

## Rainbow SPARX: A Novel Approach to Addressing Depression in Sexual Minority Youth

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*A seven-module computerized cognitive behavioral therapy (CCBT) program (Rainbow SPARX) was developed for adolescents with depressive symptoms who are also sexually attracted to the same sex, both sexes, or who are questioning their sexuality (i.e., sexual minority youth). In this paper a rationale for the use of CCBT amongst sexual minority youth with depression and a brief overview of the intervention are provided. Acceptability, feasibility, and preliminary data on Rainbow SPARX's effectiveness, based on a pilot feasibility trial, are provided. Twenty-one sexual minority youth (male 52.4%) aged 13–19 years old with significant depressive symptomatology were enrolled in the study. Almost all the participants (n = 19, 90.5%) completed at least four out of seven modules of Rainbow SPARX and the program received favorable usefulness and likeability ratings. Depressive symptoms decreased significantly post-intervention ( $p < 0.0001$ , pre- to post-effect size  $d = 1.01$ ) and this was maintained at 3-month follow-up. Rainbow SPARX is an acceptable, feasible, and promising intervention, which can be offered as a self-help resource that can be used in privacy and without stigma or can be used as an adjunct to face-to-face therapy.*

SEXUAL minority youth (i.e., adolescents who are sexually attracted to the same sex, both sexes, or are questioning their sexuality) have increased rates of depressive symptoms relative to their heterosexual or exclusively opposite-sex attracted peers (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Bezinovic & Tkalcic, 2005; Bos, Sandfort, de Bruyn, & Hakvoort, 2008; Espelage, Aragon, Birkett, & Koenig, 2008; Galliher, Rostosky, & Hughes, 2004; Hatzenbuehler, 2009; Lam et al., 2004; Lucassen et al., 2011; Udry & Chantala, 2002, 2005; Wilkinson & Pearson, 2009; Williams, Connolly, Pepler, & Craig, 2005), and although they demonstrate a willingness to discuss their health and well-being (Ciro et al., 2005; Lucassen et al., 2011), young people who are not exclusively opposite-sex attracted report they are more likely to have difficulty accessing health care for emotional worries (Lucassen et al., 2011). These difficulties may be linked to the challenges in finding a therapist skilled at working with sexual minority youth, especially in small towns or rural areas (Hardin & Hall, 2001).

Cognitive behavioral therapy (CBT) is a structured, short-term, psychological therapy (Beck, 1995), and evidence

suggests that it is an effective intervention for adolescent depression (Watanabe, Hunot, Omori, Churchill, & Furukawa, 2007). The general principles of CBT are the same for all groups, and CBT can be used effectively with sexual minority youth (Martell, Safren, & Prince, 2004; Safren, Hollander, Hart, & Heimberg, 2001); however, CBT for sexual minority youth requires some adaptation, to take into account the unique socio-political and interpersonal challenges faced by these young people (Almeida et al., 2009; Horn, Kosciw, & Russell, 2009; Purcell, Campos, & Perilla, 1996; Williams et al., 2005). For instance, from a cognitive perspective, sexual minority youth are frequently exposed to negative attitudes about same-sex sexual attraction and this often leads to the development of harmful core beliefs, which are theoretically linked to the development of psychological dysfunction (Safren et al., 2001). Furthermore, unlike people from various ethnic subpopulations, sexual minority youth do not typically share their minority status with their family, and instead of providing support, the young person's family can contribute to their levels of distress (Safren & Rogers, 2001).

Internationally there is a shortage of trained health professionals in the child and adolescent mental health field (Department of Health, 2004; Gough & Happell, 2007; Mental Health Commission, 2001, 2004; Productivity Commission, 2005; Safren et al., 2001; The Werry Centre, 2011), and despite sexual minority youth having increased rates of depressive symptoms, many CBT clinicians do not have sufficient knowledge, experience,

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or training to work with this population (Safren et al., 2001). It is important to recognize that, in addition to sexual minority youth having particular difficulty obtaining therapy for their depression, young people with depression generally also have difficulty accessing treatment (Mariu, Merry, Robinson, & Watson, 2012; Raviv, Sills, Raviv, & Wilansky, 2000). The challenge then is to make evidence-based interventions like CBT available to those who are underserved. Computerized cognitive behavioral therapy (CCBT) offers an opportunity to address this problem by using technology to deliver evidence-based interventions (Richardson, Stallard, & Velleman, 2010). CCBT consists of any Internet or computer-based program used for the delivery of CBT (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010), and includes interventions that are entirely self-help as well as those that include at least some level of clinician support.

CCBT is increasingly being offered in a stepped care approach as a form of intervention for those seeking treatment for mild to moderate depression (Kaltenthaler et al., 2008). For example, "Beating the Blues" (a form of CCBT) has been recommended by the National Institute for Health and Clinical Excellence (2006) and it is used throughout the United Kingdom's National Health Service (National Institute for Health and Clinical Excellence, 2006). There are numerous advantages or strengths associated with CCBT: it is acceptable and effective (Calear & Christensen, 2010; Richardson et al., 2010); requires less (if any) therapist time (National Institute for Health and Clinical Excellence, 2005); can be accessed at a time and place that suits the user (Abeles et al., 2009); and can be used to disseminate standardized treatment efficiently (Abeles et al.). Only a handful of CCBT programs have been developed specifically for adolescents with depression, and the programs that have been previously recommended for young people did not have an interface likely to engage with and appeal to this young audience. As a result, the authors of this paper (and others in their research group) decided to attempt to develop an appealing, interactive, and effective CCBT program (SPARX). Internationally there are only seven other CCBT programs that have been used with adolescents with depression, specifically "Stressbusters," "Master Your Mood Online," "CATCH-IT," "MoodGYM," "Reach Out Central," "Think, Feel, Do," and "The Journey" (Richardson et al., 2010; Shandley, Austin, Klein, & Kyrios, 2010; Stallard, Richardson, Velleman, & Attwood, 2011; Stasiak, Hatcher, Frampton, & Merry, 2012).

SPARX (smart, positive, active, realistic, x-factor thoughts) is a seven-session CCBT program specifically developed for young people with depressive symptoms and has been shown to be appealing to and effective for adolescents seeking help for depression and adolescents

excluded from mainstream education who suffer from depression (Fleming, Dixon, Frampton, & Merry, 2012; Fleming, Dixon, & Merry, 2012; Fleming & Merry, 2012; Merry et al., 2012). The majority of CCBT programs for adolescent depression utilize a similar short-term treatment approach to SPARX, with between 5 to 14 sessions/modules typically offered and a mean of 7.9 modules provided (Merry et al., 2011; Richardson et al., 2010; Shandley et al., 2010; Stallard et al., 2011; Stasiak et al., 2012). Most of these CCBT programs are delivered online and two, like SPARX (i.e., "Stressbusters" and "Think, Feel, Do"), have been provided via CD-ROM (Abeles et al., 2009; Stallard et al.). The efficacy of SPARX has been demonstrated in a large randomized controlled noninferiority trial (RCT; Merry et al., 2012); however, SPARX was made for young people generally and did not include content of specific relevance to sexual minority youth. CCBT may be particularly useful in the treatment of sexual minority youth with depression, as it could be made freely available and would be accessible to this often isolated population. Having a computerized version of treatment also allowed for tailoring the content to address some of the challenges that are likely to underpin depression in this population. The current study describes a customized version of SPARX (called SPARX: The Rainbow Version or Rainbow SPARX) developed for sexual minority youth.

Our objectives for the open pilot trial were as follows: (a) to ascertain the acceptability of Rainbow SPARX (using the results of a post-intervention satisfaction questionnaire and by establishing completion rates); (b) to assess feasibility (based on recruitment and uptake rates); and (c) to collect preliminary data on the program's effectiveness.

## Method

### Participants

Participants were sexual minority youth (i.e., young people attracted to the same sex, both sexes, or not sure of their sexual attractions) aged 13 to 19 years old with depressive symptoms (i.e., Child Depression Rating Scale-Revised raw score  $\geq 30$ ) at baseline, living in Auckland (a city and region with over 1.5 million people), New Zealand. Sexual minority youth with severe depressive symptoms, at risk of suicide or self-harm, could be included, provided they reported receiving additional support from a school guidance counselor, therapist, and/or general practitioner.

Potential participants who were not receiving the necessary face-to-face support pre-intervention were not excluded from the study, but were referred for support by the researcher (MFGL). Those receiving antidepressant medication or other relevant therapies (e.g., CBT or interpersonal therapy) were able to take part; these additional treatments were documented at the

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