University of Southampton

Doctoral Programme in Educational Psychology

Title: Academic critique: Cool Kids

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Introduction to case

Reason for involvement

Toby (name changed) is a year 7 pupil. His secondary school requested the involvement of the Educational Psychology Service (EPS) in January 2012. At that time Toby was presenting with anxiety about attending lessons, and he was spending significant amounts of time in the toilet in the learning support building. He was attending a maximum of one to two lessons per day, and became tearful given the prospect of going to a lesson. School staff were concerned that he could potentially become a school refuser. He had not previously been known to the Educational Service or any other agencies.

Enquiry methods

I arranged an initial consultation meeting with Toby's parents and school staff. During the meeting I explored Toby's background and established how long concerns had been present. Toby has always been a high achiever academically and both school and parents agreed that there were no concerns about his learning. There was a general consensus that Toby had found the transition to secondary school difficult and that he wished he could go back to primary school. He was described as a popular boy and enjoys break times. His mother had visited the GP about Toby's frequent need to urinate at school and no medical reason was suggested. His mother reported that he had wet himself at primary school and was embarrassed by this.

I met with Toby to explore his perceptions and understanding of the world using principles from Personal Construct Psychology (Kelly, 1963). Toby presented as a polite young man. On a scale of 0 – 10 (with 0 correlating with a low score and 10 with a high) he

rated school overall at a 2. He stated that things would be better if he could go back to primary school where he had one nice teacher all the time. School was not less than a 2 because he did have a few nice teachers. The constructs of kind or nice and mean or scary featured strongly in Toby's account of the people in his life. Toby explained that he does not like going to lessons where he has a scary teacher because he is afraid to ask to go to the toilet, and he worries because he feels like he needs to go. The more Toby worries about it the more he feels he needs to go. I hypothesised that spending time in the toilets was a safety behaviour to avoid experiencing anxiety in lessons. Furthermore, it was self-reinforcing as the more time Toby missed in lessons the more anxious he became about going back to the lessons through a fear that his teachers would be annoyed with him, dislike him or tell him off in front of his peers.

Toby also completed the Spence Children's Anxiety Questionnaire (Spence, 1998), and scored in the elevated range for generalised and social anxiety. I explored his desire to change through discussion and completion of a pros and cons table for current behaviour as well as elements from solution focused approaches to inform goal setting.

As a result of my meeting with key adults in Toby's life as well as the individual work I completed with Toby, I felt that Toby would benefit from some individual sessions to develop his coping strategies. Toby's mother received an appointment at an anxiety clinic in the local area, and following assessment, Toby was offered individual cognitive behavioural therapy. I contacted the anxiety clinic and agreed to work collaboratively with the therapist, supporting with the implementation of behavioural tasks in school. The approach was informed by Cool Kids (Lynham, Abbot, Wignall & Rapee, 2003), a cognitive behavioural programme which is also used in my EPS.

Outcomes

Six sessions into the programme Toby is attending the majority of his lessons on time and remaining for the duration. Qualitative comments from Toby indicate that he found the sessions on coping strategies to be particularly helpful. He also reported that he valued my support in terms of facilitating a meeting with his teachers. School staff reported that Toby continues to visit the toilets in the learning support building between lessons. He is still anxious about using toilets in the main school and my ongoing involvement will be to identify a staff member to continue to reinforce the principles and use of coping strategies. Furthermore, I will be involved in his transition to plan to year 8.

Literature review

Theoretical underpinning

Cognitive behavioural interventions are commonly used with anxious children and stem from traditional Cognitive Behaviour Therapy (CBT) models used with adult populations (Cartwright-Hatton, Roberts, Chitsabean, Fothergill & Harrington, 2004). CBT is based on the theory that dysfunctional thoughts lead to anxious feelings and maladaptive behaviours (Beck, 1976). Intervention includes elements of psychoeducation, cognitive restructuring and behavioural activities including graduated exposure to feared situations. Cool Kids is designed for children aged 6 – 12 years. Intervention takes place over 8 – 10 sessions that last approximately one hour.

Through the psychoeducation element, which is covered at the beginning of the intervention, children are taught to understand the link between thoughts, feelings and behaviour. Children are also taught to identify physiological sensations associated with anxiety, therefore increasing their awareness of the different ways their body reacts to anxiety and stress. Providing explanations that normalise the experience of anxiety is an important

part of this phase. Furthermore, the early stages of intervention are important for establishing rapport with the young person.

Once children can identify the somatic symptoms associated with anxiety, they are then supported to take steps to manage their worry. In support of information processing theories, which suggest that anxious people have overactive 'danger schemas' (Kendall, 1985), anxious children have also been found to interpret ambiguous information as more threatening compared to non anxious children (Vasey & Dadds, 2001). Intervention involves identifying unhelpful cognitions, followed by practice in challenging them by looking for evidence and identifying more realistic, balanced thoughts. Anxious children are also more likely to engage in avoidance behaviour (Barrett, Rapee, Dadds & Ryan, 1996), which becomes negatively reinforced. Cool Kids therefore aims to support children to face their fears through graded exposure to feared situations. Using principles from Social Learning theory (Bandura, 1977), the emphasis is on tackling small steps, with positive reinforcement through the use of rewards incorporated with each step.

Alongside exposure, children are taught problem solving strategies and coping self-talk. Legerstee, Garnefski, Jellesma, Verhulst and Utens (2010) found that anxious children were significantly more likely to use unhelpful coping strategies such as rumination and catastrophising as opposed to approaches such as positive reappraisal compared to non-anxious children. Providing information on positive coping may also provide the child with a sense of self-efficacy and control (Bandura, 1977), a lack of which is thought to be associated with anxiety (Weems, Silverman, Rapee & Pina, 2003). Homework tasks are set at each stage of skill learning to encourage participants to practice and build fluency. The aetiology and maintenance of anxiety is generally viewed ecosystemically. An additional parent component is designed to inform them of the principles of the programme and teach alternate

ways of interacting with their child, so that they can also model and reinforce the skills being practiced.

Effectiveness in practice

In the last two decades a number of controlled studies have examined the impact of CBT for anxious children and young people. Cartwright-Hatton et al (2004) conducted a systematic review of ten randomised controlled trials (RCTs) published between 1994 and 2001. They found a significant positive effect for CBT interventions (structured, skills based packages including Cool Kids) compared to no treatment controls in the reduction of anxious symptoms. Specifically, the remission rate for anxious disorders was 56.5% for CBT groups versus 34.8% for control groups. Studies were included if the participants in the samples were under 18 years old and had diagnosed anxiety disorder. All but one of the studies was conducted in a clinical setting. A similar review was conducted by Compton et al (2004), which included twenty one RCTs that used alternative active treatment controls as well as no treatment controls. Findings indicated medium to large effects for symptom reduction in anxiety following CBT intervention. Gains were largely maintained over time (3, 6 and 12 months) and up to as much as 6 years after the intervention (Barrett, Duffy, Dadds & Rapee, 2001), however, conclusions are limited due to inadequate control groups at follow up.

While these findings are promising, efficacy trials are conducted in controlled conditions and thus generalisation to natural contexts is often not clear. Furthermore, effect sizes are heterogeneous across individual studies and findings consistently show a percentage of participants who do not respond to the intervention (Compton et al, 2004; Cartwright-Hatten et al, 2004). A range of variables are likely to impact on intervention effectiveness, for example individual factors such as symptom severity and type, age, gender and external factors such as the setting, size of group and level of therapist training (Kendell &

Choudhury, 2003). Compton et al reported that gender was largely equally represented across the studies. The mean age was 9.85 and the researchers cautioned the generalisability of findings to older adolescents who were less represented in the studies. Ten of twenty one studies analysed the influence of these variables as moderators of outcome, yielding a general consensus that there was no significant impact. However, Compton et al cautioned these findings due to the low power of many of the studies to address this adequately. There is some evidence that the size of the group can have a differential impact depending on the type of anxiety, for example Manassis et al (2002) found that children with high social anxiety reported greater gains in the individual CBT condition compared to group. However, both conditions led to decreases in anxiety overall.

Neil and Christensen (2009) conducted a systematic review of school based programmes aimed at early intervention and prevention of anxiety. In addition, they sought to establish the impact of different control groups, implementation methods and intervention type on outcomes. The majority of programmes had 8 – 10 sessions. CBT based programmes made up three quarters of the sample, and produced a median effect size of 0.57. An evaluation of Cool Kids was included within this review as an indicated programme with a post-test effect size of 0.35 and a follow-up effect size of 0.57 (Misfud & Rapee, 2005). Effect sizes were considered to be marginally better than non CBT approaches but were not formally tested. The type of leader (teacher versus mental health professional) or control group (attention control versus waitlist or no treatment) did not impact on the overall significance of the findings. Teacher led interventions were successful in significantly reducing symptoms of anxiety, although median effect sizes were smaller than for mental health professionals.

The evidence-based impact of parental involvement in CBT interventions for anxiety compared to child only CBT is unclear, despite being viewed generally as a positive thing

(Cartwright-Hatton et al 2004; Neil & Christensen, 2009). In the literature, three main types of parental involvement are defined; parents as consultants (e.g. providing information), collaborators (e.g. supporting with the child skill acquisition) or co-clients (receiving support to manage own anxiety; Kendall, Furr & Podell, 2010). Some studies have suggested that parental anxiety may be important in predicting outcomes, with some studies indicating that involvement is only beneficial when parents are also anxious (e.g. Cobham, Dadds & Spence, 1998). However, this finding is not consistent. Breinholst, Esbjorn, Reinholdt-Dunne and Stallard (2012) suggest a number of factors that may account for inconsistencies in the literature including differences in treatment delivery, parental factors targeted, lack of an explicit model of change, different outcome measures, and gender of the child and parent. From a developmental perspective, Kendall and Choudhury (2003) suggest that the type and impact of parental involvement may vary depending on the age of the child, with older children needing greater autonomy. To date, few studies have addressed these issues, and those that have were not sufficiently powered to make adequate conclusions (Creswell & Cartwright-Hatton, 2007).

As well as child and parent variables, the relative effectiveness of particular components of CBT packages is also unclear in the literature, for example the role of behavioural exposure or cognitive restructuring in promoting change and for whom these elements are most likely to be effective. Developmentally, these activities place particular cognitive demands on children including 'self-reflection, perspective taking, understanding causality, reasoning, and processing new information, as well as linguistic ability and memory' (Grave & Blissett, 2004, p402). Some researchers have argued for alternative measures that tap into cognitive and behavioural changes in addition to just symptom reduction to begin to answer some of these questions (Hudson, 2005).

The role of non-specific factors in bringing about change, such as the therapeutic relationship has been somewhat overlooked in research. Kendall, Goosch, Furr and Sood (2008) highlighted the importance of 'therapist flexibility' in delivering CBT packages whilst still adhering to the programme. Therefore, variations in outcome may be attributed in part to therapist behaviours. Some studies have sought to control for this by employing active attention control groups. Hudson et al (2011) compared the Cool Kids CBT programme to a package that consisted on nonspecific, therapy components. One hundred and twelve 7 – 16 year olds were randomly allocated to the group CBT condition or a group support and attention (GSA) condition. The results showed that 68.6% of participants in the CBT group no longer met the criteria for anxiety disorder compared to 45.5% of those who received GSA indicating that cognitive behavioural principles provide specific benefits over and above non-specific therapeutic factors. There were some discrepancies between child reports versus parents and clinicians highlighting the importance of multi-informant measures. Furthermore, there was no wait-list control limiting the conclusions that can be made about the relative impact of the conditions compared to having no intervention.

Critical appraisal of the literature

Undertaking a review of the literature highlighted the complexities surrounding cognitive and behaviour change with children and young people. In the first instance it was helpful to know that a manual based approach such as Cool Kids had strong empirical support, following review of a number of RCTs. While the majority have been conducted in clinical settings, more recent findings from studies of school based approaches are encouraging. In the current case, the programme appears to have been beneficial for Toby in the short term. However, the sustainability of the gains Toby has made is crucial for me and the evidence for long term gains is patchy. Furthermore, as identified in the literature, it is

difficult to decipher whether the programme itself has made a difference or the additional attention that Toby received. I remain interested in the impact of the therapist relationship, as my own experience is that change is unlikely to occur in the absence of a trusting and supportive relationship.

Given the discrepancies within the literature, it seemed to me that a certain amount of professional judgement was required to pick out the most important factors when using a CBT package. In this case, Toby took part in an individual programme rather than participating in a group, and the evidence suggests that there is no significant difference in outcome. His mother was involved as a consultant and as a collaborator, attending the beginning and end of every session that Toby had at the clinic. Given that Toby's difficulties were largely school based I also viewed the behaviour modification teacher as a collaborator to assist with skill acquisition. The function of the school system appears to be understudied in the current literature; however it represented a key difficulty for Toby. In particular, his anxiety was exacerbated by not feeling in control, for example of his bodily functions and of when he could go to the toilet. While the coping strategies may have fostered a sense of control over his bodily functions, the system continued to be unpredictable in other ways. Furthermore, his fear of being told off remained as it was modelled around him with other students.

The school setting provided both benefits and challenges, and it was useful to analyse research on school based programmes versus clinical settings. Given that the exposure tasks took place within school, I was able to facilitate with this. However, I encountered difficulties with negotiating meetings with Toby's many teachers in such a large school. Furthermore, opportunities for positive reinforcement by acknowledging and rewarding steps were frequently lost. The need for flexibility was salient and given Toby's age and

developing autonomy, self-reinforcement became a priority. While the clinical involvement is due to end after eight sessions, a priority will be locating a member of staff within school to continue to support Toby with his other fears as he is not yet generalising skills learnt. The evidence that school staff can also successfully deliver CBT packages was helpful to know.

Future practice

I would consider using Cool Kids or a similar CBT intervention again in the future with children who are presenting with anxiety. Delivered in a school setting, I would be conscious of the systemic factors that serve to maintain or reinforce anxiety and work within this level as much as the child level. To work in the most effective and resourceful way given the limited time often available to practicing EPs, I would consider building capacity by delivering it alongside a member of staff who could follow on support. Supervision was important to me, particularly while supporting exposure tasks and would be something I would build in to any work with staff.

Given the gaps in the research in terms of the most effective elements of CBT, I would consider monitoring and evaluating the changes more sensitively throughout intervention. However, following current evidence based approaches I would include all elements currently targeted within packages so as to adhere to CBT principles. At the same time, I would be flexible in delivery in relation to the cognitive developmental demands, parental involvement and needs of the child in order to ensure rapport is maintained.

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