Child and Adolescent Mental Health

Child and Adolescent Mental Health28, No. 1, 2023, pp. 105–107 doi:10.1111/camh.12545

Editorial Perspective: The digital divide – inequalities in remote therapy for children and adolescents

COVID-19 and teletherapy

Across the world, COVID-19 has had a profound effect on people's mental well-being: impacting both mental health needs and the provision of mental health care. A rapid shift to remote delivery of mental health assessment and treatment has enabled services to be delivered when face-to-face meetings are not possible or safe. For some, this has signalled a welcome acceleration of existing long-term plans towards delivering therapy that is more scalable and better able to meet growing demand. But, the shift to telehealth also has its challenges and there is a risk that it perpetuates or even exacerbates a lack of parity of access and care depending on individual and group factors. We consider three challenges in our bid to avoid repeating prior inequalities: the financial burden of teletherapy; the necessity of safety to speak; and how telehealth may intensify challenges for engagement and therapeutic alliance formation. We focus on care of young people in the United Kingdom, where 1:6 6–16 year-olds had a probable mental health issue in 2021 (NHS Digital, 2021), though the principles identified are likely more broadly applicable. Creative solutions are suggested to address limitations so that young people are not systematically excluded from mental health support, pandemic or no.

Challenge 1: The financial burden of teletherapy and who is most affected

The NHS is free at the point of delivery, yet assumptions of device and data access inherent in telehealth threaten this key ethos. For instance, this assumption likely precludes the 4.2 million young people growing up in poverty, or the 37% of working-class children who do not have internet access at home (Francis-Devine, 2020). These numbers will likely grow due to COVID-19 related unemployment, particularly among families in the bottom earning bracket who are the least likely to have been able to work remotely from home. More alarming still is that across a number of surveys children in low-income families are reporting greater impact of COVID-19 on their mental well-being, especially in rates of anxiety and depression meaning the mental health impact of COVID-19 is felt strongest by those most affected by the cost of telehealth.

Poverty rates vary by ethnicity, and so a policy which disproportionately impacts those living in poverty, may also disproportionately impact individuals from certain ethnic groups. The UK government estimates that 29% of children from Bangladeshi households, 24% of children from Pakistani households and 22% of children from Black households are living in material deprivation, compared to 10% of children from White households (Office for National Statistics, 2020). This means that at least 25,400 children from Bangladeshi, Pakistani and Black households may experience a mental health issue while living in material deprivation likely to preclude them from accessing remote therapy[1]. In fact, the number is likely much higher as children from households in the bottom 20% of income in the United Kingdom are as much as four-to-five times more likely to develop a mental health problems. Furthermore, ethnicity will also affect the likelihood someone develops a mental health issue due to the impact of racism, discrimination and individual and societal challenges, and so the intersectionality of these issues must be considered. Our capacity to fully understand this is limited by groupings made in the reporting of government data, and this should be rectified in future government reports. For instance, the grouping of 'Black households', as opposed to considering how children from Caribbean, African or Mixed Black households may be differently affected.

Of course, not all children from these ethnic groups will be raised in material deprivation and all those growing up in material deprivation are not captured in the most at risk ethnic groups that have been discussed here. Moreover, experiences of racism or mental health issues in any ethnic group will vary and so it is important to acknowledge variation in the way inequality will be felt. What we highlight here are just some of the consequences of policy changes, and how these may be unfairly experienced by certain groups due to socioeconomic status and demographic factors that intersect with this. This is unacceptable and only widens the disparity of care.

For telehealth to work, we need co-created approaches that address these disparities, such as social prescribing of phone contracts; local schools loaning out devices to young people who are engaging in therapy; partnerships with charities to receive old smart phones; or those from low socioeconomic backgrounds being prioritised for face-to-face therapy. The pros and cons of these and other ideas should be considered by local task and finish groups or ICS's to coordinate local action alongside service user groups.

Challenge 2: Physical and mental safety to speak

For telehealth to work, there is an assumption that young people have a safe, private space to speak to their therapist while at home, which for many will not be true. Prior to COVID-19, the NSPCC reported that violence against children in the United Kingdom is committed every 7 minutes. Since COVID-19, this has likely worsened, with the UN describing the rise in domestic violence as a 'shadow pandemic'. As well as affecting their

mental and physical well-being, this means many young people will not have the physical safety to speak.

Moreover, even if the abuser is physically absent, these young people are unlikely to experience the mental space for autonomy and self-hood while in the environment where abuse takes, or has taken, place. Young people are more likely to be hypervigilant and aroused in this environment, which will particularly affect their capacity to mentalise, the process of understanding the beliefs, feelings and goals that motivate our own and others' actions. Mentalising the self, and being mentalised by the therapist is key to therapeutic relationships: enabling the client to safely think about themselves and bring an awareness of how they influence and are influenced by the world (Fonagy, Luyten, Allison, & Campbell, 2017). Mentalising develops in the context of attachment relationships and the capacity to mentalise is disrupted by trauma and abuse from caregivers, meaning that (again) those most in need of support, are also the least likely to be able to engage with it remotely.

Creative ways to find a consistent safe space to engage in telehealth are needed, and these must be collaborative, giving agency to the young person who should lead the search, with principles of safety in mind. For instance, flexibly adapt to a young person's suggestion of where they feel safe to speak, be it at a friend's, a relative's or in a local public space, like a park. Within the home, it may be possible to alter aspects of the physical environment to create a 'therapy space', either by setting up a corner of a room facing a window or calming poster; or, co-creating a 'therapy fort' with younger children, the set-up and dismantling of which offers a way to ease in and out of therapy. Additional sessions may be required to facilitate development of these spaces, or to account for the time lost each week in the setting-up and dismantling of the space. Time-limited therapeutic models will need to adjust for this while noting that joint working in this pursuit may enhance trust, generate sense of agency and benefit treatment outcomes.

Challenge 3: Developing a therapeutic alliance and the need for epistemic trust

The capacity to engage young people in the therapeutic alliance is crucial for optimising therapy and has a causal link with outcomes that transcends therapeutic modalities. These associations may reasonably be expected to persist into the digital sphere; however, factors affecting remote alliance development provide fresh challenges. For instance, telehealth may interfere with establishment of epistemic trust, defined as communication characterised by trust in the authenticity and relevance of information shared by another. Epistemic trust is crucial for positive therapeutic outcomes, as it allows the young person to integrate new information shared by the therapist and so facilitates therapeutic change. As epistemic trust develops in the context of attachment relationships, many young people arrive at therapy in a state of epistemic hypervigilance, in which they have learnt to reject communicated information, expecting it to be unreliable or mal-intentioned. As such, young people subject to maltreatment or abuse are more likely to present with epistemic mistrust or vigilance, which will impact their engagement with therapy, and predicts poorer treatment outcomes (Fonagy et al., 2017).

When working face to face, epistemic vigilance would be addressed therapeutically through the use of ostensive cues and mentalising. However, research suggests ostensive cues of subtleties in tone of voice or facial expression can be disrupted in remote communications (Fonagy, Campbell, Truscott, & Fuggle, 2020). How can eye contact be meaningfully used when you are continually forced to choose between looking into a camera, at your therapist's video or at your own video? Mentalising failures also mean that remote delivery can increase the intensity or frequency of feelings of rejection in those hypersensitive or prone to over-interpreting the actions of others, as shown with adult clients (Wurman, Lee, Bateman, Fonagy, & Nolte, 2020). So, telehealth may work well for the vast majority, providing reassuring average outcome statistics. But those whose history includes communication disadvantages may be least able to overcome shortcomings without additional assistance.

Clearly, adaptations are required. You may exaggerate, or combine multiple physical ostensive cues for understanding to ensure they are not missed (Fisher, Guralnik, Fonagy, & Zilcha-Mano, 2020), such as groaning or shaking your head in addition to furrowing your brow in order to signal or mirror a marked disbelief prompted by what the client shared. Likewise, as the therapist has less access to the client's implicit forms of communication (e.g. eye gaze or body language) the 'not-knowing' stance or curiosity may be even more vital as well as frequently 'checking-in' and indicating explicitly how they as the therapist are experiencing the discussion (Fonagy et al., 2020). Additional therapeutic sessions may be required, particularly for those least trusting to reach a point where they can meaningfully benefit from therapy. For some, it may be appropriate to more actively recruit the young person's broader personal and professional support network into their care by offering psychoeducation on developing mentalising skills and developing epistemic trust. By incorporating those who do have direct face-to-face contact with the child, they may be able to offer an in-person bridge that enables the young person to practice and try-out the processes of mentalising in real life.

Another challenge to remote alliance formation is that therapist-client differences in relation to Burnham's social graces (Burnham, 1992) may feel more exaggerated in a remote set-up, or may be more easily overlooked. Previously invisible or unvoiced aspects of the therapist's and client's identity may become more noticeable in the alliance when working from home and communicating remotely. For instance, what does the room behind or the background noise suggest about their class, culture or spirituality? How does the intersectionality of these and other aspects of their identity and lived experience align or differ from aspects of the other's? Some features of identity may feel more visible or voiced in a remote set-up; for instance, for some Orthodox Jewish clients, their religion may preclude the use of a smartphone requiring a telephone call instead; while for others, aspects of their identity may be less observable, such as the use of a walking aid, which may not be visible in remote therapy, but which will be more visible when meeting face to face. It is important to notice how these shifts in the way we access and engage with both identity and specifically the

multiple needs that some young people present with in therapy are impacted in both the young person and the therapist, and for these to be openly named and discussed within the therapeutic space.

Conclusion

Whether the move to remote therapy is motivated by policies or pandemics, it is important to consider the impact of change. We identify three obvious foci for action. The first, well-recognised issue of digital exclusion may be compounded by intersectionality leaving particular high-risk groups least will provided for and needing concerted local initiatives to address their need. Second, while some children with maltreatment histories may feel paradoxically safer communicating through digital media, for others, triggers may compromise engagement and they need to be creatively supported in finding an appropriate accessible space from which they feel safe to speak. Third, therapists cannot be assumed to fully adapt their skills to remote delivery, particularly with clients who in any case arrive for reasons of disadvantage and multiple needs with limited capacity to trust and engage in forming a therapeutic alliance formation; additional training may be crucial for therapy success. Unless we seek to address the challenges outlined here, we may see the disparity in treatment outcomes widen and we will have found a new way to fail those who need the most support. Let us seize the opportunity to overhaul a system marred by inequalities in access and care.

Georgina M. Aisbitt

Newham Personality Disorder Service, East London NHS Foundation Trust, London,

Tobias Nolte

Wellcome Centre for Human Neuroimaging, Institute of Neurology, UCL, London, and
Anna Freud National Centre for Children and Families, London,

Peter Fonagy

Anna Freud National Centre for Children and Families, London, and
Research Department of Clinical, Educational and Health Psychology, UCL, London, UK
E-mail: p.fonagy@ucl.ac.uk

Acknowledgements

This report is independent research supported by the National Institute for Health Research ARC North Thames. The views expressed in this publication are those of the author(s) and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care. G.A. prepared the manuscript, and P.F. and T.N. provided comments and suggested revisions. P.F. is co-developer of Mentalisation Based Treatment. The remaining authors have declared that they have no competing or potential conflicts of interest.

Ethical information

No ethical approval was required for this article.

Correspondence

Peter Fonagy, Psychoanalysis Unit, Research Department of Clinical, Educational and Health Psychology, University College London, Gower Street, London WC1E 6BT, UK.
Email: p.fonagy@ucl.ac.uk

Note

1 Calculations based on figures given on UK government website.

References

Burnham, J. (1992). Approach, method, technique: Making distinctions and creating connections. *Human Systems: The Journal of Systemic Consultation and Management*, *3*, 3–26.

Fisher, S., Guralnik, T., Fonagy, P., & Zilcha-Mano, S. (2020). Let's face it: Video conferencing psychotherapy requires the extensive use of ostensive cues. *Counselling Psychology Quarterly*, *34*, 508–524.

Fonagy, P., Campbell, C., Truscott, A., & Fuggle, P. (2020). Debate: Mentalising remotely – The AFNCCF's adaptations to the coronavirus crisis. *Child and Adolescent Mental Health*, *25*, 178–179.

Fonagy, P., Luyten, P., Allison, E., & Campbell, C. (2017). What we have changed our minds about: Part 2. Borderline Personality Disorder, epistemic trust and the developmental significance of social communication. *Borderline Personality Disorder and Emotion Dysregulation*, *4*, 1–12.

Francis-Devine, B. (2020). Poverty in the UK: Statistics (House of Commons Library Briefing Paper No. 7096). Available from: https://researchbriefings.files.parliament.uk/documents/SN07096/SN07096.pdf [last accessed 6 August 2020].

NHS Digital (2021). Mental Health of Children and Young People in England 2021—Wave 2 follow up to the 2017 survey. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey [last accessed 4 January 2022].

Office for National Statistics. (2020). Child poverty and education outcomes by ethnicity.

Wurman, T.V., Lee, T., Bateman, A., Fonagy, P., & Nolte, T. (2020). Clinical management of common presentations of patients diagnosed with BPD during the COVID-19 pandemic: The contribution of the MBT framework. *Counselling Psychology Quarterly*, *34*, 744–770.