and improvised dialogue. [Click on this link to see examples of games from a workshop conducted between French art therapists.](#)

There are several points to check when setting up this type of activity:

Ensure that everyone's privacy is respected, both the privacy of each participant vis-à-vis the other participants as vis-à-vis his or her family. Prior to the video call on zoom, we can ask the group members to prepare the space around them to show only what they want in the background. Furthermore, the families are asked to respect this space during the workshop: to not enter the room, to not listen. A colleague who works in child psychiatry suggested to a group of children that they each form a small cabin where they can stay for the duration of the zoom workshop .

For groups that existed prior to confinement, we maintain continuity, for example by using equipment that was used during the real life meetings, or by using games that are already known to the group members.

Encourage the expression of feelings and experiences, taking care not to induce feelings that are too violent and would be too difficult to handle at distance. Encourage relaxation, the feeling of having a bond, symbolization.

It is important for the art therapist to be very vigilant at the end of the workshop as the moment of separation can be difficult for group members. The feelings of separation following zoom workshops can be particularly difficult as with one simple click, the participants' playful and imaginary bubble comes to an end and they are suddenly back in their situation of confinement. We can therefore play several games symbolizing separation (Hello/Goodbye dialogue, making fun screen trips, taking the emotional temperature of participants). The art therapist can even propose a set of activities (writing, drawing, creation of an identity card) to do for the next session. This can help to reduce the feeling of loneliness that participants may experience following the end of a group session.

Workshop “a trip inside my house”, to keep in touch with a group of children receiving care in a socio-educational setting

Creativity, play, distance from the confinement situation

Workshops to rediscover the home where children make creations (objects, musical instruments, paintings) using materials they find in their environment. The art therapist proposes themes that were previously explored with the children to work on continuity while also introducing new topics.

Instructions for writing or sound creation given and received by telephone

Connection, creativity, self-expression and development

This activity allows the art therapist to keep in touch with people who only have a telephone. For example, each week with a group of adults in psychiatry, we assign a set part of Don Quixote (the theme of the group this year). The art therapist and his or her colleagues are very involved providing imaginary and playful material to patients to engage with during the sessions, and intervene, if necessary, to fill empty moments. For example, the therapists wrote a “certificate for circulating outside” which the patients then read aloud in an imaginary or humourous way. The patients then created a dialogue between Don Quixote and an officier to whom the certificate was presented. During the telephone call, the patient reads what he or she has written and the art therapist provides new instructions.

Reading over the phone

Support, link

Several theaters offer their spectators the opportunity to listen to actors reading texts: [pilot fish on the Hill](#), or poetic consultations at the city theater. Inspired by these artistic initiatives, art therapists can suggest to people, with whom they are already working or who have been identified by social services as being in great difficulty, to read texts to them. The texts will be selected taking into consideration the individual person, his or her history, of what she or he feels. A verbal exchange will preceed and follow each reading. The reading sesion can be frequent, up to once a day if significant support is needed.

Creation of a video workshop via a Snapchat group

Connection, creativity, self-expression and development

During confinement, Snapchat can be used to enable teenagers to continue to engage in exchanges with each other and with the art therapist. At the scheduled time of their usual meeting, the art therapist sends creative notes and the teenagers share their video recordings on Snapchat. Snapchat does not keep the productions and therefore there is no risk of the teenagers creative productions being disseminated.

Instructions for dialogue

Intertwining group and individual work

Instructions can be given to both pre-existing and new groups in order to create a group effect, while keeping the individual dimension of work. For example, each participant writes a short poem (three verses, without rhyme, using the haiku format which can be modified) on how he or she feels today. The individual sends the text to another group member, who sends a text to another person in the group as well. These texts are not shared with the rest of the group. Each person responds to the “haiku” they received with a photo taken at home and, to which they give a title. This photo is then shared with the group and a verbal exchange can take place (or not).

Series of photos taken by a group of art therapy students in response to the “haiku” sent by one of their colleagues:



Must laugh



Cramped



Bad hair day



A piece of sun



Walk with a golden background



Time flies alone outside

Support for the creation of a birth book, a life story

Link, strong symbolic dimension

Similar to an “origins story” (1), an art therapist can help a person to write a part of his or her life story, a young isolated mother can write about the birth of her child, a family can write about the memories of a deceased relative for whom visits to the grave have not yet been possible. This writing can be shared with the rest of the family or kept by the person for the future. It will facilitate the elaboration of thoughts on these concerning these important moments of life.

Furthermore, these activities can be useful following confinement to help people make sense of what has happened.

Art therapy during confinement: how to exploit the effects of artistic practice at distance in order to preserve and continue the effects of art therapy with high potential children and adolescents in difficulty

Claire Nicolas

When the art therapy session is based on the practice of visual art...

Théo, 15, discovered watercolor during individual art therapy sessions. He experienced pleasure, satisfaction and curiosity, which invited him to develop his know-how over several months. The watercolor technique requires abilities, such as anticipation, letting go but not too much, patience, methodology, etc. The art therapy objectives for Theo are directly addressed in the artistic work: effort, method, care, perseverance, self-confidence and self-esteem.

Despite the confinement, the art therapy sessions with Théo continued and increased from one session per week to twice a week at his request. In front of our computer screens, we had to invent a way to continue our work together. This happens quite naturally, given everyone’s creativity (we take a photo, we show it on the screen, etc.) and with pleasure we overcome the constraint. Productions were made during the session and continued between sessions. Théo became very productive and also took advantage of the confinement to devote more time to his guitar playing and to work on music theory.

The setting and the relationship changed during these sessions which took place during confinement. However, the first session following deconfinement allowed everything to get back into place, but not quite like before. We had experienced “something special” together.

Malo, 10, benefited from the “art therapy bubbles” developed by the art therapist at the start of confinement. Each week, he downloaded an art therapy session to work independently at home. An emotional weather report allowed him to assess his emotional state. There were two activites which relate to the plastic arts: the first production, being ephemeral, is photographed, in a land-art manner, in the kitchen or in the bedroom; the second production, with instructions that are directed, semi-directed or free of instruction, involves the use of readily available material (junk art materials, markers, scissors, paper, etc.) and simple techniques that can be implemented independently (cutting, collage, drawing, etc.). In addition, there were two proposals for listening to music: a suggestion of songs on a given theme to listen to and describe to assess Malo’s musical taste, and calm music to finish the session with a proposal for breathing to encourage relaxation. These activities, developed on a different theme each week (Asia, black and white, at the table, something that rolls...) allow an autonomous creative moment, then a presentation-exchange on the productions made, in front of our computer screens. The emotion-weather report provides the opportunity to address the young person's concerns and feelings.

Malo took advantage of these “experiences” to develop an original talent that had emerged during face-to-face sessions: he created films (stop-motion or short video) with his mother's mobile phone. Being invited to discover music tracks allowed him to work on self-assertiveness, leading Malo to be more refined in expressing his taste (before everything was “super”).

During the post-deconfinement meeting, Malo expressed the pleasure of resuming artistic practice “in real life” and talked spontaneously of his emotions. Faced with the reorganization of the classes in his school, he is separated from his friends and is able to express his sadness.

It is the joint creativity of the patients and the professional that made it possible to adapt the framework of art therapy sessions during confinement. Art therapy methods and means have been found and then enriched, and some will be continued. For example, listening to music will certainly be an activity that will be incorporated in the next sessions.

When the confinement provides an unexpected distance from the sources of difficulty in children and adolescents with high potential

Four 10-year-olds with high potential attend an art therapy group due to relationship difficulties with their peers. While we exchanged with their parents on several occasions to see how the young people were managing, we did not insist on setting up a substitute for the group or even individual sessions. Indeed, these young people had been removed from their source of anxiety- their peers, teachers and the obligation to go to class when they don't see any meaning in it. Their parents described them as being happy and relaxed: their sleep improved, relationships with siblings and parents improved and school investment was facilitated (in one case there was a notable reduction in writing difficulties).

During the deconfinement phase, school reorganization has required some time and the regular class sessions have not yet resumed. Furthermore continued home schooling is a preferred option for some parents, with no urgency for children to be confronted again with peer-relationship difficulties!

As a team, at the CNAHP (National Center for Aid to Children and Adolescents with High Potential), we wonder about the effects of this unexpected phenomenon. We are preparing to see these young people in the future and perhaps observing their difficulties when they are confronted again with school...



Claire Nicolas

CNAHP (National Center for Aid to Children and Adolescents with High Potential),
PHUPEA (University Hospital Center for Child and Adolescent Psychiatry), Guillaume Régnier Hospital Center and University of Rennes 1.

COVID-19: a new co-therapist in the context of therapeutic mediations?

Silke Schauder

How did the health crisis caused by COVID-19 and its 4 Cs explored in this book - **Clastration**, **Compression** in time and space, **Constraint** and **Contamination** - modify, influence, and color my clinical practice which is based on therapeutic mediations? During the period of confinement in France which lasted from March 16 to May 12, 2020, I had to organize my practice in compliance with health recommendations. This required me to innovate, adapt and tinker with various methods with my patients; these practices were novel and even unknown prior to confinement. Experimenting with my patients using follow-up by SMS, telephone, mail, email, zoom calls, creating collages, drawings, paintings, photographs to continue therapeutic care from a distance has enabled interesting advances on the differentiation of spaces and the dialectic presence/absence of the therapist as well as the link to the patient (who, no longer subject to geographic distance or the temporal incompatibility of face-to-face meetings was able to engage in new therapeutic activities concerning fantasies, associations and reflection). Several patients found the intimacy of revealing their homes to be very positive. For example, at the end of the session, one patient exclaimed, with a big smile: "How glad I am that you saw my interior!"

For many people, the experience of **clastration** was comparable in several ways to that of a retreat, similar to ancestral practices to leave deliberately the world to relinquish its hold. For some patients, the confinement helped them to be more in tune with their inner world. Far from a depressive decline, severing ties imposed from outside allowed people to experience living otherwise, detaching them from their daily news, on which they sometimes acted on too frantically. The maxim "Nothing is lost, nothing is created, everything is transformed" has never seemed so appropriate, as in these times the world seemed to stop like in a bad dream, which resembles our most archaic anguish, and most shameful fantasies.

Induced by confinement, temporo-spatial **compression** allowed for new reflections on the human experience, necessarily embedded in the temporo-spatial framework. The discovery of adopting a slower pace of life and focusing attention on oneself, limiting the scope of action, reducing movement and cancellation of cultural and sport events offered individuals some opportunities for creative thinking in terms of representations and the symbolization process, finally escaping from an overbooked daily life. Psychic time never corresponded directly to calendar time; some patients were able to leave clock-based time to focus on their internal world and enjoy the partially suspended time offered by confinement, to explore psychic time. How many times have I thought about this quote from Blaise Pascal: "All the misfortune of men comes from just one thing, which is not knowing how to rest in a room." Or the poignant *Voyage around my room* (1794) by Xavier de Maitre, who, locked up in prison like Stefan Zweig's *Chess Player* (1943), shows the link between creativity (an imaginary journey) and confinement.

Against all expectations, **constraint** proved to be a formula for freedom. The confinement provided some patients with the liberty to tolerate frustration and self-actualize thanks to it. For some, depression, (almost induced experimentally by sensory deprivation) had a maturative function which favored their gradual emancipation from certain neo-needs which encumbered their psychic life.

The **contamination**, in turn, helped to alter the connection that patients had with their own aggression. In a startling ambivalence, the fear of being an agent or victim of contamination alternated with basic violence - "me or the other." The fear of harming another - or even being responsible for his or her death – was mixed with the fear of being contaminated. This fluctuation between passivity and activity, the projective dimension that any contagious disease exacerbates, requires us in our clinical work, to be capable of connecting Thanatos and Eros in an ambivalent way, by supporting the psychic life with the limits imposed by COVID-19.



Silke Schauder
Professor of Clinical Psychology at the University of Picardie Jules Verne
CRP-CPO Laboratory (7273)
Clinical psychologist, art therapist
Pedagogical co-responsible of the Plastic Arts Art therapy specialty
in the Master of "Artistic creation", University of Paris

And after deconfinement?

All these practices and many others can be put in place to support the gradual return to a normal pace and life. Less time will be required for these practices to regain their regular mode if they are used during confinement to maintain the link with existing groups. New groups that have been created during confinement may be maintained even after the confinement has been lifted. For example, groups with children or adolescents may be extended until the summer holidays in order to accompany them in the transition back to normal.

This period of confinement can be very challenging for people and the deconfinement may too prove difficult for some people, who may demonstrate acting out behaviors. The participants in these workshops should therefore not be left on their own as soon as the deconfinement has started, but remain present until everyone feels sufficiently secure.

Bibliography

1. Lecourt, E., & Lubart, T. (2017). *Les art-thérapies*. Malakoff: Armand Colin. [Lecourt, E., & Lubart, T. (2017). *Art therapies* . Malakoff: Armand Colin.]
2. Winnicott, D.W. (1971). *Jeu et réalité*. Paris: Gallimard. [Winnicott, DW (1971). *Game and reality*. Paris: Gallimard.]
3. Klein, J-P. (2012). *Penser l'art thérapie*. Paris: PUF. [Klein, JP. (2012). *Think art therapy*. Paris: PUF.
4. Pitarque, S. (2017). Une dramathérapie psychanalytique. *Revue de Psychothérapie Psychanalytique de Groupe*, 68, 179-193. [Pitarque, S. (2017). Psychoanalytic drama therapy. *Journal of Group Psychoanalytic Psychotherapy*, 68, 179-193.]
5. Pitarque, S. (2019). Le récit des origines: un dispositif d'art-thérapie utilisant l'écriture dans un cadre socio-éducatif. *Revue de Psychothérapie Psychanalytique de Groupe*, 72, 151-162. [Pitarque, S. (2019). The story of the origins: an art therapy device using writing in a socio-educational context. *Journal of Group Psychoanalytic Psychotherapy*, 72, 151-162.]

To know more

- [Drama Therapy Review, Volume 6, Number 1](#)
- British Association of Art Therapists: <https://www.baat.org/About-Art-Therapy>
- British Association of Drama Therapists: <https://badth.org.uk/links>
- British association of Music Therapists : <http://www.bamt.org/>
- Association of Dance/ Movement Therapists : <http://www.admt.org.uk/>
- North American Drama Therapy Association: <https://www.nadta.org/what-is-drama-therapy.html>
- American Art Therapy Association: <https://arttherapy.org/blog-5-tips-for-teaching-art-therapy-online/>
- American Dance Therapy Association: <https://adta.org/>
- American Music Therapy Association: <https://www.musicotherapy.org/>
- <https://www.canadianarttherapy.org/covid-19/>
- <https://www.tandfonline.com/doi/abs/10.1080/07421656.2020.1754047?scroll=top&needAccess=true&journalCode=uart20>
- <https://theconversation.com/the-importance-of-art-in-the-time-of-coronavirus-135225>

VIII

Hypnosis during confinement: Benefits for children, adolescents, parents and caregivers

Eric Méner, Anne-Claude Méner



Eric Méner General practitioner; Professor of general medicine , Director of the Department of General Medicine of the Faculty of Medicine of Rennes - University of Rennes I;
Hypnosis trainer;
Represent general medicine within the university college of integrative medicine and complementary therapies ([CUMIC](#)).

Anne-Claude Méner Liberal psychomotor therapist in Guer (56);
Hypnotherapist also trained in haptonomy, Trainer in hypnosis; assessor of medical training in CPD in France.

E-Mail: hypnoseetsanteformation@orange.fr

Hypnosis is a support and care technique that is particularly useful for managing emotional imbalances (1). The confinement arising from COVID-19 pandemic has generated many adaptation difficulties for the entire population: children, adolescents, parents and adults. Healthcare professionals, on the front line or not, are not spared. As a psychomotor therapist and general practitioner, we are also therapeutic hypnosis instructors. In order for us to adapt to this new professional environment, we had to invent and use new support systems. Following several weeks of practice during confinement and having received very positive feedback, we would like to share these techniques with you.

The practice of hypnosis

A caregiver typically uses hypnosis in his or her work environment (operating room, hospital service, private practice), with a voluntary and committed patient. There are three main domains of application for hypnosis:

Hypoanesthesia

During the intervention (medical exam, technical or surgical procedure), the anesthesiologist proposes hypnosis to the patient so that he or she can imagine a place or an enjoyable activity that they have defined together. Using the technique of **visualization**, the patient removes himself or herself from what is happening in the “here and now” and travels mentally “elsewhere”, to a much more enjoyable place.

Hypnoanalgesia

Several hypnosis techniques allow the patient to observe, listen to his or her pain differently and become an **actor** to **transform the pain** into an object or something on which it can act.

Hypnotherapy

It is intended for patients with mental or somatic suffering. The patient, limited in his or her ability to adapt, is stuck in his or her current functioning. The therapist invites the patient to activate his or her own creativity with the aim of bringing change, evolution, adaptation and healing (2).



© Hypnosis and Health Training

Each individual, regardless of his or her age, can easily discover how to reach a modified state of consciousness by **appropriating self-hypnosis**. With this practice, the subject can engage in hypnosis independently. Later, we will discuss this practice of self-hypnosis in more detail.

Benefits of hypnosis during confinement

Contribution of neuroscience

Research in neuroscience has shown that stress triggers a defense reaction in the body via the limbic system, also called the “emotional brain.” This stimulates the production of adrenaline and cortisol which allow a response adapted to the situation for the duration of the danger. Once the danger has passed, these hormones stop being produced. Conversely, in a state of hypnosis, the brain triggers the production of neurohormones which are essential for an individual’s homeostasis (serotonin, melatonin, dopamine, endorphins) that rebalances the hormone system and improves physiological base mechanisms. This condition of homeostasis also strengthens the immune system by increasing the production of T and NK lymphocytes (3).

Expected benefits of hypnosis

In the current situation of isolation, helplessness, uncertainty and fear, the emotional system is bombarded daily with negative information. In the absence of references and precise perspectives, the production of stress hormones continues, causing psychological and somatic dysfunctions: sleep disorders, somatization, anxiety, depression, worsening of chronic diseases and autoimmune diseases.

Hypnosis is the art of bringing out a possible “extra” in the individual’s “ordinary existence” by relying on the creative resources of both the therapist and the individual. **Hypnosis is therefore a particularly suitable tool for dealing with this period of “extraordinary” confinement, which is very atypical and disconcerting.**

Hypnosis, accompanied or not, allows individuals:

- To travel, to experience a rejuvenating environment;
- To change their point of view on what surrounds them, to consider things differently;
- To become an actor for themselves (again), to get in motion;
- Mobilize their creativity;
- Activate their healing resources.

Digital tools: a suitable solution

In France, telemedicine is a medical practice has been validated since August 2018 in general medicine. The health authorities have yet to allow other professionals (speech and language therapists, psychomotor therapists, dieticians, etc.) to engage in distance consultations in a context well defined by the law (4). The principle is to observe and communicate with the patient over video calls from secure software.

In our general medicine and psychomotor counselling offices, we strive to be available to the patient, to open our sensory channels and to be creative. These are the foundations for having a quality alliance with the individual or the group.

The distance imposed in this time of confinement has limited in our perceptions of each other: lack of touch, of smell, of the overall vision of the other. It is however possible to achieve a sufficient presence to be able to support people in need of help, regardless of their age.

Tools developed for confinement

Audio tracks for children ... and older children

From the first week of confinement, we were contacted by relatives overwhelmed by the imposed changes of life. Besides the novelty of working from home, confinement of individuals in small living spaces, without the possibility of care outside, they are also faced with the need to oversee schoolwork and look after their children all day long. To respond to these requests, we have uploaded [audio tracks](#) of 7 to 10 minutes recorded by Anne-Claude Méner on our website. These tracks were recorded during a clinical research project (RELEASE study) initiated in 2016 by Pr Sylvie Tordjman.

This work aims to mobilize each child in his or her whole head-body-heart by activating the cortical, reptilian and limbic systems through interior journeys which allow the child to escape outside confinement and to focus on him- or herself. These short tracks can be listened by children alone or accompanied by an adult.

The proposed themes are:

- The ladybird, to discover its body: <https://soundcloud.com/user-795439735/the-ladybird>
- My secret place, to find a safe space: <https://soundcloud.com/user-795439735/my-secret-place>
- The tree, to be there in my place: <https://soundcloud.com/user-795439735/the-tree>
- The stairs, to go from my head to my stomach: <https://soundcloud.com/user-795439735/the-stairs>
- Bubbles, to learn how to free yourself: <https://soundcloud.com/user-795439735/the-bubbles>

Five other trips can be also accessed by clicking on the following link:

<https://hypnose-sante-formation.fr/trips-for-small-children/>

- My colors, to embellish the interior...
- My book of lights, to choose my best resources...
- The bee, for wanting to learn and transmit...
- My hand, to discover all my skills...



© Myriam Zilles from Pixabay



© Alexas fotos from Pixabay

For the older children or adolescents:

- To continue to forge links...
- To fly elsewhere...
- To make my cells smile...

During this confinement, the recordings are widely offered by parents to their children, by school teachers to their students, and caregivers to patients. Although originally made for children, it turns out that many adults use them also as a means of escape or as a springboard to self-hypnosis, similar to the method of cardiac coherence, as proposed for example in the following video: <https://www.youtube.com/watch?v=-7m4pm12yxQ>

Training through videoconferences for caregivers

Healthcare students and practicing caregivers (sometimes parents) have also manifested their interest in hypnosis. They sought help to overcome their helplessness given the extent of the current pandemic and its novelty, fear of receiving and transmitting the disease and the loss of control in the unclear setting of an evolving professional context that changes every day. **Self-hypnosis** seemed to us a solution particularly suited to their request.

The training through videoconferences for caregivers involves an independent practice of hypnosis. It stems from a personal choice, a time that we allow ourselves to take care of ourselves, to escape, to get away from computer and telephone screens, from school or professional work, by optimizing our physiological and emotional resources ... Learning is simple and accessible to all, in a single session with the technique that we have developed [from our training](#).

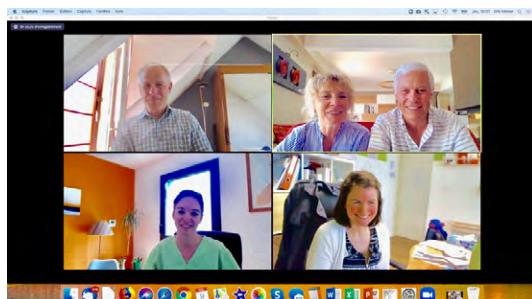
We therefore designed a collective discovery time through videoconferencing of 1h30 for groups of 5 people with Zoom software. This free training was offered from the start of the confinement to nurses, midwives, general practitioners and continues to be scheduled in this form several times a week. We would like to introduce participants to how to refocus, rejuvenate and protect themselves from the cognitive overload linked to the over-mediatization of this new disease and how to find time for themselves, and to do so independently.

Training “Support for caregivers: self-hypnosis, for better emotional balance”

Our training is essentially focused on practice: hypnosis is not learned in books but is discovered from the inside. The participants therefore experience what it is like to live in this state of dissociation and are enabled to relive it independently.



© Hypnosis and Health Training



© Hypnosis and Health Training

- Welcoming of participants

Verification of the technical conditions necessary for videoconferencing: adjustment of the sound and image quality, availability of everyone with the guarantee of not being disturbed.

- Presentation of trainers and participants.

- Sharing of each person's emotional experience, both personally and professionally in the context of the pandemic.

- Succinct powerpoint presentation of the benefits of hypnosis in the current situation.

- First experience of hypnosis

We propose that the participants discover how the unconscious (according to the definition of M. Erickson) (5) can override consciousness which usually makes choices, reasons and reflects. For that, it is enough to ask yourself the following question: “take me where it is good for me now” without making any prior choice. Then let yourself be surprised and take full advantage of what presents itself “there” with all your senses. The trainers, who are attentive to the participants and connected to each person's emotional experience, guide the experience several times for 2 to 3 minutes.

- Feedback on the group experience in turn
The participants discover the variety and the richness of the experiences of the group members, and how different each trip is for each group member with sensations and emotions related to the needs of the moment.
- Repetition of the exercise without guidance in order to gradually acquire this self- hypnosis technique
- Sending a questionnaire to assess practices remotely

This training has been restructured for use with groups of 15 people over a two hour period using videoconferencing. It was offered to 350 general medicine interns at the Faculty of Medicine of Rennes who were very solicited for first-response caregiving teams. These students very much welcomed this offer and sign up rates were very high.

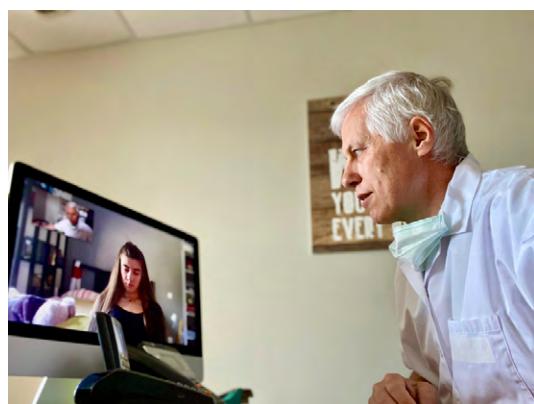
Hypnosis teleconsultations for patients

We have used therapeutic hypnosis for years in our general medicine and psychomotor therapy consultations. In all the caregiving centers, the announcement of the confinement has interrupted the caregiving and therapeutic sessions. Only urgent care has continued face-to-face. To compensate for the absence of these sessions and to ensure the continuity of patient care, professionals have had to quickly adopt teleconsultations and keep in touch with the most vulnerable patients.

In practice, conducting a hypnosis session through videoconferencing is possible, as long as the patient is motivated and committed. When making appointments, it is essential to ensure that videoconferencing conditions are optimal: availability of high speed internet with sufficient image and sound quality allowing the patient to be observed closely.

We find the five stages of a usual hypnosis process can be implemented during hypnosis sessions conducted in the form of teleconsultations:

- The creation of the therapeutic alliance
- Induction
- Dissociation
- The hypnotic trance
- Termination



© Hypnosis and Health Training

During the hypnotic trance stage, however, we cannot have access to the same therapeutic leverage points. We must therefore develop an alternative mode to “cross the screen” and reach our patient keeping in mind the fact that we do not have a global vision of the body and possibility to touch and move the patient.

Supporting the patient requires therefore new attention from the practitioner, a readjusted “tuning” to this distance relationship.

We have received various requests, including some to accompany children and adolescents:

- Patients undergoing hypnosis follow-up
Some patients immediately asked to continue their therapeutic work despite the physical distance, having already observed the benefits that this therapy brought them. Conversely, others preferred to postpone their sessions due to lack of availability.
- Former patients
They reconnected for new hypnosis sessions to manage emotional outbursts triggered by the pandemic.
- New patients
The appointment was motivated by the apparition of new symptoms: sleep disturbances, anxiety, eating disorders, irritability, various pains (abdominal, thoracic, muscular)...
- Support for children and adolescents
The support for adolescents is similar to that of the support for adults. However, supporting children requires other adaptations.
For minors, the presence of one of the parents or an authorized adult may be necessary. However, this presence can sometimes limit the freedom of engagement and the child's emotional work.
- Referential choice of induction supports
Usually, the body and movement are part of the methodology. In teleconsultation, they will be limited by the field of the camera. Materials such as drawing, modelling clay, figurines, or other materials will become increasingly important for facilitating hypnosis. When nothing is planned, everything is possible, and the child can quickly take advantage of this time granted to take care of his or her basic needs.

Advantages of hypnosis in teleconsultation after confinement?

The confinement has disturbed caregiving references for health professionals. After a time of questioning about the means for adapting and continuing assistance to patients, we have had to think differently, in order to find solutions and remain a healthcare provider despite the limits imposed by the confinement.

This mandatory questioning has allowed us to develop new skills in the transmission and use of hypnosis.

Audio tracks, training sessions through conference calls and the teleconsultations will now be part of our support tools and be integrated into our usual practices.

Bibliography

1. Bioy, A., & Célestin-Lhopiteau, I. (2014). *Hypnothérapie et hypnose médicale en 57 notions*. Malakoff: Dunod.[Bioy, A., & Célestin-Lhopiteau, I. (2014). *Hypnotherapy and medical hypnosis in 57 concepts*. Malakoff: Dunod.]
2. Lubart, T., Méner, E., Méner, A-C., & Tordjman, S. (2019). Créativité, processus thérapeutique et hypnose: un aperçu. *Transep*, 6, 46-54. [Lubart, T., Méner, E., Méner, AC., & Tordjman, S. (2019). Creativity, therapeutic process and hypnosis: an overview.]
3. Gruzelier, J.H. (2002). A review of the impact of hypnosis, relaxation, guided imagery and individual differences on aspects of immunity and health. *Stress*, 5, 2, 147-163.
4. Arrêté du 25 mars 2020 publié au Journal Officiel du 26 mars 2020, texte N° 33.[Order of March 25, 2020 published in the Official Journal of March 26, 2020, text No. 33.]
5. Haley, J. (2007). *Un thérapeute hors du commun: Milton H. Erickson*. Paris: Editions Desclée de Brouwer. [Haley, J. (2007). *An unusual therapist: Milton H. Erickson*. Paris: Editions Desclée de Brouwer.]

To know more

- Website [Hypnosis and Health Training](#)
- INSERM report Unit U1178, Evaluation of the effectiveness of the practice of hypnosis, 2015
- Roumanoff-Lefavre, C. (2016). *Diary of a hypnotherapist*. Paris: Eyrolles Edition.
- [IFPPC website](#)

IX

EMDR and Telehealth for Children and Adolescents in confinement

Mathieu Thépaut, Tony Brazil, Nicolas Cazenave



Mathieu Thépaut

Doctoral student in Psychiatry, University of Rennes 1, France. EMDR Practitioner level I.

EMDR-France Association.

Contact: mthepaut.emdr@gmail.com



Tony Brazil

European Certificate of Psychotherapy, Connecticut, USA. Accredited EMDR Practitioner and Consultant.

EMDR-France Association



Nicolas Cazenave

Lecturer in Psychology, Toulouse Jean-Jaurès University, France. Center for Study and Research in Psychopathology and Health Psychology (EA 7411), Accredited EMDR Practitioner.

EMDR (*Eye Movement Desensitization and Reprocessing*) is an efficient psychotherapy for the treatment of Post-traumatic Stress Disorder (PTSD) and stress-related disorders. Children and adolescents with these disorders may benefit from EMDR. Considering the risks of PTSD in a critical situation such as the COVID-19 pandemic, using and adapting the EMDR treatment protocol for telehealth is of utmost importance. This paper aims to show the utility of EMDR via Teleconsultation with children and adolescents in confinement.

Confinement and psychotrauma

Since its emergence, the COVID-19 pandemic caused by the SARS-CoV-2 virus has taken populations, governments and health authorities by surprise. It constitutes a global health, economic and social threat. The extent of the medical and psycho-social consequences of COVID-19 calls for unprecedented responses from national and international authorities, as well as health professionals.

On an individual scale, quarantine or confinement are factors of vulnerability. Scientific literature reports that this kind of health crisis situation leads to isolation and stress, or even characterized psychiatric disorders; studies report adverse effects such as emotional (sadness, irritability, anger), cognitive (concentration disturbance, intrusive ideation) or behavioral disturbances linked to ongoing psychotrauma (1). These psychological effects can be long lasting. The most frequently reported risk factors are: length of quarantine, fear of infection, difficulties in food supply or access to information, financial problems or stigma linked to being infected or its risk.

In response to the COVID-19 pandemic, authorities in many countries have ordered emergency measures in order to contain their populations and restrict activities in public spaces. In terms of public health, the objective is to prevent or slow down the progression of infection, sometimes at the cost of human rights. **For children, this has meant the closing of schools and confinement with their families. This has had an impact on their physical and mental health, particularly in cases of domestic violence (→ Parental resources)** (2). As of May 24th, 2020, [UNESCO](#) estimated that more than 1.19 billion children in 153 countries and territories were facing school closures.

Communicating and providing information adapted to children of all ages is an essential part of the arsenal of measures to be implemented in dealing with the pandemic. COVID-19 and its medical and psychosocial consequences have not spared any population. The unprecedented pressure on health systems around the world has mainly been due to adults. Children are epidemiologically less affected by severe forms of COVID-19. The current situation has pushed their physical and psychological needs, as well as their safety, into the background. It now appears that there has been a fragilization of younger generations through exposure to ongoing psychotrauma. The short and long-term effects on this vulnerable population must be studied and taken into account.

EMDR for children and adolescents

The standard protocol and its adaptations

Eye Movement Desensitization and Reprocessing therapy (EMDR) began to be developed by Francine Shapiro (1948-2019) in 1987. The first results, concerning what was then called EMD, were published in 1989 (3).

EMDR psychotherapy has been shown to be effective in numerous clinical studies and meta-analyses in different clinical settings (3). It is recommended by national and international Health authorities, both civilian and military (→ WHO) for the treatment of post-traumatic stress disorder (PTSD). A **standardized 8-step procedure** is applied, involving alternating **Bilateral Stimulation (BLS)** during dual attention tasks or observations (**Figure 1**). The most widely used stimulations are rapid and rhythmic eye movements. Other forms of BLS are possible, e.g., tactile or auditory. The application of BLS, within the framework of a specific protocol, makes it possible to reduce the subjective experience of disturbance and the vividness of traumatic memories. Several mechanisms of action have been proposed with various hypotheses (4).

Francine Shapiro wrote about EMDR as an integrative multi-stage therapy for the treatment of psychotrauma. EMDR is commonly described as a three-pronged approach treating past events (which have generated psychotrauma), present events (current triggers) and future events (with the installation of adaptive patterns and cognitions for adaptive strategies in dealing with disturbing events) (4).

Standard protocol in 8 phases

- **Client History and Treatment Planning:** establishing a therapeutic alliance, collecting clinical data, evaluating client safety factors, creating a treatment plan;
- **Preparation:** psychoeducation including emotional self-regulation techniques;
- **Assessment:** identifying a target to be processed;
- **Desensitization:** focusing on traumatic experiences with application of BLS;
- **Installation:** integration of adaptive positive cognitions;
- **Body scan:** working on residual bodily sensations;
- **Closure:** emotional stabilization;
- **Reevaluation:** at the beginning of the following session, verification of previous targets and patient's behavioral modifications, possible adjustment of treatment plan.

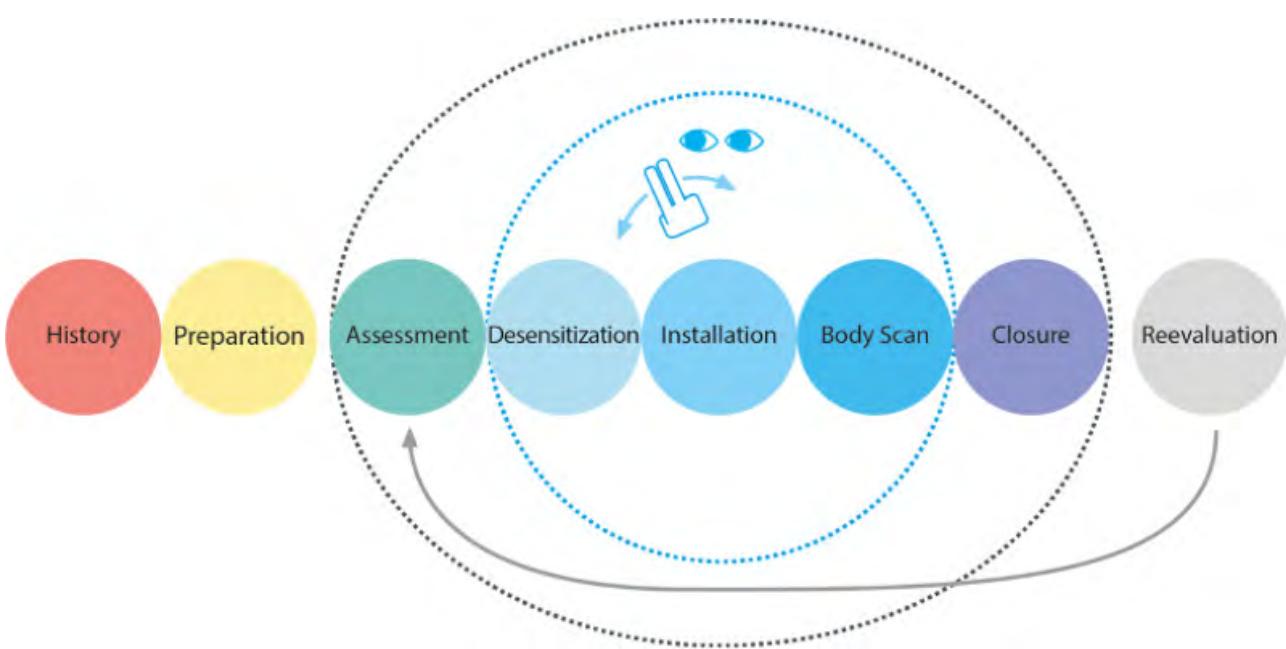


Figure 1. The standard 8-phase EMDR protocol (from F. Shapiro, 2017). Phases 3 to 7 can take place during the same session. Phases 4 to 6 involve dual attention tasks with bilateral stimulation (BLS). At the beginning of the next session, the reevaluation verifies previous targets and allows treatment plan to be adjusted. © Mathieu Thépaut & Pierre-Yves Bastard

EMDR has also shown to be effective in emergency situations, using adapted protocols, where some of the 8 steps are modified, reduced or even omitted depending on clinical circumstances ([→ Protocols of early EMDR intervention](#)). In treating recent traumatic events, studies have shown that a single session of EMDR can significantly reduce the subjective level of disturbance (5).

Adaptations for children and adolescents

The use of EMDR with children and adolescents has been validated by clinical studies and meta-analyses and represents an effective treatment option in case of trauma (6, 7), including domestic violence-related trauma and complex trauma such as sexual abuse. This psychotherapy received a “strong recommendation” by the International Society for Traumatic Stress Studies ([→ ISTSS](#)). EMDR also seems to be an interesting option in treating depression or phobia.

The standard protocol can be used with many children from 9 years up (4). The National Institute for Health and Care Excellence recommends considering EMDR in treating PTSD from the age of 7 ([→ NICE](#)). Modifications to the protocol are necessary in younger children, but are not limiting. They make it possible to offer this psychotherapy for all ages (**Figure 2**).



Figure 2. EMDR Session with child. Phases 4 to 6 involve clinician-guided ocular Bilateral Stimulation (BLS), which reduce the subjective experience of disturbance and the vividness of traumatic memories. © Cécile Meignant

EMDR-IGTP ©: a validated group protocol in children and adolescents

EMDR-IGTP© (*Integrative Group Treatment Protocol*) was developed for children, following Hurricane Pauline which struck Mexico in 1997. This protocol integrates a graphic art therapy base during highly adapted phases 2 to 6. It is particularly suitable for group application. The BLS are self-administered by the participants themselves in the form of what the authors call the “butterfly hug” (**Figure 3**). This involves crossing one’s arms over the chest and applying rhythmic and alternating stimulation to the chest, arms or shoulders (8). This protocol has since been replicated in other contexts of natural or anthropogenic disasters. → [EMDR-IGTP © protocol](#)

An adult version has also been developed, as well as an adapted variant for Ongoing Traumatic Stress (OTS). → [EMDR-IGTP-OTS © protocol](#)

A clinician using any EMDR protocol with adults or children, requires clinical experience in psychotherapy. Usual ethics and good practice standards must be guaranteed to ensure maximum effectiveness and treatment fidelity.



Figure 3. Butterfly hug (from Jarero et al, 2008).
The “butterfly hug” is a self-administered Bilateral Stimulation (BLS) and an alternative to ocular BLS.
Different positions are possible. © Mathieu Thépaut

Distance makes the heart grow fonder: EMDR and the “Teleclinician”

Challenges of telepsychiatry

How can technology be used to extend and make the clinical practice of EMDR accessible to the greatest number of people? With new threats and issues about quarantine and confinement surfacing, psychiatrists and psychologists must adapt and offer oriented telehealth solutions. A previous chapter already discussed the value of Telepsychiatry, namely the use of electronic communications and information technologies, in providing or supporting psychological clinical care.

Live, interactive, two-way audio and video communication - videoconferencing (VC) - is the most widely used method for Telepsychiatry. Several research results suggest that psychotherapy by VC can be as effective as “in person”, especially with Cognitive and Behavioral therapy (CBT) centered on trauma (9). Such Internet-based treatment represents an alternative, generally well-accepted by patients, which could remove certain obstacles to PTSD treatment, such as accessibility, information on availability, as well as cost. Psychotherapy by telephone has also been studied, but less exhaustively.

iEMDR

To date, only 2 studies on Internet-based EMDR (iEMDR) have been published. The first is a single-case study (10). The second is a pilot study with adults (11). It uses an adaptation of the standard EMDR protocol. Although it has many biases (absence of control group, confusion bias linked to the simultaneous use of CBT tools), this study reports an effectiveness comparable to that of randomized studies for patients that used EMDR.

Feedback on EMDR used in videoconferencing and teleconferencing

Phases 1 and 2 of the standard EMDR protocol need to be as complete as possible. The modalities used in phases 3 to 7 depend on the clinician's preferences. Note that **the standard protocol is efficient and valid even via telehealth**, possibly with minor adaptations for young children (less than 9 years old). We noticed that sessions via Internet presented fewer distractions. Being in their own environment can increase patients' sense of security. Less time seemed to be required to re-establish the therapeutic alliance at the beginning of each new session. Patients generally take this approach very seriously and do not appear to be troubled by the therapist's “distance.” EMDR-IGTP® is also very easy to use remotely, even individually. Its protocol incorporating an art therapy base helps to keep the child or adolescent focused during the session.

Clinicians are advised to keep verbal and visual contact with the patient even more sustained than usual, especially while accompanying possible abractions. The duration of the BLS sets as well as the overall duration of a session are roughly the same as “in person” sessions. Reprocessing violent memories is no more difficult than during “in person” consultations. However, this presupposes the therapist's ability to maintain the same continuity and therapeutic alliance through heightened verbal and visual contact. Trust remains basic to therapy.

In VC, therapists are subject to sensorial restriction, as the visual information we receive from patients is reduced to the head and upper part of the chest. But once the process is engaged, we observe that clinicians adapt quickly. Additional training or supervision for the beginner “teleclinician” can be useful.

Most of the tools useful for administering BLS remotely are for sale in commerce, some requiring a device or a periodic subscription. Clinicians can avoid buying these tools and learn to guide their patients in visual or tactile stimulation. For visual stimulation, when the patient's screen is not wide enough to support sufficient eye movement, the clinician may ask him/her to choose fixed visual cues in the immediate environment to ensure a greater range of motion (**Figure 4**). Visual BLS's benefit from the widest scientific support.

[→ Recommendations for remote practice by the EMDR International Association \(EMDRIA\)](#)

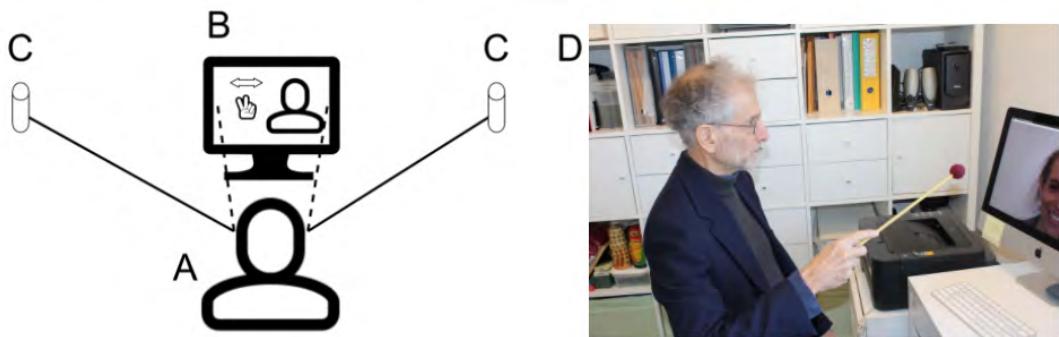


Figure 4. Proposal to facilitate the application of alternate ocular Bilateral Stimulation (BLS) in Telehealth (according to T. Brazil, personal communication).

(A) Patient in a quiet place. (B) Patient screen with practitioner applying ocular BLS. (C) Fixed objects in the patient's environment serving as landmarks to widen the field swept by eye movements. (D) Clinician guiding the BLS. © Mathieu Thépaut and Tony Brazil

Deconfinement and Resilience: anticipating the next moves

Studies will be needed to measure the extent of the medical and psychosocial consequences from the COVID-19 pandemic. They will guide both public decisions and health professionals' diagnostic, therapeutic and support interventions.

At a time when confinement and school closures are enforced in most countries, clinical research and innovative therapeutic interventions are more than ever necessary to help patients' resilience. Personal contact between patients and clinicians is likely to be reduced due to clinical and logistical barriers created by quarantine. Adapting information and interventions to vulnerable populations via electronic media seems to us to be more than useful. Such therapeutic innovations, as they confirm their interest and positive results, can readily integrate psychological and psychiatric care systems after the crisis.

→ Resources for EMDR research

We are hoping that this experience can contribute to the development of EMDR in telehealth by supporting patients' recovery. The creativity of EMDR practitioners has focused on the **development of innovative, simple protocols, practically costless in human energy or logistics, and based on proven psychotherapy**. Developing resources for the future by learning from our past and present experiences is an integral part of EMDR psychotherapy.

Acknowledgments

The authors express their gratitude to Isabelle Meignant for her active listening, encouragement and supervision, as well as to Cécile Meignant and Pierre-Yves Bastard for their artistic talents.

Bibliography

1. Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., Ho, C. S., & Ho, R.C. (2020). Immediate Psychological Responses and Associated Factors during the Initial Stage of the 2019 Coronavirus Disease (COVID-19) Epidemic among the General Population in China. *International Journal of Environmental Research and Public Health*, 17(5). <https://doi.org/10.3390/ijerph17051729>
2. Wang, G., Zhang, Y., Zhao, J., Zhang, J., & Jiang, F. (2020). Mitigate the effects of home confinement on children during the COVID-19 outbreak. *Lancet*, 395(10228), 945-947. [https://doi.org/10.1016/S0140-6736\(20\)30547-X](https://doi.org/10.1016/S0140-6736(20)30547-X)
3. Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, 2(2), 199-223. <https://doi.org/10.1002/jts.2490020207>
4. Bisson, J.I., Roberts, N.P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *The Cochrane Database of Systematic Reviews*, 12. <https://doi.org/10.1002/14651858.CD003388.pub4>

5. Johannesson, K.B., Weschke, M.F., & Ahmad, A. (2019). Eye Movement Desensitization and Reprocessing (EMDR). In L.J. Farrell, T. H. Ollendick, & P. Muris (Éds.), *Innovations in CBT for Childhood Anxiety, OCD, and PTSD* (1^{re} éd., p. 590-609). Cambridge University Press. <https://doi.org/10.1017/9781108235655.029>
6. Shapiro, E. (2012). EMDR and early psychological intervention following trauma. *European Review of Applied Psychology*, 62(4), 241-251. <https://doi.org/10.1016/j.erap.2012.09.003>
7. Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A.M., & Stams, G.J. (2009). Efficacy of EMDR in children : A meta-analysis. *Clinical Psychology Review*, 29(7), 599-606. <https://doi.org/10.1016/j.cpr.2009.06.008>
8. Moreno-Alcázar, A., Treen, D., Valiente-Gómez, A., Sio-Eroles, A., Pérez, V., Amann, B.L., & Radua, J. (2017). Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adolescent with Post-traumatic Stress Disorder : A Meta-Analysis of Randomized Controlled Trials. *Frontiers in Psychology*, 8, 1750. <https://doi.org/10.3389/fpsyg.2017.01750>
9. Jarero, I., Artigas, L., Montero, M., & Lena, L. (2008). The EMDR Integrative Group Treatment Protocol : Application With Child Victims of a Mass Disaster. *Journal of EMDR Practice and Research*, 2(2), 97-105. <https://doi.org/10.1891/1933-3196.2.2.97>
10. Andersson, G., Cuijpers, P., Carlbring, P., Riper, H., & Hedman, E. (2014). Guided Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders : A systematic review and meta-analysis. *World Psychiatry*, 13(3), 288-295. <https://doi.org/10.1002/wps.20151>
11. Todder, D., & Kaplan, Z. (2007). Rapid eye movements for acute stress disorder using video conference communication. *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association*, 13(4), 461-463. <https://doi.org/10.1089/tmj.2006.0058>
12. Spence, J., Titov, N., Johnston, L., Dear, B. F., Wootton, B., Terides, M., & Zou, J. (2013). Internet-delivered eye movement desensitization and reprocessing (iEMDR) : An open trial. *F1000Research*, 2, 79. <https://doi.org/10.12688/f1000research.2-79.v1>

To know more

- Luber, M. (2009). *Eye movement desensitization and reprocessing (EMDR) scripted protocols : Basics and special situations*. Springer Publishing Co.
- Shapiro, F. (2017). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures* (3rd éd.). Guilford Press.
- Tinker, R.H., & Wilson, S.A. (1999). *Through the eyes of a child : EMDR with children*. W W Norton & Co.

X

Conclusions and perspectives: From confinement to deconfinement

Sylvie Tordjman



*Professor in Child Psychiatry, Head of Pole, University Hospital of Psychiatry, Child and Adolescent Psychiatry (PHUPEA),
Center Hospitalier Guillaume Regnier and University of Rennes 1 ;
Laboratory of Psychology of Perception (LPP), CNRS UMR 8242 and University of Paris;
E-Mail: s.tordjman@yahoo.fr, s.tordjman@ch-guillaumeregnier.fr*

The confinement has forced us to reorganize practices to ensure the continuity of psychiatric care. This experience has highlighted the need to rethink the mental health system following deconfinement to integrate tools for remote teleconsultation as well as a reflection and practices that take into consideration the importance of the timing of physiological rhythms, changes of location and physical movement. These remote therapeutic tools and innovative practices call for the 4C skills of 21st century (communication, critical thinking, collaboration, and creativity). This period, at the border between confinement and deconfinement, has seen the emergence of new perspectives in both child and adolescent psychiatry and in general psychiatry. These new perspectives continue to develop in a context where future alternation between confinement and deconfinement phases is a possible reality. It is in this particular context that this book is being published.



Rethinking the mental health system by integrating remote teleconsultation tools

Confinement has forced healthcare professionals to use distance tools for teleconsultation (primarily the telephone and video). Up until the beginning of confinement, many of these professionals were unfamiliar with the use of these tools in the context of therapeutic relationships. Indeed, while these tools existed well before confinement, they were not frequently used during face-to-face appointments, or were reserved for specific moments in therapeutic care management (home phone interviews, etc.). However, the experience during confinement has shown the value of continuing to use these therapeutic tools which may in fact be more suited to certain situations (such as physical and geographical distance, confinement, etc.), but also to certain patients. For example, telephone interviews with psychotic adolescents who had been receiving care for several years were more effective than the face-to-face consultations used prior to confinement. The telephone interview allowed these young people to benefit from a reassuring therapeutic framework where they were no longer subject to the gaze and physical presence of others, which these patients often experience as a source of persecution. In this context, communication by telephone was much more appropriate than by video. Likewise, telephone consultations are more adapted for patients who, due to social anxiety, are more at ease when the exchange does not involve a camera and video. The telephone has the advantage of being a tool which centers on the fact of being heard and of listening to the other. In addition, by operating on a single sensory channel, the auditory channel, the telephone can facilitate communication which is not subject to interference from visual information inherent to video calls (both from the patient who is sometimes negatively impacted by his or her own image on the screen, or from the therapist and the background environment). The benefits of using the telephone as a tool are explored in the box in this chapter.

From confinement to deconfinement: Contribution of teleconsultation to the neuropsychological assessment of children with learning disabilities

Sylvie Chokron

In general, the neuropsychological approach to learning and neurodevelopmental disorders is part of an integrative approach which takes into account the interaction between the neurobiological, cognitive, psychosocial and cultural factors involved in the child's acquisition and learning. The neuropsychological evaluation of children with neurodevelopmental disorders is broken down into three stages: obtaining a detailed history, neuropsychological assessment then implementation of appropriate care with parental guidance and advice given to school and paramedical workers in order to restore the cognitive processes that do not function as they should.

During confinement, these stages of the neuropsychological evaluation were conducted using teleconsultation. To simplify the procedure, the anamnesis was taken over the telephone (without video), in the presence of both parents and the child. Following this, the neuropsychological tests with specific instructions were sent to the parents by email. The parents sent the tests back to the neuropsychologist along with the time taken by the child to complete them. A second telephone consultation was subsequently conducted to report the test results to parents and to provide them with guidance. In addition, copies of the child's school notebooks as well as short videos of the child recorded during daily activities (meals, games, travel ...) were sent by the parents to the neuropsychologist so that he or she could assess the child's degree of difficulty in various environments and contexts.

Several dozen children aged between 3 and 17 years were tested in this way (initial consultation or follow up) during the weeks of confinement and the feedback has been very positive. First, a greater freedom of speech was revealed during the initial telephone consultation that could last up to half an hour and consequently led to a detailed anamnesis. Similarly, the follow-up consultation to discuss progress made and the difficulties encountered since the last consultation proved very rich and uninhibited.

The absence of visual feedback seems to have allowed greater freedom of expression for the patients, as well as reducing preoccupations and feelings of having to control aspects of their self (for example, their appearance, facial expressions, reactions). Indeed, adolescents and young adults often use the image of themselves and their friends to assert and express themselves and to measure their popularity, as is the case with social networks. The fact of successfully conducting teleconsultations without the video feature has enabled us to avoid the preoccupation and concern with the image of oneself, which is often associated with the smartphone therefore allowing the adolescent to focus more on the content of the exchange.

During the discussions with the neuropsychologist, the focus was on the cognitive processes at the center of the child's difficulties. The absence of the video feature meant that there was no visual information disturbing the exchange. The consultation was entirely devoted to speech-based information, with parents and children being attentive and listening carefully.

The families themselves felt supported, particularly given that they had to adapt to this complex confinement period during which they had to rely on themselves to bear the consequences of school being closed. Many parents have expressed extreme gratitude about the fact that these teleconsultations were proposed during confinement and all the families requested that these telephone consultations continue after deconfinement. Teleconsultations could be particularly useful for conducting initial consultations to obtain the child's anamnesis as well as follow up consultations to monitor the child's development, to adapt the child's environment to facilitate and guide parents, teachers and other individuals involved. These teleconsultations could be particularly suitable for children with motor disabilities (cerebral palsy, hemiplegia), behavioral disorders involving a notable handicap or those who live far from assessment centers, for whom face-to-face consultations may involve considerable costs and energy such that cooperation in the face-to-face interview is thereby sometimes affected, a disappointing situation for the families that have high expectations for these appointments and who often complain about the trade-off between the energy expended (taking a day off, journey, accommodation if necessary) and the difficulty of their child to invest in face-to-face consultations.



Sylvie Chokron

*Neuropsychologist and Research Director 1st class at CNRS;
Head of the Perception, Action, Cognitive Development and Brain Plasticity team at
the Center for Integrative Neurosciences and Cognition at the University of Paris;
Head of the Institute of Neuropsychology, Neurovision and NeuroCognition of the Rothschild Ophthalmological Foundation.*

Children's experiences in a medico-social structure: from confinement to deconfinement

Dominique Brengard

The Montreuil EMP (medico-psychological day school) provides care to 19 children with disabilities. The confinement was imposed very quickly, with no possibility of anticipating a new way to organize caregiving. Thanks to the commitment and ingenuity of the multidisciplinary team, it was possible to set up a new operation:

- Providing games, educational material and masks to the children's home, as families did not want home visits for fear of contamination.
- Customized activities for each child and family using teleconsultation (WhatsApp, Zoom, and phones)/visuals with pictograms were used to explain the coronavirus and preventive measures. Individual sessions (speech therapy, psychomotoricity, sport) were offered by video transmission. Parents attended these sessions, which is not usually the case in day school. We observed that parents and sometimes siblings followed the advice and activities suggested by the professionals to mobilize the child outside the sessions and often sent us videos. Indeed, through the period of confinement we were able to draw on the skills and resources of these families.

Small groups used different mediations (nursery rhymes signed with Makaton (a communication support), theater, music and dance, speaking groups, etc.). The teacher sent out educational activities tailored to each child and the family sent back the child's work, which the teacher then corrected.

Cooking activities in the form of challenges were organised, for example imagining and making a hedgehog cake. The children found this to be a very enjoyable activity and photos of the productions were sent to the caregiving team. We chose not to rank or grade the work and encouraged appreciation in a cooperative education approach instead of a competitive one.

- The frequency of family interviews conducted by psychologists and myself, and the referent professionals meeting with the teacher was increased to once a week.
- A weekly team meeting was maintained by Zoom. Additional telephone meetings between stakeholders and the educational service manager were conducted to organize the regulation and coordination of follow-ups.
- The communication between hospital partners and child psychiatry services was hosted by videoconference (zoom), which also helped to conduct consultations involving neurological experts (regulation, treatment) for children who were already being monitored.

Deconfinement took place gradually, respecting the wishes of each family. No family wished to send the children attending part-time back to school, some however accepted a gradual resumption. In total, half of the families did not wish to return to the pyschomedical center, given that the Parisian region remained a danger zone for the pandemic; the parents preferred to wait to see how the pandemic situation evolved. For these children, activities by video transmission similar to those implemented during confinement were organized. For other children who returned to the psychiatric day school, the groups were reorganized each week with the children and the professionals who were present.

We believe that some new practices experienced during confinement could be continued during and after deconfinement:

- **The use of videoconferencing for partnership meetings** between university hospitals and more local, sectorial psychiatry units, for example to present and discuss the results of various assessments and ongoing cases. For example, we participated in a videoconference meeting with a reference hospital for Autism Spectrum Disorders (ASD) that conducted an assessment at the request of a family. We found that this videoconference allowed the different services to coordinate with each other, leading to better quality care than would have been the case if a single document was sent. The organization of meetings with the presence of all the stakeholders would be difficult, expensive, hospital – centric and energy and time consuming (the professionals of hospital centers do not go the external services for feedback, often children receive care recommendations without joint consultation, exchanges and prior consultation).

- **The use of teleconsultations for consultations specializing in neurology requiring, for example, treatment modifications when the children are already being monitored.** In the Parisian region, specialized hospital consultations are overbooked and this would allow advice to be provided rapidly. However, for the first consultation or for complex situations, we believe that we must strengthen the consultation contact and create mobile units that would provide facilities for children and people with disabilities.
- **The organization** of activities for children and families in the terms of “challenges”, by filming their creations, in a cooperative education approach has proven to be motivating and a source of children’s creativity.
- **Finally, it can be useful to rely on the resources and skills that families have shown during confinement.**



Dominique Brengard

*Pediatric psychiatrist at the IME (medico - educational institute) of Montreuil
and at the GHU Paris psychiatry & neurosciences for the Pôle psychiatrie-Précariété.
Psychiatrist emeritus of hospitals and former Head of Sector and Pole*

The effectiveness of telephone and video-call therapies has been studied in comparison with therapies conducted face-to-face, and very positive results of phone-based therapies have been reported in the follow-up of various psychiatric disorders (1). Particularly during this period of confinement, it seems important to develop and share knowledge on the effectiveness of therapeutic tools used to continue care at a distance. Indeed, evaluating the effectiveness of such tools is essential in order to develop practices. However, it is also essential to reflect on the therapeutic framework to be respected so that these new practices and technologies are most suited to the needs of both families and the therapist. Video-call-based therapy requires that the clinician first determines his or her place of exercise within his or her home, a space that will be visible on the screen. It is important that this space is carefully selected so that the privacy of the clinician’s personal home space is not invaded and that the clinician’s personal space does not distract or disturb the patient. This effect and feeling of being invaded could even, potentially, be expressed by professionals during telephone consultations at their home.

Child Psychiatry and teleconsultation: ethical considerations and clinical prospects

Dina Joubrel

During confinement, teleconsultation (Skype, WhatsApp with video, telemedicine platforms or simply by phone) very quickly replaced face-to-face consultations. From the beginning of the health emergency, it was necessary to communicate the message to the children and families who attend our CMPP consultation center that life despite everything continues and that they could count on our psychological support.

Co-construction of the framework and the method

The first telephone contact with the family makes it possible to assess the family's situation, the contextual parameters, the means made available to them (internet connection, smartphone, computer, etc.), the child's availability, age, difficulties, psychopathology, language and speech development, and also and above all, the quality of the transference link that the child has established with the therapist. Some directives are given to families: the importance of differentiating the time of parental guidance from the consultation with the child, the importance of identifying a place in the child's home where the child can engage in the consultation, the definition of a rhythm and a temporality of the teleconsultations that is agreed on together.

Disadvantages of teleconsultation

- The meeting with a therapist is generally preceded by a ritual which begins from the departure from the house or from another place, by taxi, on foot, alone or accompanied by the parents to the consultation center. From the start until the end of the journey to the consultation center, something is happening in the *movement toward the therapist*. This ritual, this **travel time and journey** are lost in teleconsultation.
- **The question of privacy:** the child is in his or her home, most often in his or her bedroom, which exposes the child in the eyes of the other. For some children, this can have an effect on their psychic development. This can be illustrated by the example of a child whose mother asked him to show his bedroom and his teddies to the doctor. The child reacted by withdrawing completely and refused to continue the consultation. Some children are forced to retreat into the bathroom to ensure the privacy of their session. During video consultations, certain children can feel invaded by the therapist's image in his or her intimate space. The consultation by video transmission attracts some children's curiosity and we have seen children scrutinizing, looking worried or fascinated, looking "inside" their therapist's space, bending over to see better and not being able to concentrate on verbal exchanges. It appears essential for the professional to consult from a suitable professionalized space, whether it is his or her usual consultation office or a space at home reserved for professional activity. This entry into the privacy of the other can affect the future relationship after confinement. It is therefore important to co-construct a framework prior to beginning teleconsultations. This framework should outline a place in the home for these consultations that will preserve the privacy of the child and the professional.
- The teleconsultation is characterized by **the absence of the body**, of its materiality, of the reception space: we welcome the other with his or her psychic being, but also with his or her physical being, with his or her movement, breath, smell, and also his or her withdrawal. Bodily presence, body presence and floating moments of presence, body presence and prohibition to touch (this prohibition requires that touch is possible). The voice, the image, certainly represent the body. But what about silence during a consultation or a session? The silence without the body can cause a feeling of radical absence. For some children, the consultation without physical presence, only by voice, can cause fear of a dangerous proximity for them and they want to stop the sessions: "I do not recognize this voice" exclaims Nolan in a worried tone. Some have found creative solutions: using a speaker, for example in order to represent the voice that speaks as a third party; for others, there may be a risk of psychic dissociation, so they make their stuffed animals talk: "my stuffed animals tell me to stay myself."

Advantages of teleconsultation

- In general, teleconsultation is a means of ensuring that contact is maintained during the health emergency, especially for vulnerable families. Teleconsultations ensure the continuity of prevention and care, thereby preventing situations from deteriorating and leading to emergencies.
- In clinical terms, for some children it was a privileged time of **subjectivation**: “it's a call for me” said Jonathan, this child who considered himself as transparent and insignificant. For others, it was the experience of **creative invention**: the absence of usual objects, to support speech during face-to-face sessions in the therapist's office, allowed, by necessity, the possibility of inventing others. Finally, for other children, the telephone consultation, in the absence of the gaze of the other, helped to release their inhibition (inhibition caused by “bodily presence” in the face-to-face consultations), to **free their speech** and get right to the essential. Although the absence of the body can be problematic for some children, as mentioned above, it can be facilitating for others. It is therefore necessary to adapt the framework on a case-by-case basis, both during the preliminary co-construction of the therapeutic framework, and in a possible phase of readjustment of this framework. This is not only important during periods of confinement but also of deconfinement!
- In practical terms, one may wonder if it is in fact necessary to remove the child from **school** to attend face-face consultations, thereby risking the stigma of missing school time, especially as the consultation centers can be many kilometers away (although for certain children, it is essential to remove them from their school environment to offer relief to both the child and to those surrounding them).

To conclude

We have precious lessons to learn from this extraordinary and unprecedented experience on the diversity of consultation tools at our disposal. The choice of tools could be based on different environmental elements (location, family, school, etc.), the difficulties presented by the child and medical treatment available in the proximal environment of the child and his or her family.



*Dina Joubrel
Psychiatrist*

Medical director of the Vitré medico-psycho-pedagogical center (CMPP)

Synchronization of physiological rhythms



We have seen in this E-book how confinement, with a loss of temporal reference points, can lead to disturbances of the sleep-wake rhythm, affecting mental state, and more generally disturbing physiological rhythms. The experience of confinement shows us that structuring time with routines can prevent individuals from becoming physiologically and psychologically disorganized. Structuring time in this way enables individuals to organise the planning of their day and more importantly, to maintain an internal and external rhythm which is essential for both mental and physical health.

After confinement, it will be necessary for physiological rhythms in mental health to be considered to a greater extent. This will be important within the treatment framework in child psychiatry (importance of *zeitgebers* with fixed mealtimes and a regular sleep schedule), and in therapeutic follow-up where these physiological rhythms can be valuable indicators of a positive evolution. For example, the disappearance of sleep disorders in depression is a fundamental indicator of mental and physical well-being. The value of sleep monitoring extends far beyond the field of depression and in fact concerns many psychiatric disorders, including disorders observed in child, adolescent and adult psychiatry (such as autistic, anxiety, depressive, bipolar, schizophrenic disorders, attention deficit hyperactivity disorder, behavioral disorders), which could be related to, or maintained by, a desynchronization of physiological rhythms; this desynchronization can increase vulnerability to certain mental disorders and somatic illnesses: <https://doi.org/10.3390/ijms18050938>



A prerequisite for the effectiveness of many therapies is to (re) establish regular, synchronized physiological rhythms, in order to reach and maintain an internal homeostasis which allows the individual to adapt to his or her external environment. Indeed, Steven Marans at the Child Study Center (Yale University, United States) integrates physiological rhythms (regular meal times, sleep and social activities) into the monitoring and treatment of adolescent behavioral disorders prior to psychotherapy, much like building foundations before one can build a house.

Phase shifts are concerning increasingly younger adolescents and preadolescents, in particular phase shifts in the waking/sleeping rhythm which in some cases can result in an inverted rhythm and contribute to anxiety or depression-related disorders. It is essential, therefore to work on the regularisation and synchronisation of physiological rhythms prior to (ideally) or in parallel with individual or group therapies. Indeed, these physiological rhythms create metaphorically the backdrop of the score of music with the staves and a basic tempo, whereas the therapies enable and support the composition and writing of harmonious music. Using the metaphor proposed by Descartes who referred to the dualism of body and of mind, well being is achieved when the clocks of the body and mind work in perfect harmony because their pace is synchronous. We can hypothesize that the synchronicity of rhythms plays an essential role in the relations between body and mind. Far from being two independent clocks, the body and the mind would be permanently connected by their rhythm. Thus, the rhythm disturbances of one impact the rhythm of the other and alter its functioning.

This shows the importance of examining physiological rhythms and their role in typical child development and in the development of pathologies. Research in chronobiology and cognitive neuroscience on the synchronization of physiological and interpersonal rhythms (biological and emotional rhythms as well as behavioral and relational rhythms) can contribute to new understandings in child psychiatry and open new perspectives on causes and subsequent development of disorders and their possible treatments and therapeutic approaches.

Benefits of changing locations

As discussed in the introduction, the confinement has led to individuals being restricted primarily to their home. This confinement to the home environment can cause psychological distress and cause certain individual to develop a fixed identity and a rigid, “frozen” thought pattern. The change of places and environments permitted by deconfinement has a dynamic effect on mental representations and can lead to new perspectives and points of view, thereby affecting the therapeutic process (2).

The benefits of changing location can be illustrated by the work of “mobile teams”. For example, in child psychiatry, mobile teams provide support in different meeting places selected by the child and his or her family. Interestingly, the young person and family act and express themselves in a different way depending on the setting and location. They adopt a different narrative, and this participates in the activation of representations which is a major lever for mobilizing the problem and thought processes.

Analysis of data from the EMEA (Mobile Team for Children and Adolescents), concerning 690 preadolescents and adolescents (3), conducted by the university child and adolescent psychiatry department PHUPEA (Hospital-University Center for Child and Adolescent Psychiatry of the Guillaume Régnier Hospital Center), shows that the most frequently observed pattern of locations, chosen by families, is as follows: the first meeting takes place in the family home, then in the mobile office (a specially designed camper van with an office), and the last meeting takes place at the Medico-Psychological Center (CMP). The consultation therefore passes from the home (place corresponding to “the interior” and corresponding to “the here and now”) to the place of care (an exterior place corresponding to a space for psychic development) which was not initially possible. The mobile office constitutes an intermediate space, a transitional area, allowing this movement towards access to care.

Finally, statistical analyses indicate that the change of locations is significantly associated with engagement in the therapeutic process and a continuity of the consultations with the mobile team. Conversely, the absence of changes of locations (meetings taking place in a single place) is significantly associated with a breakdown in care, regardless of the type of place (home, mobile office, medical care center). These results highlight the importance of patients leaving the home, the role of physical movement in psychic mobilization, as well as the plurality of representations associated with the diversity of places. Finally, these results have significant therapeutic benefits, which extend beyond the context of the mobile team; and which question our usual therapeutic frameworks by showing the benefits of changing places to promote the access to and continuity of care.

Role of movement

Given our remarks on the relation existing in a period of confinement between limited movements/displacements and a confined space-time (see chapter I), as well as our clinical observations, we have been able to note the effectiveness of the movement “to go towards” promoted by mobile teams in situations of confinement where the adolescent may no longer be able to leave his or her home. This movement “to go towards” makes it possible to fight at the same time against the suspended time of a “mental freeze” and the isolation of the individual in a space which becomes, like dried skin, more and more confining.

In order to understand better how the movement of the mobile team can lead to a psychic movement in the young person, it is important to consider the subject in interaction with his or her social and physical environment. A frozen environment where nothing moves can numb thought processes. Conversely, an environment which takes into account movement can enable the individual to come out of a psychic inertia and help initiate a thought process. Alain Berthoz (4) writes: “we cannot understand anything about brain functioning if we do not know that its main problem is to set moments of inertia in motion.”

If we focus once again on research relating to the mirror neurons mentioned in Chapter I and apply it to the mobile team’s engagement with the young person, we can hypothesize that the observation of movement by the young person will have a mobilizing effect with a cerebral activity similar to that provoked by the execution of movement in the young person him or herself. Cognitive neuroscience shows us the advantages of using movement as a mobilizing therapeutic lever, whether it is by traveling to meet the young person and his or her family, or by changing meeting places, as previously mentioned. By approaching the young person, the mobile team initiates a physical movement which facilitates psychic mobilization. This physical movement is supported by the mobile team’s action, but also by the change of meeting places, both of which are possible

during deconfinement. This shows the importance, post confinement, of developing new perspectives in child psychiatry which are centered on physical and mental movement, both from the practice of mobile teams and from therapeutic consultations that can take place in different places.

The 4 Cs of the 21st century

The confinement and its 4 Cs (claustrophobia, compression of time and space, constraint, and contamination) have led to the rapid development and use of new tools and therapeutic practices for patients and vulnerable populations in child psychiatry and in general psychiatry. These new practices rely on 21st century skills, namely Communication, Critical thinking, Collaboration and Creativity.

Communication and Critical Thinking

As we have seen, many of the tools used remotely during the pandemic outbreak and confinement are communication and information technology tools. The importance of staying connected with others, communicating, and accessing information is clear, both for families and healthcare professionals, as highlighted throughout this ebook, along with the need to process this information with critical thinking to avoid the propagation of rumours and misinformation. Indeed, critical thinking is promoted in teams during conference calls that combine information and discussion with constructive criticism.

Collaboration

Furthermore, these therapeutic tools and devices put in place during confinement, such as telephone platforms, would not have worked effectively without the essential collaboration of partners. The presentation of phone platforms in Chapter I illustrates the major collaboration with professionals on the front line, in maternity services and PMI for the *Perinatal* platform, the collaboration with professionals of the National Education system for the *Adolescence* platform and the collaboration with the police and pediatric services for the platform for *Children exposed to domestic violence*.

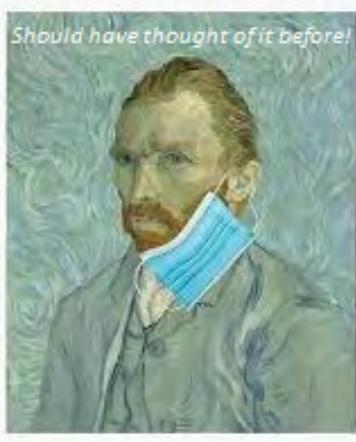
Creativity

Finally, caregivers, teachers, associations and families are coping with the extraordinary circumstances that confinement has created and are looking for new ways to build and maintain links. By relying on his or her creative resources, any individual who is confined or on the front line, has the potential to play a role, to occupy a place, to make a contribution. We witnessed a general mobilization which showed creativity, solidarity and humanity; this effort extended beyond the borders of different age groups and nationalities.

The creative ideas adopted by other countries to fight against the international contamination by Covid-19, this pandemic without borders, are important to identify and disseminate. Among the creative ideas displayed by individuals across the world, humor - *humor without borders* - has been widely used in response to this pandemic. Funny photos and videos circulated on social networks, in very large numbers (several thousands of documents on Facebook: see the section “To find out more”), enabling people to laugh, for example, about barrier measures and protective equipment, to help people defend themselves from the anxiety of contamination, and to share these laughs, and strengthen social ties. Derision served distancing!

This humor relates precisely to the 4 Cs of confinement: Claustrophobia (physical effects of social isolation in the absence of the gaze of others, but also strategies to combat social isolation), Compression of time and space (temporo-spatial confusion with loss of temporal references, and even disorganization, regression and decompensation), Constraint (humor about the ways of defeating the restriction of freedom of movement or of circumventing other constraints, like those of having one's children at

home all the time), and Contamination (humor on protective equipment, barrier measures, coronavirus). The photos and links below illustrate how humor has been used throughout this pandemic in relation to the 4 Cs:



- <https://www.youtube.com/watch?v=8KPbJ0-DxTc&feature=youtu.be>
- <https://youtu.be/giDttMU-k00>
- <https://youtu.be/KYpln-MxoQo>
- <https://youtu.be/3AHRzj7EVIY>

During the pandemic, creativity has also been expressed through beautiful concerts filmed in confinement and broadcast on social networks, like Ravel's Bolero by National Orchestra in France: when the individual musicians playing separately from their own homes culminate in a superb orchestra playing a concert together! https://youtu.be/Sj4pE_bgRQI

But mockery is also present, with humorous remakes of these concerts: Ravel's *Boléro* revisited version and entitled "Le Beau Lérot" (the handsome lerot, which is a squirrel like-rodent) <https://youtu.be/GDpcsSEejN8>

Throughout the confinement period, creative ideas were also shared between child psychiatry teams, including academics (transmission of advice sheets, sharing teleconsultation experiences, etc.), by e-mail, conference calls or videoconferences (see the box in Chapter I).

This book was created as part of this concept of sharing ideas to achieve two means: First, to contribute to an inventory of creative therapeutic approaches that have been developed during confinement and enriched by the experience of professionals from all over the world. Second, to create a bank of ideas (concerning in particular the tools and therapeutic practices in child psychiatry) which will serve the interest of all, from babies to adolescents passing by children, parents and families, from the caregiver to the confined person, in France and across borders, from confinement to deconfinement.

To be continued...

From confinement to deconfinement: history remains to be written on the long-term use of these tools for teleconsultation and the development of new therapeutic practices in child psychiatry after deconfinement...

Bibliography

1. Irvine, A., Drew, P., Bower, P., Brooks, H., Gellatly, J., Armitage, C.J. et al. (2020). Are there interactional differences between telephone and face-to-face psychological therapy? A systematic review of comparative studies. *Journal of Affective Disorders*, 265, 120-131.
2. Tordjman, S. (2013). From physical mobility to psychological mobilization: The benefits of changing location and caregiver in a mobile team for adolescent psychiatry. *Health*, 5, 33-40.
https://www.researchgate.net/publication/272674266_From_physical_mobility_to_psychological_mobilization_The_benefits_of_changing_location_and_caregiver_in_a_mobile_team_for_adolescent_psychiatry
3. Tordjman, S., Keromnes, G. (2019). Equipe mobile en psychiatrie de l'enfant et de l'adolescent : les apports de la recherche [Mobile team in child and adolescent psychiatry: contributions from research]. *L'Information Psychiatrique*, 95(6), 364-371. DOI : 10.1684/ipe.2019.1970
4. Berthoz, A. (2003). Le sens du mouvement [Sense of movement]. Paris : Odile Jacob.

To know more

And if you want to end on a touch of humor which knows no borders:

- <https://www.facebook.com/groups/629057101260482/>
- https://www.facebook.com/groups/641276389992064/?ref=br_rs
- https://www.facebook.com/groups/170545074195305/?ref=br_rs
- https://www.facebook.com/groups/1525232880987663/?ref=br_rs
- https://www.facebook.com/groups/1295116017362361/?ref=br_rs