
Implementing Group Parent Training in Telepsychology: Lessons Learned During the COVID-19 Pandemic

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Data from Children’s Hospital of Philadelphia (CHOP) were collected and managed using Research Electronic Data Capture (REDCap; [Harris et al., 2009](#)) electronic data capture tools.

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Abstract

Objective We recently transitioned from in-person delivery of a brief behavioral parent intervention to telepsychology delivery to meet families’ needs during the COVID-19 pandemic. In this topical review, we describe how we used treatment fidelity as a guiding principle to orient adaptations for telepsychology, as well as preliminary findings and early lessons learned in this implementation. **Methods:** Using rapid-cycle quality improvement methods, we adapted a brief parent training group (Bootcamp for Attention-Deficit/Hyperactivity Disorder; BC-ADHD) to three groups of caregivers (i.e., 5–7 families) of school-aged children with ADHD ($n = 20$; 85% males). Families were from the following ethnic backgrounds: 75% White non-Hispanic, 15% White Hispanic, and 10% Black. Clinicians completed measures on their implementation experience. Observers completed measures on content/process fidelity and attendance. Caregivers completed measures on demographics, treatment satisfaction, and telepsychology experience. **Results** Telepsychology BC-ADHD can be implemented with comparably high levels of content and process fidelity and treatment satisfaction to in-person groups; and it appears to be feasible and acceptable to caregivers. Caregiver and clinician qualitative feedback revealed themes of appreciating the convenience of telepsychology, while experiencing some challenges in relating to others and sharing over video. **Conclusions** When treatment fidelity is used as a guiding tool, telepsychology parent training groups can be delivered with high fidelity and appear to be acceptable and feasible to caregivers and clinicians. Future research using larger and more diverse samples, multimethod and multi-informant measurement approaches, and controlled designs is needed to further assess the generalizability and efficacy of telepsychology parent training groups.

Key words: ADHD; attention; evidence-based practice; hyperactivity; parent stress; parenting.

Introduction

The public health constraints necessitated by the COVID-19 pandemic and availability of digital technology have recently impelled a *rapid* expansion of telepsychology offerings (Patel et al., 2020). Adapting interventions for telepsychology is a promising strategy to support families in this time of substantial need (Stiles-Shields et al., 2020; Wosik et al., 2020). As pediatric psychologists and co-investigators in a multisite pilot study evaluating a brief group behavioral intervention for caregivers of children with newly diagnosed Attention-Deficit/Hyperactivity Disorder (ADHD), we encountered the dilemma of offering the intervention under these unusual circumstances. Given physical distancing requirements and guidance that telepsychology approaches might enhance access to care (DuPaul et al., 2020), we transitioned from in-person delivery to telepsychology following a rapid-cycle quality improvement (RCQI) approach (Schurman et al., 2015). In this topical review, we describe how we used treatment fidelity to guide adaptations, as well as our preliminary findings and lessons learned.

Behavioral parent training (BPT), provided individually or in groups (Daley et al., 2018), is an evidence-based intervention for children with ADHD (Evans et al., 2018). Preliminary evidence supports the efficacy of telepsychology delivery of individualized BPT. Promising approaches have included (a) the use of webinars and other parent-paced learning tools (DuPaul et al., 2018) and (b) individualized therapy using telepsychology (Gurwitsch et al., 2020; Sibley et al., 2017). Recent research has further illustrated that individualized BPT can be delivered effectively in other populations experiencing similar needs (e.g., parenting-related stress, Riegler et al., 2020; family adjustment to neurological conditions, Wade et al., 2020). Emerging evidence also supports implementation of group parenting interventions using telepsychology (Reese et al., 2015; Xie et al., 2013). However, these studies have not formally measured or used content and process fidelity to guide the telepsychology adaptations. By using treatment fidelity as a guiding principle to preserve the intervention's essential components, our approach may offer useful directions for research and practice in pediatric psychology.

Using Treatment Fidelity to Guide Adaptations for Telepsychology

Bootcamp for ADHD (BC-ADHD), a brief (four-session) in-person group intervention for caregivers of children ages 5–11 newly diagnosed with ADHD, includes components of BPT, motivational interviewing, and supportive therapy to promote family engagement in follow-up treatment (Nissley-Tsiopinis, Mautone, & Power, 2012). In March 2020, we were

in year 2 of a multisite pilot study of BC-ADHD when physical distancing orders led us to transition to telepsychology. We employed RCQI methods to deliver BC-ADHD using telepsychology and electronic methods to evaluate the program. Our transition raised important questions: Can telepsychology parent training groups be delivered with high quality (i.e., fidelity); and how acceptable and feasible are these for caregivers and clinicians?

When transitioning to telepsychology, we sought to maintain a balance between content and process fidelity. Treatment fidelity provides a foundation from which clinicians can monitor and enhance the implementation of interventions. Power et al. (2005) defined fidelity as a multidimensional construct that subsumes the content (how *much* of the treatment is delivered) and process (how *well* the treatment is delivered) of an intervention. Overemphasizing content would result in didactic lectures, minimizing opportunities for participant self-discovery and self-empowerment; whereas overemphasizing process would deprive caregivers of knowledge they need to advocate for their children and navigate complex healthcare and educational systems. In planning for telepsychology groups, we endeavored to promote fidelity to the five core therapeutic processes that we consider key to BC-ADHD: (a) keeping caregivers focused on foundational principles and evidence-based practices, (b) encouraging active caregiver engagement, (c) providing emotional validation, (d) eliciting and strengthening change talk, and (e) building connections among caregivers.

In addition to the fidelity with which an intervention is delivered, family engagement or *responsiveness* (Carroll et al., 2007) and treatment satisfaction are important considerations. Table I provides definitions, implementation challenges, and recommended adaptations for group telepsychology to maximize fidelity, engagement, and satisfaction. For example, anticipating that it might be more difficult to engage quiet families in telepsychology, clinicians asked caregivers' permission to call on them at the beginning of group, identified non-verbal reactions to other caregivers' comments, and prompted others to respond. Additional adaptations included shortening sessions from 90 to 60 min in some groups due to caregiver feedback; highlighting key points and referring families to handouts for further details; and informing families that we would be available after session if they wanted additional time to speak with us or each other (two families utilized this option).

Preliminary Findings and Lessons Learned

Our team implemented BC-ADHD in a telepsychology format to three groups of caregivers of a total of 20

Table I. *Adapting Parenting Interventions for Group Telepsychology Using Process Fidelity: The Example of Bootcamp for ADHD (BC-ADHD)*

Process construct	Brief definition	Implementation challenges	Recommended adaptations
Keeping parents focused on foundational principles and evidence-based practices	<ul style="list-style-type: none"> Refocusing off-topic discussions, including when caregivers suggest something that would be contraindicated (e.g., pro-corporal punishment) 	<ul style="list-style-type: none"> Distractions during telepsychology (e.g., emails/texts, phone calls, other family member intrusions) are greater than for in-person groups Distracted caregiver may only “half-listen” to the group discussion and unintentionally respond in a way that is off-topic or disruptive Difficulty supporting family organization of group materials 	<ul style="list-style-type: none"> Ask caregivers to (a) use a quiet and private room, (b) limit involvement in other activities, (c) focus on group interactions, (d) use a large and stable screen to see all group members, (e) connect with audio and video if possible, (f) use earphones to prevent feedback sounds, (g) turn off their own mirror video to prevent unneeded distractions, (h) mute their speaker unless they talk to the group, and (i) if available, use the Raise Your Hand function to request the right to talk Clarify and amplify key communications to ensure mutual understanding and keep caregivers focused
Encouraging parents’ active engagement	<ul style="list-style-type: none"> Using open-ended questions, affirmations, reflections, and summaries to encourage caregiver engagement; adapting material to individual caregiver situations 	<ul style="list-style-type: none"> Challenges with distributing handouts and other materials could lead to less parental engagement in group Limited ability to respond to non-verbal communication could result in clinicians inadvertently adopting a more prescriptive and less engaging approach Chat and Q&A functions imply delayed question and answer—and one speaker at a time—further limiting engagement 	<ul style="list-style-type: none"> Send handouts to caregivers in advance electronically Use screen sharing/whiteboard to highlight key information, give homework, and facilitate discussion Scan caregivers for non-verbal responses and call on caregivers based on non-verbal reactions Ask caregivers’ permission to call on them when they are quiet and then do so once permission is received Reflect caregiver responses even more frequently to keep families engaged Divide content into segments and provide introductory content for each specific segment to generate interest/engagement Ask caregivers to avoid using Chat and Q&A functions
Providing emotional validation	<ul style="list-style-type: none"> Providing social support, emotional reassurance, or validation of parents’ feelings 	<ul style="list-style-type: none"> Many body language indicators of active listening and eye contact are challenges to perceive online Attention to individual group members’ emotions and non-verbal cues requires more effort Bandwidth problems may reduce opportunities for validation 	<ul style="list-style-type: none"> Take advantage of the increased ability to identify facial expressions online when using the “Speaker view,” if available Scan participants’ reactions and emotions as other participants are talking; name and validate reactions as they are noticed Periodically look at clinician camera to improve perceived eye contact by all members, especially when validating participant emotions
Eliciting and strengthening change talk	<ul style="list-style-type: none"> Affirming parents’ desire, ability, reasons, and need for change (e.g., accepting their child’s diagnosis or treatment) 	<ul style="list-style-type: none"> Diminished ability for group members to see other family members’ non-verbal affirmations of their efforts Telepsychology platforms encourage turn-taking more than cross-talk Diminished affirming vocalizations from other caregivers, because they do not want to “steal” the camera from others 	<ul style="list-style-type: none"> Consider use of an interactive whiteboard to show a change continuum; ask caregivers to indicate where they see themselves on the “acceptance range” Pause to summarize caregivers’ narratives, key points, emotion cues, and non-verbal affirmations Use homework review as an opportunity to affirm caregivers’ efforts
Building connections among parents	<ul style="list-style-type: none"> Building connections among parents by highlighting shared experiences or efforts 	<ul style="list-style-type: none"> Sometimes feels more impersonal for caregivers to connect virtually with others Fewer informal opportunities for families to connect before and after sessions Takes more effort to encourage parent–parent connection 	<ul style="list-style-type: none"> Use the ‘Gallery View’ to see all group members Restate responses to the group to connect families Scan, acknowledge, and reflect participants’ reactions to build connections among parents To reduce disruptions and improve group cohesion, encourage the use of the ‘Raise Your Hand’ function Offer to keep the online connection open after the session for interested participants to allow follow-up conversations with other group members

Note. BC-ADHD = Bootcamp for Attention-Deficit/Hyperactivity Disorder.

children (17 boys; 15 White non-Hispanic, 3 White Hispanic, and 2 Black; age 5–11) who were recently diagnosed with ADHD at two tertiary care children's hospitals in large Northeastern U.S. cities. At the start of the program, five children were taking medication to treat ADHD. These families were referred to in-person groups after initial evaluations in ADHD clinics using established mechanisms for follow-up care. All participating caregivers chose to follow through with the program upon transitioning to telepsychology. The groups were comprised of 5, 7, and 8 families, and the families of racial/ethnic minority background were distributed among the groups. Session times were based on clinician availability and caregiver preferences. Caregivers who completed assessments were 17 biological mothers, 2 adoptive mothers, and 1 biological father. The majority of caregivers had at least a college degree (80%) and lived in two-parent households (80%). Attendance was high (95%) across sites and sessions. The majority of two-parent households had both parents jointly attend at least one session (88%). Overall, 19 mothers and 15 fathers participated in the program by attending at least one session. Study procedures were approved by each institution's Institutional Review Board, and caregivers and clinicians provided informed consent.

Clinicians and observers were psychologists or psychology graduate students (three clinicians and three observers). Observers completed the same content and process fidelity measures that were used in our previous research with in-person groups (Normand et al., 2019). The content fidelity checklist included 13–14 items (0–1 scale, 0 = not implemented, 1 = implemented), and the process fidelity checklist included 5 items (1–4 scale, 1 = low process fidelity, 4 = high process fidelity). We used the sum of content fidelity scores and the average of process scores in analyses. Both content ($M = 96\%$ of content covered) and process fidelity ($M = 3.7$, $SD = 0.5$) were high. Post-treatment satisfaction questionnaires were administered at the end of the group using the same treatment evaluation form that was used for in-person groups (Nissley-Tsiopinis et al., 2012). Caregivers were asked to provide 7-point Likert ratings (1 = 'Not helpful'; 4 = 'Helpful'; 7 = 'Extremely helpful') on the following program elements: handouts, information provided, session organization, sharing with other caregivers, and between-session homework. To accommodate caregivers' needs and schedules, the data collection process was changed from real-time, paper-based survey completion to surveys administered electronically; 13 families completed post-treatment satisfaction questionnaires. Preliminary results indicated that caregivers were highly satisfied with all aspects of the program (overall $M = 5.7$, $SD = 1.2$, range = 5.4–6.0 across items).

In addition, caregivers were asked to share qualitative feedback about their telepsychology experience after each of the four sessions (see Table II). Our data collection methods varied across sites using RCQI methods to quickly adapt from in-person to telepsychology and to maximize the amount of meaningful feedback received from caregivers while reducing time burden (e.g., focus groups at the end of the session by videoconference, emailed questions, REDCap survey). Two coders conferred, independently categorized, and agreed upon themes addressed by caregivers ($ICC = .77$). Themes included appreciation of not having to travel or find childcare, concern about disrupted flow of conversation due to the time it takes to mute and unmute, feeling inhibited about sharing personal information via telepsychology, and concern about interrupting others (see Table II).

Clinicians' feedback indicated that although it took intentional effort to facilitate sharing between caregivers, particularly about emotional experiences, families engaged with each other and shared experiences during virtually every telepsychology session. Clinicians indicated that materials could be effectively shared with families by emailing the handouts and sharing the clinician's screen, but it was challenging to collect homework assignments and post-treatment satisfaction questionnaires from families. Clinicians also noted that caregivers had to contend with many distractions. Overall, clinicians highlighted the additional effort required to monitor, engage, and connect all families in the group when attempting to achieve fidelity to group processes.

Discussion

By accelerating the removal of barriers to telepsychology, the emergency response to COVID-19 has raised hopes that virtual methods of service delivery may improve access to behavioral health services, including evidence-based group BPT, for many families. The proliferation of telepsychology (more specifically group telepsychology) has also generated questions about quality of care—treatment fidelity—that need to be addressed. A comparison of clinician fidelity and caregiver satisfaction among groups delivered in person (Nissley-Tsiopinis et al., in preparation; Normand et al., 2019) with these three groups delivered via telepsychology suggests that content (96% for telepsychology vs. 97% for in-person) and process fidelity ($M = 3.7$, $SD = 0.5$ for telepsychology vs. $M = 3.7$, $SD = 0.5$ for in-person) and parent satisfaction ($M = 5.7$ for telepsychology vs. $M = 5.6$ for in-person) are comparable across delivery formats. Numerous caregivers commented about the convenience of telepsychology and data suggest that for two-parent families, this may

Table II. Parent Feedback about Group Telepsychology Implementation

Themes	Number of comments indicating this theme	Example quotes
Perceived advantages		
Convenience—commute/travel	8	<ul style="list-style-type: none"> • It was worth the considerable cost and time savings for us not to travel • I really liked that I was able to do it from the comfort of my room
Convenience—childcare	4	<ul style="list-style-type: none"> • No need for a babysitter
Convenience—both parents can be there	3	<ul style="list-style-type: none"> • I like the video format in general, because both of us can be here . . . because someone does not need to stay home with the children. • Both dad and I can be there
Perceived challenges		
Technical difficulties/connection issues inhibiting flow of conversation	16	<ul style="list-style-type: none"> • I was not able to see everyone at the same time. So I never knew if someone was waiting to speak and I did not want to end up cutting someone off or interrupting them. • . . . muting and unmuting takes precious time in which you can miss your window to speak. • Trouble with video connection at times
Rapport using telehealth	10	<ul style="list-style-type: none"> • Harder to be open and honest and let your real emotions show which tends to get the ball rolling for more engaging and honest dialogue • Would be good to have more discussion with each other. Sterile feeling with virtual
Discomfort sharing personal information via telepsychology	3	<ul style="list-style-type: none"> • I think it is awesome that we are able to do it like this. But I think it is awkward, because it is very personal stuff we are sharing and it is a very impersonal way to share it

Note. BC-ADHD = Bootcamp for Attention-Deficit/Hyperactivity Disorder. The above feedback was given in response to four questions: (1) What was it like participating in a group session using video technology? (2) Were there any things about using video that you liked or thought were helpful? (3) Were there any things about using video that you thought made it difficult to participate or learn? (4) What suggestions do you have to improve these video sessions (or the program when delivered by video)? The number of comments indicating a theme is based on comments from three post-session focus groups (responses not separated by family) and 13 participating families' individual replies to post-group surveys. Many of the families who completed surveys after participating in BC-ADHD also participated in the focus groups that were conducted after each of the four sessions of BC-ADHD. Given the strategies used to collect these data, it is possible that a family identified a specific theme more than one time.

result in greater participation by both parents in sessions; 88% of two-parent households had both parents jointly attend at least one telepsychology session, while only 45% of two-parent households had both parents jointly attend at least one in-person session.

Although quantitative feedback regarding the feasibility of sharing with other caregivers via telepsychology was high, qualitative feedback indicated concerns about disrupted flow of conversation and feeling inhibited to disclose personal information. Clinicians affirmed that telepsychology group parent training can be provided effectively, although ensuring high levels of process fidelity and facilitating connections among caregivers requires considerable effort. Also, given that between-session homework completion is associated with better outcomes for group BPT (Clarke et al., 2015), it is important to identify strategies to address the understandable challenges related to ensuring implementation of homework assignments online.

Our findings and recommendations should be examined in the context of several considerations. First, our sample was very small and limited to primarily White, college-educated caregivers from two-parent households. Given that disadvantaged populations are

less likely to have technology resources needed to participate in telepsychology (Swenson & Ghertner, 2020), the promise of telepsychology may be considerably more modest in this population. Single-parent families are also known to experience unique challenges in implementing BPT (Chacko et al., 2009), which need to be addressed in providing care via telepsychology. Future research needs to identify methods to reduce group telepsychology barriers among low-income and single-parent families. Second, we were only able to collect parent satisfaction ratings from 13 of 20 families, which is lower than our typical response rate, although expectations for data capture may need to be adjusted during the pandemic. Also, due to our data collection methods, it was not possible to determine the number of caregivers who identified each theme related to telepsychology service delivery. Third, research is needed to determine if these findings are generalizable beyond the COVID-19 era, as caregiver perceptions of acceptability of care were likely influenced by their high need for care in the context of shelter-in-place orders. Fourth, the status of future reimbursement for telepsychology service delivery is uncertain, but given its potential to reduce barriers to care, advocacy efforts are needed to ensure financial sustainability. Finally, future research using larger and

more diverse samples, multimethod and multi-informant measurement approaches, and controlled designs is needed to assess the efficacy and generalizability of telepsychology parent training groups (see Stiles-Shields et al, 2020, for additional pediatric psychology research considerations during COVID-19).

In conclusion, our experience suggests that telepsychology parent training groups can be delivered with high quality (i.e., fidelity) and are acceptable and feasible for caregivers and clinicians, although findings may not generalize to other caregiver populations. This approach has promise for increasing access to services for families of children with ADHD, disruptive behavior, and executive functioning difficulties.

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