

Examination of Barriers to Treatment and User Preferences With Computer-based Therapy Using *The Cool Teens CD* for Adolescent Anxiety

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Abstract

In a pilot series, five adolescents received a multimedia computer-based self-help treatment program for young people with an anxiety disorder. They used the eight-module *Cool Teens CD-ROM* over a 12-week period on a home computer. A Preferences and Attitudes Questionnaire and a 10-question Barriers to Treatment Participation measure were developed and administered after 12 weeks of program use to assess the usability of this format of treatment delivery. Feedback showed that participants were generally satisfied with the multimedia content, the modules, and the delivery format of the CD-ROM. Specific likes and dislikes were reported and suggestions for improvement were made. These tended to reflect personal preferences rather than any recurring program weaknesses. Some treatment barriers were identified, with "finding time" rating highest. These findings can inform future design of treatment programs relying on multimedia delivery.

Keywords: *Anxiety disorders; adolescents; computer-based CBT; multimedia; self-help*

Introduction

Anxiety is one of the most common mental health disorders in young people in many countries and can produce marked interference in their lives (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kendall, Chu, Pimentel, & Choudhury, 2000). Despite the development of many effective cognitive behavioural therapy (CBT) programs for this problem (James, Soler, & Weatherall, 2005; Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004), access to treatment services remains a problem and it is estimated that only one in four teenagers in Australia receive professional help (NYMHF, 2005). A variety of treatment barriers may be involved, including lack of confidentiality, stigma, cost, geographic isolation, access to therapists, and discomfort with traditional therapy procedures and formats (NSW CAAH, 2005; Booth et al., 2004). Therefore, more creative and innovative approaches to treatment may be worth

exploring in this age group (Department of Health and Ageing, 2004).

Computer-based CBT (CCBT) might be one way to overcome some of these barriers by offering accessible, confidential, time-limited, low cost, non-face to face interventions that might also be less confronting and more engaging to adolescents. Promisingly, CCBT interventions have been shown to be a clinically efficacious and acceptable therapy format for various forms of anxiety in adults (Griffiths & Christensen, 2006; Spek et al., 2006). In order to better service adolescents with anxiety, a project team at Macquarie University's Anxiety Research Unit at the Centre for Emotional Health set about offering a new computer-based treatment option. As a result, we developed *The Cool Teens CD-ROM*, an independent self-help therapy program specifically for adolescents with anxiety (Cunningham et al., 2006; Cunningham, Rapee, & Lyneham, 2006).

The independent nature of self-help computer programs with adolescents, however, raises concerns about motivation, compliance, and effectiveness. Three potential problem areas are loss of the therapist-patient alliance, inability of the young person to be an independent learner, and lack of commitment to practice and implement the techniques that are learned. Once a young person has learned a technique during CBT, it is important to practice applying the new skill. "Homework" compliance has been shown to have an impact on treatment outcome in adults (see Kazantzis, Deane, & Ronan, 2000 for a review) and this may also be important for younger users (Rapee, Abbott, & Gaston, 2001). For the technique of exposure, Velting, Setzer, & Albano, (2004) note that unsupervised or unsupported development of stepladders (exposure therapy hierarchies) may lead to inappropriate or incomplete exposure, which may result in premature dropout or incomplete recovery. Therefore, the design of the CD-ROM to be engaging especially for the exposure modules was a major content challenge for the development of *The Cool Teens CD* (for full details on the content and modules of the program, see Cunningham, Rapee, & Lyneham, 2006).

Due to these potential problems with independent computer-based learning of CBT skills, when developing this program, great effort was made to find ways to engage young people, and increase independent learning and homework compliance. One of the main techniques used was to capitalise on the wide range of multi-media formats available with a CD-ROM. Our resulting program therefore consists of eight CBT therapy modules, which are used over a 12-week period. Modules target the two main CBT techniques for anxiety (cognitive restructuring and exposure), complemented by sections on psycho-education, goal setting, coping, maintenance and relapse prevention. The presentation of the concepts and skills used a combination of media formats including text, music, illustrations, audio voice-overs, cartoons, animated flow charts, interactive forms, and live video to deliver the content. The beauty of this format meant that we could include case examples of young people talking about their anxiety (played by actors), and interviews with psychologists describing the program. It was hoped that this range of media formats would engage the young person and keep them interested in the program.

Further, modules were designed to be relatively short, with each one taking 30 to 60 minutes to complete. Users were then encouraged to carry out additional practice tasks outside of time spent on the computer. In order to overcome potential problems with lack of homework compliance, in addition to using engaging media formats we also included some strategies proposed by Hudson & Kendall (2002) such as: positioning practice in a positive light, avoiding the term "homework", starting with easier tasks and moving to more difficult ones, and suggesting a reward system for completing and attempting practice tasks. This was coupled with the use of interactive forms that adolescents could complete online, i.e., doing thought challenging or building exposure hierarchies, which eliminated the need for pencil and paper.

CCBT programs are typically delivered using two formats: Websites, offering an online Internet experience, and CD-ROMs or DVDs, offering an offline delivery option. It should be noted that offline programs are often developed using software that could allow Internet downloading of the files required, thus offering the additional possibility of reduced distribution cost and delivery time while still not requiring continuous online access. There are several pros and cons for both of these computer-based delivery formats (Christensen, Griffiths, & Evans, 2002), and these have been discussed in a recent comparison (Cunningham, Donovan, & March, 2007) of two Australian programs for anxiety in adolescents: *The Cool Teens CD-ROM* (Cunningham et al., 2006), and the BRAVE-ONLINE website (Spence et al., 2008).

When the Cool Teens project began in 2004, no substantial data existed regarding the feasibility or user acceptance of CCBT for anxious adolescents. So to

begin, preferences and attitudes towards a prototype version of *The Cool Teens CD* were elicited from nine adolescents who had previously been treated for an anxiety disorder and 13 non-clinical teens (Cunningham, Rapee, & Lyneham, 2006). Participants rated all multimedia components positively, but showed a preference for live video in some sections. They reported the CD-ROM format was easy to use and visually appealing. Those adolescents who had previously participated in face-to-face group treatment all reported they would be satisfied to use this format for learning anxiety management skills.

In order to prepare for a large randomised controlled trial comparing a group treated with *The Cool Teens CD* with a waitlist group, a pilot case series was conducted. The clinical results of this case series indicated that the adolescents showed clinical improvement in anxiety and that they were generally satisfied with the multimedia content, modules, and delivery format of the program (Cunningham et al., 2008). However, given the potential for computer-based treatments to become widespread, a more detailed analysis of treatment participation and barriers, as well as user preferences when using CD-ROM-based treatments, is warranted. The present article therefore focuses on the detailed findings from the Barriers to Treatment and User Preferences questionnaires that were developed to provide specific feedback on the format of *The Cool Teens CD-ROM* program.

Method

For a detailed description of the diagnostic and symptom assessment methods and materials used in this case series, the reader is referred to the article reporting the clinical data (Cunningham et al., 2008).

Participants

Four females (aged 14 to 16 years) and one male (aged 16 years) were recruited from successive parental referrals to the Macquarie University Anxiety Research Unit, Sydney, Australia between March and May 2006. The main inclusion criteria were: a principal diagnosis of an anxiety disorder, age between 14 and 18 years, and access to a home computer. Each adolescent and a parent gave their written consent for the adolescent to participate. The study was approved by the Macquarie University Ethics Review Committee (Human Research).

Measures

Preferences and Attitudes Questionnaire. This questionnaire was developed specifically for this study. It asked participants to list their likes and dislikes about the CD-ROM and to rate each of the multimedia components (screen text, non-moving pictures, live video, cartoons, sound voiceovers, animated flow charts, interactive forms, navigation system, appearance enjoyment) on a 5-point scale ("Very Bad" to "Very

Good”) and the eight CBT modules on a 4-point scale (“Very Useful” to “Not Useful”).

Barriers to Treatment Participation Scale. Participant satisfaction with the program was measured using a brief, adapted version of the Barriers to Treatment Participation Scale (Kazdin, Holland, Crowley, & Breton, 1997). The scale was reduced to a more adolescent-friendly list of 10 questions about the delivery of CCBT eg. Q1: Finding time to use the CD was difficult and Q2: I had technical problems with the CD. All ten items are listed in Table 1. Questions were answered using a scale from 1 (“Never a problem”) to 5 (“Very often a problem”).

Treatment

Participants received the 8-module, multimedia *Cool Teens CD-ROM* and used it over a 12-week period on a home computer. The content of the CD-ROM modules is based on material from the well-established Cool Kids anxiety management program that delivers these same cognitive behavioural skills through a 10-week therapist-lead group treatment program—The Cool Kids Program: Adolescent version, Macquarie University Anxiety Research Unit, Sydney (Lyneham, Schniering, Hudson, & Rapee, 2005). This program has previously been shown to be efficacious in clinical settings, school settings, telephone-based delivery, and bibliotherapy format (Mifsud & Rapee, 2005; Lyneham & Rapee, 2006; Rapee, Abbott, & Lyneham, 2006). The CD-ROM is an adaptation of this CBT program.

In this pilot study, use of the CD was supported by some therapist contact. A clinical psychologist made a telephone call to each participant every two weeks. During these support calls, the therapist worked through a set of questions regarding the user’s progress and understanding of material completed over the previous two weeks. Another purpose of the contact calls was to provide motivation, to keep participants moving through the modules at a reasonable pace, and, if needed, to provide a way for them to seek additional help or clarification around the skills they learned.

Procedure

Once all questionnaires and consent forms were received, participants were sent *The Cool Teens CD-ROM* for use over an initial period of 12 weeks. They were asked to work through the self-help program on their own and were informed that they would receive a brief telephone call from a psychologist every two weeks to assess their progress. A further 12 weeks of follow-up use was completed for clinical assessment.

After 12 weeks of therapy, all participants completed post-treatment clinical interview over the telephone. They were asked to complete post-treatment questionnaires, a Barriers to Treatment Participation feedback form, and a User Preferences and Attitudes questionnaire. When all study data were received, each participant was sent a \$30.00 payment to compensate them for their time spent on the research components.

Results

Four of the five participants completed between six and eight of the modules on the CD-ROM within the 12 weeks. One participant dropped out in week 4 after completing only two modules, reporting she no longer had anxiety and required no further therapy; this participant and her mother reported that the early CD content, especially the psychoeducation module, had helped her discuss and work on her problems more with her family. Her improvement in anxiety symptoms was reflected in her post-assessments and questionnaires. The length of the scheduled telephone support calls with participants ranged from 5-20 minutes per session (mean = 13.5, SD = 6.82) and there was no additional adolescent-initiated contact through telephone calls or emails. Participants reported spending a range of between 0-7 hours using the skills they had learned in the program during the previous week (outside of time on the computer).

Four participants returned completed program use and barriers questionnaire forms. The feedback regarding the usefulness of the eight CBT modules varied from “A Bit Useful” for the Stepladders I and II and Other Coping Skills modules, to “Very Useful” for the psychoeducation (Understanding Anxiety) and Setting Goals modules.

The feedback ratings for many of the media components of the CD were positive (mostly rated as “Good” or “Very Good”), with the exception of the Interactive Forms section, which received a lower overall rating (“Average”). The most highly rated component was the Overall Appearance, followed by Audio voiceovers, Flowcharts, and the Navigation system. The Screen text, Images, Live video, and Cartoons were all rated as “Good”. The “Enjoyment Factor” was rated as “Average” by two participants and “Good” by two others. The qualitative feedback comments from participants regarding their main likes and dislikes about the CD-ROM were as follows:

Likes:

- Hearing other people’s stories (I’m not alone)
- Explained what anxiety was and how to help me through it
- Calming music
- Anxiety case examples
- Structural content
- Stepladders for working on problems

Dislikes:

- Some questions could be easier to understand
- Admitting my anxiety
- Doing practice tasks
- Not fun
- Not enough detail about my own problem
- Amount of sections that need input (writing steps)

Three participants made suggestions for improvement:
 “Maybe have more animated components”
 “Make it a bit more interesting and fun”
 “Maybe more variety”

“Technical problems”. “Didn’t understand tasks”, “Too much personal information” and “Not enough therapist support” were not seen as barriers (see Table 1).

With regard to barriers to treatment, participants listed “Finding time” as the biggest barrier, followed by

Table 1: Barriers to Treatment ratings by participants.

Barrier	Very often	Often	Sometimes	Occasionally	Never
Finding time	●	●	● ●		
Technical problems		●	●	●	●
Understanding the content		●	●		● ●
Lost interest		●	●		● ●
Too much personal data			●		● ● ●
Not enough therapist support					● ● ● ●
CD was boring			● ●		● ●
Didn’t address my problems			● ●	●	●
Didn’t understand tasks				● ● ●	●
Didn’t want to practice tasks			●	● ● ●	

● = 1 participant rating of how often this barrier was a problem during program use

Discussion

The pilot research reported here was a case series that evaluated several clinical outcomes with five adolescents who used *The Cool Teens CD-ROM* for the treatment of diagnosed anxiety disorders over a 12-week therapy period. This article focuses on the User Preferences and Barriers to Treatment data collected during this pilot study.

Participant user feedback indicated that the program was well received by the pilot audience for delivering and practicing the various CBT techniques it presents. The range of likes and dislikes that were identified in this sample may suggest that individual users might have personal preferences regarding what they deem to be the most positive and negative aspects of a CCBT program such as Cool Teens. For example, some adolescents particularly liked the case examples and related to the adolescent shown, while others did not relate to these characters as strongly.

However, most the feedback regarding the media aspects of the program was positive and the format seems to have worked in terms of maintaining user interest in the program. Reported dislikes seemed to relate more to the content or the therapeutic process; for example, having to admit anxiety, understanding a specific module, and carrying out practice tasks. Practice tasks are an inevitable part of CBT. Although some participants did not like filling in forms, the feedback ratings and comments show that most were able to complete all forms enough to benefit from the program. Perhaps future program developers might try

to find innovative ways to reduce the dislike of practice tasks further.

The Barriers to Treatment data indicated that the biggest barrier for adolescents using this program was “finding time”. This is supported by clinical notes that indicated some adolescents had difficulties maintaining regular use of the CD during exam and assessment periods at school. Other common barriers to treatment were “technical problems”. This related partly to the fact that some adolescents thought they needed to install the program, and also due to a few other technical glitches throughout the course of using the program (e.g., forgotten passwords, a non-functioning CD that had to be replaced).

Fortunately, potential barriers such as: “CD was boring”, “Didn’t want to do practice tasks”, “Too much personal information”, “Didn’t address my problems”, “Not enough therapist support” and “Didn’t understand tasks” were not seen as major barriers in this sample. Due to the therapist contact that formed part of the research protocol, the latter two issues could not be properly assessed in this case series study and need to be explored in a self-help context in future studies.

Given that finding time was listed as the biggest barrier to treatment, program developers need to find ways to reduce the impact of this barrier. Suggestions include allowing more time and more flexible use of the program so that adolescents can afford to not use it during exam weeks and instead use it more in school holiday periods.

Since the overall pilot cases data suggested that there could be compliance and motivation issues with the

CD-ROM for some adolescent users, some changes to the program and research approach were made after the pilot study before embarking on our full randomised controlled trial. Since exposure therapy was not fully understood by some participants, one structural and one content change were made to the associated two modules of the CD-ROM.

The very small number of participants in this pilot series resulted in a restricted range of ages and anxiety diagnoses; the user preferences and barriers to treatment feedback needs to be further assessed across anxiety disorders, gender, and age ranges in further studies. We are currently measuring these Barriers and User Preferences in our randomised controlled trial.

While *The Cool Teens CD* was designed as a self-help program, it could potentially be used for delivery as a minimal-support therapy with the involvement of a non-psychologist such as a family doctor, as explored by other researchers (Shandley et al., 2008). The professional could assist the teenager to remain motivated and to problem solve their challenges. In the current research approach, the CD-ROM was coupled with minimal contact from a clinical psychologist. This method of treatment delivery could also be explored as an adjunct therapy for reducing frequency of face-to-face sessions, thereby reducing overall therapist time.

In addition to future considerations for design enhancements to the CD-ROM, other delivery improvement options can be explored (e.g., add some parent involvement, offer a peer support website, integrate two or three live sessions with a therapist at key periods in treatment). Based on early studies and future research, alternative instructional design approaches and improvements can be explored to improve clinical efficacy and user satisfaction.

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Research Profiles

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