Chapter 16
Transition to Teletherapy with Adolescents in the Wake of the COVID-19 Pandemic: The Holding Environment Approach

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Introduction

Governor Andrew Cuomo’s executive order for New York State schools to close by March 18, 2020, came suddenly, with the expectation that schools would plan for alternate educational instruction during closure (Governor Andrew M. Cuomo 2020). The order, made on account of the COVID-19 pandemic, caused an array of programmatic concerns and disruptions in the way residential schools provide services to students. Clinical staff, accustomed to the structure and direct contact with students that exists within schools, were challenged to create and adapt to innovative ways of providing services as we moved our interactions with students to the telephone or online. Social workers were challenged to adjust their lives and living space to accommodate this new norm; bedrooms, living rooms, dining rooms, and kitchens became the home office for many, including myself. In addition, my personal laptop became the device that I used to complete paperwork and to participate in teletherapy sessions with some students. Personal cell phones were also utilized to maintain contact with students. We faced this challenge while navigating our own feelings of uncertainty, shock, and surprise at this unprecedented reality.

Students, meanwhile, had varying reactions to the change. Many had come to know both program and staff as the primary providers of structure in their lives, both familiar and therapeutic. In ideal instances, students had come to know staff as being flexible, understanding, and respectful of privacy and boundaries, as well as consistent, warm, empathic, and sensitive to their needs, both spoken and unspoken; such qualities are those that Zelechoski et al. (2013) identify as best qualities for staff working with youth in residential treatment settings. Other students met participation and engagement in residential schooling with reluctance or even hatred. Closures thus prompted mixed
feelings among the students; some were willing and excited to go home during this
time, while others experienced dread, anxiety, and fear not knowing what the next steps
would entail. Whatever their initial feelings about the closure, residential students
negotiated an abrupt change as they went from residing in the program full time to
remaining home without a date of return. This caused a surge of anxiety in almost all
of the students served, as did the “new norm” of receiving therapy by phone or online.

Cell phones, Google hangout chats and meets, and Zoom video conferencing
provided the means for school social workers to continue to provide treatment to
students during the COVID-19 pandemic. These modes challenged clinicians to
adapt their face-to-face treatment interventions to remote implementation, which
has proven to be advantageous but challenging. Studies have shown the efficacy of
providing treatment interventions utilizing technology (Barak and Grohol 2011;
Beeson et al. 2013; Epstein 2011). However, a drawback to this method is compro-
mised confidentiality: the potential release of student’s personal information, their
identity, and particularly the vulnerability to hackers that became evident when
Zoom, a platform that many school districts utilized to conduct teleservices, was
hacked (Strauss 2020; Wilson 2011). In addition to technological issues, there is a
risk that students will refuse to answer the social worker’s call or respond to their
messages or that some students may be unwilling to talk in detail due to lack of
privacy at home, which has been my experience. I have also experienced a student’s
willingness to talk in greater detail over the phone. In such cases, the phone serves
as a psychological defense mechanism against the anxiety and discomfort that can
surface when talking about thoughts, feelings, and past experiences in person.

The change in clinical services from face-face to remote provided social workers
with opportunities to implement essential and innovative therapeutic interventions.
While treatment approaches are many and varied, creation of the holding environ-
ment should be considered paramount given its function of creating a space in which
students feel safe enough to express their deepest anxieties in both face-to-face and
remote treatment. The purpose of this chapter is to discuss the importance of the
holding environment: its creation and its continuation during face-to-face sessions
and following the change to teletherapy. Beginning with a brief overview of
Winnicott’s (1956) concept of the holding environment, followed by two case
vignettes using the holding environment as a fundamental approach, the chapter
also discusses the best practices for creating a holding environment, both in person
and by phone, as well as obstacles and complications that can arise in remote treat-
ment. For the purposes of this chapter, the technological maintenance of the holding
environment during COVID-19 is limited to the use of the cell phone.

**Holding Environment**

As a clinical social worker in a residential treatment center, I utilize a psychody-
namic approach when working with high school students, focusing on past and
present experiences and the way in which they manifest in present behavior. Such
an approach creates a safe space for adolescents to feel vulnerable and share their anxieties, thereby creating opportunities for a therapeutic alliance to be formed and therapy to progress. Winnicott (1956) described the holding environment as the relationship established between a mother and infant within the infant’s first few years of life, which creates a sense of security and “hold” within the mother/infant relationship. Winnicott described a mother’s uterus as the first holding environment, one in which “maternal preoccupation” becomes apparent (Applegate 1997). The mother in Winnicott’s description is preoccupied with the care of her infant, often neglecting any other responsibilities. The attention and devotion that the mother dedicates to her infant during his/her first weeks offer a secure psychological hold, creating an environment that is safe.

This type of hold, one that provides safety and security, can be applied to the therapeutic relationship (Wright 1992). Winnicott drew parallels between the mother/infant relationship and the client/therapist relationship, emphasizing the need for parents and therapists alike to be “good enough” or attuned enough to the needs of the infant/patient to understand and accept the struggles that the infant/patient is faced with and to withstand assaults from the infant/patient without retaliation or withdrawal (Altman et al. 2002; Wright 1992; Chescheir 1985). The client’s view of the therapist as “good enough” is important in creating the foundation of a holding environment. Once the holding environment is established, opportunities are presented for clients to feel safe to explore their feelings, experience growth, and communicate (Lanyado 1996). While there are many elements to the holding environment, I suggest that there are interpersonal qualities therapists maintain that allow clients to see them as “good enough.” Such qualities included consistency, reliability, mirroring/vocal matching, and presence. A display of these qualities during session pave the way for safety and trust to be established, thereby creating the “holding environment.” These qualities are outlined in the cases that follow and are further explored in the discussion section of this chapter. In addition, this chapter discusses ways in which administrators can implement the holding environment in school settings when shared trauma is experienced between employees and students.

The Case of Jane

Jane¹ was a 17-year-old female who became a student at a residential program due to truancy, risky behavior, and parental discord. Jane had a difficult time adjusting to the new program. On the day of her admission, she appeared stoic as she sat with her parents and two strangers: a school administrator and me, her new social worker. Jane was adamant about her refusal to participate in therapy, stating that it was pointless and a waste of time.

¹All names and other personal identifiers in the cases have been changed to protect privacy and confidentiality.
After years of working together, our therapeutic relationship was well-established and founded upon the holding environment. This therapeutic relationship allowed Jane to feel safe enough to express her deepest anxieties, which were many. Whereas at first she engaged in superficial conversation responding to a verbal prompt, she eventually delved deep into her feelings of depression, anxiety, and insecurity as manifested through her body language, facial expressions, and behavior on campus.

In March of 2020, Jane and I suddenly changed from face-to-face sessions to remote therapy due to the COVID-19 pandemic. Though it felt uncomfortable at first, the phone rapidly became our primary connection. We continued with regularly scheduled appointment times, with me the one responsible for calling. Jane came to expect my phone call on the scheduled day and time, which quickly became the “new norm” for our session. While some sessions were cancelled by Jane or me for specific reasons, I sought to avoid cancelling sessions whenever possible in order to maintain the holding environment.

During our phone sessions, Jane opened up about her life experiences, recalling and sharing details of her past that she was reminded of as she sat in her room. The phone connection became personal, and Jane discussed issues relating to her family members that were prompted by being at home. She discussed deep issues and feelings related to peers and relationships. During a phone session, Jane expressed, “You are one of the top people that I feel most comfortable with because you know me. I can tell you a lot.” She also noted, “As a high school worker you are way more on a personal level. I didn’t tell you a lot of things [at first] because I wasn’t used to having a social worker and didn’t want one.”

The holding environment and therapeutic relationship was established with Jane prior to the pandemic, allowing therapy to continue by phone. In contrast, my experience with Alex was difficult and largely unsuccessful, as you will read in the next brief vignette.

The Case of Alex

Alex is a 17-year-old Caucasian cisgender male who became a residential student months prior to the COVID-19 pandemic. During our face-to-face sessions, Alex was minimally engaged and often needed prompts and reminders to attend his sessions. When he did attend, he would discuss topics relating to his interests, mostly animals and video games. Alex avoided talking about his feelings and often asserted his uncertainty as to the reason for his placement in a residential program. He lacked motivation and was unwilling to engage in the program. Creating the holding environment and establishing a therapeutic relationship with Alex were my two main goals in working with him, and I attempted to do so by remaining consistent in my efforts to engage him, even when my efforts were met with refusal. Alex’s lack of motivation to engage in the program led him consistently to refuse my overtures toward establishing a holding environment and therapeutic relationship, and this presented a major obstacle to my efforts.
As much as my attempts to establish a therapeutic relationship and holding environment with Alex prior to the pandemic were unsuccessful, my efforts to engage him remotely following the arrival of the pandemic was even more challenging. Whereas on campus I had the option to visit with him in the cottage when he refused to attend session, this option was not available with remote therapy. If Alex missed a session while we were still meeting face-to-face, I contacted his cottage staff, who offered a level of therapeutic support to help get through to Alex. This was not an option during remote therapy. Instead, Alex’s mother, whom I contacted weekly when Alex did not answer my calls, served as the liaison between Alex and me. Though I continued to make the effort to call him, he refused to get on the phone, often stating in the background “I don’t need therapy” and asserting his unwillingness to speak with me. Engaging in remote therapy was unsuccessful with Alex, as was the establishment of the therapeutic relationship and the holding environment.

**Discussion**

In any treatment approach, it is important to create a space for adolescents to feel safe enough to express themselves and their anxieties. While treatment approaches, diagnosis, and psychopharmacology have their place in work with adolescents, such interventions are best introduced in the context of a “holding environment”; its creation in residential school settings is essential, given that treatment tends to be long term.

The importance of the therapeutic relationship can be lost amid the demands of our jobs, heavy workloads, and back-to-back meetings with students, leaving us to focus on addressing the student’s presenting behavior without giving weight to the need for the secure foundation of the “psychological hold.” In the wake of COVID-19, when therapy changed from in person to remote, the results of having established or missed establishing a holding environment were seen starkly, as revealed in the cases of Jane and Alex. While time demands as professionals are inevitable, I suggest the following best practices for creating and maintaining the holding environment that will allow for a therapeutic relationship to grow: consistency, reliability, mirroring/vocal matching (Beebe 2010), and presence, all of which create the ability to hold the child’s anxiety and presence.

**Consistency**

During the first months of our acquaintance, Jane often missed appointments. I would meet Jane in her classroom to encourage her to attend her appointment, visit her in the cottage when she refused school, and attempted to engage her in the hallway whenever an appointment was missed. Many of these efforts were met with
opposition, while some with compliance. Regardless of Jane’s reaction, I attempted to remain consistent in my efforts to engage her, though at times this was a challenge. I approached my work with Alex similarly in that I remained consistent with encouraging him to attend his therapy sessions and would often meet with him in his cottage when an appointment was missed. There were days where he responded to my efforts, while other days he refused my efforts. In either case, I attempted to remain consistent. When my efforts were met with refusal or opposition, I felt discouraged and unsure of my ability to engage both Jane and Alex. The self-doubt hampered my ability to be present with both students and, at times, interfered with the creation of the holding environment; instead of holding their anxieties, I focused on my own. A level of self-awareness helped me to contend with such feelings when they arose and to remain consistent in my efforts to engage Jane and Alex. Like Winnicott’s “good enough” holding figure, I recognized that being “good enough” included my imperfections. This recognition allowed me to remain consistent and “good enough,” which in turn created the foundation for the holding environment for Jane both in person and by phone. However, my “good enough” was not enough to engage Alex in person or by phone. It’s possible that the COVID-19 pandemic may have hindered the establishment of an in-person holding environment that could have extended to teletherapy. Regardless, the creation of the holding environment was unsuccessful with Alex, which was in part due to his lack of engagement in the therapeutic process and my lack of consistency with attempts to engage him therapeutically when my efforts were met with refusal.

**Reliability**

Jane’s ability to rely on me started with my availability to Jane during our planned sessions. Following through on requested tasks also helped establish me as reliable in her view. With Alex, as best as I was able to, I stayed committed to my word in doing what I said I would do. For example, I would often tell Alex that I would stop by his cottage to check in on him and would follow through when he requested actions of me. Showing reliability is critical when creating the holding environment.

The change from face-to-face sessions to phone sessions presented another opportunity to demonstrate reliability with both students. When remote therapy began, I was sure to call both students at the allotted time. Jane remained consistent with answering my calls while Alex refused. In fact, in a conversation with Alex’s mother, he was in the background insisting that he did not need therapy and asserted his refusal to participate. Jane came to expect my calls at the same time and on the same days. Unfortunately, although I was reliable with Alex (i.e., calling him at our scheduled time), he nonetheless refused my calls which hindered his progression and interfered with the establishment of the holding environment.
Vocal Matching

Vocal matching is a topic that has been greatly researched in the context of the mother-infant relationship; it describes a communication between mother and infant that is “a nonintrusive way of helping the infant feel sensed” (Beebe 2010, p.0.22). Just as Winnicott’s work drew a parallel between mother/infant and therapist/client, my approach with Jane used a similar type of matching to what has been shown effective in mother-infant communication. I was careful to match my tone of voice with hers as a way to connect with her. I attempted to match Alex’s tone as well when we met in person. There were times when he showed excitement about his interests in animals and video games and other times where he expressed his anxiety about life and past experiences; I attempted to match my tone of voice with his in order to connect with him. I offered Jane and Alex my attention during session and was mindful to ensure that my tone of voice created a space for them to feel sensed.

Both Jane and Alex reserved a large part of themselves for themselves, often avoiding talking about topics relating to romantic relationships, past experiences, and incidents that would reveal their negative sides. When I broached such topics with Jane, she usually replied, “I don’t want to talk about it.” I respected her boundaries; however, I often mirrored back to her the feelings she was evincing, often sadness or depression and occasionally happiness, which she rarely admitted to feeling. I found that when I respected her expressed desire not to talk about a topic, but rather focused on the underlying feeling, the session tended to be productive. My mirroring her feelings often led to her opening up about them. Her eyes often welled up, and on several occasions, she commented, “I wore waterproof mascara today,” or became giggly when a feeling of discomfort arose or was acknowledged. She sometimes apologized for crying. In a calm, empathic tone, I would respond, “I see that you are crying and that’s OK.” This response was often followed by further tears. Mirroring Jane’s feelings was the start of our therapeutic relationship and was the very intervention that caused her to further open up. Remote therapy did not provide me with the same opportunity. Jane chose not to video chat and instead chose our sessions to be held over the phone. I was unable to look her in the eyes to mirror the expressions that often contradicted her words. Vocal matching, therefore, became more important; my attunement to her tone of voice created a space for her to feel sensed, which is important for creating the holding environment.

Presence

Being present was important, both over the phone and in person. In person, prior to distance learning, my sense of presence was maintained through consistent eye contact, stillness in body language, facial expressions, and follow-up responses to things said. I was careful not to look at the clock or answer phone calls during our session. As much as I was able to, I avoided answering the door when students
knocked, instead offering a gesture letting them know that I was in session. There were times that I needed to answer the phone or a knock at the door, or be mindful of the time. Ideally, I would have rescheduled my appointment with Jane or attended to whatever the interruptions were prior to session, in order to avoid a disruption in my attention. I warned Jane and Alex about any interruptions that were known in advance, and if not known, I would apologize for the interruption.

I recognized that it was my responsibility to ensure that I was able to provide Jane and Alex with my undivided attention during remote therapy. I did this by doing my best to hold the session in a location free of interruptions. As a mother of an infant, however, some distractions were inevitable during a lockdown when normal child care options were not available. When sessions were interrupted by my son’s crying or “happy sounds,” I apologized and acknowledged the interruption: “That’s the baby talking in the background.” “I know, Cierra” and “No need to apologize” were Jane’s usual responses, which demonstrated an understanding of the need for me to be present both for her and for my son. I further discuss these challenges in the next section.

Challenges of Remote Therapy

The COVID-19 pandemic was unexpected; students and staff alike were not prepared or equipped to engage in remote therapy. Forced to manage professional as well as personal matters, many social workers had to attend to family needs and be present with a child or loved one while also being present with their students. Other unusual challenges included ensuring confidentiality and securing a location within our homes to hold sessions. Furthermore, dealing with the personal effects of COVID-19 and living through it as a shared experience with our students, while offering hope to many students during a time that felt hopeless, proved difficult. Engulfed by many feelings, I appreciated the opportunity to work from the comfort of my home while also being able to spend time with my loved ones. However, I found that the situation was not always conducive to my work in the same way the office environment that I’ve grown accustomed to was conducive. Going into work provided a level of privacy that made it much easier to give my undivided attention to my students during session. At home, distractions were inevitable, and many required my instant attention, such as responding to the cry of my son. Additionally, I had grown accustomed to going to a student’s classroom, cottage, or even checking in with them in the hallway when they missed session. Remote therapy did not provide that option.

My colleagues and I shared common concerns when sessions moved to teletherapy:

- students would not participate in therapy; there would be a regression in a student’s behavior; and the once personal therapeutic relationship was now more impersonal. The physical distance between my students and me was sometimes mirrored by an emotional distance.
- Some students maintained a stoic affect over the phone, appeared agitated when I called,
and at times kept their responses to a minimum. Although I’ve attempted to create a holding environment with all of my students, I acknowledge the difficulty in establishing such a holding for many students in a remote therapy situation. Reasons included the lack of a preexisting therapeutic relationship, their dislike of talking on the phone, and experiencing boundaries being crossed when I called their cell phone, the usual mode of communication during remote therapy.

Such problems were particularly evident in the case of Alex. When sessions became remote, I found it difficult to maintain my drive to engage him. My efforts to contact him by phone became infrequent, the more so as he continued to refuse. I might have explored different ways of engaging him, be it through messaging him on Google hangouts, arranging a teletherapy session and inviting his parents to participate for additional support, or even continuing to call him at the time of our arranged sessions, rather than calling his parents. Creation of the holding environment was unsuccessful with Alex, in part because I did not maintain the practices outlined in this chapter to fidelity and in part because of his unwillingness to engage in therapy.

For some of my students, these issues (the lack of a therapeutic relationship, refusal to talk on the phone, and lack of willingness to engage in therapy) proved to be major obstacles in creating the holding environment, both in person and over the phone. In these cases, my “good enough” actions were, perhaps, not good enough, which points to the question of what constitutes “good enough” and how it might be gauged. Understanding that what may be “good enough” for one student can fail to move another is important, given their unique experiences and individual makeup. Perhaps my interactions with Jane were “good enough,” and I was attuned enough for the holding environment to be established, which allowed for the successful implementation of the practices identified in this chapter.

**Shared Trauma and the Holding Environment**

Shared trauma is a term used to describe a collective traumatic occurrence simultaneously experienced between the therapist and client, affecting their thoughts, feelings, and actions (Tosone et al. 2012). School social workers, staff, and students experienced the coronavirus pandemic as a shared traumatic experience, as it impacted the well-being of staff and students alike. The shared trauma created opportunities for school social workers to create innovative therapeutic treatment approaches for working with students, which have led to sessions that were personal and intimate in nature. It also created mixed feelings within social workers (fear, anxiety, uncertainty), which I previously described and further addressed in this section. Such feelings should be acknowledged and attended to by school administrators as a way to be in tune with staff both personally and professionally.

The unexpectedness of the COVID-19 pandemic required workers to immediately shift from their “normal” lives to the unexpected reality of working remotely. Schools required workers to fulfill their work responsibilities without missing a
beat, so to speak. We were expected to continue with our work responsibilities, frankly with limited to no acknowledgment or discussion of the emotional or psychological impact the situation had on us. It would have been preferable if more attention had been given to our potential for compassion fatigue, which Tosone et al. describe as “reactions to working with trauma survivors” pg. (2012, p. 232). Figley (1995) describes the long-term effects of compassion fatigue and its negative impact on employee work performance. This lack of acknowledgment and discussion can lead to employees feeling unprepared to return to their work environment and their general dissatisfaction with organizational responses (Bauwens and Tosone 2010). While COVID-19 may not have been a direct “physical happening” for most of us, its impact continues on our work environments and may cause feelings of stress, anxiety, and depression, including long-term effects on the mental well-being of clinicians (Tosone et al. 2012). School administrators should consider implementing a strategic approach for addressing feelings elicited from their employees by shared traumatic experiences such as the present pandemic and recent protests and social upheaval relating to the Black Lives Matter (BLM) movement, police violence, and inequality afflicting Black Americans.

As they weigh this strategic approach, school administrators should consider the impact of trauma experiences on both their employees and students from a perspective of shared trauma. Creating a holding environment for staff within school settings is crucial in the wake of shared trauma experiences. Any organizational response to addressing the anxieties of school staff should be supplemented with an offer of therapy that staff may benefit from, given the long-term effects of trauma experiences. Whatever its features, an administrative response to shared trauma experiences should be implemented, and the holding environment, which can be established by outsourced therapists, should be prioritized as an effective approach for staff experiencing the same trauma as the clients served. Such an approach can create a space for staff to feel safe enough to express their anxieties relating to the traumatic event and can, perhaps, decrease compassion fatigue and increase productivity, work ethic, and efficiency within the organization and in the service of students’ needs.

Conclusion

The COVID-19 pandemic presented school social workers with opportunities to connect with students in new, technologically facilitated ways, be it via Zoom or Google Hangouts or over the phone. Though the change from face-to-face sessions came suddenly and unexpectedly, school social workers adapted to this “new norm” in the provision of services. Winnicott’s concept of the holding environment proved relevant and successful in the case of my student Jane, both before and during COVID-19. Instead of retaliating or withdrawing from Jane when she displayed resistance to therapy, I remained consistent in efforts to engage her, showed reliability in various
ways, mirrored her tone of voice and manner, and stayed present to her feelings. These efforts served as the foundation for the sense of safety and trust on which the holding environment can be established. Unfortunately, attempts to create a holding environment were not fruitful with Alex. Though I attempted to implement the practices outlined in this chapter to fidelity, I came across challenges that hindered my implementation, including Alex’s lack of engagement in the program and my own loss of motivation as a result. Nonetheless, the holding environment should be considered as a useful treatment approach working with adolescents in person and by phone. The holding environment reflects the social worker’s availability to the student and the student’s need for a social worker’s devotion to them and their unique needs.

School social workers are presented with many opportunities to “hold” students. These opportunities must be handled carefully, but they should always be considered valuable opportunities to build the therapeutic relationship. This approach can be used to engage adolescents in person and by phone; in either case, best practices center on consistency, reliability, presence, and mirroring/vocal matching, which foster the student’s sense of trust and ultimately allow for the establishment and progression of the therapeutic relationship. School administrators should also consider implementing these best practices in order to create a holding environment for employees experiencing shared traumas. Implementation of the holding environment from an organization’s administrative team, through the outsourcing of therapists, creates opportunities for relational experiences between administrators and employees to be established. Such experiences can provide opportunities for staff to feel safe enough to express their anxieties surrounding the traumatic event, thereby enhancing school staff’s productivity and compassion in working with students.

References

Altman, N., Briggs, R., Frankel, J., Gensler, D., & Pantone, P. (2002). Relational child psychotherapy. Other Press.

Applegate, J. S. (1997). The holding environment: An organizing metaphor for social work theory and practice. Smith College Studies in Social Work, 68(1), 7–30.

Barak, A., & Grohol, J. M. (2011). Current and future trends in internet-supported mental health interventions. Journal of Technology in Human Services, 29(3), 155–196. https://doi.org/10.1080/15228835.2011.616939.

Bauwens, J., & Tosone, C. (2010). Professional posttraumatic growth after a shared traumatic experience: Manhattan clinicians’ perspectives on post 9/11 practice. Journal of Loss and Trauma, 15(6), 498–517.

Beebe, B. (2010). Mother-infant research informs mother-infant treatment. Clinical Social Work Journal, 38(1), 17–36. https://doi.org/10.1007/s10615-009-0256-7.

Beeson, P. M., Higginson, K., Rising, K., & Oetting, J. (2013). Writing treatment for aphasia: A texting approach. Journal of Speech, Language and Hearing Research, 56(3), 945–955. https://doi.org/10.1044/1092-4388(2012/11-0360.

Chescheir, M. (1985). Some implications of Winnicott’s concept for clinical practice. Clinical Social Work Journal, 13(3), 218–233.
Cuomo, A. M. (2020, March 16). No. 202.4: Continuing temporary suspension and modification of laws relating to the disaster emergency. Governor.ny. https://www.governor.ny.gov/news/no-2024-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency

Epstein, R. (2011). Distance therapy comes of age. Scientific American Mind, 22(2), 60–63. Governor Andrew M. Cuomo (2020, June 1). Governor Andrew M. Cuomo. Retrieved from https://www.governor.ny.gov/

Figley, C. R. (Ed.). (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner Mazel.

Lanyado, M. (1996). Winnicott’s children: The holding environment and therapeutic communication in brief and non-intensive work. Journal of Child Psychotherapy, 22(3), 423–443.

Strauss, V. (2020, April, 4). School districts, including New York City’s, start banning zoom because of online security issues. The Washington Post. https://www.washingtonpost.com/education/2020/04/04/school-districts-including-new-york-citys-start-banning-zoom-because-online-security-issues/

Tosone, C., Nuttman-Shwartz, O., & Stephens, T. (2012). Shared trauma: When the professional is personal. Clinical Social Work Journal, 40, 231–239.

Wilson, J. (2011). Texting patients could breach confidentiality. Pulse, 71(37), 12.

Winnicott, D. W. (1956). Primary maternal preoccupation. In Through pediatrics to psycho–analysis (pp. 300–305). New York: Basic Books.

Wright, B. M. (1992). Treatment of infants and their families. In J. R. Brandell (Ed.), Countertransference in psychotherapy with children & adolescents (pp. 127–139). Jason Aronson Inc.

Zelechoski, A. D., Sharma, R., Beserra, K., Miguel, J. L., DeMarco, M., & Spinazzola, J. (2013). Traumatized youth in residential treatment settings: Prevalence, clinical presentation, treatment, and policy implications. Journal of Family Violence, 28, 639–652.