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EDITORIAL

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Editorial: How Online Treatment Research Can Enrich Child and Adolescent Psychiatry

Patty Leijten, PhD

Evidence is accumulating that treatment for psychiatric problems can in some cases be effectively delivered online.[1] Online treatment does not necessarily imply less therapist support (eg, treatment can be delivered through video call), but most online treatments are at least in part self-directed. Research on online treatment therefore not only answers to calls from policy makers and clinical practice about when online treatment can safely replace or outperform in-person treatment, but also challenges assumptions on hypothesized key therapeutic principles (eg, essential common elements) and can discover new therapeutic principles.

Engelbrektsson *et al.*[2] tested whether an online version of Comet, a parenting program based on social learning theory to help parents break coercive parent–child interaction patterns, is noninferior to its original in-person group format in reducing conduct problems in children. The authors randomly assigned 161 families with children (3-11 years old) seeking help for conduct problems to receive either a 7-session self-directed online parenting program, with a therapist available for phone calls and 3 individual sessions, or a 10-session group program. The noninferiority margin (ie, the difference between online and in-person treatment considered acceptable for the online treatment to be considered "not worse") was set at $d = 0.43$. The findings of this study suggest noninferiority of the online treatment on both primary and secondary outcomes except for 3 of 19 secondary outcomes immediately after treatment, but these differences disappeared at later follow-up. The authors concluded that the online treatment is noninferior to its in-person counterpart (range of differential effects across outcomes: $d = -0.12$ to 0.29), with effects maintained at least 1 year following treatment.

Engelbrektsson *et al.*[2] provide a valuable contribution to our understanding of whether online parenting programs can safely replace in-person parenting programs. Strengths include its setting in regular clinical practice with referred families and with therapists who were not connected to the research project. However, several intervention and study design features may have influenced the authors' noninferiority finding. First, although the majority of the online intervention sessions were self-directed, families were offered 3 individual in-person sessions, and most families used these (average number of sessions per family was 2.3). Because even single sessions can yield meaningful effects,[3] their contribution to the online treatment effects should not be underestimated. Second, the noninferiority margin of 0.43 is relatively large compared with margins used in other studies in this field (P. Leijten, PhD, *et al.*, unpublished data, February 2023) and with the within-group effect size for Comet found in the present study (0.50). More stringent tests (eg, the noninferiority margin of 0.26 used in a recent meta-analysis of online parent programs) (P. Leijten, PhD, *et al.*, unpublished data, February 2023) would have led the authors to conclude that noninferiority could not be ruled out. These study features by no means undermine the authors' finding that online treatment for child conduct problems can be noninferior to in-person treatment, but indicate the importance of interpreting findings of noninferiority in light of intervention characteristics and margins.

Underlying the question whether online treatment is noninferior to in-person treatment is the question of what makes treatment effective. If we know what the driving principles underlying our most effective in-person treatments are, we can develop the best possible ways to deliver these principles in person or online. This approach requires empirical studies that dismantle effective interventions to identify the therapeutic principles that drive their effects and distinguish them from principles that are ineffective or superfluous in the light of other principles. Different research strategies can be used for this, ranging from basic experimental research on the effects of single principles (ie, microtrials) to meta-analyses of associations between treatment characteristics and treatment effects.[4] Comparative studies on in-person vs online treatment can make a unique

contribution to this research because they can manipulate elements that are difficult to manipulate in in-person treatment (eg, therapist factors).

When we decide what treatment to offer to families, client preference plays a vital role. In the study by Engelbrektsson *et al.*,[2] dropout rates were significantly smaller in families who were randomly assigned to their preferred format (2% vs 22% for families not randomly assigned to their preferred format). At the same time, the authors found that families do not always know a priori what treatment they will prefer: pretreatment preference was greater for online treatment, but posttreatment client satisfaction was greater for in-person treatment. Inconsistencies between parents' a priori and post hoc treatment preference are not uncommon,[5] but make it difficult for professionals to know when to follow parents' original preference and when to use, for example, motivational interviewing techniques to determine if parents might be open to alternative formats. Because parents' a priori and post hoc treatment preference can differ, and because parents have preferred online formats in some studies (P. Leijten, PhD, *et al.*, unpublished data, February 2023), but not in others,[2] we should be cautious in adapting policy and practice based on client preference findings from single studies.

In sum, with the help of Engelbrektsson *et al.*[2] and others, a sound foundation for noninferiority of online treatment is being established. The next step for the field is to identify the most effective therapeutic principles of in-person and online treatment. When we better understand the circumstances under which parents prefer and benefit more from either format, we can provide clearer guidance for policy makers and practitioners on when online treatment can safely replace or outperform in-person treatment.

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