

Clinical Demonstration of the Potential of Parental Feedback in Reducing Deterioration During Group Psychotherapy With Children

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Abstract: In recent years, great efforts have been exerted to minimize the rates of deterioration in clinical practice, especially in child psychotherapy. The present study explored the potential effect of routine outcome monitoring (ROM) with parents as a preventive intervention to reduce deterioration in children. Twenty-five children receiving treatment for emotional problems were randomized to parent-based, ROM-assisted group psychotherapy or to treatment as usual (TAU). A mixed-methods approach was utilized, with the number of deteriorating cases compared at the group level and two case illustrations assessed at the individual level. At the group level, there were fewer cases of deterioration in child's anxiety, parental stress, and quality of parent's alliance in the ROM-assisted group, compared with TAU. Case studies illustrated how ROM can be used as a tool to communicate with parents to prevent deterioration. Routine outcome monitoring in child psychotherapy may thus benefit therapy process and outcome. Limitations and directions for future research are discussed.

Key Words: Routine outcome monitoring, child psychotherapy, group psychotherapy, parents, alliance

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Many therapeutic interventions focus on patients' recovery and clinical improvement as the main objective of treatment, whereas less attention has been given to the prevention of deterioration in clinical practice. Nonetheless, the occurrence of deterioration during psychotherapeutic interventions has long been documented (Lambert and Ogles, 2004; Shimokawa et al., 2010). Defined as the process of worsening in psychotherapy as indicated by impairment from a previously higher state of functioning (Lambert et al., 1977), clinical trials indicate deterioration rates of 5% to 10% in adult patients (Lambert, 2013), with estimated higher rates in routine practice settings. Cases of deterioration appear across different treatment modalities and theoretical approaches, and can be easily overlooked by the therapist (Hannan et al., 2005). Deterioration during treatment may have a devastating effect on patients' psychological functioning and on the likelihood of their seeking and benefiting from treatment in the future. It may also have financial consequences for patients and managed care companies (Linden and Schermuly-Haupt, 2014; Shimokawa et al., 2010). Therefore, in recent years, substantial efforts have been exerted to identify, address, and minimize the rates of deterioration in clinical practice.

One of the most promising and well-studied methods for addressing the problem of treatment failure and deterioration is the implementation of routine outcome monitoring (ROM) in clinical practice. Routine outcome monitoring has been operationalized to include ongoing evaluation of patients' progress while providing feedback to the therapists. Routine outcome monitoring enables therapists to detect

changes in patients' clinical states and to modulate their interventions when patients fail to make adequate progress. This type of clinical measurement and feedback has been implemented in various forms, such as measurement-based care (Scott and Lewis, 2015) and measurement feedback system (MFS) (Bickman, 2008), with each system implemented on a different technological platform and emphasizing different aspects of measurement and module of feedback. In mental healthcare, ROM and MFS are considered the most common approaches to monitoring and feedback process (Bickman et al., 2016a, 2016b; Lewis et al., 2019). Many studies have documented the effect of ROM on patients with the potential risk of deterioration, identified as "not on track" (NOT) patients (Lutz et al., 2015). Studies comparing ROM-assisted therapy to treatment as usual (TAU) indicate that NOT patients are 2.3 times more likely to deteriorate in usual care than in the ROM-assisted condition (Shimokawa et al., 2010). A recent meta-analysis conducted by Lambert et al. (2018) concluded that feedback reduces deterioration rates and nearly doubles clinically significant or reliable change rates in patients who were predicted to deteriorate or to have a poor outcome. Thus, ROM is considered one of the most effective approaches to reduce deterioration in adult psychotherapy.

The need to address patient deterioration is especially pronounced in child and youth psychotherapy. Although the existing literature on psychotherapies with children and adolescents indicates that treatment can be effective for a range of childhood disorders (Midgley and Kennedy, 2011), studies indicate that deterioration rates in child psychotherapy are even larger than those reported in adult studies, with estimates ranging between 14% and 24% (Warren et al., 2010). At the mean level (aggregating successful with deteriorating cases), the effect size of the effectiveness of therapy from pretreatment to posttreatment for children and adolescents in community-based care settings is near zero, which might account for the high rates of dropout (Lopes et al., 2018), reported to be as high as 40% to 60% (Weisz, 2004). These discouraging findings attest to the need for monitoring and evaluating children's responses to treatment (Kazdin, 1996), as well as for testing different approaches to improve therapy outcome.

Compared with the extensive research on ROM in adult populations, there has been less empirical research on ROM in children. These studies have produced promising results, suggesting that ROM may enhance therapy outcomes in child psychotherapy (Hansen et al., 2015; Bickman et al., 2011), particularly when clinicians view and respond to the provided feedback (Bickman et al., 2016a, 2016b; also see Kelley and Bickman, 2009, for review and Tam and Ronan, 2017, for systematic review and meta-analysis). In a recent clustered randomized controlled trial assessing the effect of feedback in child psychotherapy of 38 children aged 7 to 11 years, significantly greater reductions in parents' difficulties were observed compared with those in the control condition (Cooper et al., 2019). Furthermore, Dyason et al. (2019) examined the effect of feedback in adult and youth psychotherapy, and found that feedback-informed psychotherapy was more effective than TAU, with 50% of adults and 64% of youth significantly improving after psychotherapy (Dyason et al., 2019). It has been suggested that children may especially benefit from ROM because they usually do not enter therapy voluntarily and tend to under-report symptoms and

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distress (Cannon et al., 2010). Furthermore, as research suggests that systematic feedback may help to reprioritize therapy outcomes to the clients' frame of reference (Duncan and Reese, 2015), the utility of feedback in youth might provide more control over therapeutic processes and decision-making, elements to which this population is highly sensitive (Zack et al., 2007).

There have also been suggestions that ROM can be used with parents to increase the chances that their child's psychotherapy will be effective. In line with the common practice of ROM (Boswell et al., 2015), such utilization entails parents routinely responding to clinical measurements of the child's symptoms and the provision of an integrated report to the child's therapist so as to inform the therapist's clinical decision-making during treatment. Empirical research has shown that parents have a marked effect on their child's psychotherapy (Dowell and Ogles, 2010). Although it has been suggested that change trajectories in children can be assessed through salient elements such as the child's play profile (Halfon et al., 2019), clinical evaluations usually rely to some extent on the patient's self-report, which has been demonstrated to particularly vary in children and adolescents across contexts and informants (Goodman et al., 2010). Because of such variations, parents' perspectives, as well as the report of multiple caregivers, are of significant importance in a child's mental care. Furthermore, parents' confidence in the chances that the treatment will be effective for their child and their agreement with the therapists on the goals and tasks of treatment have been found to have a critical effect on the risk of dropout and treatment failure (Deakin et al., 2012; Martinez et al., 2017). Parent-based ROM may enhance the parents' experience as well as the sense that they are an integral part of the therapy process and that they have some control over the process. A direct communication path between the therapist and the parents may lower the risk of communicating dissatisfaction through action, for example, by missed sessions or dropout. This aspect is especially important in settings where, because of financial or other considerations, parents do not receive training and have no regular meetings with the therapists (such as in many hospital settings). Engaging the parents in the process of treatment by parent-based ROM may also be instrumental in alleviating the stress involved in caring for a child with emotional problems (Lyons et al., 2010). Parental stress is highly associated with the child's treatment success and failure (Liber et al., 2008); therefore, alleviating parental stress can be potentially beneficial for both parental functioning and children's therapeutic outcomes.

In this study, we explored the potential effect of parent-based ROM on parental stress, parents' evaluation of their children's progress in therapy, and parents' level of alliance with their children's therapist. Specifically, we aimed to explore whether the utilization of ROM might improve therapists' alliance with the parents and reduce cases of deterioration in parents' emotional state and in the child's progress during therapy course. Using a mixed-model approach, we sought to evaluate closely the effect of routine monitoring and feedback on children and youth aged 8 to 16 years treated in group psychotherapy, focusing on its potential to prevent deterioration. First, we present the process and outcomes of seven children participating in child group therapy whose parents completed ROM assessment forms, as compared with seven children randomly allocated to participate in the same treatment, with the same therapist, but without the provision of ROM. In the second stage, we performed an in-depth exploration of two cases, one from the ROM group and the other from the TAU group, to elucidate the means and trajectories through which parent-based ROM might be beneficial for reducing deterioration.

METHODS

Participants

Participants were recruited from one of four outpatient units of the Shalvata Mental Health Center (MHC), a psychiatric hospital

located in an urban area in Israel. The children and adolescent sample was collected as part of a larger study assessing the effect of ROM in public mental health services, which included 25 children and adolescents and their parents, recruited from the child and adolescent unit (Tzur Bitan et al., 2020). The child and adolescent unit is located inside the physical perimeters of the hospital and accepts approximately 12 children aged 6 to 18 years for group and individual psychotherapy per month. Inclusion criteria for the children's sample were parents' informed consent and sufficient understanding of Hebrew. A total of 14 children and adolescents were randomized to the ROM group and 11 children to the TAU group. Of the entire sample of 25 participants, a total of five children dropped out of the study: in the ROM group, one child dropped out of the study, and in the TAU group, three dropped out of the study, and one dropped out of therapy. For the purpose of the present study, we assessed only children whose parents had completed assessments regarding their children's symptoms and reported on their own parental distress and on their alliance with their children's therapists. As such, a total of seven children (50%) from the ROM group and seven (63%) from the TAU group were further analyzed.

Procedure

The study was approved by the institutional review board of the Shalvata MHC in November 2013. Before the randomized controlled trial, an implementation process was conducted for a year and a half (Tzur Bitan et al., 2018a, 2018b). During the implementation phase of the study, staff meetings were held in all the units participating in the study, and therapists were provided with explanations regarding how to use ROM as a tool to assist with clinical decision making. Clinical teams experienced the benefits and limitations of the ROM process, and an assessment of the barriers and benefits of ROM in public mental health was conducted. Children were recruited after an intake meeting with a senior psychiatrist and an interdisciplinary staff evaluation. The staff conducting the intake meeting is usually responsible for assigning a diagnosis and formulating the treatment strategy. Children were assigned to therapists immediately after the intake meeting and randomized to the study groups after their parents agreed to participate in the study. All of the children who went through an intake meeting were given the opportunity to participate. The assignment of the type of therapy and specific therapist was based on clinical judgment and routine clinical procedure. Both parents received explanations about the objectives of the study and the potential utility of the assessments by the therapist, and they were then requested to sign the informed consent for the child to participate in the study. The children participating in the study were informed of the assessments conducted by their parents and agreed to take part in the study, but they did not sign an informed consent. Upon agreeing to participate, parents in the ROM group completed assessments about their children's anxiety symptoms on a weekly basis and also completed assessments of their own alliance with their children's therapist after each group session. The parents in the TAU group completed assessments every 3 months. Assessments were completed by the same parent and were performed within the hospital parameters while the child was being treated. When a therapy session was canceled, the measurements were sent to the parent via e-mail. Feedback was sent to therapists via e-mail within 24 hours after completion of the assessments. The therapist reviewed the feedback reports during the week between the group sessions. Parents did not receive any feedback but were only informed of the potential utility of the assessments by the therapist as a clinical aid for clinical decision making.

Type of Therapy

All of the children and adolescents in the study participated in group psychotherapy. The therapy groups were held once a week and comprised both play and interpretative psychotherapy. Each group included up to seven children with varying emotional problems. The

contents of the group therapy focused primarily on the emotional, interpersonal, and social aspects of children's adjustment and daily living. The main themes that were addressed in the group therapy included identification and naming of emotions, the ability to be with others, the need to belong, and the reconstruction of self-worth. All groups were guided by the same two group leaders. Both groups received the same type of treatment; however, although the parents of the children in the ROM group completed assessments every week and the therapist received the feedback on the child's progress, the parents in the TAU groups completed assessments every 3 months, and no feedback was provided to the therapist. Leading the groups were two psychotherapists specializing in art therapy, with 4 to 8 years of experience in children's group therapy. The groups met weekly for up to one academic year. Measurements were collected routinely for up to 6 months of treatment. The parents of the children participating in the group therapy did not have formal meetings with the group leaders. A portion of parents sporadically engaged in parental guidance with a different therapist, when needed. The relationship between the therapists and the parents consisted primarily of brief random encounters outside of the therapy room, before and after the session. As needed, the parents could approach the therapist and consult with the therapist on various aspects of their relations with their child, but these consultations were not formal, and the primary intervention was with the child.

Parent-Based ROM

The parents of children who were allocated to the ROM group received a weekly assessment kit, which included measures of children's emotional distress (as reported by the parent), parental stress, and parents' alliance with the child's therapist. The completion of the assessments was performed either electronically or by paper and pencil. Parents did not typically choose the type of administration, and electronic versus paper and pencil was based on availability of electronic devices. When paper and pencil administration was performed, research assistants produced the feedback report within 1 day of the completion of the assessment. After completion, the results were sent to therapists as a graphical presentation of session by session changes in parents' reports to their organizational e-mail address. Therapists used the information provided by the feedback report according to their clinical judgment. Therapists were instructed to send a confirmation e-mail stating that they had viewed the content of the e-mail, and 99% of the reports were reported to have been viewed.

Measures

The Session Alliance Inventory

The Session Alliance Inventory (SAI) is a 6-item self-report measure of the working alliance that aims at assessing three components: agreement on treatment goals, agreement on therapeutic tasks, and positive emotional bond. The SAI (Falkenström et al., 2015) has demonstrated a high correlation with the full version of the Working Alliance Inventory (Horvath and Greenberg, 1989) and has shown high reliability for the composite sum or mean of the six items (Falkenström et al., 2015). The Working Alliance Inventory was previously found suitable for detecting weekly changes in alliance and was associated with changes in outcome, in chronically depressed patients (Klein et al., 2003). For the purpose of the present study, we used a revised form of the SAI, in which parents were asked to assess the level of their alliance with their children's therapists. The alpha coefficient in the current sample indicated good internal reliability for the revised version (Cronbach's alpha = 0.94).

PROMIS Emotional Distress–Anxiety Parent/Guardian Scale

The Patient Reported Outcomes Measurement Information System (PROMIS) anxiety scale is a self-report measure for parents of children aged 6 to 17 years (PROMIS Health Organization and PROMIS Cooperative Group, 2012), developed by the National Institutes of Health for the PROMIS. For the purpose of the present study, we used the parent/guardian version of the 10-item anxiety scale. The PROMIS anxiety scale focuses on fear, anxious misery, hyperarousal, and somatic symptoms related to arousal. The scale has been validated with other commonly used anxiety instruments (Schalet et al., 2014) and found to be sensitive to change in intervention studies (Schalet et al., 2016). Acceptable reliability and ecological validity were also reported (Stone et al., 2016). In the current sample, the alpha coefficient indicated good internal reliability (Cronbach's alpha = 0.89).

The Parenting Stress Index–Short-Form

The Parenting Stress Index–Short-Form (PSI-SF; Abidin, 1995) is a 36-item questionnaire designed to measure stress in the parent-child interaction. The measure consists of three subscales: Parental Distress Scale, pertaining to parent's stress with spouse, social support, and the general restrictions in life roles; Parent-Child Dysfunctional Interaction Scale, assessing parent-child interaction; and Difficult Child Scale, assessing parents' perceptions of their child. High scores on the subscales and PSI-SF total score indicate greater levels of stress. The PSI-SF has been shown to be valid and reliable (Abidin, 1995), and has been widely used in studies of parents of children with different disabilities (Zaidman-Zait et al., 2011). The alpha coefficient in the current sample indicated adequate internal reliability for the revised version (Cronbach's alpha = 0.84).

Statistical Analysis

Due to the small sample size, we restricted the group level comparisons to include only size effects of the proportion of deteriorating cases in each study group. To evaluate deterioration, we first calculated the delta scores from the first to the last session. The number of deteriorating cases was then summed, and χ^2 tests were used to determine differences in the frequency of deteriorating cases. Cramer's V was used as an indicator of size effect. To compare the clinical trajectories of the two cases, we employed an empirically based case report structure and utilized the Jacobson and Truax (1991) approach to reliable clinical change, which includes a calculation of the Reliable Change Index (RCI > 1.96) and return to a functional distribution (SD > 2.0). Cohen's *d* formula was utilized for effect sizes for all outcome and process measures. We obtained means and SDs for the PROMIS scale from the PROMIS Health Organization and PROMIS Cooperative Group (2012). Reliability measures were obtained from the first wave of adult self-reported health outcome item banks (Cella et al., 2010). These studies report a mean *t* score of 50 and SD of 10 for normative populations, with a *t* score of 70 and above representing severe symptoms. For the PSI, we obtained normative data from a study assessing parental stress among low-income children and their families (Reitman et al., 2002), which reported a mean parental stress index of 24.67 (SD = 9.13), mean child-parent interaction index of 22.22 (SD = 8.9), and mean difficult child index of 26.61 (SD = 6.69). Clinical means and SDs were obtained from a study assessing parental stress among parents of children with emotional and behavioral problems (Vaughan et al., 2013). For the working alliance, we used data from the validation study of the SAI (Falkenström et al., 2015), which evaluated patients attending primary care counseling and psychotherapy of different orientations. The reported mean across all items ranged between 5.81 and 6.37, and the SD across all items of the WAI ranged between 0.92 and 1.18; therefore, we set the SD to the value of 1.11.

RESULTS

Characteristics of Evaluated Children

Table 1 summarizes the main characteristics of the children participating in the study. Children's age ranged between 8 and 16 years, with a mean age of 11.13 (SD = 2.55). The majority were boys (78.57%), suffering from either a developmental disorder, attention deficit hyperactivity disorder (ADHD), or generalized anxiety disorder. By randomness, the distribution of diagnoses across the two groups was exactly the same (see Table 1). Most children also had additional comorbid psychiatric conditions, with two children suffering from comorbid anxiety (28.5%), one with oppositional defiant disorder (14.2%), and three with comorbid ADHD in the ROM group (42.8%), and four children suffering from anxiety (57.1%) and two with ADHD (28.5%) in the TAU group. In the general population of adolescents in Israel, the prevalence rate of ADHD is reported to be 3% (SE = 0.6) and 1.5% (SE = 0.4) for generalized anxiety disorder (Farbstein et al., 2010), and the majority of adolescents with developmental disorder are reported to have a comorbid anxiety disorder (Gothelf et al., 2008). The majority of the children had been previously followed, diagnosed, and treated in the mental health center, with a mean duration of treatment in the mental health system of 2.41 years (SD = 2.43). Aside from group psychotherapy, additional therapeutic sessions included individual psychotherapy (two children), parents' group guidance by a different therapist (three parents), and psychiatric medication follow-up (eight children). In the ROM group, the mean age of the included children was 12.98 (SD = 2.28), compared with the excluded cases that had a mean age of 11.66 (SD = 1.96). In the TAU group, the mean age of the included children was 9.28 (SD = 0.95), compared with the excluded cases that had a mean age of 10.20 (SD = 2.28). In the ROM group, 85.7% of the included children were boys, compared with 40% in the excluded cases. In the TAU group, 71.4% of the included children were boys, compared with 50% in the excluded cases. Diagnoses of the included cases in each group are elaborated in Table 1. Of the excluded cases, five children in the ROM group were diagnosed with developmental and attention deficit disorders, and two with somatic

TABLE 1. Patients' Demographic and Clinical Characteristics

	ROM (n = 7)	TAU (n = 7)	Total (n = 14)
Age (mean, SD)	12.98 (2.28)	9.28 (0.95)	11.13 (2.55)
Sex, male	6 (85.71%)	5 (71.42%)	11 (78.57%)
Parent's marital status (% married)	5 (71.4%)	7 (100.00%)	12 (85.71%)
Primary diagnosis			
Pervasive developmental disorder	3 (42.85%)	3 (42.85%)	6 (42.85%)
ADHD	3 (42.85%)	3 (42.85%)	6 (42.85%)
Generalized anxiety disorder	1 (14.28%)	1 (14.28%)	2 (14.28%)
Comorbidity	5 (71.42%)	5 (71.42%)	10 (71.42%)
Total days in research, mean (SD)	177.07 (65.39)	182.72 (38.39)	179.90 (51.60)
Total number of sessions, mean (SD)	36.42 (23.37)	27.00 (4.04)	31.71 (16.84)

TABLE 2. Cramer's V Size Effect for the Differences in Number of Deteriorating Cases in Each Experimental Group (ROM/TAU)

	No. Deteriorating Cases		χ^2	Cramer's V Size Effect ^a	Cohen's Criterion (df = 1)
	ROM	TAU			
Anxiety (DSM-A)	1	3	1.40	0.31	Large
Working alliance with child's therapist (SAI)	0	2	2.33	0.40	Large
Parental distress (PSI)	3	4	0.06	0.07	Small
Parent-child interaction (PSI)	1	4	2.23	0.41	Large
Difficult child (PSI)	0	1	0.92	0.26	Medium

Notes: Cramer V was calculated on delta scores.

disorders, whereas in the TAU group, three children were diagnosed with developmental and attention disorders, and one with an anxiety disorder. From the overall number of items, parents in the ROM group completed 73.1% of the items, whereas parents in the TAU group completed 76.7% of the items.

Group Comparison

The frequency of deteriorating cases was calculated in both the ROM and TAU groups across all measured psychological constructs. The number of children showing a deterioration in anxiety symptoms was higher in the TAU group (n = 3) than in the ROM group (n = 1, Cramer's V = 0.31). Higher rates of deterioration were also reported in the level of alliance of parents with their children's therapist (n = 0 in ROM vs. n = 2 in TAU), parental distress (n = 3 in ROM vs. n = 4 in TAU), difficult child (n = 1 in ROM vs. n = 4 in TAU), and parent-child interaction (n = 0 in ROM vs. n = 1 in TAU). As can be seen in Table 2, the number of cases reporting deterioration was lower in all parameters.

Treatment Process Illustration: Comparison of Single Cases

To provide an in-depth exploration of the utilization of parent-based ROM, we describe the clinical course and associated vignettes of two children both suffering from generalized anxiety disorder. Case selection for the clinical demonstration was based on the common diagnostic theme and presenting problem, as both patients suffered from anxiety. All personal identifiers in the following clinical demonstrations have been removed or extensively disguised, so that patients are not identifiable and cannot be identified through the clinical description.

Case 1: Daniel (ROM)

Daniel is a 10-year-old boy who suffers from general anxiety. The psychologist who conducted the intake meeting believed that he would benefit from meeting other children his age who suffered from the same problems, and referred him to group therapy. Because of his anxieties, Daniel did not go to school and stayed at home with his parents. Daniel's mother completed the questionnaires every week. She would frequently stay after the group meeting and ask the therapist anxiously about Daniel's progress. Reviewing the mother's reports, the therapist noticed a further increase in her already high levels of distress. Often, the mother would approach the therapist at the end of the session and ask about her child's behavior: "How was he? Did he behave ok? Was he anxious?" The therapist noticed that the mother was often

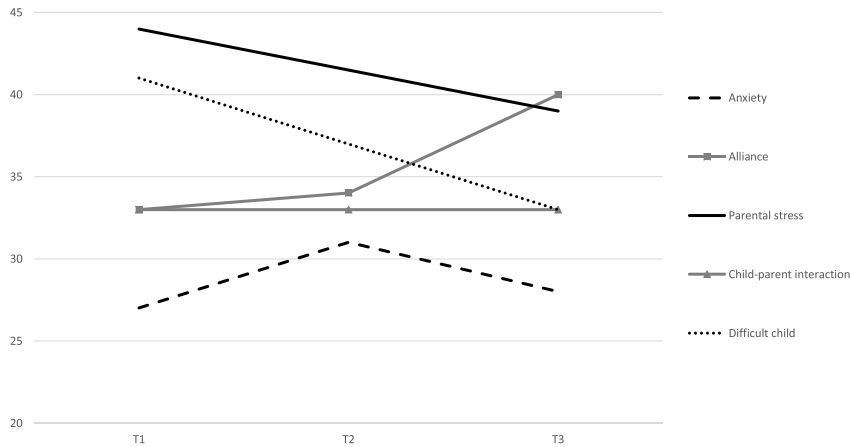


FIGURE 1. Changes in symptoms, alliance, and parental stress as reported by Daniel's mother (ROM case). Notes: Y-axis represents scale scores. Higher scores on the anxiety scale represent higher distress. Higher scores on the parental stress, child-parent (dysfunctional) connection, difficult-child, represent higher parental distress. Higher scores on the alliance scale represent better alliance of the parent with his/her child's therapist.

surprised to learn that the meeting went well and that her son communicated with other children. In telephone communications, the mother informed the therapist of Daniel's avoidant behavior and inability to socially adapt to new and unfamiliar situations. The mother's reports, as well as her behavior after and between sessions, indicated that her interpretations of her child's responses and behaviors were influenced by her own anxiety. Noticing this trend, the therapist began to approach Daniel's mother after the sessions to briefly reassure her. As therapy progressed, Daniel's mother started to report less parental stress and improvement in the alliance with the group therapist. Changes in symptoms, parental stress, and alliance with the therapist are plotted in Figure 1.

Case 2: Yotam (TAU)

Yotam is a 9-year-old boy who suffers from generalized anxiety and comorbid behavioral problems. Both parents seemed involved in the therapeutic process and stayed in touch with the therapist, but the therapist often noticed that Yotam's behavior during group sessions was deteriorating. After and between sessions, the parents reported many events of helplessness and frustration with their child. Although the parents did not report any dissatisfaction with the therapy, the therapist often wondered whether the sessions were helping Yotam to progress. In a brief discussion with the parents, they told the therapist that

“our son needs a protected social environment to see others and socially interact with them, and the group is the only place where we feel he gets what he needs.” In the parents' reports, no changes in anxiety symptoms were reported in Yotam's treatment, and alliance did not improve throughout the therapy. In addition, there was an increase in parental stress during treatment (Fig. 2).

Changes in Outcome and Process Measures

As can be viewed in Table 3, there was a reliable change in Daniel's scores on the parental alliance with the therapist, indicating an increase in the working alliance from pretreatment to posttreatment. A reliable change and movement from clinical to functional distribution was also noted in the difficult child index of the parental stress inventory, indicating that parents' perceptions of their child as being difficult improved from pretreatment to posttreatment. No reliable change of either improvement or deterioration was found in anxiety symptoms, or on the parental stress and child-parent interaction indexes of the PSI. On the other hand, Yotam's scores indicated a reliable deterioration in anxiety symptoms, with a reliable deterioration and movement from a functional to a dysfunctional distribution in the difficult child index of the PSI. No reliable change was detected in parents' alliance with

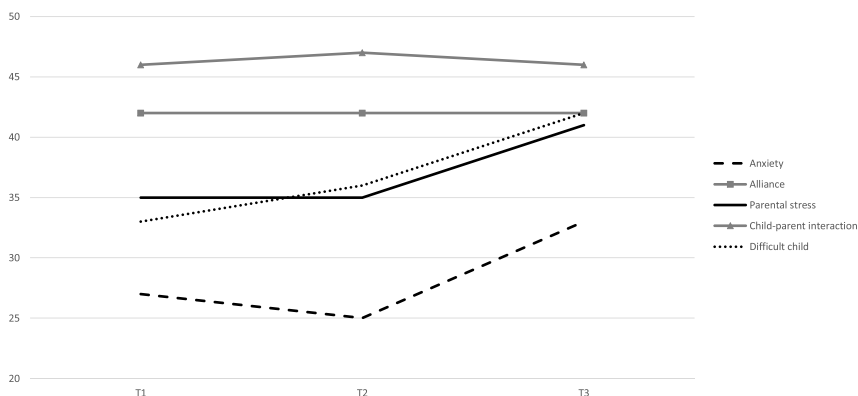


FIGURE 2. Changes in symptoms, alliance, and parental stress as reported by Yotam's mother. Notes: Y-axis represents scale scores. Higher scores on the anxiety scale represent higher distress. Higher scores on the parental stress, child-parent (dysfunctional) connection, difficult-child, represent higher parental distress. Higher scores on the alliance scale represent better alliance of the parent with his/her child's therapist.

TABLE 3. Mean Scores of Symptom Severity (Anxiety), Parental Stress and Process (Alliance) by Time of Measurement (Pretreatment, Midtreatment, and Posttreatment) in the Two Clinical Demonstrations Comparing ROM-Assisted Therapy (Daniel) Versus TAU (Yotam)

	Daniel (ROM)				Yotam (TAU)			
	t1	t2	t3	RCI	t1	t2	t3	RCI
Anxiety (PROMIS)	27.00	31.00	28.00	-0.22	27.00	25.00	33.00	-1.31 ^b
Parents' alliance with child's therapist (SAI)	33.00	34.00	40.00	-13.45 ^a	42.00	42.00	42.00	0.00
Parental stress index (PSI)	44.00	41.00	39.00	1.31 ^a	35.00	35.00	41.00	-19.29 ^b
Child-parent interaction index (PSI)	33.00	33.00	33.00	0.00	46.00	47.00	46.00	0.00
Difficult child index (PSI)	42.00	37.00	33.00	23.14 ^c	34.00	36.00	42.00	-20.57 ^d

Effect sizes were calculated between pretreatment scores (t1) and posttreatment scores (t3). ^aClinically significant change (improvement) according to Jacobsen and Truax (1991); RCI > 1.96. ^bClinically significant change (deterioration). ^cMovement from dysfunctional to functional distribution. ^dMovement from functional to dysfunctional distribution.

their child's therapist, or in parental stress or child-parent interaction indexes of the PSI.

DISCUSSION

Using empirical data as well as clinical illustrations, we found indications for a potential beneficial effect of parent-based ROM in reducing rates of deterioration, and in addressing parents' concerns and distress associated with their child's clinical state. Specifically, the current study illustrates reduced rates of deterioration in the child's anxiety, in parents' alliance with their children's therapists, and in parental stress, compared with usual care. The scope of empirical evidence supporting the utilization of ROM in child and youth psychotherapy is limited, a gap that is especially pronounced when compared with the accumulating evidence on ROM in adult psychotherapy. A number of studies reported several barriers to the implementation of ROM in children and adolescents, which might account for this gap, such as clinicians' concerns regarding the added strain in using ROM, the fear of criticism (Norman et al., 2014), and parents' concerns that clinicians might use the feedback to cease treatment (Moran et al., 2012). Nonetheless, studies also indicate that parents value the option of expressing their opinions (Batty et al., 2013), and also collaborate more intensively with routine monitoring when having a stronger alliance with their children's treating staff (Lamers et al., 2015). These findings highlight the potential benefits of acquiring feedback from parents of children participating in psychotherapy, as well as the importance of forming an alliance not only with the child but also with his/her accompanying parent.

Most studies assessing the effect of ROM in child and youth mental health have used parental feedback as complementing the child's report. For example, Bickman et al. (2011) assessed the effect of feedback when provided by youths, caregivers, and clinicians, and found that when clinicians received integrated weekly feedback, their young patients improved faster than did youths treated by clinicians who did not receive feedback. On the other hand, Shechtman and Sarig (2016) assessed the effect of children's and adolescents' feedback on therapy outcomes with no parental feedback, and found that feedback had no effect on symptom reduction, the level of alliance, or bonding with the group therapist. In a recent systematic review assessing the effect of client feedback in psychological therapies for children and adolescents with mental health problems, the authors concluded that there is currently insufficient evidence to reach any firm conclusions regarding the role of ROM in children's mental health and that additional research on this important topic is still needed (Bergman et al., 2018). Although these findings indicate that parental feedback might be an important element in facilitating therapeutic processes using ROM, there have been very few studies that focused exclusively on the effect of parental feedback in the context of the child's psychotherapy and even fewer that

addressed the effect of feedback in early childhood. This gap is especially pronounced in low-income areas and public mental health services, where children often receive psychotherapy without accompanying parental guidance.

The results of the current study indicate that parents in the ROM group reported less deterioration across all of the evaluated outcome measures compared with parents in the TAU group. These findings support previous studies aimed to assess the effects of implementing ROM in children's routine care (Lamers et al., 2015; Tzur Bitan et al., 2018a, 2018b). The clinical case studies further illustrate how parental feedback can be utilized not only for monitoring patients' progress but also as a means of communication with children's parents, who are known to be important agents of therapeutic success (Liber et al., 2008). The clinical trajectory presented in the case reports demonstrates that Daniel's mother was able to communicate and approach the therapist more easily compared with Yotam's mother, and that the brief encounters outside of the therapy session enabled her to be reassured about her child's progress. On the other hand, Yotam's parents were less communicative with the therapist and were not able to take advantage of the brief encounters with the therapist. These changes can complement and explain observed changes in the clinical dynamics during child psychotherapy (Halfon et al., 2019), and possibly reflect on the patient-therapist dynamics. Thus, the use of ROM in child and adolescent psychotherapy may enable therapists to detect a loss of communication with parents, recognize possible gaps in the therapists' and parents' views of the child's symptoms, and possibly ameliorate parental stress and its negative effects on the child.

The current study has several clinical and empirical implications. The use of ROM with children and adolescents may benefit from reformatting feedback with the aims of not only monitoring the therapy process but also using it as a tool to communicate with and engage parents in collaborative efforts to help their children overcome their problems. Parents often wonder what is going on in their children's therapy. At times, they feel neglected and excluded from the therapist-patient dyad (Shyu et al., 2010). The advantage of routine monitoring in this regard lies in the ability to provide a sense of belonging to the children's parents, by requesting that they report their children's progress as well as their own. These reports can be subsequently used to inform the therapists of the parents' views and perceptions of therapy progress, and affect the clinical decisions made when communicating with the parent. These potential beneficial effects should be further explored.

This study has several limitations. Due to the small sample size, formal statistical testing could not be performed. Therefore, we relied on measures of effect size and the reliable change index, which represent common ways to evaluate the feasibility of an effect in mixed-methods psychotherapy studies (Gaudiano et al., 2015; Neto et al., 2015; also see Bartholomew and Lockard, 2018, for an extensive review). As this study was aimed to primarily exemplify the clinical

advantages of parent-based ROM, the interpretation of the differences in the outcome measures across the two groups should be interpreted with caution, while taking the known limitations of statistical power and type 2 errors into account. Due to the sample size, significant baseline differences between groups could not be reliably assessed. Although the study participants were randomized to the study groups, a review of the descriptive information of the study groups reveals some differences in age and number of sessions, and no differences in sex and main diagnoses. Furthermore, this study did not evaluate completion rates and differences between dropouts and completers, which could have resulted from parents' inability to fit the therapy into their time schedule, or the necessary patience for completing the assessments. Thus, the possibility of a differential rate of completion cannot be ruled out. As baseline differences and differential completion rates could potentially affect the results, additional studies are needed to establish the effect of parent-based ROM while controlling for such differences. Although the case reports enabled an in-depth investigation of potential therapeutic processes, the selection of cases based on the primary diagnosis may have created a problem with generalization. Although this problem is common in case report studies, this limitation should be taken into account. Furthermore, although random reassuring interactions between Daniel's therapist and his mother were at least partially facilitated by the feedback reports, these interactions can also be attributed to parents' characteristics, which can in turn produce differential results in the study groups. Future studies should assess the effect of parent-based ROM while controlling for such differences. Although the study employed a randomized control design, the possibility of nonrandom attrition should be taken into account when interpreting our results. Patient-reported outcomes were not collected in the present study, and future studies should assess possible discrepancies between parents' and children's reports. Finally, future studies are needed to assess the effect of monitoring parents' stress and bonds with the children's therapists, and with the children themselves, on the children's outcomes.

CONCLUSIONS

This study demonstrates the potential of ROM as a tool for communicating with parents, who are known to be important agents of therapeutic success. As ROM has been previously utilized primarily to inform therapists of patients' reports of therapy progress, the novelty of the study is reflected in the possibility of utilizing this platform for parents' reports of their child's progress as a proxy to facilitate therapy. The initial findings reported in this article demonstrate that parents participating in ROM-facilitated psychotherapy reported lower rates of deterioration in child's anxiety, parental stress, and quality of parent's alliance with therapist. These changes can be attributed to the therapist's response to their weekly reports. Future studies employing a larger sample size should further explore the clinical and empirical utilization of ROM as a means of communicating with parents, and further attest to its effect on psychotherapy process and outcome.

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DISCLOSURE

The authors declare no conflict of interest.

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