Pivot to Telehealth: Narrative Reflections on Circle of Security Parenting Groups during COVID-19

Alison Cook¹, Judith Bragg² and Rebecca E. Reay²

¹ Perinatal and Infant Mental Health Consultation Service, Canberra Health Services, Canberra
² Academic Unit of Psychiatry and Addiction Medicine, Australian National University Medical School, Canberra Hospital, Canberra

In response to COVID-19 hygiene and physical distancing restrictions, our service rapidly shifted to delivering Circle of Security-Parenting™ (COS-P) groups via telehealth. In this article we report the perspectives and experiences of the group facilitator and the parents who received the intervention during the COVID-19 pandemic. We use semi-structured, qualitative interviews to explore the advantages, challenges, and positive impacts of the online parenting group from the perspectives of the group leader and the five group participants. Participants’ narrative reflections show that they were satisfied with the convenient and engaging online delivery of the program and would recommend it to other parents. Parents reported significant improvements in their parenting and greater awareness of their strengths and struggles. The online delivery of COS-P resulted in more efficient service delivery, greater attendance rates, and adherence to the model. The stressors on the experienced facilitator, due to the abrupt transition and multiple technical and communication challenges, may have been mitigated by supervisor and collegial support, as well as careful preparation for herself and the participants. Future research should investigate the effectiveness of online versus face-to-face delivery of the intervention, including what works for whom.

Keywords: Circle of Security, parenting program, telehealth, online interventions, perinatal mental health

Key Points
1. Circle of Security-Parenting™ may be successfully delivered online to small groups of parents/carers.
2. Facilitators may find the transition stressful due to multiple technology and communication challenges, requiring additional time to gain confidence.
3. Regular reflective supervision and use of clinician–observer was invaluable.
4. There are many potential advantages with online groups, including greater attendance rates, fewer drop-outs, and greater adherence to the model.
5. Parents’ reflections on participation indicate that the online delivery was convenient, engaging, and associated with positive improvements in parent–child relationships.

The Circle of Security® program (COS; Marvin, Cooper, Hoffman, & Powell, 2002) is an innovative, relationship-based approach to working with families. The 8-week Circle of Security-Parenting™ program (COS-P; Cooper, Hoffman, & Powell, 2009, 2018) is a modified version of the original 20-week program and was designed for use in community settings due to its brevity, ease of use, and less intensive protocol. COS-P has been enthusiastically taken up by clinicians in Australia and internationally (McMahon, Huber, & Schneider, 2016) who value its grounding in attachment theory, simplicity, generalisability, flexible delivery, and effectiveness (Rea et al., 2019). Research on the COS-P program is emerging, however, it has more limited empirical support compared to the original 20-week intensive version (see Coyne,
Powell, Hoffman, & Cooper, 2019 for a review). The program aims to improve the quality of the parent–child attachment relationship by enhancing caregivers’ sensitivity and responsivity to their children’s needs and communications.

COS-P provides parents and carers with a user-friendly explanation of attachment theory using engaging graphics, video-clips, and easy-to-understand concepts. Central to the model is the COS graphic, which illustrates children’s various needs and behaviours as they shift between two systems: exploratory (top of the circle) and attachment (bottom of the circle; Cooper et al., 2009). Parents are assisted to be effective attachment figures and act as a secure base and safe haven as their children move between these two systems. These two key functions of the parent are represented by the ‘hands’ on the circle. Using archived video examples and facilitated discussion, parents are encouraged to recognise and reflect on their children’s needs when they are at the top of the circle (e.g., watches over, delights in, and/or helps the child’s exploration) or at the bottom of the circle (e.g., protects, comforts, delights in or organises the child’s feelings).

Parents are also supported to establish an appropriate hierarchy in the relationship by taking charge and setting boundaries when appropriate. ‘Shark music’ refers to uncomfortable feelings which are triggered in the parent by a child’s healthy emotional need; feelings which can, if not recognised, impede the parent’s capacity to meet that need for the child. Caregivers are supported to become aware of their own ‘shark music’ and to prevent it getting in the way of meeting a safe need in their child. Examples of parent difficulties with being effective ‘hands’ include when faced with a take-charge moment, a parent gives in or distracts, or becomes overly harsh, in order to avoid dealing with their child’s intense emotions.

The program is traditionally delivered by two trained, licenced presenters and written materials are provided in the form of a workbook. A key mechanism for change is also the therapeutic relationship they develop with the group facilitators. Just as parents are supported to provide a safe haven and secure base for their children, therapists provide a secure base for group participants. Registered group facilitators attend regular clinical supervision to reflect on their own thoughts, feelings, and responses regarding the group. The support of an experienced supervisor is seen as critical for managing participants’ sensitivities, defences, and the facilitator’s own countertransference.

During the COVID-19 outbreak in Australia, the Perinatal and Infant Mental Health Consultation Service experienced an unprecedented disruption to their normal service delivery. Our staff sought to ensure that essential programs continued to be provided to the vulnerable population they served, especially those parents who had been on the COS-P waiting list. Many families had been under great stress due to the January bushfires and the impact of very hazardous air quality in the region. The arrival of COVID-19 cases in Australia increased our clients’ feelings of distress, anxiety, and uncertainty. Thus, we were interested in investigating the impact of the novel online delivery of the COS-P program to allow for physical distancing and hygiene measures.

This paper has two objectives: 1) to understand the experiences of the facilitator during the rapid transition to delivering COS-P via telehealth with a small group of parents; and 2) to understand the experiences of parents who received the intervention during the COVID-19 pandemic. To investigate these objectives, we use semi-structured interviews to explore the advantages, disadvantages, satisfaction levels, and
positive impacts of the program from the perspectives of the facilitator and group participants.

Methods

The setting

The Perinatal and Infant Mental Health Consultation Service provides services to women and their families experiencing moderate to severe mental illness during pregnancy and up to 12 months postpartum. The service provides preconception advice, consultation services, psychiatric assessment and treatment, and clinical support for women who have a range of mental health diagnoses. These include: depression, anxiety, post-traumatic stress disorder, psychosis, obsessive compulsive disorder, and comorbidities including personality disorders, grief, and disability. The service is staffed by a multidisciplinary team, consisting of a medical officer, psychiatrists/registrars, psychologists, social workers, and occupational therapists.

Our service has been delivering COS-P to women engaged with the service for over four years. Four groups are run each year and 6–10 participants are recruited to each group. Women and their partners are invited into the group when their mental health is stable enough for them to be able to attend and potentially benefit from the group. Women are clinically assessed before and after the group to understand their goals for attending the group and to establish the ‘lynch pin’ issue for each parent. Examples of lynch pin struggles can include parents who: become ‘mean’ without being kind, act ‘weak’ and unable to take charge, or become emotionally or physically unavailable (‘gone’).

With the group supervisor, the group leaders focus on the individual struggles of each participant attending closely to their defensive strategies (sensitivities) and working with these to enhance the experience of the participants. When it is clinically indicated, participants who complete the program may be invited to have follow-up mother–infant sessions with one of the therapists. Although women engaged with the service have young infants, many have older children they wish to focus on during COS-P.

Participants

All COS-P group members ($N = 6$) were invited to participate in a semi-structured, narrative interview of their experiences post the group. All five female participants and one male partner agreed to participate in the individual interviews. The group facilitator and her supervisor participated in a post-group interview to obtain their reflections on their experiences. Both had extensive experience as perinatal and infant mental health practitioners, and experience in co-leading groups and using COS-P individually with parents.

Online delivery procedures

Early in the COVID-19 pandemic, COS-P International varied the licence to allow remote facilitation of COS-P groups and circulated the ‘COS-P Remote Facilitation Decision Matrix’ which provided helpful and practical recommendations for online delivery and ways to be present during this time of heightened feelings of helplessness and uncertainty. The recommendation to use the USB format, and not the internet
version, was beneficial in terms of bandwidth and use of subtitles. The advice included using only one facilitator and a smaller group size (three participants).

There were several people who had been on the waitlist for an extended time due to COVID-19 restrictions which resulted in the cancellation of a prior group. For this reason and due to our experience of participant dropout in previous groups, the decision was made to have a larger group. A new and junior team member, who had not been trained in COPS-P, was recruited to assist the facilitator by observing the online sessions and keeping a record of participants’ responses. The observer’s role was made clear to all participants. The facilitator trialled the equipment and tested the ideal positioning for video conferencing (e.g., computer elevated with camera at eye level to enhance eye contact, seated further back to frame face and shoulders).

We had anticipated several potential issues with running an online group and managed them in the following ways. The pre-group interview was conducted with each individual via video conference to test the software, their internet connection, and equipment. As participants would be joining the group from their homes, the group rules around the importance of confidentiality, privacy (and not recording the session) were discussed at this point. We asked parents to mute their microphones when they weren’t speaking to reduce background noise and improve the experience of each participant. We also informed them that the leader would be individually inviting participants to contribute to the discussion and if they wanted to add a comment or ask a question at other times, they should signal this visually. The facilitator emphasised that there was no pressure to comment when invited to do so. There was discussion about each parent’s arrangements for having young children minded during the sessions. Pre-group assessments and the workbook were mailed to each participant.

At the conclusion of the group, the group facilitator met with each participant for a post-group interview. Post-group interviews are routinely used by the service to improve our delivery of COS-P, plan future clinical care, and offer further interventions if required. Frequently, during the course of a group, the facilitators and supervisor identify which participants would benefit from further work. In addition to the routine post-group interview questions regarding changes in the parent/child relationships and specific episodic examples, the interviewer enquired about the participants’ experience of the online delivery of COS-P and recorded their verbatim comments. The transcripts were then analysed to examine the experience of participants and underlying themes. (See Table 1). Lastly, the group facilitator and supervisor were interviewed by the last author to obtain their reflections on the transition to online delivery of COS-P.

Results

Group facilitator reflections

Despite checking the capacity for connection using our video-conferencing software prior to the group, one person was not able to join the first group using her home computer. It transpired that this participant had used her phone for the initial assessment and the home computer connection was not adequate for the group. The decision was made for this participant to do COS-P individually with the facilitator at another time. The lesson learnt was to be specific about trying out the connection to
be used prior to commencing the group. No other connection difficulties were encountered during the eight weeks. One participant rarely had the camera focused on their face and another did not arrange childcare, and thus was frequently distracted by their infant, which affected their participation. Attendance during the online group was high with only one participant missing one session due to a scheduling conflict. One participant attended the group despite being unwell at the time. This result was better than our attendance rates for face-to-face groups, as illness in children and participants is the main cause of missed sessions.

The facilitator experienced online delivery as more challenging than in-person, with some unanticipated issues. For instance, compared with face-to-face groups, discussion between group participants did not fully develop and participants rarely commented on or responded to comments made by another. There was less spontaneous interaction or free-flowing conversation between group members about the content. Overall, they tended to talk less than participants in face-to-face groups. There was also a decrease in the richness of comments, due to the need to sequentially invite each participant for a comment, and it was not possible to cover all the recommended questions.

Although a smaller group may make a difference, the facilitator thought that this was not likely because of the constraints imposed by the technology on the spontaneity and flow of conversation. Our finding of the therapist’s difficulties with the sudden transition to telehealth groups is consistent with prior research. For example, a survey of therapists who were forced to transition to online delivery during the pandemic found higher levels of professional self-doubt due to feeling less confident, competent, connected, and authentic during sessions (Bekes & Aafjes-van Doorn, 2020).

In our experience with face-to-face groups, participants would occasionally stay behind after the group to access more support from the facilitator. This occurs most often when the facilitator has a therapeutic relationship with the parent. Even though some of the participants had a therapeutic relationship with the facilitator, this did not occur in the online group: participants sought extra support from the service

| TABLE 1 |
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| **Post COS-P Interview Questions** |
| 1) How did you find the online group format? What worked well and what did not go so well? |
| 2) Do you have any recommendations for improving the participants’ experience for future groups? |
| 3) Would you recommend doing a COS-P group online to a friend? [Why? Why not?] |
| 4) How did you use the workbook? |
| 5) Are there any concepts raised from the COS-P program that you found confusing or difficult to understand? |
| 6) Are you doing anything differently with your child as a result of doing the COS-P group? Can you provide a specific example of an incident that illustrates this? |
| 7) Where are your strengths and struggles on the circle? |
| 8) Is there anything you would like to change in how you are relating to your child? |
| 9) Discussion of further referral or other supports. |
through the usual channels at other times. This resulted in the sessions finishing on time each week, and as recommended in the decision matrix, they were shorter in duration than the face-to-face groups.

The facilitator also found it difficult to monitor the facial expressions and body language of individual participants when the video material was being shared on screen because of the minimised screens (and thus the size of participants’ faces). The group leader became very aware of how important subtle, non-verbal cues are in her clinical work. She felt as though she was working without a significant part of her toolbox. This made the role of the observer especially important. The observer worked behind the scenes to adjust the video settings, enlarging the speaker screen so that non-verbal cues could be more accurately observed. The observer was another set of eyes, recognising cues from participants who may have wanted to contribute to the discussion.

During weekly supervision, the therapist expressed her sense that she may not be getting the key messages through to specific participants. She also found it more challenging to deal with participants when their defences arose; for example, when one participant reported that she could not organise her child’s feelings when she had another child to care for and a house to run. The facilitator was able to gently validate and acknowledge that it is challenging, to consider the cost of not meeting the child’s need and what it would mean for her child to have her help when he cannot manage overwhelming feelings alone. However, it was challenging to ‘be with’ parents in moments when they struggled with concepts, potentially reducing their capacity to be vulnerable and open to self-reflection. ‘Being with’ and tolerating silence is invaluable in allowing participants in COS-P groups to experience having someone non-judgementally accept their struggles and feelings of discomfort or shame.

The facilitator reflected that the online format mitigated the tendency for participants to look to the leader as an expert and seek opinions on what to do in particular situations. It was easier for the facilitator to encourage parents to wrestle with questions and work out for themselves where the child was on the circle, what the child needs from the parent in the moment, and most importantly to see that meeting that need is not only possible but rewarding for both parent and child. Even experienced facilitators from time to time get caught doing the work for the parents, something which undermines the value of COS-P. However, the facilitator experienced this pull much less and postulated that it may have been in part due to everyone watching the material simultaneously and the sense of equality generated by all being visible in the same way to each other on the computer screen.

The importance of supervision

Weekly supervision was an important opportunity for the facilitator to express her feelings and concerns about the transition to remote group facilitation. Throughout, the leader was unsure if participants had accurately identified their struggles on the circle and their shark music. She found the parallel process of the supervisor ‘being with’ her when she was experiencing strong feelings while ‘on the bottom of the circle’ herself, to be very helpful. The supervisor provided empathy, validation, and reassurance to ‘trust in the COS-P model and its processes.’ The contributions of the observer were also invaluable in being able to highlight the parents’ reflections and insights during the group.
The observer wrote detailed quotes from the parents noting that the parents were able to recognise their strengths and areas for further development in responding to the needs and behaviour of their children. She observed the parents growing in confidence as they described examples of how they had implemented COS-P throughout their week. Sometimes the observer noted nonverbal expressions that indicated that someone was ‘getting’ a particular concept or that someone was still confused. When it was identified that there was ongoing confusion, the facilitator and supervisor discussed ways of re-explaining the tricky concept during the check-in and review at the start of the next session.

**Group participants: Qualitative findings**

All five participants completed COS-P online and one completed it individually online. The attendance was higher than any previous group and all parents stated that they would recommend the online group to a friend. Benefits included the reduced hassle, time, and costs associated with travel. Another parent was able to participate despite having a sick child at home, reducing the need for an additional, individual catch-up session. Parents reported that, in addition to the DVD program, the caregiver workbook, circle graphic, note-taking, and facilitated discussion were very engaging, assisting them in understanding and applying the model. Parents explained that ‘the materials came across well’ and ‘the booklet and DVD subtitles helped to reinforce concepts.’

One parent highlighted the importance of the facilitated discussion, commenting ‘(the facilitator) asked me helpful questions and made me think about my parenting struggles.’ Parents commented on the benefits of the program, including the immediacy of applying the model, for example, ‘I could use it straight away.’ Two women commented that they were more comfortable with the online delivery:

I’m a very shy person and I wouldn’t normally talk in a group. I was able to say things to the (online) group.

Another commented that observing the couple discussing things between themselves on screen made her reflect on the value of parents thinking about parenting together.

On the other hand, some missed the company and talking with other parents, especially during the COVID-19 lockdown. One parent recommended having the first group in person before moving to online groups, to assist with bonding between group members.

During the post-group interviews parents described the positive improvements in their relationship with their children. One participant (who had significant difficulties with taking charge in a kind way), commented that when her child exhibited signs of distress, ‘I can meet that need. It is quite simple. He just needs a cuddle.’ At the post-group interview, the majority of participants identified their parenting strengths and unique lynchpin struggle, describing a greater understanding of their shark music. For example:

I recognise that I tend to become uncomfortable when we are in public places or if I’m feeling overwhelmed.
This parent reported an improvement in her responsiveness with her child and ability to recognise her shark music, whilst being able to meet her child’s healthy needs.

Conclusions
Our paper presents reflections on telehealth adaptations of COS-P practice during the COVID-19 pandemic public health measures. Several factors assisted the group facilitator during this abrupt and rapid transition: 1) reflective supervision and peer support; 2) preparation and practice with clients for online delivery; and 3) feedback from participants regarding improvements in their parenting. As a result of our positive experiences, the service has decided to use telehealth when a parent has to miss a session (due to minor illness or a sick child) when the face-to-face groups resume. Our practice has been to organise an out-of-group catch up session and this option will save considerable time and resources for the service. It will also allow the individual participant to remain connected with the group, decreasing the risk of dropouts.

While the group size is too small to draw strong or definitive conclusions from our observations, it indicates that despite the facilitator’s concerns, the goals of the intervention may be met in the online format. Quantitative research would be helpful to investigate differences in outcomes between online and face-to-face groups, as well as to help identify who is most likely to benefit from which format.

The online format, while more challenging for the facilitator, resulted in more efficient service delivery. The set-up for each session was quicker and there was no need for refreshments and child care. The sessions were shorter in duration, there was less deviation from the material, and it was easier to stick with the framework. During the follow-up interview, parents reported on the positive changes in their parenting confidence, understanding of their own linchpin struggles, and greater responsiveness towards meeting their children’s needs. The participants reported that they were satisfied with the program and provided episodic examples of changes in their parenting.

As well as supporting the facilitator, the observer (being a new graduate and recent addition to the team) benefited from the opportunity to learn about COS-P, the framework we use across the whole service, when it was not possible for her to attend a course because of COVID-19 restrictions. Having used this format successfully, the service is encouraged to attempt online mother—infant interaction therapy as an option for struggling dyads who cannot attend in person for a variety of reasons, not just COVID-19 restrictions.

Lastly, research into online groups is very limited and clinical services would benefit from evidence-based guidelines about how to deliver it effectively, including ways to establish group cohesion and a therapeutic presence online.

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