REOPENING NEW JERSEY AND ITS SCHOOLS: PSYCHOLOGICAL PERSPECTIVES AND WHAT PARENTS/GUARDIANS AND THE REST OF US NEED TO KNOW ABOUT THE "NEW NORMAL"

I. INTRODUCTION

Brief COVID-19 History: Since the onset of the COVID-19 pandemic six months ago, people in New Jersey and elsewhere have lived in survival mode. To suppress the spread of SARS-Cov-2, the coronavirus that causes COVID-19, a highly contagious and potentially lethal respiratory disease, extraordinary measures have been taken. At the time, relatively little was known about this mysterious virus. It was commonly referred to as the "novel coronavirus." The basic facts were that this new coronavirus spread rapidly and caused serious illness, including death, at an alarmingly high rate. There were no vaccines or treatments to stem the tide of sickness and death. In a flash, we became vulnerable.

In what turned out to be a prescient response, stay-at-home orders were issued by government officials under the guidance of public health experts. In New Jersey, such orders went into effect on March 21st, and remained operative until June 9th. At its inception, the emergency lockdown, which was unprecedented, induced a mix of perplexity and dread. Such emotions were compounded as nonessential businesses and schools were also ordered shut. Many normal activities were put on hold. Life was suddenly and radically transformed in a desperate effort to manage an ominous existential health threat.

To protect ourselves and others from this invisible menace, we learned to rely on guidance from public health experts and political leaders. Besides the stay-at-home order, we were also advised to wash hands thoroughly, social distance when outside, avoid crowds, and wear a mask in situations where social distancing is not practical. But would these simple behavioral adjustments work? Would they save lives? The public health experts, with little to go on where SARS-Cov-2 was concerned, based their tentative affirmations on lessons learned from other pandemics.

Despite confusion and uncertainties, New Jersey, an early epicenter for COVID-19, responded with robust compliance. As residents stayed indoors, however, once crowded malls and shopping districts stood vacant. Among a host of ordinary life changes, rush-hour traffic jams disappeared along with some smog and air pollution. Massive unemployment and financial insecurity climbed as businesses shuttered across such sectors as manufacturing, retail, sports, travel, entertainment, etc. Increases in anxiety and depression followed. As classrooms were emptied of teachers and students, education shifted to the internet with mixed results. Students were not only deprived of the benefits of learning directly from teachers, but they also lost opportunities for peer-to-peer socialization. Mask wearing along with social distancing became standard

behaviors for the few who warily ventured from their dwellings to shop for food or perform other necessary errands.

Even though our state has made substantial progress mitigating the onslaught of COVID-19, the landscape we now inhabit seems eerily surreal and less trustworthy. Peril, in the form COVID-19, lurks. It is spiking this summer in "hotspots" created whenever and wherever individuals socialize without heeding safety measures.

We cannot afford to let our guard down, especially now as New Jersey is in the process of reopening gradually and thoughtfully. There is greater freedom of movement today, but in the **"new normal"** we now inhabit we still must social distance, wear face masks and avoid large crowds. Only a vaccine can do more to enhance personal freedom.

Rationale: The purpose of this article is to shed light on some of the features of our "**new normal**" and the adjustments -- attitudinal and behavioral -- required of us as our state gradually and purposefully reopens. Special attention will be given to the reopening of our schools.

As we enter the **"new normal"** the challenge is to balance public health with reopening the many complex and interdependent parts of our society. There is a pressing need to restore our economy, return education to the classroom and allow individuals and groups to expand social activities. To rush ahead blindly, however, is to put the public health at certain risk. To protect the public health, we must move forward responsibly and incrementally, carefully assessing the effects of each cautious step ahead in order to determine if the next step can be taken without excessive risk to our collective health and welfare. We are figuratively walking on thin ice until an effective vaccine is available. In the interim, we must follow the direction of those with expertise in walking on ice. To do otherwise, to deviate from the prescribed path on the basis of "gut feelings" or "instinct," risks all the progress we have made.

Think Clearly - Stay Focused: It is easier said than done, but, to prevail, we will have to persist at doing what we know works: social distancing, mask wearing, etc. Further, we must also stay grounded in a reality defined by relevant facts and their informed interpretation. We cannot afford to be distracted by impatience or its opposite complacency.

To continue to make progress, we must also guard against other frailties of the human mind that can impair our rational thinking and threaten our survival. Tendencies we must avoid or manage include but are not limited to: 1) magical thinking such as a belief in personal invulnerability or that SARS-Cov-2 is going to suddenly vanish; 2) unfounded skepticism; 3) misguided rebelliousness; 4) stubborn oppositionalism; 5) fatigue; 6) nostalgia and 7) politicization, an

inclination to base healthcare guidance on partisan ideological motives as opposed to rigorously vetted scientific data and sound objective reasoning.

Accepting Temporary Restrictions: The limitations on our freedoms imposed by COVID-19 safety measures are temporary. They are also life saving. We should accept them as a sensible set of procedures alike in principle to those we follow when driving. As drivers, we buckle up, obey speed limits, stop at red lights, etc. In so doing, we protect ourselves and others from harm. We tolerate these restrictions for the benefit of safety. Following the rules of social distancing, mask wearing and related COVID-19 safety measures is not much different. These health-promoting rules are intended to save our lives and protect others. By accepting COVID-19 regulations as we do the "rules of the road," we can reduce frustration and remain on the route to reopening our state.

Refreshing Our Collective Memory: To stay focused on our rational goal of reopening while managing the health of all, it may also help to recall what we collectively experienced during earlier phases of the COVID-19 pandemic. The unfolding scene, which had the feeling of a suspense movie or a nightmare, was terrifying and grim. Starting in early March, the COVID-19 case count in our state exploded from one initial case to a current total of about 180,000. Sadly, nearly 16,000 COVID-19 deaths have also been registered state wide in that time period. Nationally, the number of COVID-19 deaths is climbing towards 175,000. It is reasonable to assume the grisly death total would have been several times greater had no steps been taken to mitigate the spread of SARS-Cov-2.

Before our state's reopening started in June, we endured a nearly three month long nightmare beginning in March, during which time the healthcare system of New Jersey teetered on the verge of collapse under the relentless onslaught of COVID-19 cases. Tens of thousands of residents suffered in isolation and despair from this debilitating -- and all too often deadly -- respiratory disease. New cases, hospitalizations and deaths soared in what seemed like the blink of an eye. Funeral homes could not accommodate the onrush of families seeking to bury loved ones cut down by COVID-19. We wondered whether we would ever see light at the end of a very long and bleak tunnel. We worried whether safety measures such as social distancing and mask wearing advised by public health officials on the basis of scientific evidence would actually slow the spread of infection. Then in mid-May, our state officials announced that data trends for new COVID-19 cases, hospitalizations and deaths were on a fourteen day decline within the state. Radical behavior change adopted throughout our state was working. These favorable trends were, and remain, consistent with benchmarks identified by the Centers for Disease Control (CDC) as indicators that a region is out of immediate danger and ready to implement a phased reopening plan.

Looking ahead: Public health experts have suggested that as the cooler autumn winds lower air temperatures this fall the transmission of the SARS-Cov-2 may be enhanced, increasing its danger. In the absence of vaccines, the only sure way to offset the cold-weather threat and minimize new COVID-19 cases, hospitalizations, and deaths is to remain fixed in our commitment to resolutely practice the behavioral safety measures we now know to be effective: social distancing, hand washing, crowd avoidance and mask wearing. In this connection, it is worth noting that the Institute for Health Metrics and Evaluation (IHME) at the University of Washington has predicted that 60,000 U.S. lives can be saved by November 1 if starting now (early August) 95% of us wear face masks as directed. The savings in New Jersey would be about 480 lives, which would make the Thanksgiving holiday that much more meaningful.

The prospect of cooler autumn winds is a reminder that a new academic years is approaching. COVID19 will make educating our children in the **"new normal"** far more challenging than usual. What are some of those challenges as schools reopen, and how might we meet them?

IIA. REOPENING SCHOOLS

Background: On June 26, Gov. Murphy issued state guidelines for reopening schools in New Jersey to all students. Implementation is being widely debated among the principle stakeholders, e.g., parents, teachers, school staff members and administrators. In this light, Gov. Murphy made a return to reopened schools optional. This approach has been adopted here at St. Augustine of Canterbury School. Parents/guardians can choose either to send their children to school for in-class learning or they can decide to keep their children at home and on remote home-based learning. (For details see page 17 of our "Return to School Plan.") A main purpose of this article is to provide those involved, particularly parents/guardians, with relevant information about COVID-19 and the psychosocial dimensions of the educational process so that they can arrive at solutions that best meet the educational needs of their children at a time of great uncertainty.

Here at St. Augustine of Canterbury we are prepared, thanks to the diligence and forward thinking of our "School Reopening Task Force," to offer a mix of in-class and remote learning modes for the 2020-21 academic year. (Specifics are provided on page 17 of our "Return to School Plan.")

Why Reopen Schools?: Only a few months ago elementary, middle and high schools across our state and nation were abruptly closed under emergency conditions. As a consequence, during the fourth quarter of the 2019-2020 academic year, schools throughout New Jersey transitioned to remote learning, a radically different teaching format with which many educators were unfamiliar. That extraordinary leap -- and all the nerve-wracking adjustments it entailed for students as well as teachers (and let's not forget parents/guardians) -- was

justified by the urgent need to protect the lives of students, teachers and staff at a time when we were operating in a near vacuum of knowledge concerning the spread of SARS-Cov-2. We are grateful for the adaptability of our teachers and staff in meeting the many challenges of remote learning. We appreciate as well the cooperation and support shown by the parents/guardians of our students during the abrupt transition to remote learning.

What has changed to give rise to the impetus to reopen schools this fall? The pandemic, after all, is still with us, and we remain without vaccines and medical treatments.

As previously indicated, however, we now know that behavioral safety measures such as social distancing, crowd avoidance, hand washing and mask wearing are effective in mitigating the risks of SARS-Cov-2 spread. These proven safety measures, buttressed by rigorous testing, contact tracing and isolating to keep transmission rates down appear to justify reopening schools to students this fall.

Besides, and here is the really good news: scientific data gathered through on-going investigations in the U.S. and abroad suggest that the impact of COVID-19 is least worrisome where school-aged children are concerned.

In a short few months, we have gone from the dark ages into an age of increasing enlightenment with respect to understanding SARS-Cov-2, the disease it generates, COVID-19, and how that disease spreads within various components of our population. The emerging picture is clearer, but not yet crystal clear, however. In preliminary stages of investigation, as in the present moment, science sometimes raises more questions than it answers and, due to contradictory findings, leaves some questions temporarily unresolved. The situation is fluid. COVID-19 data are provisional, but certain trends are becoming increasingly apparent.

Reasons for Reopening Schools: There appear to be two main reasons for reopening our schools. One is based on reviving the economy. The other is based on restoring the educational and psychosocial benefits of in-class learning.

It is easy to overlook, but the fact is that here at St. Augustine of Canterbury we provide essential childcare services for many working parents/guardians, who need to be at a job site to earn a pay check. This is true for our heroic first responders, among others. Working from home is not always an option.

If schools do not reopen, these and other workers face a stressful dilemma: go to work and leave children unsupervised, if they are not in school; or stay home and face financial insecurities and likely mental health issues, Significant increases in anxiety and depression among adults during the pandemic have

been documented by the CDC. Unemployment is likely one of the more salient factors contributing to the erosion of mental health among adults, many of whom are parents, which in turn puts children and families at risk. Reopening schools is an essential part of any plan to reopen the economy.

Of course, we cannot sacrifice the health and lives of our children or their teachers for the sake of the economy, even if it is tied to prosperity and improvements to the mental health of working parents. Fortunately, we do not have to choose one alternative or the other. Given what has been learned about the SARS-Cov-2 virus over the past several months, leading public health experts are today of the opinion that, provided proven safety measures are rigorously integrated into school policies and practices, students and teachers can safely return to the classroom. The next several sections will take up a review of the evidence for this optimistic outlook.

IIB. EVIDENCE FOR REOPENING SCHOOLS SAFELY

COVID-19 Infection In School-Aged Children: As to the health risks for students involved with the reopening of schools, the relevant data from peer reviewed studies published in respected journals suggest that school aged children, especially those below age ten, are at low risk for contracting COVID-19. Moreover, those who become infected, tend to have mild cases. While pre-teens and teens may be more susceptible to SARS-Cov-2 infection than younger children, their COVID-19 illnesses tend to be just as mild.

However, special consideration will have to be given to those students, regardless of age, who have pre-existing medical conditions such as asthma, immune deficiencies, obesity, Type 2 diabetes, etc. that make them particularly vulnerable to COVID-19. Parents/guardians of at-higher-risk children are advised to consult with their child's healthcare provider(s) and school administrators before making a decision about registering their children for in-class learning.

Assessment of COVID-19 Risk in School-Aged Children: Nearly 95% of all COVID-19 cases in the U.S. consist of adults aged 18 or older. In other words, children between the ages of 0 through 17 account for just a little over 5% of all COVID-19 cases It is likely that as students leave the cocoon of their homes to mix with classmates, teachers and staff in reopened schools the percentage of new cases among children will rise. As mentioned, however, COVID-19 cases in children under the age of 18 tend to be mild.

Some children, however, have regrettably lost their lives to COVID-19. Such facts cannot be ignored. Although the data on COVID-19 mortality in children are not pleasant to contemplate, they deserve a look, particularly as they help define the **"new normal,"** and may, paradoxically, provide some reassurance to parents/guardians as schools reopen.

COVID-19 Mortality in Children: While intensely tragic, child COVID-19 mortality accounts for 0.1% of the approximately 170,000 COVID-19 deaths in the U.S. This rather low percentage also suggests that thus far about 170 children across the nation may have died due to COVID-19. The low proportion of COVID-19 deaths attributable to children is both surprising and reassuring, since children make up about 22% of the nation's overall population.

In the state of New Jersey, where the overall COVID-19 death tally is about 16,000, the actual number of COVID-19 deaths listed among school-aged children (5-17) is zero as of August 15, 2020. Three COVID-19 deaths have occurred in pre-school aged children (0-4), however. The percentage of COVID-19 deaths for New Jersey's children between 0-17 is .025%, which is considerably less than the national rate.

Why comparatively few children below 18 are numbered in COVID-19 mortality rates nationally and in our state is yet to be determined. However, it is a fact for which we can be thankful.

COVID-19 vs. Flu Deaths in Children: How do COVID-19 deaths in children compare to child mortality rates for other diseases? To answer this question, child deaths from COVID-19 were compared to child deaths from the flu. Keep in mind that flu vaccines are available for children, whereas there is at present no vaccine for SARS-Cov-2

The analysis performed for this article used CDC data for U.S. deaths in children between the ages of 0 and 14 during a six month period from February 1, 2020 through August 8, 2020. In all, 49 children in the U.S. reportedly died of COVID-19. However, during the same time period and for the same age group, 107 children died of influenza. Children in the age group under review were 2.2 times more likely to die of the flu than they were to die from COVID-19. These results may be particularly helpful to parents/guardians who are undecided about whether or not to return their children to school this fall.

Keeping SARS-Cov-2 Down in Reopened Schools: In an effort to prevent SARS-Cov-2 spread within reopened schools, the New Jersey *Restart and Recovery Plan for Education* (June 2020), a document prepared by the NJ Department of Education (DOE), stipulates that all school districts "must adopt a policy for safely and respectfully screening students and employees for symptoms of and history of exposure to COVID-19." Examination of the document suggests that symptom screening consists of a visual check for a cluster of thirteen target COVID-19 signs. Persons exhibiting one or more of the target COVID-19 symptoms, who cannot provide a satisfactory explanation for their COVID-19-like symptoms will, according to the DOE document, "be asked to leave or not come into school." These persons will be required to undergo

viral testing (nose swab) before returning to school either after a negative test result or a fourteen-day isolation period.

During isolation, or while awaiting test results, remote learning will be available to students at their homes. Necessary equipment will be provided for students in need.

Contact tracing, which also includes viral testing, will be used with students, teachers and staff who have been in close proximity (six feet or less) to a known SARS-Cov-2 carrier for a period of at least ten minutes. Those involved in contact tracing will also be isolated until test results determine that they are free of infection. It is hoped that research will continue to improve the practice of testing and contact tracing by making viral tests less invasive and able to provide results in minutes or hours as opposed to days.

Isolation, an integral feature of the testing and contact tracing protocol designed to limit the spread of SARS-Cov-2, can adversely impact mental health. For instance, parents and children subjected to quarantining in earlier pandemics evidenced more pronounced posttraumatic stress symptoms relative to those who did not experience isolation. Recently, researchers in China reported an alarming increase in suicidal and self-harm ideation among college students who were quarantined as a result of COVID-19. The report did not study the relationship between quarantining and instances of suicide or actual self harm. Toxic ideation in the form of suicidal ideation and self-harm thoughts, however, can be a precursor to deadly action or serious bodily injury.

Since quarantining/isolation is part of the testing and contact tracing procedures that are critical to reopening policies and plans, its potential for negatively impacting mental health must be addressed. It will likely help if, with permission, those who undergo isolation are heralded as courageous individuals and given strong support from classmates and teachers as they undergo the hardship of social isolation in order to protect the school community. Stigmatization and ostracization have no place in our school, especially when solidarity and cooperation are needed to meet the challenges of a pandemic.

It is herein further suggested that stress reduction strategies be embedded into our school's COVID-19 prevention protocols by teaching students the skill set of diaphragmatic breathing, muscle relaxation and both soothing and problem-solving imagery. Access to mental health services should be made available to those showing signs of anxiety and/or depression, especially if such individuals are to undergo isolation.

Will Children Bring SARS-Cov-2 Home From School?: By attending school this fall, will children pose a significant risk of spreading SARS-Cov-2 to their families and the communities in which they reside? This is a somewhat thorny question. However, at present, studies conducted in several different countries

indicate that children do not appear to be contributing to the spread of SARS-Cov-2 in a significant way.

A Swiss study, which was reviewed in *Pediatrics* (July 2020), the Journal of the American Academy of Pediatrics, followed 40 children under the age of 16 from 39 households. The 40 children had each tested positive for SARS-Cov-2. Researchers determined that the infected children were responsible for spreading SARS-Cov-2 in only 8% of the cases in which adult family members tested positive for COVID-19. The results of this study are consistent with similar findings in France and China.

Under the circumstances it appears that school aged children who contract SARS-Cov-2 at school, or elsewhere, are not likely to transmit the virus to others, whether in their immediate family or the wider community. This conclusion was echoed in a recent editorial written by Naomi Bardach, M.D., a pediatrician, affiliated with the University of California, San Francisco. The gist of her editorial, which appeared in *The New York Times* (August 15, 2020), was expressed in its heading: "Don't Call Kids Covid Spreaders." Reasons for the low transmissibility rate of SARS-Cov-2 by infected children are yet to be determined.

A recent study found that the amount of SARS-Cov-2 in the upper respiratory tracts of infected individuals is about the same for adults and children. Transmission rates for various age groups were not studied, however. Given earlier findings reviewed herein suggesting that adults are more likely than children to infect others with SARS-Cov-2, it would seem that, if infected children and adults carry similar viral loads, children are less efficient at SARS-Cov-2 transmission than adults. Along these lines it has been speculated that due to differences in pressure or force children may not expel the same quantity of SARS-Cov-2 into their surroundings through, say, a cough, sneeze or shout as adults. Let us also not forget that children tend, for the most part, to be shorter than adults, another factor that may make children inefficient transmitters. Before this matter can be satisfactorily resolved, however, further data is required.

Under the circumstances, parents/guardians are advised to use the same preventive protocols they follow on returning home from work or a trip to a food market with children who are coming home from school. In multigenerational homes, prudence dictates that social distancing and mask wearing be practiced when school aged children who regularly attend reopened schools are likely to be in close proximity to elderly family members for extended periods. As an extra precaution it may make sense to check the temperature of a child returning from school and conduct a visual screen for the COVID-19 symptoms listed in the DOE *Restart and Recovery Plan.*

Data Trends Clarify Perceptions of COVID-19 Risk to Children: If COVID-19 mortality among school aged children is low, 2.2 times less than flu deaths among children, and COVID-19 infections among children tend to be mild, and

children below age 16 do not significantly contribute to SARS-Cov-2 transmission, why the alarm about returning children to school this fall? It is likely that heightened parent/guardian concern regarding the COVID-19 threat to children is largely the result of the newness of the disease and the paucity of age related data until recently.

Summing up, the data trends reviewed thus far indicate:

1. In terms of deaths among children aged 0 to 14, the flu is a greater risk than COVID-19 by a factor of 2 to 1.
2. Children below age 10 are at low risk for contracting COVID-19.
3. Children below age 18 are likely to have mild cases of COVID-19.
4. Children below age 16 appear to be less likely to transmit SARS-Cov-2 than older children and adults.
5. St. Augustine of Canterbury will routinely screen children, teachers and staff for symptoms of COVID-19. When needed, testing, contact tracing and isolation will be integral parts of COVID-19 mitigation protocols. (For further details see pages 8-9 of our "Return to School Plan.")

IIC. RESTORING ADVANTAGES OF SCHOOL EDUCATION

Benefits of In-Class Learning: A return to school can also be justified in its own right. Our recent experience with remote learning suggests that overall it may not be as effective as in-class learning when it comes to meeting the academic and psychosocial needs of students in grades K-8. With few exceptions, elementary school children, especially those from kindergarten through third grade, appear, for instance, to lack the attention span, study habits and self-regulation required to succeed at remote learning. These youngsters may fall appreciably behind if their only means of acquiring basic academic skills is remote learning in the 2020-21 school year. The effects of lost learning opportunities may compound and adversely impact future learning and progress. Fortunately, those most susceptible to the effects of lost learning opportunities due to remote-learning are least vulnerable to COVID-19.

Further, at all grade levels, school closings deprived students of the sort of ready access to teachers and aides through casual banter, spontaneous "Q&A," as well as timely feedback and constructive criticism aimed at performance as well as product. These student-teacher interactions are conducive to building productive educational relationships needed to enrich the learning experience.

Remote learning also cut students off from informal but essential direct social learning experiences with peers that contribute to basic aspects of child development associated with: 1) self-image formation, 2) bonding, 3) group membership, 4) moral development, 5) social problem-solving, 6) the acquisition of skills related to communication, 6) cooperation and competition, etc.

The long-standing tradition of sending children to school rather than keeping them at home doubtless reflects an adaptive practice designed to: 1) foster independence and self-confidence; 2) extend relationships beyond those connected to family members; 3) bring children face-to-face with a wider variety of points of view and behaviors; 4) promote familiarity with and curiosity about the wider world, etc.

The school experience during the 2020-21 academic year will not be the same as it was before the pandemic hit. However, in light of the relatively low COVID-19 health risks for school-aged children when compared to the flu, educational and psychosocial benefits to be gained through school attendance may make in-class learning a viable option for parents/guardians who wish to maximize the learning experience of their children while managing the threat of COVID-19.

IID. WORKING TOGETHER IN THE BEST INTERESTS OF STUDENTS

A Word to Parents/Guardians & Educators: Final decisions regarding how New Jersey's student population will learn this fall will require clear, honest and transparent dialogue between parents/guardians, educators, government officials and public health experts conducted in an atmosphere of mutual respect and cooperation. The challenge is to provide an optimal educational experience to students while protecting them, together with their teachers and school staff, from health risks of SARS-Cov-2 contagion.

A sampling of a few on-line surveys of parents conducted in some New Jersey school districts suggests that in several districts the majority of parents/guardians presently favor in-class learning for their children over remote-learning. In one survey conducted in a district of moderate size, where 70% of the parent/guardians responded, 84% favored in-class learning. A state-wide survey conducted by Farleigh Dickinson University found that parents were more evenly split, with 46% for in-class learning and 42% for remote learning.

Undecided parents/guardians are advised to consult with their children's pediatricians and educators as part of the back-to-school decision-making process.

Returning Students Need Parent/Guardian Support: Parents/guardians who opt for in-class learning, need to display an attitude of reasonable confidence to their children that teachers and school staff will provide a safe learning environment for all members of the educational community. A realistic framework, one that speaks to the probability that some students, teachers or staff may, despite precautions, contract COVID-19, will help reduce student anxieties and worries. Since COVID-19 cases among students are likely to be mild, children (including, their parents/guardians) need not worry more about a SARS-Cov-2 infection than they would about an ordinary case of the flu, strep

throat or bronchitis. In general, young students are less anxious when they know what to expect. False hope or unrealistic expectations only serve to increase anxieties and worries.

Students also need to know before entering school what procedures will be in place to keep risks down and how SARS-Cov-2 carriers at school will be identified and then isolated. They also need to know that those exposed to a carrier at school will also be tested and isolated so as to protect the rest of the school community. To avoid stigmatization, it is important that isolation be held up as a public service and that those who undergo a period of isolation be viewed as socially responsible individuals deserving of respect and support.

Parents/guardians should be open to answering any questions children may pose regarding COVID-19 and school safety. Information to aid parents/guardians in this regard can be found on the following websites: The Centers for Disease Control, The Johns Hopkins Coronavirus Resource Center, The American Academy of Pediatrics, New Jersey COVID-19 Information Hub, The American Psychological Association, and the New Jersey Psychological Association among others.

IV. COVID-19 AND MENTAL HEALTH CHALLENGES

Preserving One's Mental Health During a Pandemic: As noted, we are living in uncertain and dangerous times. Heightened levels of anxiety and stress are to be expected. However, at this point we have reason for measured optimism that can take some of the edge off our worries and fears. We can now say with confidence that the set of safety measures recommended by our government leaders and public health experts actually work, imperfectly perhaps, but reasonably effectively. They will continue to provide protection if we all use them conscientiously while we travel the bumpy road to reopening and renewal.

To further reduce anxiety and stress and optimize rational decision-making, readers of this article are encouraged to develop a mindset that incorporates a "best practices" approach to navigating through the COVID-19 crisis by using strategies and techniques based on scientific data and rational judgment shaped by concern for the welfare of all.

It is also recommended that readers discuss anxious feelings and thoughts with trusted others and return the favor by listening patiently and nonjudgmental to worried family and friends. If needed, volunteer mental health professionals can be contacted through state and local agencies. Our school counselor, Dr. Walsh, is also available for consultation. He may be reached at 732-549-2384.

Although it is vital to be informed, readers are encouraged to self-care by taking breaks from COVID-19 coverage. Occasionally, divert attention to pleasant thoughts or memories, chat with someone, perform acts of kindness and express gratitude for kindnesses received, be prayerful, read, take a walk,

engage in noncontact sports outdoors, etc. It is also recommended that readers practice slow and rhythmic diaphragmatic breathing and muscle relaxation along with soothing and constructive imagery. Envision a society where a concern for others is a salient feature. Remember, self-care enables us to care for others.

Conclusion: In summary, both the preservation of gains made with regard to COVID-19 and any further improvements will require that members of our school community adjust to the **"new normal"** by:

1) Heeding warning signs and learning from the mistakes of others.
2) Staying up-to-date with recommendations from the St. Augustine of Canterbury school leadership as well as trustworthy government officials and public health experts.
3) Being realistic about expectations and avoiding false hope.
4) Integrating social distancing, mask wearing and other recommended preventive measures into daily living activities.
5) Cooperating with comprehensive testing and contact tracing procedures.
6) Practicing social responsibility by avoiding unnecessary risks out of consideration for the health and welfare of others.
7) Remembering that old habits may carry new risks.
8) Educating our youths to the reality that in a just society the exercise of autonomy should not infringe on the rights of others to healthy and prosperous lives.
9) Putting today's sacrifices in perspective with those made by earlier generations during past times of crisis.
10) Reserving time for self-care.

This article was prepared by William F. Walsh, Ph.D. a psychologist in private practice in Metuchen, NJ. Dr. Walsh has over 40 years of experience in the treatment of anxiety and stress in children, teens and their families. As part of his practice, he has been a long-time consultant to St. Augustine of Canterbury School. Earlier in his career, Dr. Walsh served as an Assistant Professor of Psychology & Education at Teachers College, Columbia University. This article is provided with the intention of sharing useful and timely information that will ease the reader's adjustment to **"the new normal"** and help parents/guardians decide how best to meet their children's educational and psychosocial needs as school resumes in a COVID-19 world.