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## **Engagement and Assessment within Low Intensity Cognitive Behavioural Therapy for Children and Young People Presenting with Anxiety: Principles and Practice**

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### **Abstract**

The implementation of the Improving Access to Psychological Therapies (IAPT) programme has allowed for the expansion of low intensity psychological interventions offered to individuals with depression and anxiety in England (Department of Health, 2008), with over 900,000 people accessing services per annum and increasing year-on-year recovery rates (Health and Social Care Information Centre, 2017). The relationship between positive therapeutic outcomes and the therapeutic alliance between practitioner and client has well-documented within current literature (Horvath, De Re, Flückiger, & Symonds, 2011), with numerous studies highlighting the essentiality of the therapeutic relationship with regards to effective intervention. However, comparatively few studies have identified the most influential factors which contribute to the therapeutic alliance, particularly within the specialism of low intensity psychological interventions for children and young people. This article discusses factors such as warmth, empathy, and collaboration as well as outlining and exploring concepts relating to the assessment procedures for children and young people awaiting low intensity cognitive behavioural therapy (LICBT).

*Keywords: Therapeutic alliance, relationship, low intensity, cognitive behavioural therapy,*

Low intensity cognitive behavioural therapy is a relatively new form of treatment for mild to moderate presentations of common mental health issues (Papworth, Marrinan, Martin, Keegan & Chaddock, 2013). The availability of low intensity (LI) psychological interventions has largely increased in recent years, following calls for a transformation of the UK mental health services (Layard et al., 2006), consistent with the recommendations in ‘Talking Therapies: A Four-Year Plan of Action’ (Department of Health, 2011). The IAPT services aimed to improve access to psychological therapies for common mental health diagnoses and introduced psychological wellbeing practitioners (PWP) to offer LI interventions at a high volume. This has led to the wide use of LICBT; this approach allows PWPs to work collaboratively with a high volume of clients, offering shorter, 30 minute appointments (Papworth et al., 2013), and therefore improving service efficiency. This low intensity approach depletes fewer resources and can be facilitated through the use of specific vehicles including guided self-help, computerised CBT and group interventions, all of which require less therapist input.

With regards to anxiety disorders in particular, systematic reviews and meta-analyses have demonstrated that LICBT may be an effective treatment for mild to moderate presentations, and that such methods are equally as effective as high intensity interventions (Cuijpers, Donker, van Straten, Li, & Andersson, 2010; Grist & Cavanagh, 2013). Despite this, in their systematic review of controlled trials, Coull and Morris (2011) concluded that a lack of reported follow-up results mean that study outcomes should be interpreted with caution. Similarly, the paucity of studies specifically addressing LICBT for anxiety in children and young people highlights the need for further research. Emerging evidence however, has supported LI interventions and highlighted positive results for recovery rates and maintenance of improvement at a six month follow up assessment (Thirlwall et al., 2013). Conversely, the reduced therapist input and reliance upon LI methods has raised questions over the capacity to develop and maintain therapeutic relationships in LICBT, and subsequently facilitate patient engagement. As the relationship is a central component of healing (Lambert & Barley, 2001; Krupnick et al., 2006; Arnd-Caddigan, 2012), it is unclear how LI methods impact the relationship and clinical outcomes. In addition, given that the LI approach is relatively untested and novel within children’s services, it is unclear as to how the reduced therapist input may impact upon the therapeutic relationship and the assessment and engagement of children and young people.

Despite researchers being under unequivocal agreement about the therapeutic relationship being important to recovery (Arnd-Caddigan, 2012), there still exists uncertainty in how to establish and maintain relationships across therapies. Along with a shift towards the use of more low intensity interventions, difficulties have emerged in developing and maintaining therapeutic relationships when utilising such methods. The first half of the following article aims to explore research on factors which contribute to effective development and maintenance of therapeutic relationships, with a focus on LI interventions. The discussions will highlight issues involving the relationship when using LI interventions, to cast further light on how best to facilitate the relationship in this innovative and scarcely researched approach. The second half of the article will discuss the assessment procedure for Children's Psychological Wellbeing Practitioner (CPWPs) in relation to anxiety presentations and will discuss concepts and competencies in relation to the engagement and assessment of children and young people. As the authors are members of the first cohort of trainee CPWPs within the North East of England, the discussions will provide one of the first insights into how low intensity interventions can be implemented specifically with children and the challenges faced, with a view to casting light and guidance for future LI children's clinicians.

### **Factors Contributing to Therapeutic Relationships**

Many researchers have cited therapeutic relationships as an integral component of effective therapy. One widely reported finding is that the quality of the relationship is associated with the clinical outcome (Wampold, 2001; Orlinsky, Ronnestad & Willutzki, 2004). This is supported by the conclusion that positive perceptions of early therapeutic alliance are strong indicators of clinical outcomes (DeRubeis, Brotman & Gibbons, 2005). The therapeutic relationship has also been shown to influence specific symptoms. Krupnick et al. (1996) report the relationship has significant predictive effects on symptoms of depression. The relationship is now central to clinician's practice, with considerable emphasis on possible factors that influence the development and upkeep of a strong therapeutic relationship.

Factors that influence the development and maintenance of therapeutic relationships include qualities such as warmth, empathy, listening skills, and collaboration (Richards & Whyte, 2010), as well as therapist training (Fine & Turner, 1991) and personal values (Aponte, 1992). These factors complicate the dynamic relationship, causing difficulty in developing empirical theoretical concepts (Johnson & Wright, 2002), and in defining

therapeutic relationships. However, there are ‘common factors’ essential across all therapies, including warmth, genuineness and empathy (Papworth et al., 2013). There are also Bordin’s essential components of therapeutic alliance (Bordin, 1979) including agreement on goals and tasks, and a bond made up of reciprocal regard and confidence. Bordin’s framework emphasised the need for collaborative working to overcome the patient’s difficulties. Beck et al. (as cited in Bennett-Levy et al., 2010) also stressed the importance of ‘collaborative empiricism’, referring to the therapist and patient working together to facilitate change. However, with the rise of LI interventions, LI therapists may find it difficult to establish therapeutic relationships. It could be hypothesised that reduced input from therapists and reliance on LI resources will restrict the development of a bond, agreements over tasks and goals, prevent opportunities to demonstrate therapeutic skills and prevent collaborative working. The following discussion will critically explore these specific factors.

### **Bordin’s Therapeutic Alliance**

The therapeutic alliance has been the subject of few studies within LI interventions. A study by Hadjistavropoulos, Pugh, Hesser and Andersson (2017) investigated therapeutic alliances with patients receiving internet-delivered cognitive behavioural therapy (ICBT). ICBT is effective in treatments of anxiety and depression (Andersson, 2015), and overcomes inaccessibility by providing modules online. Hadjistavropoulos et al.’s (2017) findings were consistent with past research, finding high ratings of therapist alliance in ICBT. However, post treatment ratings were collected only from patients who completed the therapy. Dissatisfaction with the relationship is often reported as a common reason for patient drop-out. Therefore, it could be assumed that participants who did not complete treatment would have given lower ratings of therapeutic alliance. Although, the authors did gather mid-treatment ratings, and their conclusions that therapeutic alliances can be established in ICBT are supported by previous studies. Preschl, Maercker and Wagner (2011) found comparable results for therapeutic alliances between patients receiving face-to-face CBT and those receiving ICBT. Although, drop-out rates for the ICBT group were also significantly higher, and therefore may restrict the validity of findings. Though, Preschl et al. (2011) argue that drop-outs were due to anonymity when receiving online treatment as opposed to poor therapeutic alliance. Due to these methodological limitations amongst research, caution is needed when interpreting these findings. One interpretation could be that the lack of therapist-patient contact restricts development of bonds. As bonds are essential to alliance, as

outlined by Bordin (cited in Papworth et al., 2013), this could diminish the therapeutic relationship leading to higher drop-outs.

The bond refers to positive attachments including acceptance and trust between therapist and patient, and is an important feature in therapeutic alliances (Campbell & Simmonds, 2011). The bond involves empathy, unconditional positive regard and congruence (Green, 2010). In LI interventions, the reduced therapist-patient contact restricts opportunities for these skills to be presented and for a bond to be created. Additionally, shortened and fewer sessions means initial assessments are of high importance, as it could be expected that the restricted time results in fewer opportunities to demonstrate therapeutic skills such as empathy to build a therapeutic relationship. The shortened assessment may lead to practitioners making fundamental clinical mistakes, such as having to miss out sections of the interview or not providing a sufficient rationale for homework (Papworth et al, 2013), which may de-motivate the client and impair the therapeutic relationship. Additionally, if sections of the assessment are missed due to the shortened assessment time, practitioners may begin treatment without having gathered enough information and patients may be left feeling as though they are not having their needs met, which may impact upon the development of therapeutic alliance. As such, there is a strong emphasis for CPWPs to complete efficient assessments whilst utilising therapeutic skills to facilitate a therapeutic alliance and promote subsequent engagement. However, building a therapeutic alliance with reduced contact has led to criticisms (Farrand & Williams, 2010). These criticisms are consistent with Walther's (1996) findings that length and frequency of contact and amount of information exchanged improves relationships. However, recent research has contradicted this notion, with studies finding methods with reduced contact such as ICBT (Knaevelsrud & Maercker, 2007), and telephone CBT (Ormrod, Kennedy, Scott & Cavanagh, 2010) facilitate effective and strong therapeutic alliances. This is further supported by Klein et al.'s (2009) findings that patients with infrequent therapist-contact gave comparable ratings of therapeutic alliance than those who had significantly more therapist-contact. This implies that therapist contact and exchange of information are not key variables in developing therapeutic alliances. As such, it could be interpreted that Bordin's (as cited by Papworth et al., 2013) components of therapeutic alliance can still be effectively developed and maintained within LI interventions. Additionally, as therapeutic alliances have been found to promote patient use of self-help materials (Glasman, Finlay, & Brock, 2004), the reduced contact may not be a barrier to collaboration as the therapeutic alliance includes agreement on tasks and goals.

## Collaboration

Within traditional CBT, collaboration has positive associations with therapeutic alliances (Martin, Gaske, & Davis, 2000) and improved clinical outcomes for common mental health difficulties (Sighinolfi et al., 2014). However, with reduced therapeutic-contact and higher emphasis on patients completing homework tasks in LI interventions, it is important to build a collaborative relationship efficiently. Collaboration is essential within early experiences of treatment. Therefore, assessments within LI interventions are designed to be collaborative (Bennett-Levy et al., 2010). A core skill for PWP is to combine their theoretical expertise with patients' problems (Richards & Whyte, 2010). Although, LI therapists follow protocols, which could lead to therapists being overly task-oriented and neglecting the relationship. Chadwick (2006) argues that therapists need to develop a collaborative understanding of the problem rather than focusing on completing tasks. The protocols intend to be collaborative, but Reynolds (2003) claims protocols are a 'tick-box' exercise and not a genuine consideration of patients and not collaborative working. However, Turner (2015) found PWPs viewed telephone treatments to balance power by increasing patient contributions to therapy. Hence, LI interventions may facilitate collaboration by making patients more active within treatment and balancing control. This is consistent with Dahlberg, Todres and Galvin's (2009) research, which found low therapist input and more active roles for patients increases collaborative working and establishes reciprocal trust and respect. However, early therapeutic alliance may also aid collaboration (Glasman et al., 2004). With LI interventions, there is emphasis on collaborative working within the initial assessment. Therefore, it could be hypothesised that this counteracts the limited therapist input by focusing on educating and empowering patients to participate from the beginning of treatment (Turner, 2015).

Following the above discussion, a logical conclusion would be it is possible to develop and maintain a therapeutic relationship within LI interventions. Despite doubts raised over the capacity to build therapeutic relationships with reduced therapist input and contact (Farrand & Williams, 2010), research has shown factors which contribute to therapeutic relationships to be strong within LI interventions. Therapeutic alliance and collaboration have both been shown to be effectively developed with the specialism of LI interventions (Hadjistavropoulos et al., 2017; Dahlberg, Todres & Galvin, 2009), and both contribute to therapeutic relationships. These findings are likely due to the emphasis placed on collaborative working early in treatment (Bennett-Levy et al., 2010), the immediate focus

on empowering patients (Turner, 2015), and the more active role of patients within LI interventions (Dahlberg, Todres & Galvin, 2009). However, confounding variables such as patient drop-out have not been consistently controlled for and research is still scarce within LI interventions and therapeutic relationships. The lack of controlled, consistent research warrants further exploration of factors that contribute to effective therapeutic relationships in LI interventions. Future research should provide further empirical support to confirm or refute these findings, and investigate other factors including therapeutic skills such as empathy, and across other LI methods such as group interventions. However, considering current findings, it seems increasingly likely that collaborative working and therapeutic alliances can be effectively established in LI interventions. Although, due to LI interventions only recently being introduced to children's services, it remains to be seen whether this conclusion can be generalised to LICBT with children and young people.

The following half of the article aims to explain and explore concepts relating to engagement and assessment with children. It will discuss the assessment procedures for CPWPs in relation to anxiety presentations, to cast further light on the unproven applicability of LI interventions within children and adolescent mental health services.

### **Children and Young People's Psychological Wellbeing Practitioners**

The role of Children and Young Persons Psychological Wellbeing Practitioner (CPWP) was developed to assist with the expansion of the children and young people's mental health workforce (Health Education England; HEE, 2017). The primary duty of the CPWP is to deliver a high volume of low intensity interventions to children and young people presenting with mild to moderate mental health difficulties (HEE, 2017). With shorter appointment times and fewer sessions offered to clients, competency literature (Richards & Whyte, 2011) highlights the requirement of the CPWP to hastily develop therapeutic relationships, as well as establishing and maintaining client engagement, even within the early stages of treatment episodes. Throughout the following discussion, foundational skills and CPWP competencies will be examined in relation to client engagement and assessment.

### **Assessment Procedure**

As aforementioned, trainee practitioners are required to demonstrate an ability to engage patients and develop a strong therapeutic relationship. According to Cavanagh (2010), in order to engage clients, treatment should be accessible and well-matched to their

individual needs. Cavanagh also suggested that practitioners should possess an awareness that pre-therapy expectations can influence willingness to engage. With this in mind, it seems appropriate that providing information within initial sessions will offer a clear expectation of what to expect and reduce anticipatory anxiety (Abramowitz, Deacon, & Whiteside, 2011), thus strengthening the therapeutic relationship and aiding engagement. Core foundational skills utilised within initial assessments should therefore include information providing, validation of client's current problems, summarising, collaboration and Socratic questioning to generate discussion.

To promote engagement, information should also be given at the start of the assessment and practitioners should provide an opportunity for clients to ask questions before proceeding. This may include discussion around the purpose and the agenda of the session (including timescale), information sharing and confidentiality. CPWP assessment follows the suggested schedule outlined by Richards and Whyte (2011). This schedule is parsimonious in nature, as a means of gathering the minimal level of information required to inform treatment (Creed, Reisweber, & Beck, 2011). As a means of establishing a therapeutic alliance, the sessions are child-centred and information is provided in a developmentally-appropriate manner, as outlined by Fuggle, Dunsmuir, and Curry (2013).

**Information Gathering.** Here and now presentations are elicited and synthesised using the Four W's (what, where, when, and with whom is the problem better or worse) and a Socratic questioning approach (Richards & Whyte, 2011). As a means of developing a personal understanding of client's presenting difficulties, CPWPs create a brief five-aspect model (Padesky & Mooney, 1990) through the use of Socratic questioning and guided discovery (Wells, 1997).

**Impact.** Impact of the current problem is then discussed. Validation and positive reinforcement are provided throughout this process as a means of demonstrating empathy and developing rapport. As suggested by Fuggle et al. (2013), the initial session may also incorporate general discussion about hobbies and interests to facilitate the development of the therapeutic relationship, as well as ensuring that the initial session is not entirely problem-focused.

**Risk Assessment.** Risk is assessed within the initial appointment both subjectively and objectively through the use of observation and direct questioning. Additional information gathering regarding intent and plans highlights level of risk around suicide and self-harm to the practitioner. If necessary, information is then sought to establish a safety plan and protective factors.

**Routine Outcome Measures.** Standardised measures are used to guide assessment (Wright, Williams, & Garland, 2002) and a clear rationale should be provided to facilitate engagement. According to The Child Outcomes Research Consortium (CORC, 2017), both the Revised Child Anxiety and Depression Scale (RCADS; Chorpita, Moffitt, & Gray, 2005) and Goodman's Strengths and Difficulties Questionnaire (SDQ; 1997) are too developmentally advanced for young people under the age of eight. Therefore, if clients are below this threshold, measures may be offered to parents or carers to complete within the initial session as a means of measuring impact, total difficulties, and symptoms of anxiety and depression. It is possible that results provided by parents could be susceptible to inherent biases (Beitchman & Corradini, 1988) however, information gathered can provide an important perspective on the client's current difficulties.

Alongside assessment information and diagnostic criteria outlined in the DSM-IV (American Psychiatric Association, 2013), results from these measures can support discussion around intervention and treatment decisions (Thomas, Bruton, Moffatt, & Cleland, 2011).

**Problem Statement.** As a means of summarising current difficulties, CPWPs collaboratively develop a problem statement with their client, consisting of a trigger, symptoms experienced, and impact (Papworth et al., 2013). This approach has been highlighted as an effective means of prioritising client problems and selecting a suitable intervention (Richards & Whyte, 2011); as well as a helpful aid when developing treatment goals. It is possible however that developing a problem statement with clients could lead to adverse outcomes as potentially distressing issues are being summarised and drawn together (Papworth et al., 2013). Despite this, it could be argued that therapists demonstrating positive characteristics such as empathy and warmth could alleviate such difficulties and lead to the development of a therapeutic alliance, even within the early stages of therapy (Ackerman & Hilsenroth, 2003; Dunkle & Friedlander, 1996; Orlinsky & Howard, 1986). For some clients,

this task may be viewed as a positive experience as it can initiate discussion regarding potential treatment goals.

**Onset and Maintenance.** CPWPs then generate discussion around the onset of the problem and the possibility of this being subsequently maintained through safety-seeking behaviours (Rachman, Radomsky, & Shafran, 2008; Wells et al., 1995). The value of interventions offered for current difficulties may be weakened if such behaviours are not addressed (Clark & Ehlers, 1993; Freeman et al., 2007). Anxiety maintenance cycles highlight that avoidance and escape strategies utilised by clients may provide short-term relief, but do not allow for learning to take place regarding exposure and habituation (Centre for Clinical Interventions, 2016). Thus, resulting in clients attributing success to such behaviours as well as an overall increase in anxiety-based symptoms.

Safety-seeking behaviours may consequently be pursued during assessment. However, according to Thwaites and Freeston (2005), it can be difficult to distinguish whether such behaviours should be categorised as safety-seeking or a coping strategy. It was also contended that if such behaviours were cautiously utilised particularly in the early stages of intervention, it may have a facilitative effect for the client. Taking these findings into account, it could be argued that such behaviours are in fact adaptive coping strategies for catastrophic thoughts and could therefore be discussed further within clinical supervision.

**Precipitating and Predisposing Factors.** Information gathered during the assessment may also highlight a number of combined factors that could have resulted in the client being vulnerable to their current problem; including transmission of misinformation regarding adverse events, parental anxiety and behaviour inhibition. Adversities within childhood are well documented within the current evidence base as a predictor of anxiety (Clark & Watson, 1991; Friis, Wittchen, Pfister, & Lieb, 2002). Conversely, Rapee (2001) suggested that parental anxiety influences their reaction to such events and in turn, their child's genetic predispositions. Similarly, a review conducted by Murray, Creswell and Cooper (2009), maintained that vulnerability was heightened for children whose parents also experienced anxiety. Similar research proposed that paternal anxiety alongside behavioural inhibition could result in childhood anxiety and poor development of appropriate coping strategies and social skills (Muris, van Brakel, Arntz, & Schouten, 2011). Further, research posits that behaviourally inhibited children are predisposed to the development of anxiety

disorders (Kagan, Snidman, & Arcus, 1998; Svihra & Katzman, 2004). Each of these factors could therefore be considered throughout assessment and treatment.

**Goals and Expectations.** Client expectations are also discussed during the assessment processes. This information is used to collaboratively develop a SMART goal (Fuggle et al., 2013) based on the problem statement. The client's individual goal is then addressed in forthcoming appointments to track progress.

**Idiosyncratic Case Conceptualisation.** A combined formulation is then developed using the five-aspect model (Padesky & Mooney, 1990), applying relevant theoretical models such as Schneider and Lavalley's (2013) Integrative Separation Anxiety Disorder model and the Intolerance of Uncertainty model of GAD (Dugas & Robichaud, 2007). The relationship between cognitions, behaviour, emotions, and physiology is then explored with the client. The formulation produces a shared understanding of the current problem, so how it developed and how it was subsequently maintained, and allows for discussion to take place to socialise the client to LICBT in a way that is suitable for their development and literacy level, further promoting engagement.

## **Conclusion**

Assessment and follow up sessions allow CPWPs to gather information regarding their client's current problem, explore safety seeking behaviours and precipitating factors maintaining their anxiety. Interpersonal skills such as empathy, warmth and acknowledging the problem are conveyed throughout these sessions. Engagement can also be demonstrated through the use of non-verbal cues such as appropriate eye contact and nodding, as well as reflecting on items discussed. Additionally, engagement can be promoted through the use of information providing, collaboration, negotiation and validation.

As suggested by Fuggle et al. (2013), sessions are child focused and can allow clients to be creative. For example, pens and paper can be provided so that clients can draw any thoughts and feelings that they may be unable to verbalise. It was also important for CPWPs to find an appropriate balance between child-centred work with it not being too overwhelming or distracting. For instance, there may be potential distractions in the room such as posters, toys, drawings, and games. However, preparing a session plan and discussing this with the client beforehand can allow for participation in some of the games

present, and work creatively in a way that does not impede their session. In fact, it could be argued that working in this way may assist assessment and engagement as it allows for collaborative practice, as well as the development of the therapeutic alliance.

In summary, the above article outlines the factors involved in the development and maintenance of therapeutic relationships within LI interventions, and highlights the principles and practice of engagement and assessment with children, particularly for presentations of anxiety. CPWP assessments are short but effective means of gathering information from clients, and practitioners are trained and assessed on competencies relating to client engagement to ensure that sessions are personal and non-mechanistic. Consistent with the conclusion that research indicates that PWPs can establish effective therapeutic relationships with patients using LI approaches, the early signs indicate that a similar conclusion can be drawn for CPWPs. By following appropriate assessment schedules and portraying interpersonal skills, CPWPs can effectively assess and formulate clients' current difficulties, as well as develop and maintain authentic therapeutic relationships with clients and families alike; hereby promoting overall engagement.

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