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Have Phobias, Will Travel: Addressing One Barrier to the Delivery of an Evidence-Based Treatment

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Although a host of evidence-based treatments exist for youth with anxiety disorders, less than 30% of youth and their families receive these treatments. One of the main barriers to receiving these treatments is the lack of access to care, due largely to the absence of mental health professionals who have expertise in the delivery of these treatments in certain geographic locales. The current study examined whether a brief intensive treatment for specific phobias (SPs), Augmented One-Session Treatment (OST-A), would result in comparable treatment gains for families who traveled a considerable distance to receive this treatment when compared to families who resided in our local community. Participants included 76 youth with a clinically confirmed diagnosis of SP (38 local families and an age- and sex-matched sample of 38 nonlocal families). Although SP severity at pretreatment was significantly greater for the nonlocal youth than the local youth, both nonlocal and local youth showed commensurate improvement and maintenance of treatment gains over a 6-month period across several clinical outcome measures. Findings from this study show that OST-A is effective when families choose to travel for treatment, addressing at least one of the barriers to use of this evidence-based treatment.

Keywords: specific phobias; children and adolescents; one-session treatment; brief interventions

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ANXIETY DISORDERS ARE AMONG the most common disorders affecting children and adolescents, with up to 32% of youth meeting a lifetime prevalence for an anxiety disorder (Merikangas et al., 2010) and up to 10% meeting criteria for an anxiety disorder at any one point in time (Essau & Gabbidon, 2013). These disorders tend to emerge in mid to late childhood and result not only in a poor quality of life (Liberman, Larsson, Altuzarra, Öst, & Ollendick, 2015) but also negative mental health outcomes across the lifespan (Creswell, Waite, & Cooper, 2014). As a result, the financial and societal costs of these disorders are considerable (Lynch and Dickerson, in press). Despite the public health burden of these disorders, they remain largely untreated in youth, with a majority of youth either not having access to or simply not receiving evidence-based treatments (Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016; Kazdin, 2015).

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In recent years, the efficacy and effectiveness of cognitive-behavioral therapy (CBT) for the treatment of anxiety disorders in youth has been well established (see Higa-McMillan et al., 2016; James, James, Cowdrey, Soler, & Choke, 2013; and Reynolds, Wilson, Austin, & Hooper, 2012, for reviews). For the most part, this evidence base has been accumulated from "standard" CBT interventions that typically consist of 10 to 16 weekly sessions delivered on an outpatient basis by highly trained professionals. Although effective for a majority of youth in these studies, between 25% and 40% do not remit (Higa-McMillan et al., 2016; James et al., 2013; Ollendick & King, 2012; Reynolds et al., 2012). On a broader scale, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) has estimated that fewer than half of the individuals who are in need of psychological services actually receive treatment. Furthermore, Wang and colleagues (2005) estimated that only about 30% of the treatments individuals do receive fall into the "at least minimally adequate treatment" category (p. 631). Recently, Harvey and Gumport (2015) reaffirmed these estimates worldwide and identified access to care as one of the major barriers to evidence-based treatments.

To address lack of access to care, recent trends in psychotherapy research have witnessed the development of brief, intensive treatment approaches. These trends reflect a movement for more parsimonious and effective interventions that have the potential to deliver treatment in a cost-effective way and to reach more individuals who are in need of treatment (Öst & Ollendick, 2017). In general, these brief, intensive approaches have modified traditional CBT approaches by reducing either the number of sessions or the time period in which or over which the treatment is delivered. Like traditional CBT, these approaches are typically delivered face-to-face and in a clinic setting by highly trained professionals. As noted by Öst and Ollendick, these new approaches constitute a revolution in the delivery of mental health services in that they provide intervention outside the typical "therapy hour" and in fewer than the 10 to 16 sessions that characterize traditional CBT in the treatment of childhood anxiety disorders.

In a recent set of papers published in *Psychopathology Review* (see Ollendick, 2014), the potential applicability of brief, intensive interventions was reviewed in the treatment of six major anxiety disorders in childhood and adolescence: specific phobias (SPs), social anxiety disorder, separation anxiety disorder, generalized anxiety disorder, panic disorder with and without agoraphobia, and obsessive-compulsive disorder (formerly categorized as an anxiety disorder in the DSM-IV; American Psychiatric Association, 2000). Although the papers in this review suggested the potential cost-effectiveness of these brief interventions and that they might be more desirable to some families who do not have access to standard CBT interventions in their local communities, these papers did not examine the effectiveness of these approaches. In a recent meta-analysis of 23 randomized control trials examining brief, intensive interventions across various childhood anxiety disorders, Öst and Ollendick (2017) reported that the effect sizes for these brief treatments in comparison with waiting-list and placebo control treatments were significant, and did not differ from those found with standard CBT approaches. Indeed, remission rates at posttreatment and follow-up for the brief treatments (54%/64%) and standard CBT (57%/63%) were virtually identical; furthermore, both were significantly higher than placebo control conditions (26%/35%) and wait list control conditions (7%/9%). Within-group effect sizes at post and follow-up were large for both the brief treatments and for standard CBT, indicating maintenance of the effects of these brief treatments up to 12 months, just as with standard CBT approaches. Of importance, although six different anxiety disorders were examined in this meta-analysis, support was greater for brief, intensive treatments for SPs than it was for the other anxiety disorders; indeed, 13 of the 23 studies (56.5%) examined outcomes for SP with each of the 13 studies showing these treatments to be effective. Similarly positive outcomes were obtained for the other five disorders, although the amount of support was limited.

Advantages of these brief interventions are evident. First, the children and adolescents do not have to attend sessions on a weekly basis since the treatment can be carried out in 1 day, 1 weekend, or 1 week. Second, these approaches reduce functional impairment and distress more rapidly than standard treatments since they are carried out in a briefer period of time. Third, these approaches fulfill a need for nonlocal families who live some distance from a professional trained in the delivery of these cost-effective and evidence-based treatments. Families can travel to the therapist's place of practice and stay for a brief period while receiving these effective treatments.

In the current study, we addressed whether a brief intensive treatment, One-Session Treatment (OST) for SPs (Öst, 1989, 1997), would be as feasible and efficacious for families who chose to travel a considerable distance to receive this treatment as it was for families residing in our local community. OST consists of a single, 3-hour session of graduated exposure in combination with elements of psychoeducation, participant modeling, positive reinforcement,

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