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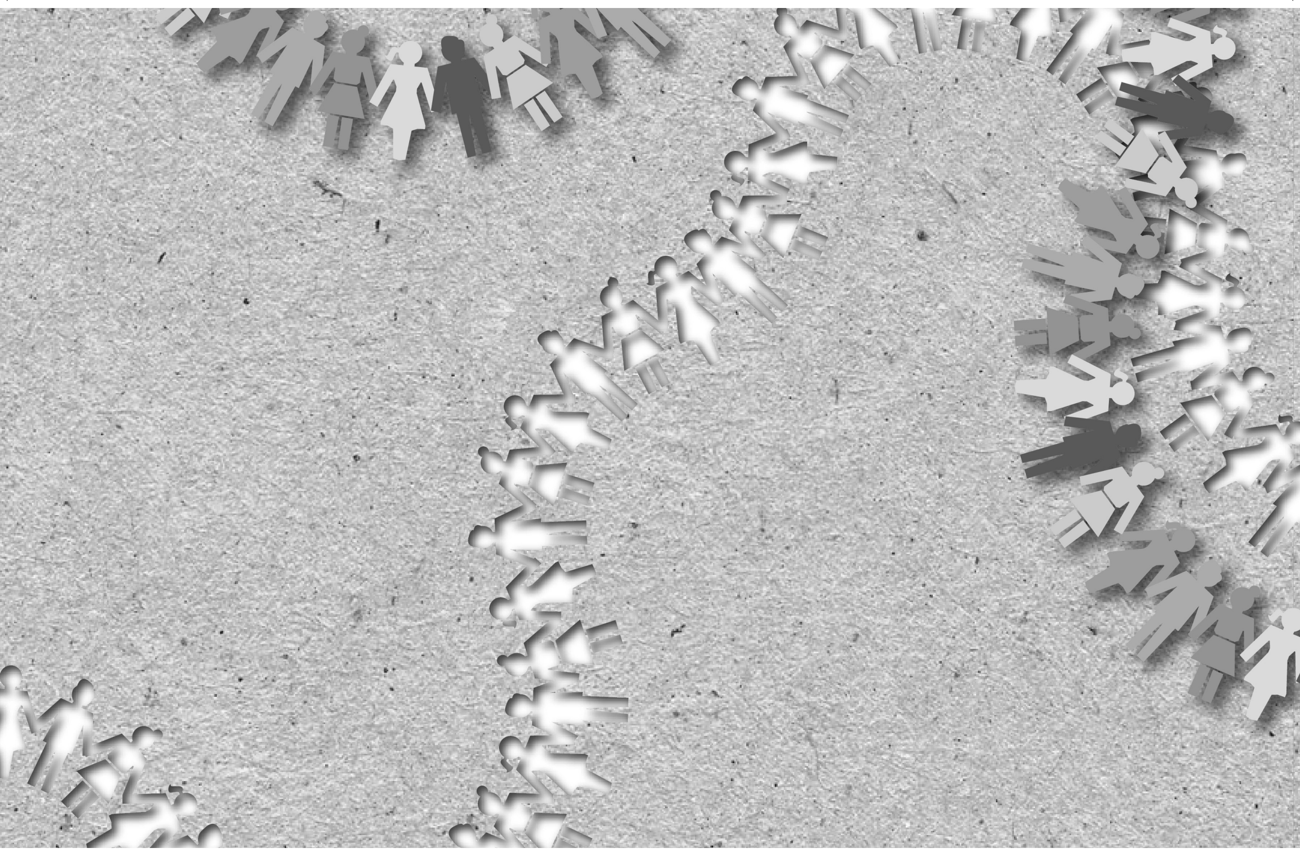

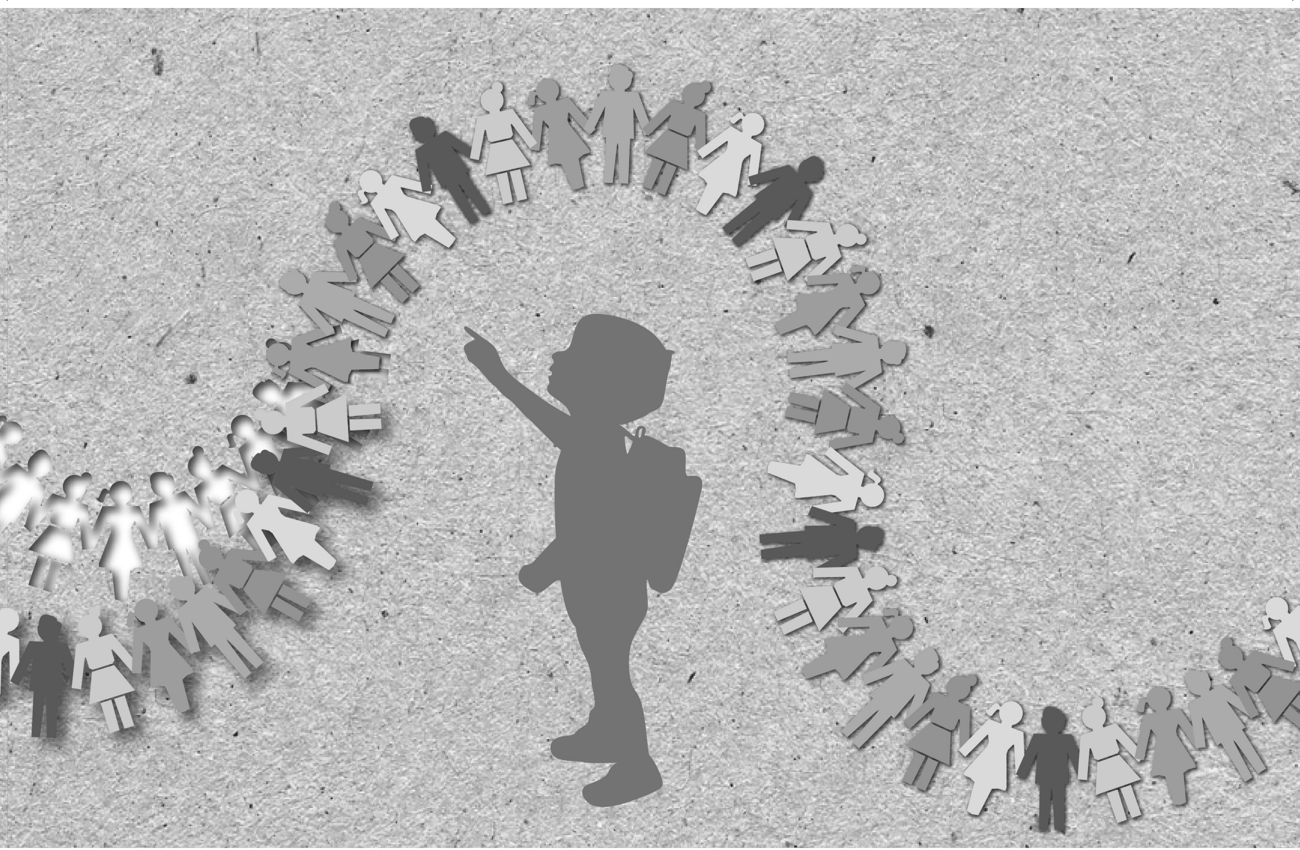

General Introduction

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Parents are increasingly viewed as key to successful child (semi-) residential treatment. There has been a drastic change in the way parents are involved during psychiatric hospitalization of their child. In the eighties, from a psychoanalytic perspective, parents were not allowed to see their child the first weeks and the contact between the team and parents was minimal, with the idea behind it that negative interaction chains needed to be broken (Verheij & Van Loon, 1989). Parents were often held partly responsible for the psychiatric problems of the child (Harper, Cotton, & Sederer, 1991), leaving them behind with extreme feelings of guilt. The authority of the clinicians was often leading, with them being fully responsible for the treatment of the child. Already in 1979, however, Robertson and Friedberg (1979) stated that adverse family circumstances change less during psychiatric hospitalization than the child's symptoms do. Team members mentioned in interviews that without involvement of the parents little progress can be achieved with children (Scharer, 1999). The parent-treatment team relationship in a (semi-) residential setting is a therapeutic contact that needs attention, according to Christ and Griffith (1965).

Abstract Christ and Griffith (1965)

Pathological interactions of parents with their hospitalized child easily can be enhanced by untherapeutic contact between nurse and parent. Goals should include keeping parents informed and actively involved in their child's hospitalization, clarifying and modifying current tension-producing interactions. This leads to faster progress of parents in psychotherapy, cooperation with therapeutic efforts with the child and a better understanding of the parent-child interactional patterns.

Positive outcomes for both the parents as the child with a psychiatric disorder are more likely to occur when effective levels of therapeutic alliances exist between team members and parents. Unfortunately, it remains unclear from the literature, how the establishment of the parent-treatment team alliance best contributes to child residential treatment outcome. Therefore, a more systematic approach is needed to help practitioners in making optimal use of the parent-team therapeutic alliance during child psychiatric residential psychiatry.

Child (semi-) residential treatment

It was not until the 1970s before day and inpatient treatment became an integrated part of child- and adolescent (here after youth) psychiatry in The Netherlands (Coole & Jansma, 1986). A diversity of names are used in the literature for day and inpatient psychiatric treatment, such as psychiatric hospitalization and residential psychiatry. In this current paper the term, (semi) residential psychiatry, is used for a multimodal treatment intervention, offered within an Institute for Youth Psychiatry by a multi-Professional team, which children with psychiatric disorders attend for at least 3 days a week till a week long overnight stay. There has been a rapid increase in the number of children in (semi-) residential psychiatric treatment in The Netherlands. The amount of treatment days doubled from 317 thousand in 1993 to 647 thousand in 2009 for residential settings and even increased six fold from 51 thousand to 333 thousand for semi-residential settings (van Dijk, Knispel, & Nuijen, 2011). The current political and clinical climate advocates, these days, diminishing (semi-) residential units and shortening its treatment lengths. Insufficient scientific knowledge exists about the most effective residential treatment factors, which can support clinical practice in their task to effectuate (semi-) residential psychiatric treatment.

Research in youth psychiatric (semi-) residential settings lags far behind on research in outpatient settings (Curry, 2004; De Jonge, De Beer, Van Oortmerssen, & Doreleijers, 2003; Knorth, Harder, Zandberg, & Kendrick, 2008). One factor contributing is that treatment content in youth residential psychiatry is often described as a “black box”, as multiple team members are involved and the target group is heterogeneous according to the severity and complexity of the problems (Knorth et al., 2008). There are little treatment manuals available and treatment is often a multidisciplinary tailor made process. Another factor contributing are the methodological challenges mentioned for (semi-) residential settings like the lack of a control group, low response rates and small sample sizes (Blanz & Schmidt, 2000; Gavidia-Payne, Littlefield, Hallgren, Jenkins, & Coventry, 2003; Green et al., 2001; Setoya et al., 2011).

Only one systematic review on psychiatric residential treatment was written fifteen years ago (Blanz & Schmidt, 2000). Blanz and Smith (2000) concluded in this review that psychiatric hospitalization is often beneficial for youth, especially when certain aspects of treatment are fulfilled, like a therapeutic alliance, cognitive-based problem solving skills or a planned discharge. About the same time, a review on semi-residential treatment was written by Schimmelman and colleagues (2001). The treatment

form was found to be effective for a broad range of disorders and the impact of parental involvement was emphasized (Schimmelmann et al., 2001). In the following years, a handful of outcome papers were published on youth psychiatric (semi-) residential treatment (Gavidia-Payne et al., 2003; Green et al., 2007; Green et al., 2001; Mayes, Calhoun, Krecko, Vesell, & Hu, 2001; Remschmidt & Mattejat, 2006; Setoya et al., 2011), confirming the effectiveness of residential psychiatry for youths. Residential psychiatry appears to be an indispensable form of treatment for a specific target group. Therefore, more research into its effective elements is necessary, in particular given the current tendency of policy to invest only in evidence based programs. One promising effective treatment factor in youth (semi-) residential settings is the parent-team therapeutic alliance (Green et al., 2007; Green et al., 2001; Kabuth, De Tychey, & Vidailhet, 2005).

Therapeutic alliance

Therapeutic alliance has consistently shown to be a strong predictor of youth therapy outcome across theoretical orientations, presenting problems, and modes of treatments (McLeod, 2011; Shirk, Karver, & Brown, 2011). The concept of the therapeutic alliance is rooted in Freud's psychodynamic theory of a positive relationship between the therapist and his client (Freud, 1914). The first theoretical framework around therapeutic alliance was formed by Bordin (1979), describing three components: the affective bond, mutual agreement on tasks and goals of the therapy. Hougaard (1994) provided the most coherent and recent model until now, based on an empirical review, in which the therapist and client contribute to a 'personal alliance', referring to interpersonal aspects, and a 'task alliance', which involves agreement on diagnoses, goals and treatment planning. Alliance was considered to be a factor that facilitated positive treatment outcomes through an unconscious intrapersonal process of change (Horvath, 2006).

Notwithstanding these thorough conceptualisations, the study of alliance, like that of other treatment process variables, is fraught with complexity (Green, 2009). Different researchers recently argued that most of the work on alliance may be essentially methodologically flawed (Dunn & Bentall, 2007; Elvins & Green, 2008). First of all, the concept of the therapeutic alliance is distorted as it is transposed from one clinical context to another in which often the same research instruments are used (Catty, 2004). Secondly, as the alliance is regarded as an explanatory variable in outcome studies, research is needed to confounding or related factors, such as motivation, engagement,

adherence, therapist and patient characteristics. Last, alliance as a process factor is measured mostly as a fixed factor at the start or end of treatment instead of longitudinally. Longitudinal research seeking to understand the alliance -outcome relationship would help to better inform practice (Bickman et al., 2012; Hawley & Garland, 2008; Shirk et al., 2011). If the therapeutic alliance concept is to fulfil its potential as a process variable in studies of complex treatment, it will have to meet the conceptual and measurement challenges.

The parent-team alliance in youth (semi-) residential psychiatry

The construct of the parent-team therapeutic alliance differs from the therapeutic alliance in a psychotherapy setting. In youth residential psychiatry, there are multiple alliances; they exist among the multidisciplinary team, children and their parents (Kroll & Green, 1997). Furthermore, these alliances have mutual influencing effects and shift as treatment progresses. Kroll and Green (1997) tried to capture these complex alliances in the (semi-) residential clinical practice in the model formulated in Figure 1. Punctuated are the different roles that team members fulfil towards children, parents and peers, like therapeutic, collaborative and parenting roles. By conceptualising therapeutic alliances as interconnected in (semi-) residential settings, Kroll and Green (1997) made an important first step. The next step would be to examine if Hougaard's (1994) components of 'task' and 'personal' alliance are also related to the construct of the therapeutic parent-team alliance. The distinction between different elements of the alliance might be essential to create insight to their relation to treatment outcome factors. As we cannot assume equivalence between the psychotherapeutic alliance and the parent-team therapeutic alliance, there is a need to conceptualize the construct of the parent-team alliance and thoroughly examine adjusted instruments. Two alliance instruments are relevant in this respect. The first is the Family Engagement Questionnaire (Kroll & Green, 1997), which was specifically developed in the United Kingdom to measure alliance in a (semi-) residential setting. The second is an adjusted version of the Working Alliance Inventory-12 (Stinckens, Ulburghs, & Claes, 2009; Vertommen & Vervaeke, 1996), which is the alliance instrument most widely used in adult empirical research (Ross, Polaschek, & Wilson, 2011). As the parent-team alliance is considered by clinicians as a crucial factor related to treatment outcomes (Gross & Goldin, 2008; Scharer, 2000), it is a necessity to psychometrically examine alliance instruments.

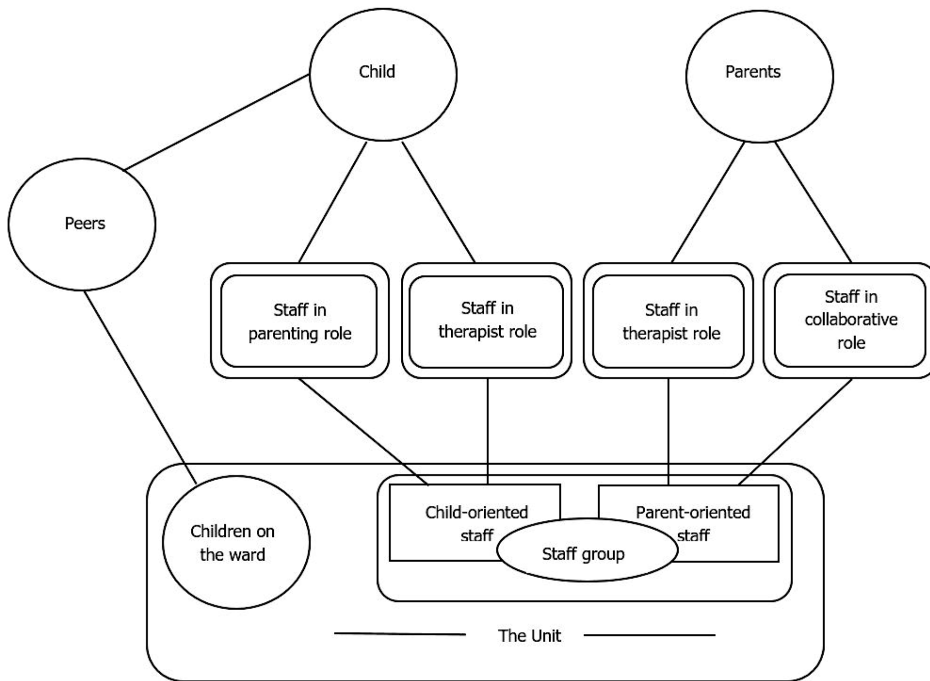

Figure 1 Model of therapeutic alliances in (semi-) residential psychiatry (Kroll & Green, 1997).

Parent-team therapeutic alliance building in child (semi-) residential psychiatry

Forming a strong parent-team alliance in a (semi-) residential setting is more challenging, than forming an alliance in outpatient treatment. The more clinicians involved, the more complicated to form strong alliances. In addition, more disturbed patients have poorer alliances (Horvath & Bedi, 2002). Children in residential treatment rate the alliance less positive than outpatients, suggesting poorer alliances in this group (Munder, Wilmers, Leonhart, Linster, & Barth, 2010). As the intensity of treatment increases from outpatient to (semi-) residential, corresponding to an increased complexity of the psychiatric disorders, difficulties in alliance formations also increase (Byers & Lutz, 2015). Furthermore, a long history of care often precedes the admission process, with several disappointments, which will influence parents' trust in the new treatment team (Scharer, 2000). Parents of children admitted to (semi-) residential treatment experience high levels of stress, which might have an impact on the parent-team therapeutic alliance (Geraghty, McCann, King, & Eichmann, 2011). How the child's symptoms and parental stress influence the development of the parent-team alliance in a (semi-) residential setting stays unclear from the literature.

A structured investment of team members in the parent-team alliance in (semi-) residential psychiatry is likely to improve treatment effectiveness. Alliance building has only been investigated in youth outpatient and in adult settings (Byrne & Deane, 2011; Creed & Kendall, 2005; Diamond, Liddle, Hogue, & Dakof, 1999; Flückiger et al., 2012; Jungbluth & Shirk, 2009; Karver et al., 2008). Although the literature on parent-team alliance building in (semi-) residential psychiatry is primarily descriptive (Brown, Parker, McLeod, & Southam-Gerow, 2014; Ford, Davenport, Meier, & McRee, 2011), it provides substantial guidelines for clinicians. A next important step would be to investigate their effectiveness on the outcome of (semi-) residential treatment.

Routine Outcome Monitoring

Implementing Routine Outcome Monitoring (ROM) might be beneficial especially for a (semi) residential setting. Routine Outcome Monitoring (ROM) is the assessment of treatment outcomes at regular intervals in order to monitor clients' progress during treatment (de Beurs et al., 2011). First of all, ROM might be an effective strategy to build stronger parent-team alliances in semi-residential psychiatry. Research with adults showed that when a measure of the therapeutic alliance is used in conjunction with an outcome scale, clients are twice as likely to achieve a change of clinical significance (Whipple et al., 2003). ROM provides feedback to clinicians, parents and children on process and outcome factors, which will help them to assess and redirect the treatment. Secondly, a system of integrated routine measurement helps to address the methodological challenges of a (semi-) residential setting. It provides longitudinal assessments of large samples, making sound empirical research possible. Despite these benefits, the implementation of ROM in (semi-) residential settings is hindered by the multiple participants and heterogeneous target group. More in general ROM implementation has appeared to be complicated; ROM in daily clinical practice is seldom realized in The Netherlands (Delespaul, 2015). Already in 1988, Ellwood proposed routine and frequent assessment of patients' health and suggested to build large databases from these data (Ellwood, 1988). While the importance of ROM is widely recognized, ROM implementation in The Netherlands seems to get stuck between fulfilling benchmarking goals and keeping its original goal of being clinically relevant (Delespaul, 2015). In a child semi-residential setting, careful approaches to ROM implementation need to be developed in a strong collaboration with clinicians and parents.

Aim of the present study

The aim of this thesis is threefold: 1. Development of assessment strategies (instru-

ments) of the parent-team alliance, 2. Longitudinal investigation of the relation between parent-team therapeutic alliance and semi-residential treatment outcome factors and 3. Examining the effect of strengthening the parent-team alliance on (semi-) residential treatment outcomes. The studies described contribute to these aims by examining the:

1. Psychometric qualities of a translated version of the Family Engagement Questionnaire.
2. Cross-informant agreement between different team members.
3. Psychometric qualities of an adjusted version of the WAV-12.
4. Development and implementation of a ROM system.
5. Parents' completion rates of questionnaires during the use of a ROM system.
6. Longitudinal relation between parent-team alliance, parental stress and child's symptoms.
7. Effect of strengthening the parent-team alliance.

Study sample and design

Routine Outcome Monitoring was implemented at five semi-residential treatment units of Curium-LUMC, a Centre for Child and Adolescent Psychiatry. All newly admitted children and their parents, 46 children (6-12 years old) in total, between April 2011 and December 2012, were included in the ROM assessment. One client referred to one of these treatment units was excluded due to insufficient knowledge of the Dutch language. With three month intervals multiple team members and both parents completed ROM questionnaires, which included: Dutch versions of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001; van Widenfelt, Goedhart, Treffers, & Goodman, 2003), Health of the Nation Outcome Scales (HoNOSCA; Gowers et al., 1999), Working Alliance Inventory revised short form (WAV-12R; Stinckens et al., 2009), Parenting Stress Questionnaire (PSQ; Vermulst, Kroes, De Meyer, Nguyen, & Veerman, 2012), Empathy and Understanding Questionnaire (EUQ; Kroll & Green, 1997) and Family Engagement Questionnaire (FEQ; Kroll & Green, 1997). Participants involved in the studies of this thesis are mothers, fathers, licensed clinical psychologists, parent counselors, former teachers and group workers.

As one important goal of this thesis is studying the effect of alliance building strategies, an AB-study design was applied for these 46 children out of the ROM study.

Table 1 *Overview of the study Sample and Design*

Semi-residential ROM sample						
Assessment	Time in treatment	*M(SD)* Length of treatment	N	*M(SD)* Age at admission	Of which girls	Of which Control Group
T0	Before intake	322 (116)	46	8.9 (1.6)	9	24
T1	After 6 weeks		46			24
T2	3-4 Months		45			24
T3	6-7 Months		39			22
T4	9-10 Months		33			19
T5	12-13 Months		20			12
T6	15-16 Months		5			4
FU	One month FU		46			24
Additional (semi-) residential sample for factor analysis						
Assessment	*M(SD)* days in treatment		N	*M(SD)* Age at admission	Of which girls	Of which Residential
T random	517 (198)		41	11.7 (3.7)	8	17

Note. FU: Follow Up; At T0 only outcome was assessed, at T1 only alliance.

In Stage A the first 24 of these 46 children, received treatment as usual. Then team members were trained in alliance building strategies. In Stage B, for the next 22 of the 46 children, team members applied these strengthening strategies.

For the purpose of factor analysis of the questionnaires this sample of 46 children was enlarged with an additional 48 children. Parents and team members of six other semi-residential and residential units at the same psychiatric centre, where asked to fill out the alliance questionnaires at a random time point in the treatment. For 40 children one of the participants filled out the FEQ and for 41 children one of the participants filled out the WAV-12R. See for the overview of the study Sample and design Table 1.

Outline of this thesis

This thesis focuses first on the development of optimal assessment procedures of the parent-team alliance in child (semi-) residential psychiatry. Two psychometric studies are described, which were based on the fourth month ROM assessment (T2) of the ROM sample and the random assessment of the additional sample (T random FEQ/WAV-12R).

In Chapter 1 the psychometric properties of the Dutch version of the Family Engagement Questionnaire (FEQ) was examined with explorative factor analyses and reliability and concurrent validity assessment. The FEQ assesses the youth-team and parent-team alliance from the perspective of team members. In addition, agreement among team members' perspectives on the therapeutic alliance was explored.

Chapter 2 dives deeper into the specific conceptualization and routine assessment of the parent-team alliance in the youth semi-residential setting. The psychometric properties, including factor structure and validity of the subscales, were explored of the Working Alliance Inventory-Short Version (WAV-12R). This widely used alliance instrument was adjusted to assess parent-team alliance from both a parent and team perspective within a youth residential setting.

Next, in Chapter 3 a Routine Outcome Measuring system is introduced for the child (semi-) residential setting. The ROM sample and completion rates of ROM participants were described. As participants' engagement, especially of parents, in Routine Outcome Monitoring (ROM) has shown to be difficult, predictors associated with low completion rates of questionnaires by parents were identified.

Chapter 4 is based on five assessment times (T0/T1, T2, T3, T4, T5) of the ROM sample, investigating the longitudinal relation between the parent-team alliance, parental stress and child's symptoms during child (semi-) residential admission. Parents of children with severe psychiatric disorders often experience high stress levels, which might impact the formation of the parent-team alliance.

In Chapter 5 we studied strategies derived from the literature to strengthen the parent-team alliance. A thorough description was given of the training of team members in these strategies and warranting the treatment integrity. The AB-design, with a control and experimental group was used, to explore the effect of these strategies on the strength of the therapeutic alliance and child's symptoms.

Finally, the results found in previous chapters are summarized, strengths and limitations are addressed, and findings are overall discussed. Given that this study was conducted in a challenging treatment setting, a special focus is given on the clinical implications and integration of our findings, as well as directions for future research.