2ND EDITION

Low-Intensity CBT Skills & Interventions

A practitioner's manual

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1

Low-Intensity Cognitive Behavioural Therapy

Revolution Not Evolution

Paul Farrand

Learning Objectives

By the end of this chapter, you should be able to:

- Appreciate the context justifying the emergence of low-intensity CBT
- Critically evaluate the fundamental characteristics of low-intensity CBT
- Demonstrate a critical awareness of the evidence base supporting low-intensity CBT and methodological limitations
- Critically appraise differences between low- and high-intensity CBT
- Demonstrate an awareness of key challenges associated with low-intensity CBT.

Background

On a worldwide scale, mental health service delivery is associated with underinvestment, excessive waiting times, lack of choice, significant demands on patients, large workforce variation and being poorly informed by the evidence base (Ngui et al., 2010). This has resulted in the World Health Organization seeking to increase the availability of mental health care for 100 million people over 5 years (World Health Organization, 2019), consistent with the ambitions proposed in the WHO Mental Health Action Plan (2021). These ambitions identify long-term ambitions to transform mental healthcare with *Closing the Gap: Priorities for Essential Change in Mental Health* (Department of Health, 2014) translating these into short-term action. To achieve these ambitions,

however, it has been recognised that an entirely new way of reorganising mental health delivery would be required (NCCMH, 2024).

Reorganising Mental Health Delivery

Improving Access to Psychological Therapies (IAPT) represents the first national implementation of a mental health programme to make evidence-based psychological therapies available to every adult needing them for the treatment of common mental health problems 'at the right time and in the right place' (Seward and Clark, 2010: 480). As the programme has now been fully implemented into mainstream service delivery across England, the name has been changed to NHS Talking therapies for anxiety and depression (TTad).

—Key Point—

The main drivers justifying development and implementation of TTad services for the treatment of common mental health problems (Seward and Clark, 2010) are:

- Justice-based care arising from the personal impact of mental health problems on patients (Layard and Clark, 2015)
- A strong clinical evidence base determined by the National Institute for Health and Clinical Excellence (NICE) informing mental health treatment
- A powerful economic case to address societal and lost productivity costs associated with mental health problems calculated to be in the region of £7–10 billion (Centre for Economic Performance, 2006)
- Recognition that solely focusing on increasing the availability of the high-intensity mental health workforce was no longer a viable option (Bennett-Levy et al., 2010).

These drivers created a strong '*constellation of rationale and evidence*' providing the initial momentum to justify and establish the IAPT programme (Seward and Clark, 2010: 480). The organisation of mental health service delivery informing TTad services has informed similar service developments on a worldwide scale in countries such as Australia (Hickie, 2004), Sweden (Svedin et al., 2021), Saudi Arabia (al-Harbi et al., 2023), and the USA (Renn et al., 2023).

Stepped Care

Prior to development of the IAPT programme it became apparent that achieving long-term ambitions to transform mental healthcare and meet epidemic level demands for treatment would require a fundamental change in the organisation of mental health treatment (Richards, 2010a). The change was to develop a mental health stepped care

delivery model enabling service delivery to be least restrictive (Chapter 5). Lower demands would be placed on patients in terms of costs and personal inconvenience and on service providers through the utilisation of a different workforce at Steps 2 and 3 of the stepped care model (Richards, 2010a). Rather than relying solely on high-intensity Step 3 face-to-face psychological therapists, the revolution in service delivery spearheaded the evolution of a new Step 2 LICBT psychological therapies practitioner workforce.

What is Low-Intensity CBT?

CBT is a psychological therapy with a strong evidence-base for the treatment of common mental health problems, alongside several severe and enduring mental health problems such as psychosis and schizophrenia (CG178; NICE, 2021). However, without unsustainable increases in the levels of funding (Layard et al., 2007) it is unlikely to radically improve access to evidence-based psychological therapy when only available within a traditional high-intensity CBT (HICBT) format. Revolution not evolution in the delivery of CBT was therefore required, leading to the implementation of CBT in the form of supported low-intensity CBT (LICBT) self-help interventions. Whilst LICBT has been implemented within Stepped Care (Richards, 2010a) and alongside wider organisational systems such as case-management supervision (Chapter 12) within TTad services, it represents a fundamental shift in the delivery of CBT.

—Key Point—

The core characteristics of LICBT are:

- Use of CBT-informed self-help resources to deliver CBT techniques (Richards, 2004)
- Delivery through a variety of CBT self-help interventions, primarily within written, computerised (cCBT), internet-based (iCBT) or mobile phone (mCBT) formats (Chapter 7)
- Support available through an increasing variety of platforms such as face-to-face (Chapter 7), telephone (Chapter 9), email (Chapter 10) or via a video (Chapter 11) format.
- CBT self-help interventions supported by a Step 2 LICBT psychological practitioner workforce supporting patients to use CBT self-help interventions (Health Education England, 2024a)
- Briefer session times required to support the patient to use LICBT techniques delivered through CBT self-help interventions
- Adoption of CBT self-help interventions for the treatment of common mental health problems directly informed by the evidence base.

Continued developments in the evidence-base still make a single definition capturing the elusive key characteristics of LICBT (Bennett-Levy et al., 2010). However, greater consensus is emerging following implementation within TTad services (Farrand et al., 2022).

Evidence Base

Consistent with HICBT, a large evidence base supports the implementation of LICBT in the form of guided written CBT, mCBT, cCBT and iCBT self-help interventions. This has informed the clinical evidence base for LICBT treatment of common mental health problems determined by NICE (National Collaborating Centre for Mental Health (NCCMH), 2023).

Interventions

There are over 30 systematic reviews and 50 controlled trials demonstrating the effectiveness of CBT self-help interventions for the treatment of common mental health problems (Delgadillo, 2018). Systematic reviews comparing guided CBT self-help with face-to-face psychological therapies have identified no significant differences in treatment effectiveness or drop-out up to one year post assessment (Cuijpers et al., 2010). However, variability in effect size across studies highlights the need for further research to recognise moderators that may be associated with effectiveness (Delgadillo, 2018). Research to date has identified clinical moderators to include mental health condition, support type and patients with existing depression rather than those at risk (Farrand and Woodford, 2013). Evidence is continuing to confirm effectiveness of LICBT for specific anxiety disorders, such as Generalised Anxiety Disorder (GAD; Powell et al., 2024), with emerging evidence highlighting benefits for specific groups, such as older adults (Wuthrich et al., 2023) and people with medically unexplained symptoms (McDevitt-Petrovic and Kirby, 2020).

Delivery and Support

The evidence base regarding ways to improve access through the provision of choice regarding cCBT, iCBT (Ritterband et al., 2010), telephone-based (T-CBT; Castro et al., 2020; Chapter 9), video working (Cromarty et al., 2020; Chapter 11) or email to support LICBT (Hadjistavropoulos et al., 2018; Chapter 10) is encouraging. A systematic review comparing face-to-face with iCBT demonstrated no difference in effectiveness (Carlbring et al., 2018), although greater effectiveness has been reported when supported (Karyotaki et al., 2021). Additionally, no differences emerged regarding drop-out, which has previously been identified to be a challenge for internet-based interventions (Christensen et al., 2009). Evidence has also demonstrated the utility of T-CBT (Bee et al., 2008; Chapter 9). In a randomised controlled trial comparing high-intensity face-to-face with T-CBT there was little difference

in effectiveness post treatment with lower attrition with T-CBT (Mohr et al., 2012). However, caution should be exercised given that treatment gains were better maintained with face-to-face CBT following the end of treatment.

Acceptability

An increasing body of research is highlighting the acceptability of LICBT, with features related to structure, content and procedure (Haller et al., 2019), and for specific groups such as armed forces veterans (Farrand et al., 2019a) and older adults (Cremers et al., 2022). In particular, acceptability is considered to be associated with a combination of guidance in the use of the self-help intervention alongside enhancing the patient's self-reliance (Haller et al., 2019).

Furthermore, good levels of acceptability have been demonstrated with telephone support for LICBT interventions (Lovell et al., 2006; Ludman et al., 2007), and patients' experience of cCBT for depression (Rost et al., 2017). Additionally, whilst some patients have expressed a preference for cCBT, the majority are generally ambivalent (Knowles et al., 2015). A complex relationship is therefore likely to exist between patients' preferences expressed towards delivery format and support type (Bee et al., 2010). This reinforces promoting choice of support type within a stepped care model (Bower and Gilbody, 2005).

Key Point

Evidence-based conclusions associated with LICBT:

- Guided CBT self-help is as effective as face-to-face psychological therapies for the treatment of common mental health difficulties, excluding post-traumatic stress disorder (PTSD) and social anxiety
- Use of cCBT, mCBT, iCBT and T-CBT offers the opportunity to improve access without reducing effectiveness
- Good levels of acceptability are associated with T-CBT and cCBT.

Differences Between HICBT and LICBT

Whilst both are grounded within a CBT model and informed by the evidence base, significant differences exist between HICBT and LICBT beyond time taken to deliver the intervention. Awareness of wider differences related to the clinical method and workforce is especially important if confusion between LICBT and Brief CBT is to be avoided. Brief CBT is a variation of HICBT with delivery of techniques condensed because of greater specificity and flexibility afforded to the therapist following treatment protocols (Hazlett-Stevens and Craske, 2004).

Clinical Method

With both LICBT and HICBT, the most obvious (often only!) difference identified by many is related to the dose of therapy (NCCMH, 2018) received by the patient. However, whilst a CBT model informs the clinical model within both high- and low-intensity CBT, several additional clinical features differentiate them (Table 1.1).

Table 1.1 Main differences between High- and Low-intensity CBT

Category	Difference	Definition
Clinical method	Therapeutic dose	Amount of therapeutic resource (session length, number of sessions) recommended to bring about change
	'Here and now' v. 'Longitudinal' cognitive behavioural formulation	Focus of the low-intensity CBT clinical method and treatment on the patient's presenting problem being experienced rather than on an appreciation of developmental factors
	Specific factor skills employed when questioning	Type of skills employed to reach an understanding of the patient's mental health difficulties
	Single-strand v. Multi-strand intervention	The number of CBT 'techniques/interventions' adopted in the treatment of a patient's mental health difficulty
Workforce	Responsibilities	Roles and responsibilities undertaken by a low-intensity psychological practitioner workforce compared to a high-intensity therapist
	Supervision	Differences in the type and characteristics of supervision received

Therapeutic Dose

Within HICBT the optimal dose of therapy is typically in excess of ten weekly 60-minute treatment sessions recommended by NICE for the appropriate common mental health problem. However, following an assessment in the region of 40 minutes, an average of five to eight briefer support sessions is typically received with LICBT (Bennett-Levy et al., 2010), thereby making better use of scarce resources (van Straten et al., 2015). Using NICE guidelines (NCCMH, 2018) to inform delivery of different doses of CBT, LICBT represents a way to achieve high-volume working that helps to improve access and democratise CBT (Bennett-Levy et al., 2010). Although treatment dose directly provided by the practitioner is lower in LICBT, it is likely that patients themselves spend similar amounts of time engaging with the interventions as with HICBT (van Straten et al., 2015). This possibility arises because of an increased emphasis on patients to engage with self-help interventions between sessions; engagement with HICBT is often limited to completing homework set.

Here and Now v. Longitudinal Cognitive Behavioural Formulation

During an LICBT assessment, the practitioner employs a range of common factor and questioning skills (Chapter 6; Richards and Whyte, 2011) to gain an understanding of features associated with the patient presentation in the here and now (Chapter 2). This informs the cognitive-behavioural model shared with the patient and informs selection of the appropriate CBT self-help intervention (Chapter 5). Within HICBT, however, a greater range of questioning skills, such as the downward arrow technique (Beck, 1995) are employed to inform a longitudinal cognitive-behavioural formulation that extends beyond the here and now (Figure 1.1).

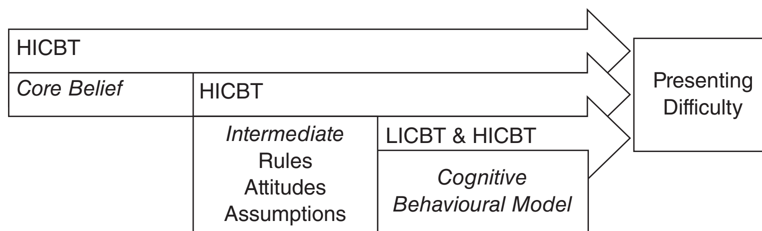

Figure 1.1 High- and low-intensity CBT formulation

A longitudinal formulation seeks to appreciate the influence of enduring cognitive distortions, such as intermediate – rules, attitudes, assumptions – and core beliefs, on the cognitive model that accounts for the way the presenting problem is impacting on the patient in the here and now (Beck, 1995).

Specific Factor Skills Employed When Questioning

As determined by the longitudinal formulation, HICBT assessment requires several specific factor skills (Chapter 6) to be employed to gain an understanding of the influence that intermediate and core beliefs have on the presenting problem. These include techniques such as continuum methods to evaluate negative schemas (Padesky, 1994). However, beyond skills such as funnelling (Chapters 2, 7) adopted at both high- and low-intensity CBT, the focus of an LICBT assessment on the here and now requires a narrower range of questioning and specific factor skills.

Single-Strand v. Multi-Strand Interventions

LICBT represents a single-strand approach (Turpin et al., 2010) whereby following assessment (Chapter 2) a clinical decision is reached (Chapter 5) to adopt a specific CBT self-help intervention from the LICBT toolkit (Part II). The practitioner then supports the patient to engage with the single-strand intervention. This contrasts with HICBT where evidence-based protocols specify the delivery of several different interventions as part of a multi-strand approach. For example, in the treatment of GAD, a treatment

protocol (Dugas and Robichaud, 2007) informing NICE (2020) guidelines specifies adopting cognitive restructuring to identify and challenge worry beliefs, problem-solving and exposure to uncertainty.

Workforce

Representing movement away from sole reliance on a Step 3 high-intensity CBT therapist workforce, the development and implementation of a Step 2 psychological practitioner role – Psychological Wellbeing Practitioner (PWP) – denotes a core feature of the IAPT programme. Whilst both workforces share generic and basic CBT competences, the CBT and problem-specific competencies associated with assessment and treatment differ (Roth and Pilling, 2024). With the high-intensity therapist workforce, specific multi-strand CBT interventions are delivered to the patient. This contrasts to competencies held by the Step 2 LICBT Psychological Wellbeing Practitioner workforce that empowers patients to manage their own recovery by providing them with ongoing support to engage with CBT self-help interventions (Chapter 7). Consequently, different competencies have implications for responsibilities placed on each workforce, making training and supervision of the Steps 2 and 3 workforces fundamental to the IAPT programme (Roth and Pilling, 2015).

Responsibilities

Similar to debates within healthcare surrounding responsibilities of assistant practitioners (Wakefield et al., 2010), there has been little clarity regarding how the LICBT psychological practitioner role fits within the wider mental health workforce. However, this is beginning to be addressed through the Psychological Professions Network (Psychological Professions Network, 2018), alongside development of professional body PWP registration processes. Professional bodies have now established accreditation criteria to recognise LICBT psychological practitioners as a competency-based and autonomous mental health workforce that make their own treatment decisions. With assistant practitioners or paraprofessionals (Farrand et al., 2009) there is vertical substitution of roles delegated by a professional role higher up the occupational ladder (Nancarrow and Borthwick, 2005). Within the IAPT programme, however, PWPs neither undertake delegated roles nor assist HICBT therapists. The PWP psychological therapy practitioner level role therefore has equal status with that of the HICBT therapist within the stepped care model, with outcomes mutually dependent on both workforces.

Training and Supervision

Within the IAPT stepped care model, significant focus is placed upon ensuring that the Step 2 LICBT and Step 3 psychological therapy workforce have received high-quality competency-based training. Training is informed by a nationally specified HICBT (HEE, 2022) and LICBT training curriculum (HEE, 2022), itself informed by a CBT competence

model (Roth and Pilling, 2007a). LICBT Psychological Wellbeing Practitioner training is supplemented by educator and student materials (Richards and Whyte, 2011) that have informed several features of this training manual. Ensuring accreditation of trainers and training programmes also helps to enhance fidelity to treatment delivery of LICBT interventions (Hides et al., 2010). Furthermore, separate curricula to inform training for the high- and low-intensity CBT workforce potentially reduces the likelihood of therapeutic drift, helping to maintain evidence-based practice (Waller, 2009). Differences between HICBT and LICBT also exist with respect to the types of supervision received (Chapter 12).

Challenges Encountered

Following implementation of the IAPT programme, a number of challenges associated with LICBT have been identified. In addition to accounting for an emerging evidence base, overcoming such challenges may serve to enhance an understanding of LICBT and assist in determining a suitable definition (Bennett-Levy et al., 2010).

Clinical Heterogeneity

Whilst based on a CBT model, significant variation exists with respect to the content and delivery of CBT self-help interventions (Farrand et al., 2022). In addition to differences in the content of interventions included within CBT self-help for the treatment of specific common mental health difficulties, variations are also evident regarding the CBT self-help format. Variation extends beyond differences between the modality to deliver self-help interventions, for example mCBT (Farrand et al., 2024), but also arises with respect to types of written CBT self-help approach. These can vary between intervention specific stand-alone worksheets, intervention specific CBT self-help booklets (e.g. Farrand et al., 2019a, 2019b), and books (e.g. Gilbert, 2009) that target a specific common mental health difficulty and include psychoeducation in addition to worksheets.

Lack of Consensus Regarding Single-Strand Interventions

Although LICBT represents a single-strand approach (Turpin et al., 2010), there is little consensus between researchers, LICBT psychological therapy practitioners and HICBT therapists regarding the composition of single-strand interventions. For example, within *A Recovery Programme for Depression* (Lovell and Richards, 2012), the cognitive restructuring intervention comprises a ‘thought diary’ to identify unhelpful thoughts and ‘evidence table’ to challenge them. However, ‘as long as the intention is cognitive or schematic change’ (Clark, 2013: 2), interventions such as behavioural experiments have also been associated with cognitive restructuring. This approach has been adopted within a cognitive restructuring intervention (Farrand et al., 2019a). However, when using this intervention, consideration needs to be given to ways of supporting the

behavioural experiment when undertaken outside the session (Chapter 7). Unlike HICBT, where in-vivo experiments are encouraged (Rouf et al., 2015), supporting interventions outside of a support session are not commonly undertaken in LICBT.

Therapeutic Drift during Support Sessions

Although clear distinctions should be drawn between LICBT and HICBT, challenges can be encountered when an LICBT psychological therapy practitioner drifts between supporting single-strand CBT self-help interventions and delivering multi-strand interventions (Waller, 2009). When the practitioner drifts into HICBT, adopting techniques such as downward arrow (Beck, 1995) or continuum methods (Padesky, 1994), challenges to working outside of competencies developed during training (Roth and Pilling, 2007a) or working within constraints imposed by the therapeutic dose is encountered. They may be more likely to arise when the LICBT psychological therapy practitioner drifts into employing HICBT techniques to deliver specific stand-alone worksheets within sessions rather than supporting the patient to work through CBT self-help workbooks between sessions. However, LICBT psychological therapy practitioners losing confidence in the LICBT interventions when patients show little sign of recovery has also been recognised as a factor that can lead to therapeutic drift (Telford and Wilson, 2010).

Therapeutic Drift within CBT Self-Help Interventions

The genesis of self-help as a concept informing self-help books (Smiles, 1859) precedes the development of CBT self-help. Consequently, CBT has been adapted in many different ways to inform the content of the self-help interventions leading to significant heterogeneity. This has resulted in some CBT self-help interventions being more representative of HICBT by adopting multi-strand interventions, longitudinal formulations and techniques to address more enduring cognitive distortions (Beck, 1995). For example, a commonly adopted written CBT self-help book for depression, *Overcoming Depression* (Gilbert, 2009) includes techniques such as cognitive restructuring but as part of a multi-strand approach including a compassion focus and addressing other difficulties that can be co-morbid with depression, such as anger. Additionally, multi-strand interventions have been adopted within iCBT programmes proposed to be LICBT with support provided by LICBT practitioners (Richards et al., 2018). For example, ‘Space from Depression’ includes techniques for depression such as behavioural activation, self-control desensitisation and cognitive restructuring alongside techniques used to challenge core beliefs. NICE guidelines for depression are cited as the justification for the approach taken. However, these guidelines highlight these techniques when used as part of a multi-strand approach within HICBT. LICBT self-help interventions adopting a multi-strand approach is therefore inconsistent with a single-strand approach associated with LICBT. They can drift away from

the focus of the difficulties presented in the here and now and address a longitudinal formulation and require a psychological practitioner workforce to drift from the LICBT clinical method.

Reflection Point

What implications for practice when selecting LICBT interventions arise as a consequence of heterogeneity in the CBT clinical method included within self-help interventions?

Whilst there is guidance informing the selection of CBT self-help interventions (Farrand et al., 2022; Richards and Farrand, 2010), the focus is largely upon criteria related to presentation, style and the evidence base but it largely fails to address characteristics differentiating low- from high-intensity CBT.

Key Point

Challenges encountered with LICBT:

- Clinical heterogeneity regarding the content and delivery of CBT self-help interventions, self-help format and types of written CBT self-help interventions
- Lack of consensus exists as to what constitutes single strand with respect to LICBT interventions
- Therapeutic drift between low- and high-intensity CBT arising with respect to both clinical support sessions and within the CBT self-help interventions.

Summary

For many years, service delivery has evolved to meet large increases in demand for mental health treatment. However, simply evolving mental health services has resulted in excessive waiting times, lack of choice and poor connection to the evidence base. Revolution in mental health service delivery based on the implementation of LICBT provides a solution to these challenges. This chapter has highlighted that whilst based on a CBT model, key characteristics associated with the LICBT clinical method serve to distinguish low- from high-intensity CBT with these characteristics addressed more extensively in other chapters. As can be common with a revolution however, several new challenges to be addressed have emerged.

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Further Reading and Resources

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