

# Improving accessibility of cognitive behavioural therapy for children and adolescents: Review of evidence and future directions

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## Key words

accessibility, CBT, child and adolescent, formats, prevention, treatment.

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## Abstract

**Background:** Despite great progress in Cognitive Behavioural Therapies (CBTs) for children and adolescents over the last two decades, as many as four out of five young people who could benefit from therapy are not accessing it. The demand on available services, the stigma of mental health difficulties, costs and time demands of treatment, and geographic isolation are some of the many barriers to effective treatments.

**Method:** The aim of this narrative review is to explore the literature on alternative formats of delivery that have the potential to reach more young people by lessening the barriers to access. Group delivery, intensive and brief formats, electronic and remote formats, and preventive approaches are considered with relevant literature in each area explored.

**Results:** There is a substantial body of evidence, including some large-scale controlled trials, to support the group delivery of CBTs for children and adolescents. Preventive approaches also show great promise with some positive results from controlled trials. Intensive and brief delivery formats are emerging as an area of promise but to date they have not been the subject of large-scale controlled trials. Similarly, there is emerging evidence of the effectiveness of electronic CBT formats. Although each of these areas has been progressing, no direct comparison between these alternative approaches were found.

**Conclusions:** Although evidence is developing for alternative formats of delivery that can be effective as well as reducing the barriers to accessing them, there remains a relative paucity of large-scale and controlled studies except those involving standard delivery formats. Further research validating alternative formats, their relative effectiveness and their impact on reach is necessary.

## Key Points

- 1 Many children and adolescents who have mental health difficulties are not accessing treatment due to barriers such as demands on services, stigma, and physical access.
- 2 Cognitive Behavioural Therapy (CBT) is often the treatment of choice for many young people and

- promising alternative delivery formats utilising CBTs, such as group delivery, intensive and brief time formats, electronic and remote formats, and preventive approaches could increase access.
- 3 There is a clear need for future studies that explore how alternative CBTs formats can be effective as well as reducing the barriers to accessing them, and as such, increasing their reach. Future studies would ideally also provide comparisons of alternative formats to establish their relative strengths and weaknesses.

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Over the last two decades child- and family- focused Cognitive Behavioural Therapies (CBTs) have progressed to the point where they are currently the treatment of choice for most childhood internalising disorders (James, James, Cowdrey, Soler, & Choke, 2013; Reynolds, Wilson, Austin, & Hooper, 2012). CBT approaches for children, as for adults, have typically been administered over 10–12 weekly or bi-weekly sessions by qualified clinicians in a one-on-one clinic setting with varying amounts of parent input (James et al., 2013). These approaches commonly include a combination of psycho-education, relaxation training, recognition and modification of negative cognitions, graded exposure, problem solving strategies, social skills training, and reinforcement protocols (James et al., 2013). In these formats, CBT has produced moderate to large treatment effects (James et al., 2013). However with the incidence of childhood mental health problems affecting an estimated 20% of young people worldwide (Kieling et al., 2011; Patel, Flisher, Hetrick, & McGorry, 2007), services are struggling to meet demand and many young people are not accessing professional care (Collins, Westra, Dozois, & Burns, 2004). It is estimated that as many as 80% of young people with internalising disorders worldwide are not receiving appropriate treatment (Cobham, 2012; Essau, 2005). This corresponds to a lifetime cost of \$2.1 trillion for children experiencing mental illness in the United States alone (Smith & Smith, 2010).

There are many barriers that contribute to the under-treatment of mental health conditions in young people including but not limited to the demand on available services, the stigma of mental illness, costs and time demands of treatment, and geographic isolation (Collins et al., 2004). Therefore, Elkins, McHugh, Santucci, and Barlow (2011) have argued for the increased transportability of effective CBT approaches through creative modifications that allow existing effective treatments to be delivered to young people who are not able to access traditional delivery formats. C. M. Turner and Krebs (2013) discuss low-intensity CBT methods and propose that increased access can be achieved by reducing the cost through reducing therapist input per patient or employing staff only trained in the protocol being delivered, or by reducing the burden to the individual through briefer interventions and the integration of communication technologies. The term “Low-Intensity CBT” has been more thoroughly defined by Bennett-Levy, Richards, and Farrand (2010) who described its purpose as “... to increase access to evidence-based psychological therapies in order to enhance mental health and wellbeing on a community-wide basis, using the minimum level of intervention necessary to create the maximum gain” (p. 8). However, to date the effect of many of the

different formats that increase transportability of child-focused CBT on uptake and outcomes has been the subject of little empirical investigation or discussion (James et al., 2013). Accordingly, the aim of this article is to undertake a narrative review focused on studies and bodies of research that show promise in increasing transportability and access of child-focused CBT.

## Method

To inform this narrative review, OVID (PsycInfo) & Google Scholar searches were conducted between July and August 2015 with a date range from 1970 until August 2015, focusing primarily on titles. Key words were applied in three categories, intervention type (CBT OR Cognitive Behavioural Therapy), format (intensive OR brief OR rapid OR transportable OR “low intensity” OR telephone OR video OR Internet OR bibliotherapy), and age range (child OR adolescent OR paediatric). Key articles were located in this manner, articles in their reference sections were then manually searched for further relevant studies. Key studies or reviews that discussed a CBT-based intervention, with children and/or adolescent (less than 19 years old), in a format where the core intervention differed from a standard 10 to 12-week individual clinician led interventions were included in this review and are referred to as “Alternative Formats.” Although we did not limit the search to internalising disorders, most studies found focused on the treatment or prevention of anxiety and depression.

## Alternative Formats

Many avenues for increased transportability (use of standard treatments in more accessible ways) of child-focused CBT have been proposed. The extent to which these alternative formats have been investigated has varied. The use of *group* rather than individual therapy to reach larger numbers of children is one of the best researched areas in the transportability of child-focused CBT, with evidence of effectiveness as well as unique benefits such as normalisation and peer learning (Bieling, McCabe, & Antony, 2013). Delivering treatment protocols with *greater intensity over shorter periods* of time is also an area of emerging research on increasing transportability, with some authors reporting equivalent outcomes for intensive (short) formats compared to standard formats (Storch et al., 2007). Other formats that are the subject of active investigation include bibliotherapy and online delivery. To date, there is little evidence to support bibliotherapy approaches where therapy is delivered purely through a self-guided workbook (Rapee, Abbott, & Lyneham, 2006). Online and

electronic delivery, is quickly emerging as an effective and engaging way of reaching some young people who are not otherwise able to access services (Spence et al., 2011). These formats allow for remote delivery through Internet-based, video conferencing and phone contact, with early but promising results (Bieling et al., 2013; Calear & Christensen, 2010; Calear, Christensen, Mackinnon, Griffiths, & O’Kearney, 2009; Donovan, Spence, & March, 2013; Richardson, Stallard, & Velleman, 2010; Rooksby, Elouafkaoui, Humphris, Clarkson, & Freeman, 2014). Most of these alternative formats and modifications offer promising ways of reaching more of the young people who are experiencing emotional difficulties but are not accessing the needed help. The emerging area of universal preventive, child-focused, CBT approaches offer another alternative that can reduce the number of young people who are experiencing mental health difficulties. These interventions are showing promise in reducing the future incidence of internalising disorders in young people reaching them before they become part of the statistics above (Fisak, Richard, & Mann, 2011).

## Groups

As noted above, group formats are an evidence-based format that makes effective CBT-based treatments more accessible through disseminating treatment in a more efficient manner. The body of research evidence supporting group-based treatments for children and young people has grown substantially over the last decade, with group CBT formats producing medium treatment effect sizes for anxiety and other mental health difficulties in children and adolescents across two major meta-analyses including several randomised controlled trials (James et al., 2013; Reynolds et al., 2012).

The first of these, a recent Cochrane review which included 41 studies with 1 806 participants (James et al., 2013) found moderate effects for CBT-based treatments for child and adolescent anxiety, showing that only 369 per 1 000 participants who completed CBT-based interventions still met diagnostic criteria after the trial compared to 818 per 1 000 in wait-list control conditions (OR = 0.13) and noted that “No clear evidence indicates that one way of providing CBT is more effective than another (e.g. in a group, individually, with family/parents), (p. 2).” This finding supports group CBT formats as an equivalent to traditional individual CBT whilst reducing therapist time and costs by delivering the intervention to several young people at once, therefore potentially making the treatment more accessible. This analysis did however reveal some gaps in the literature

with comparisons to “treatment as usual” and non-CBT controls being limited and inconclusive.

The other major meta-analysis, undertaken by Reynolds et al. (2012), incorporated an even larger range of studies, with 55 studies focused on children and young people who met a diagnosis for any anxiety disorder in treatment groups. This study also reported moderate effects sizes overall in reduction of anxiety symptoms compared to control groups. However, whereas group-based CBT interventions were reported to be associated with moderate effect sizes ( $d = 0.58$ ) in reducing anxiety, individual therapy produced large effect sizes on average ( $d = 0.85$ ), a finding which differed from that of James et al. (2013) who found no difference. One possible explanation for this could be that James et al. (2013) excluded phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder, and selective mutism, whilst Reynolds et al. (2012) included all anxiety disorders. Reynolds et al. (2012) point to the need for individual formulation and treatment planning as an explanation of why individual formats may be more effective. Some of the disorders excluded by James et al. (2013) can be more complex and as such may fit with Reynolds et al. (2012) account of a need for individual formulation and treatment planning.

These two large meta-analyses outline the evidence for group-based CBT for childhood emotional challenges, and specifically anxiety, as an effective and efficient treatment modality with lasting effects. Studies investigating the effects of group-based CBT for children and adolescents for conditions other than anxiety, in areas such as depression, are less abundant. A small meta-analysis of 10 studies of which 8 were group-based CBT interventions for depression in children did show moderate effect sizes ( $d = 0.66$ ) in reducing depressive symptoms; however, the review identified challenges such as a lack of follow-up and methodological issues in the studies (Arnberg & Öst, 2014).

## Intensive, Brief, and Rapid Delivery Formats

Various brief formats of CBT have also emerged ranging from one-session interventions for phobias (Davis, Ollendick, & Öst, 2009; Ollendick et al., 2009; Öst, Svensson, Hellström, & Lindwall, 2001), to multi-session formats delivered in quick succession for post-traumatic disorder (PTSD) (Ehlers et al., 2010, 2014), Panic Disorder and Agoraphobia (Gallo, Chan, Buzzella, Whitton, & Pincus, 2012) and OCD (Abramowitz, Foa, & Franklin, 2003; Bolton et al., 2011; Storch et al., 2007; Whiteside, Brown, & Abramowitz, 2008). All of these studies aimed to increase the transportability of CBT interventions for

children and adolescents, and as such fit within Bennett-Levy *et al.* (2010) definition for low-intensity CBT. Yet the actual intensity of the delivery in some instances would arguably be greater than traditional formats, with multiple sessions delivered in short succession rather than across many weeks (Storch *et al.*, 2007; Whiteside *et al.*, 2008). Such formats remove the need to maintain long-term attendance at weekly sessions and involve less travel, thereby making the interventions more accessible for some. For the purpose of this review, an intervention that reduced the number or duration of sessions will be referred to as brief whilst interventions that maintained the same content but reduce the period of time over which it was delivered will be referred to as “intensive”

Storch *et al.* (2007) compared family-based individual CBT in weekly and intensive (daily) formats for OCD in children and adolescents. Storch *et al.* (2007) found positive results in both the intensive and weekly deliveries, with 75% of the intensive participants meeting remission criteria at post-treatment compared to 50% in the weekly groups. Furthermore, 90% of intensive participants were considered treatment responders on the CGI compared to 65% of weekly group participants. This result provided promising data on the potential effectiveness of an intensive CBT-based approach in children, but it was limited by its small sample size ( $n = 40$ ), lack of control group, and short follow-up periods. A similar, 10-session intensive intervention for OCD delivered over five days also showed substantial improvements on OCD symptoms and overall functioning for three adolescents in a series of case studies by Whiteside *et al.* (2008).

Bolton *et al.* (2011) addressed some of the methodological limitations of the Storch *et al.* (2007) study by undertaking a randomised controlled trial (RCT) with 96 children and adolescents who suffered from OCD, comparing brief and standard CBT formats to a wait-list control. In contrast to Storch *et al.* (2007) daily sessions, Bolton *et al.* (2011) “Brief” format comprised five sessions delivered over five weeks and was supplemented with workbooks. Nevertheless, this brief format produced outcomes that were comparable to those of Storch *et al.* (2007) with 49% meeting remission criteria at post-treatment compared to 61% in the standard treatment and 8% in the wait-list control. These results are also consistent with similar studies of standard interventions in the adult OCD literature (Abramowitz *et al.*, 2003).

The effectiveness of intensive and brief treatment in children and adolescents has also been investigated in several studies of specific phobias including two randomised controlled trials of one-session, 3-hour CBT-based interventions which were compromised primarily of exposure-based strategies. (Davis *et al.*, 2009; Ollendick

*et al.*, 2009; Öst *et al.*, 2001). These studies showed improved outcomes for the intensive treatment relative to control as measured by “clinically significant improvement” defined as statistically significant reduction, as well as a reduction of at least two standard deviations, on independent assessor ratings of severity, behavioural assessments, and self-rated anxiety scales. Öst *et al.* (2001) conducted their intervention with 60 children and adolescents who met criteria for a specific phobia whilst Ollendick *et al.* (2009); Öst *et al.* (2001) conducted their RCT with 196 children and adolescents in the United States and Sweden who met criteria for a specific phobia and compared it to an education support group as well as a wait-list control group. Öst *et al.* (2001) showed clinically significant improvements for 90% or more of young people who completed it by themselves and 60% of young people who completed it with their parents present. Ollendick *et al.* (2009) showed clinically significant improvement for 52% of those in the one-session treatment compared to 21% in the education group. Further studies are necessary to establish the effectiveness of this one-session approach. Nevertheless, the evidence is promising, albeit limited to phobias at this stage.

A more comprehensive eight-day intensive CBT-based treatment investigating the effects of treatment for panic disorder and agoraphobia on non-targeted comorbid diagnoses has been implemented with adolescents who met criteria for both panic disorder and agoraphobia, as well as other comorbid diagnosis (Gallo *et al.*, 2012). An uncontrolled trial of the intervention found a substantial reduction in adolescents who met comorbid diagnosis from 78.2% before treatment to 43.6% after, with remission being greatest among those who met criteria for social phobia, specific phobia, and generalised anxiety disorder before treatment. The intervention also showed promise for those who met criteria for Major Depressive Disorder and OCD although the small sample size was insufficient to demonstrate statistical significance. This study demonstrates that even specifically targeted brief interventions can have generalizable effects on other common comorbid difficulties, despite the brief nature of the intervention.

Although outside of the scope of this review, the adult literature has also yielded promising findings for intensive CBT interventions. For example, in a recent study Ehlers *et al.* (2014) investigated the use and effectiveness of a seven-day intensive cognitive therapy programme for adults with chronic PTSD compared to standard cognitive therapy over three months, emotion-focused supportive therapy over three months, or a wait-list control. Of the 121 participants who were randomised into the treatment conditions, both standard and intensive

cognitive therapy were superior to control with 77% of standard cognitive therapy group and 73% of intensive cognitive therapy participants having recovered after treatment, compared to 43% of the supportive therapy group and only 7% of the wait-list control.

## Electronic and Remote Delivery Formats

Research on electronic and remote delivery formats is a rapidly expanding area as communication technologies become increasingly more prominent and accessible (Donovan et al., 2013). Telephone, Internet, and video-conferencing delivery formats of CBT-based interventions have been trialled with young people.

Turner, Heyman, Futh, and Lovell (2009) conducted a very small telephone-based CBT study involving 10 adolescents with OCD. At post-treatment 7 out of the 10 participants were in remission, which was maintained at 12-month follow-up. However, this pilot study included no controls and employed only a very small sample. Telephone calls appear to be common as a support medium for CBT-based interventions (Lovell, 2010); but as a primary CBT intervention for children and adolescents, the literature remains sparse (Slone, Reese, & McClellan, 2012). Another format closely related to telephone-based intervention is the use of Short Messaging Services (SMS) on mobile phones; however, the evidence for its use in delivering CBT interventions for children and adolescents remain focused on its role as an adjunct strategy to increase adherence, reduce drop out and relapse, and promote self-monitoring (Shapiro & Bauer, 2010).

In a similar approach but with the addition of video, Storch et al. (2011) delivered web-camera-based CBT to a group of adolescents with OCD. Thirty-one young people were randomly assigned to either a treatment or wait-list control group. Of the 16 intervention participants, 13 (81%) responded to treatment with 9 meeting remission criteria, compared to only 2 (13%) out of the 15 participants in the wait-list control. Again the use of video conferencing although better established in the adult literature is sparse in the delivery of CBT with children and adolescents (Slone et al., 2012).

Spence, Holmes, March, and Lipp (2006) also conducted a study utilising modern technology in delivering CBT to children with anxiety although this was in combination with a clinic-based intervention, with half of the sessions being delivered through web-based links and half involving individual therapy. The study included 72 children between the ages of 7 and 14, who were randomly allocated to a clinic, clinic plus web, or wait-list control condition. Both of the intervention groups showed significant treatment responses

compared to the wait-list condition with 13 out of 20 children in the clinic-based intervention and 14 out of 25 children in the combined clinic plus web-based intervention no longer meeting diagnostic criteria after treatment. By contrast, only 3 out of 23 children in the wait-list control no longer met diagnostic criteria for an anxiety disorder. The effects for both intervention groups were also maintained at 12-month follow-up. The use of online or Internet-based CBT interventions is rapidly expanding in the child and adolescent literature partly due to the prolific use of this medium by children and adolescents. These interventions are taking the form of online chat, emails, and discussion boards, as well as psycho-educational materials such as videos, interactive games, and self-guided programmes (Slone et al., 2012). Slone et al. (2012) identified and reviewed four areas in which most of the research within this area is focused including smoking cessation, alcohol/drug use, eating disorders, and emotional distress, although not all of the interventions identified were strictly CBT based. They concluded that Internet-based interventions for children and adolescents had a strong emerging evidence base with positive results across all areas reviewed from several RCT's, with large sample sizes, and relatively good study designs.

Overall, there is increasing focus on the remote electronic formats for the delivery of CBT-based interventions to children and adolescents and the findings to date suggest that these approaches offer considerable promise. However, further high-quality, systematic research is required as outlined by Donovan et al. (2013), Rooksby et al. (2014), and Slone et al. (2012) who offer more comprehensive reviews in this area.

## CBT-Based Resilience Programmes

Although there is a need to improve the availability of treatments for children and adolescents with emotional difficulties, it is also vital to consider the role of preventive, universal, programmes which aim to provide skills to young people before they experience a mental illness (Fisak et al., 2011). Large-scale reviews such as that by Kieling et al. (2011) emphasise the need for early intervention and prevention.

Many studies show clear preventive effects (Fisak et al., 2011; Merry et al., 2012) as well as unique benefits of reduced stigma and in some cases, improved academic performance (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Merry et al. (2012) conducted an extensive Cochrane review spanning 15 studies and 3 115 participants, for the efficacy of a range of educational and health programmes in preventing the onset of depression in children and adolescents and

concluded that there is evidence that prevention programmes were effective as compared to no intervention. Merry *et al.* (2012) did however note some methodological issues inherent in much of the research in the area, pointing to allocation concealment and heterogeneity of findings as some of the major issues. Another large meta-analytic review by Fisak *et al.* (2011) found significant improvements in measures of resilience post-intervention with mixed results at follow-up across 27 studies. On further analysis of moderating factors, Fisak *et al.* reported that although factors such as universal versus targeted intervention type, gender, and age were not significant predictors of outcome, the FRIENDS programme was associated with superior outcomes with an average effect size of  $d = 0.25$  compared to a size of  $d = 0.11$  for non-FRIENDS interventions.

Studies using the FRIENDS programme have consistently demonstrated preventive effects. For example, in a universal sample of Australian school students in Grade 6 and 9, Barrett, Farrell, Ollendick, and Dadds (2006), showed that at three annual follow-up time periods those who had completed the FRIENDS programme were significantly less likely to be in a high-risk group (operationalised as high CDI or SCAS scores) than children in the control group. At 36 months, only 12% of the intervention group were in the high-risk group compared to 31% of the control group. A recent large-scale RCT of a universal prevention programme in a school setting using a younger developmental version of the FRIENDS programme for children aged four to seven years old (Fun FRIENDS) as well as an active control demonstrated similar effects (Anticich, Barrett, Silverman, Lacherez, & Gillies, 2013). Anticich *et al.* (2013) showed significant improvements on clinical and resilience measures at completion for both Fun FRIENDS and “You Can Do It,” the active control, as compared to the wait-list control, with Fun FRIENDS producing superior outcomes to both the “You Can Do It” intervention and control conditions at completion. These improvements were maintained at 12-month follow-up, with Fun FRIENDS still showing significantly better outcomes compared to the active control.

## Conclusion

We acknowledge that this narrative review was not conducted in a fully structured, systematic manner and might therefore have missed some relevant literature. Nevertheless, it is clear that the weight of evidence suggests that there are effective treatment and prevention CBT-based protocols in more transportable and accessible formats than the standard 12-week individual

delivery of CBT. These provide more ways of reaching the estimated 80% of young people who are experiencing emotional difficulties but are not receiving the psychological help they need potentially lessening the lifetime burden of mental illness. The research also strongly supports group delivery as an effective way of disseminating CBT-based interventions to children and adolescents with large reviews showing effects that are comparable to standard formats, potentially reaching more young people with less clinicians in a more cost-effective manner. Other adaptations are also showing promise, including intensive and brief delivery formats, with several studies demonstrating effectiveness equivalent to standard delivery formats whilst reducing either the duration or time period that is usually required in standard formats. Remote and electronic formats are also showing promise in smaller studies; especially Internet-based interventions, where the majority of the research has been focused to date. Many studies in this area are still utilising these interventions as adjunct therapies rather than the primary format. There is, however, a paucity of large-scale and controlled studies in all of the areas except those involving standard delivery formats. Although this review set out to explore alternative formats that have the potential to increase access to CBT-based interventions, the studies identified focused only on the investigation of treatment or prevention outcomes; none investigated whether alternative formats actually increased the accessibility and reach of these interventions.

In this review, we have outlined several alternative formats, which are often compared to a standard CBT format; however, existing studies have not undertaken direct comparisons of the effectiveness of these alternative formats relative to each other. Research on CBT-based interventions has been used for a vast range of presenting difficulties and populations and individual studies that investigate alternative CBT formats have often focused on particular populations or difficulties. Furthermore, the term “CBT” is used to describe a range of interventions that share conceptual underpinnings but often differ substantially in their content. Clearly, it is not possible to draw firm conclusions about the relative effectiveness of each of the alternative formats from the current literature as the different formats likely differ in their content and have largely focused on different populations and presenting difficulties. It could be that some delivery formats lend themselves better to different presenting difficulties or ages; however, no data was found to support such claims.

Since the need for providing accessible treatment and preventive interventions to more young people is very real, research validating alternative formats to enable

this is essential. Future research could explore whether a range of alternative formats with similar CBT-based content has different effects for different ages, presenting difficulties, or cultures. Furthermore, there is a critical need to investigate how alternative formats are impacting on availability and reach of these interventions and how effective modifications in format are at addressing barriers to engagement.

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