The concept and definition of low intensity cognitive behaviour therapy

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Abstract
There is confusion in the terminology used to describe different forms of cognitive behaviour therapy, in particular low intensity CBT. Such confusion has implications for research, clinical practice and service organisation. This thought-piece aims to describe the key components of low intensity CBT in comparison to brief standard high intensity CBT. It is proposed that low intensity CBT (i) utilises self-help materials, (ii) is six hours or less of contact time with each contact being typically 30 minutes or less, and (iii) any input can be provided by trained practitioners or supporters.. These components distinguish the intervention from brief standard high intensity CBT which (i) is based on the standard evidence-based CBT treatment, with therapy contact time 50% or less than the full CBT intervention, (ii) is usually delivered by someone with a core mental health professional qualification or equivalent. Brief CBT can refer to either low intensity CBT and/or brief high intensity CBT. We hope that making the distinction between these different forms of intervention stimulates debate and helps consistent and appropriate categorisation for future research and practice.

Background

The concept of low intensity psychological therapies, particularly cognitive behaviour therapy, has grown in importance over the past decade in response to the need to provide efficient, effective interventions that can meet the growing demand for mental health treatment. Such interventions are at the heart of the adult Improving Access to Psychological Therapies programme in England (Clark, 2018) but are also central to addressing the global need to access effective interventions across the age range and contexts (Michelson et al., 2020). Such interventions are frequently the first level of intervention provided to adults with depression and specific forms of anxiety who are then stepped up to a higher dose of treatment if there is an insufficient response to low intensity interventions. Low intensity interventions are designed to require less therapeutic input than conventional treatment and therefore considered low intensity from the providers perspective. Such treatments were building on a pre-existing, established evidence-base of brief CBT interventions, such as four sessions of problem-solving for emotional disorders provided over six weeks in primary care (Catalan et al., 1991), self-help interventions for anxiety and depression (Marks et al., 2003), and abbreviated versions of full CBT protocols (Cape et al., 2010; Clark et al., 1999). In this programme, high intensity therapy refers to standard CBT delivered by a qualified mental health practitioner, face-to-face, typically weekly for 12-20 sessions.

Low intensity CBT falls within the umbrella term of brief CBT but the two terms are not synonymous. The literature on brief CBT (often used as a shorthand for brief high intensity therapy) and low intensity psychological interventions has developed relatively independently. Additionally, new variants of standard , high intensity CBT such as blended CBT (Kooistra et al., 2014) and concentrated CBT are beginning to emerge (Öst & Ollendick, 2017). It is important to define these constructs since there are important clinical differences between them in terms of who delivers them, what is provided, where the treatment takes place, when they are considered appropriate, how the intervention is delivered, why each of them is selected and what happens if someone does not improve.

The evident inconsistency in the use of the constructs brief CBT and low intensity CBT also has significant research implications. Some meta-analyses of brief interventions have operationalised brief as more than two and less than 10 appointments and excluded self-help and psychoeducational groups (Cape et al., 2010) whereas other reviews included different forms of brief psychological treatments operationalised as interventions of fewer than 16-20 sessions within a time-limited framework, regardless of the use of self-help materials (e.g., Churchill et al., 2002; Hazell, Hayward, Cavanagh & Strauss, 2016). Reviews and syntheses of brief interventions have sometimes included both low intensity and abbreviated versions of full CBT protocols delivered by a qualified mental health professional (e.g., McNaughton, 2009; Cuijpers, Riper & Lemmer, 2004) and sometimes not (Cape & Kendall, 2011). Low intensity interventions have previously been considered as those designed to help patients self-manage their symptoms primarily using a health technology such as self-help books and independent of professional or paraprofessional input (defined as three hours or less) (Bower et al., 2013). However, this is not the definition used by others, for example five hours of practitioner input for parent-delivered guided self-

help was considered a low intensity intervention (Creswell et al., 2017). More recently, a low intensity internet intervention was described in a Swedish study as one which was unguided with weekly text reminders, but the high intensity intervention was 15 minutes of guidance with either a qualified clinician or a Masters student delivered over 12 weeks (Sundström et al., 2020). The varied use in labelling of interventions is likely to be influenced by context and settings, demonstrating the need for international consistency in the use of terminology to allow proper comparison and aggregation of data.

Aims

Given the inconsistency in the use of terms, the aim of this thought-piece is to compare and contrast the nature of brief high intensity CBT interventions with low intensity CBT to clarify differences and pave the way for a consensus for clinical and research purposes. A secondary aim is to clarify the differences between these constructs and blended and concentrated therapies. To achieve these aims, key definitions and conceptualisations of each of the constructs are synthesised based on reviews and meta-analyses (e.g., Bower et al., 2013; van Stratten, Hill, Richards & Cuijpers, 2014; Titov, Andrews & McEvoy, 2010), descriptions in clinical services (NHS England, 2020) and other influential works such as the Oxford Handbook of Low Intensity CBT Interventions (Bennett-Levy et al., 2010; Papworth & Marrinan, 2018). For example Bennett-Levy et al (2010) considered the central components of low intensity interventions to comprise a reduction in time spent with patients, use of specifically trained practitioners, use of CBT resources whose content is less intense such as self-help books and improved access to early intervention and preventative CBT components. The intensity of psychological treatments was considered only as time to deliver in the meta-analysis of van Stratten and colleagues (2014). The comparison below draws heavily on previous definitions but is also integrated with the descriptions from the other sources and, where specified, research data.

Table 1: A comparison of low intensity CBT and brief standard CBT

	Low Intensity CBT	**Brief Standard High Intensity CBT**
Who – delivers the intervention?	Any input is usually provided by practitioners or supporters who have been specifically trained to deliver the intervention. There is often no input (e.g. unguided self-help books, technology-based programmes).	Input is usually provided by mental health workers with a core professional qualification or equivalent e.g. accredited CBT practitioners.

Who – is it suitable for?	Not yet established; widely used to address anxiety and depression across the age range and behavioural problems in children (e.g., Bennett et al., 2019; Cuijpers et al., 2010) Evidence supports its use for cases of all severity (Bower et al., 2013; Karyotaki et al., 2018) Typically not advocated where there are significant risk issues.	Typically used widely for disorders where longer standard CBT would be appropriate.
What – is delivered?	Interventions are based on the principles of generic CBT to enable individuals to learn specific techniques (for example graded exposure, cognitive restructuring, problem solving) with the goal of alleviating emotional distress and improving functioning. Between-session reading and exercises are central.	Intervention is an abbreviated version of full CBT, supplemented with provision of between-session materials and exercises.
Where – is it delivered?	When guidance is provided to support the self-help materials, it is typically done so via telephone, face-to-face, video-facility, email, texts or online support/the internet.	Standard CBT delivered face-to-face or via video-facility and less often via email/text
When – is it delivered?	Typically as first treatment intervention.	Can be first treatment intervention or, in countries with stepped care , provided after insufficient response to first treatment intervention and/or full therapy is indicated due to complexity such as suicidality.

Why – is it delivered?	To deliver least burdensome intervention, have high volume caseloads with rapid turnover and meet demand; based on principles of clinical and cost effectiveness and appropriate dose of intervention.	Improving cost-effectiveness and aiming to provide appropriate dose of intervention.
How – is it delivered?	A health technology such as self-help books or technology-based intervention is used.	Between-session materials and exercises are advocated.
How – long is therapy?	Any input is typically 6 hours or less of contact, often delivered in 20-30 minute sessions.	Therapy contact time is typically 50% or less than the full CBT intervention, usually delivered in 50-60 minute sessions.
If not recovered, then what?	Referral to full high intensity therapy.	Referral to full therapy or specialist service.

Proposed definition of Low Intensity CBT

Based on the above, we propose a definition of low intensity CBT that (i) utilises self-help materials , (ii) is six hours or less of contact time with each contact being typically 30 minutes or less, and (iii) any input can be provided by trained practitioners or supporters.

We consider brief high intensity CBT (i) to be based on the standard evidence-based CBT treatment, with therapy contact time 50% or less than the full CBT intervention, (ii) is usually delivered by someone with a core mental health professional qualification or equivalent.

Brief CBT can refer to either low intensity CBT and/or brief high intensity CBT with therapy contact time 50% or less than the full CBT intervention but we recommend that a distinction is drawn between the different forms for clarity.

Defining other terms

The term blended psychological therapy should not be confused with either of the above but instead should be used when describing a blend of face-to-face (including remotely delivered via a video-conferencing platform) sessions with a qualified mental health professional and modules in an online programme that individuals follow independently with the actual duration of therapy being equal or shorter than standard face-to-face therapy (van der Vaart et al., 2014).

Concentrated psychological treatment (Öst & Ollendick, 2017) refers to interventions that have the same number of sessions as standard CBT but is carried out during a much shorter

time period, e.g. five sessions per week for three weeks where standard CBT is provided one session per week for 15 weeks.

The term intensive psychological treatment can be used to refer to therapies that are both brief and concentrated e.g., the one-session treatment for specific phobias (Öst & Ollendick, 2017).

Format of delivery

Group-based intervention is a format that can be delivered either as low intensity CBT, brief standard high intensity CBT or full CBT; duration of contact hours, use of CBT materials and the level of training of the person delivering the intervention should all be considered when determining into which category the specific group intervention falls.

As with group-based interventions, technology-based interventions (particularly internet-based interventions or digitally enabled therapy) could be blended , low-intensity or brief high-intensity depending on the nature of the intervention.

Troubleshooting

We appreciate that this proposed definition may cause some controversy and there may be examples whereby interventions described in published papers as low intensity will not fit the current proposed definition. Similarly, there will be some cases where an intervention does not appear to fit any of the definitions, for example, the recommendation for CBT for depression is 16-20 sessions (NICE, 2009) but a study might provide 7 hours of therapeutic input from a professional but using a guided self-help framework via chat or texting. Such difficulties of categorisation reflect the grey area between low intensity and other intensities or types of psychological interventions, where different permutations of input duration and type are provided in response to varied clinical needs. If interventions that do not fit neatly into the category of low intensity but are to be included in aggregated research syntheses, we suggest that they are simply considered within the umbrella term of brief CBT and described properly in detail to help facilitate replication of any findings.

Conclusion

There have been multiple terms used to describe the variants of psychological therapies which can be confusing and unhelpful when it comes to understanding the impact of different forms of CBT and their delivery. When synthesising the available research evidence, we have recommended that brief interventions distinguish between the low intensity interventions as described above, brief high intensity interventions and other abbreviated forms of CBT. The proposed definitions warrant further discussion and and evaluation based on empirical data. We hope that an increase in the use of consistent terminology will reduce confusion regarding the nature of the intervention, facilitate optimal service organisation and improve understanding of the efficacy of the specific forms of psychological treatment.

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