

Parent-delivered CBT may reduce intervention cost, but questions arise about effectiveness

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Commentary on: Creswell C, Violato M, Fairbanks H, *et al.* Clinical outcomes and cost-effectiveness of brief guided parent-delivered cognitive behavioural therapy and solution-focused brief therapy for treatment of childhood anxiety disorders: a randomised controlled trial. *Lancet Psychiatry* 2017;4:529–539.

Context

Psychological treatment of anxiety-related problems in youth has a rich history, dating back to Sigmund Freud's work.¹ After decades of clinical literature and scores of treatment outcome studies, a growing consensus formed among experts that cognitive-behavioural methods were especially effective, particularly the behavioural component involving graded exposure to feared stimuli. Delivery of this treatment approach by professional therapists can involve substantial cost, so the effort by Creswell and colleagues to investigate the use of parents to deliver the treatment has practical significance, and the study's comparison between brief guided parent-delivered cognitive-behavioural therapy (GPD-CBT) and solution-focused brief therapy (SFBT) could add to the practical value of the study, as the authors suggest that SFBT is a common form of usual treatment in the settings studied.

Methods

In this randomised controlled trial, parents of participants allocated to GPD-CBT received a self-help book and weekly therapist-support sessions (four face-to-face sessions and four brief phone sessions), focusing on parent psychoeducation, anxious thought identification, graded exposure and problem solving. Participants allocated to SFBT received two parent-child sessions and four child-only sessions of future-focused counselling aimed at building solutions using individual strengths. The primary outcome was improvement on the Clinical Global Impression of Improvement (CGI-I) based on the Anxiety Disorders Interview Schedule (ADIS). Secondary outcomes included ADIS clinical severity ratings, anxiety symptom questionnaires and recovery from anxiety disorders on the ADIS for children who met diagnostic criteria at baseline. Treatment cost-effectiveness was assessed using parent-reported patient resource use and parent-reported and child-reported child quality of life questionnaires.

Findings

Participants (n=136) were randomly allocated to GPD-CBT or SFBT, with 59% of children in the GPD-CBT group and 69% in the SFBT group improving

on the CGI-I score at post-treatment. There were no significant differences between groups on primary, secondary or economic outcome measures. GPD-CBT was associated with non-significantly lower costs compared with SFBT. The authors suggested that analyses using methodology that accounted for uncertainty in base case cost-effectiveness estimates indicated that GPD-CBT was likely to be cost-effective compared with SFBT.

Commentary

The study addressed important questions, including evaluating the cost-effectiveness of two brief interventions that could be used in a stepped-care approach to youth anxiety treatment. However, the cost-effectiveness findings are difficult to interpret due to limited information on intervention content and the inconclusive nature of the effectiveness findings. The very brief description of SFBT (which was not designed specifically for treatment of youth anxiety) does not clarify what content that therapy included, and the brief description of GPD-CBT notes topics included in the parent training but not what parents actually did with their children. For example, exposure, which many experts consider essential to effective anxiety treatment,² is listed as one component of GPD-CBT, but implementing exposure with children can be challenging even for professional therapists, and it is unclear how much actual exposure was done with children in this study. The fact that GPD-CBT, designed specifically for youth anxiety treatment, showed no better clinical outcomes than generic SFBT makes it important to understand what actually occurred in the two treatments.

Whatever was done in the two interventions, the absence of a control group makes it hard to evaluate whether either produced gains that surpassed the natural time course of anxiety-related problems. Meta-analyses³ show that anxious youths assigned to control conditions improve from preintervention to postintervention assessments, so the questions of interest in randomised controlled trials would ideally include whether any active treatment being tested outperforms the spontaneous recovery or regression to the mean that typically occurs in youths from pretreatment to post-treatment. Taken together with questions about the actual nature and effectiveness of the two interventions, this makes it difficult to evaluate the importance of the cost-effectiveness conclusion, which would only matter in the context of an effective intervention.

Implications for practice

Actively engaging parents in CBT for their children might possibly be beneficial, but further research is needed to help clarify (a) what parents actually do in such treatment, and (b) whether parent-delivered CBT produces clinical outcomes that are substantial enough for cost considerations to be relevant.

Competing interests None declared.

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