UNIVERSITY OF Southampton

Doctoral Programme in Educational Psychology

FRIENDS for Life: An Academic Critique

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Introduction

Childhood Anxiety

Experiencing some anxiety in childhood is considered developmentally normative, and sometimes adaptive (Miller et al., 2011). Nevertheless, when anxiety results in significant distress and impairment, it can be pathological. The most prevalent form of psychopathology in children are anxiety disorders (Neil & Christensen, 2009) and an NHS report estimated the prevalence at 7.2% in 5-19-year olds (Vizard et al., 2018). Prevalence could also be higher, with many children presumably remaining undiagnosed, and others estimate that anxiety affects over 20% of children (Friends Resilience, 2017). Anxiety disorders typically emerge during childhood, adolescence or early adulthood and peak in middle age (Bandelow & Michaelis, 2015), with a common onset before 11 years old (Kessler et al., 2005).

Children with anxiety disorders can experience significant impairments in multiple domains, including compromising their quality of life and psychosocial functioning (Mendlowicz & Stein, 2000). Higher childhood anxiety has been associated with social impairments like decreased peer acceptance and higher victimisation (Erath, Flanagan, & Bierman, 2007). Childhood anxiety disorders are also associated with increased risks of developing depression and substance misuse, educational underachievement, withdrawal from school, lower earnings in adulthood and substantial economic costs to society (NICE, 2014; Woodward & Fergusson, 2001; Ameringen, Mancini, & Farvolden, 2003; Public Health England, 2016; Fineberg et al., 2013). Given the relatively high prevalence of anxiety disorders and their potential impact, prevention and early intervention is crucial.

School Setting

The recognition of anxiety disorders in primary care can be poor (NICE, 2014) and only around one in five young people with anxiety disorders receive treatment (Essau, 2005). Additionally, many children who do not meet DSM-5 criteria or have subthreshold anxiety levels will not receive clinical intervention and pressures on child mental health services mean that schools

are increasingly supporting children with high anxiety. Schools can be effective settings to implement mental health interventions as they enable children to practice skills in natural contexts, in a range of social interactions. They enable modelling, opportunities for peer/group feedback and reduce the barriers people typically face when accessing community services (Barrett & Pahl, 2006; Henefer & Rodgers, 2013). Additionally, NICE (2013) recommend that children and young people with Social Anxiety Disorder (SAD) should be offered treatment where they feel most comfortable. Given the high prevalence, low treatment rate and significant impact on functioning evaluating methods to prevent the development of childhood anxiety disorders through the school environment is imperative.

The FRIENDS for Life Programme

The FRIENDS for Life (FFL) programme (Barrett, Lowry-Webster, & Holmes, 2000a, 2000b, 2000c, 2000d) is a well evaluated school-based programme for the prevention and treatment of childhood anxiety. FFL is a Cognitive Behavioural Therapy (CBT) based intervention aimed at reducing anxiety and promoting emotional resilience (Henefer & Rodgers, 2013) in children aged 8-11 years old. FFL is based on the 'Coping Cat' programme (Kendall, 1994) and is designed to be facilitated by teachers, and mental health professionals.

FFL is a 10 session, manualised programme, with each session expected to run weekly for roughly one hour. FFL is intended to be implemented in small groups of six to 10 children, with two booster sessions following completion to facilitate the generalisation of skills (Barrett & Pahl, 2006). FFL also includes two parent sessions which aim to encourage parents and children to work together to increase confidence, problem solving and coping skills (Barrett & Pahl, 2006). FFL can be delivered as a universal or targeted intervention and is intended to address all levels of prevention, early intervention and treatment in schools (Wigelsworth et al., 2018).

Cognitive Behavioural Therapy

FFL is based primarily on the CBT model. CBT is a talking therapy that links thoughts with feelings and behaviours and is based on the work of Beck (1964). Individuals learn to recognise unhelpful thoughts which leads to developing more helpful thinking styles, changes in feelings and modifications to behaviour (Wigelsworth et al., 2018). CBT interventions usually involve developing anxiety management strategies, systematic desensitisation, operant conditioning, modelling, cognitive restructuring, relaxation techniques and problem-solving skills (Barrett & Pahl, 2006). FFL teaches children skills in the following areas: cognitive (identifying and challenging unhelpful cognitions), emotional (identifying and managing anxiety), and behavioural (developing problem solving skills and using graded exposure), informed by the CBT model (Wigelsworth et al., 2018). Many studies highlight that CBT is effective at reducing children's anxiety (e.g. Kendall, 1994; Barrett, Dadds & Rape, 1996; Higa-McMillan, Francis, Rith-Najarian and Chorpita, 2016). Furthermore, a Cochrane review found CBT to be an effective treatment for childhood and adolescent anxiety disorders (James, James, Cowdrey, Soler, & Choke, 2013). Consequently, individualised/group CBT is a recommended treatment for children with SAD (NICE, 2013).

Evaluating the Evidence Base

The appendix gives details of the systematic search strategy used for this critique. 23 papers were identified for review.

FFL has developed a large international evidence base since its launch in 1998 (Wigelsworth et al., 2018) and is the only anxiety prevention programme acknowledged by the World Health Organisation (WHO, 2004). Large-scale reviews suggest that FFL has a positive impact on anxiety and typically report small to medium effect sizes. For example, Briesch, Sanetti and Briesch (2010) systematically reviewed 14 studies comprising of over 1800 participants ranging from six to 19 years old in Australia, Canada, the UK and the US. Effect sizes ranged from small to large and authors suggested that FFL is a viable intervention for use in schools. Furthermore, Higgins and O'Sullivan (2015) systematically reviewed 14 Randomised Controlled Trials (RCTs) from Australia, Germany and Ireland, comprising of over 3000 participants, ranging from four to 16 years old. This review identified that FFL has a positive impact on anxiety with small to medium effect sizes.

Systematic reviews often include studies adopting randomised designs using control comparisons, and the RCT design allows stronger conclusions to be made about causality of outcomes. Nevertheless, the heterogeneity of studies included in these reviews make generalisations to certain populations within specific schools difficult. Often, the age range of participants are wide, ranging from four to 19 years old in the above reviews. Since FFL's intended audience is eight to 11 years old, these wide age ranges make it difficult to draw conclusions on the efficacy of the intervention as it was originally intended to be implemented. There are also implementation differences between studies in reviews. Although FFL appeared to be delivered as intended, the frequency of booster and parent sessions varied, differences in measurements of intervention fidelity were found and variances in follow up measures were evident. Lastly, reviews tend to include both universal and targeted use of FFL. Whilst systematic reviews suggest that FFL has a positive impact on children's anxiety, the heterogenous studies included highlight difficulties with solely relying on reviews to make conclusions about FFL's effectiveness in specific schools. Consequently, evaluating findings from single studies can be efficacious.

Universal Intervention

Many individual studies have looked into FFL's effectiveness as a universal programme and many have found FFL to be effective in reducing children's anxiety (e.g. Rose, Miller & Martinez, 2009; Stallard et al., 2005; Stallard, Simpson, Anderson, Hibbert, & Osborn, 2007). Nevertheless, some studies show that FFL does not have a significant impact on anxiety (e.g. Wigelsworth et al., 2018; Ruttledge et al., 2016). These inconsistent findings suggest that several factors impact the effectiveness of FFL as a universal intervention.

Firstly, findings vary depending on who implements FFL within school. Wigelsworth et al., (2018) identified that high-quality delivery of FFL predicted reductions in self-rated worry and Stallard et al's., (2014) RCT concluded that FFL led by health professionals, compared to school

staff/teachers, led to significantly higher reductions in anxiety. In Briesch et al's., (2010) systematic review, studies where clinically trained staff implemented FFL achieved medium effect sizes compared to small effect sizes when teachers/school staff implemented FFL. Gallegos-Guajardo, Ruvalcaba-Romero, Garza-Tamez and Vilegas-Guinea's (2013) qualitative findings suggest that students and parents found 'changing negative thoughts into positive thoughts' the most helpful component of FFL and, similarly, Rose et al., (2009) reported that students liked understanding the difference between unhelpful and helpful thoughts. Although all implementors are likely to have the same initial training, clinically trained staff or health professionals may have expertise in therapeutic skills which evoke the most positive impact for children. Supervision could also be essential for enhancing effectiveness. Ahlen, Hurtstil, Tanner, Tokay and Ghaderi (2018) found a reduction in children's anxiety symptoms only amongst teachers who attended a larger number of supervision sessions. Consequently, experience and supervision opportunities could be important predictors of FFL effectiveness as a universal programme.

Secondly, some universal studies have measured protocol fidelity and found that teacher adherence is good (e.g. Ahlen, Breitholtz, Barrett & Gallegos., 2012; Ruttledge et al., 2016). In contrast to reviews that stress the importance of programme fidelity (Durlak & DuPre, 2008), Kösters et al., (2017) showed that when prevention workers implemented FFL and did not strictly adhere to protocol, this did not negatively impact outcomes. Lower programme adherence was actually rated more positively by students. Notably, prevention workers may have therapeutic skills and experience with CBT principles that enables them to rely less on protocols, therefore, protocol fidelity may be more important for teachers/school staff.

Thirdly, findings from individual studies can vary depending on participants' initial baseline anxiety. Following analyses of the universal FFL intervention, several studies have separately analysed data of participants whose anxiety levels are highest at baseline. These analyses tend to show significantly higher reductions in anxiety (e.g. Ahlen et al., 2012; Stallard et al., 2005; Stallard et al., 2007). Whilst these findings could result from floor effects that may occur in universal samples with lower symptomology, they may also suggest that FFL is most effective for students with higher baseline anxiety.

Additionally, various studies devise their 'highly anxious' groups in an arbitrary way and solely rely on child self-report measures to do so. For example, Stallard et al., (2005) identified the top 10% of children with the highest anxiety through self-report to form their 'high risk' group. Whilst self-report may be a convenient data collection method in schools, it increases the chance of social desirability biases if used alone and does not create a holistic understanding of a child. Research shows that children often self-rate anxiety differently to

their mothers (e.g. Pereira, Marques, Russo, Barros, Barrett, 2014), therefore studies solely relying on child self-report to create arbitrary groups risk reducing validity (Stallard et al., 2005; Stopa, Barrett, & Golingi, 2010; Ahlen et al., 2012; Stallard et al., 2007). Nevertheless, some studies adopt a multi-informant methodology, measuring anxiety from multiple perspectives using combinations of child, parent, teacher and peer ratings showing mixed results (e.g. Ahlen et al., 2018; Kosters, Chinapaw, Zwaanswiik, Wal, & Koot, 2015; Pereira et al., 2014; Ruttledge

et al., 2016). Inconsistent findings could be because parents, teachers and peers may not have accurate insight into a child's internalised anxiety symptoms and may be better at recognising externalised symptoms. This could explain differences found between child and parent ratings in the Pereira et al., (2014) study or why Kosters et al., (2015) found no significant effects in teacher report data and increases in internalised anxiety according to peers following FFL. Consequently, these studies highlight the importance of adopting a multi-informant methodology to a gain holistic understanding.

Lastly, universal studies vary in using follow up measures. Children require time and practice to generalise skills from FFL (Ruttledge et al., 2016) and research shows that children aged nine to 10 show treatment gains immediately, whereas children aged 11-12 show anxiety reductions at six- and 12-months following interventions (Essau, Conradt, Sasagawa, & Ollendick, 2012). Additionally, when CBT is taught to children, impact can usually be seen several months post-intervention (Rose et al., 2009) and it is intended that two booster sessions are run following FFL for children to generalise skills (Barrett & Pahl, 2006). FFL has been shown to have long-lasting impact at 12, 24- and 36-months following intervention (Barrett, Farrell, Ollendick, & Dadds, 2006; Stallard et al., 2014; Stallard, 2007). Nevertheless, many research designs are too short to capture sleeper effects by not including follow up measures (e.g. Gallegos, Rodriguez, Gomez, Rabelo, & Gutierrez, 2012; Rose et al., 2009). This highlights the importance of using follow up measures to make more robust claims about FFL's long-term impact.

Targeted Intervention

In their review, Briesch et al., (2010) found FFL has small effects for general populations of students (ES = 0.24), with increased effectiveness for 'at risk' students (ES = 0.44) and those with anxiety disorders (ES = 0.84). Studies looking at the effectiveness of FFL as a targeted intervention to reduce anxiety generally show promising results (e.g. Gallegos et al., 2012; Schoenfeld & Mathur, 2009; Martinsen, Aalberg, Gere, & Neumer, 2009). This may be because targeted samples are more homogeneous in terms of participant baseline anxiety levels which are higher than the general population, also providing more potential for change. Nevertheless, many targeted studies do not include control groups, threatening the validity of their findings.

While some universal studies suggest that experience, skills and supervision of the FFL implementor matter, effectiveness may also depend on the intervention's location. In the Martinsen et al., (2009) study, psychologists administered FFL in an outpatient clinic for children with anxiety disorders. Treatment effects were evaluated as modest in this targeted study, but authors reported that replicating results of effectiveness of FFL from previous studies in schools is difficult in the clinical setting. Consequently, the administration of FFL may be best placed in schools. The familiar setting may provide a safe space to practice and generalise FFL skills in a supportive environment.

Targeted studies have also looked into the effectiveness of FFL with specialised populations of children who form part of our school communities. Schoenfeld and Mathur (2009) showed

that FFL can be adapted and is effective at reducing anxiety for students with emotional and behavioural disorders. FFL was adapted and implemented for three students on a 1:1 basis, with shorter but more frequent sessions. All students showed reductions in teacher rated anxiety, however, no statistical analyses were formally used. It is important to note that students were also taking medication and were undergoing counselling. With targeted studies, it is important to consider the impact of confounding variables such as other treatments or comorbid conditions, which can impact the validity of findings. Also, Burke, Prendeville, and Veale (2017) ran FFL with seven students with High Functioning Autism (HFA) with elevated anxiety by adjusting the FFL protocol. Quantitative findings found no significant reductions in student anxiety, yet qualitative data suggested that FFL had a very positive impact on children's lives. Authors argue that using standardised scales with this population may not show accurate construct validity and suggest that this population may also have difficulty with insight required by standardised measures. This highlights the importance of using mixed methodologies and multi-informant measurement with specialised populations to capture impact, and shows that FFL can be accessible for children with HFA.

Conclusions and Implications

FFL is the only anxiety prevention programme acknowledged by the WHO and large-scale reviews suggest that FFL has a positive impact on reducing children's anxiety, typically reporting small to medium effect sizes (e.g. Briesch et al., 2010; Higgins and O'Sullivan, 2015). FFL is also well liked by students, parents and teachers (e.g. Ahlen et al., 2012; Gallegos et al., 2013) and is relatively affordable, costing £64 per pupil per year (Wigelsworth et al., 2018). Whilst reviews often synthesise findings from RCTs, the gold standard method for evaluating causality, studies are often heterogenous in participant ages, use of FFL as a universal/targeted intervention and differ in implementation. Consequently, evaluating FFL in single studies is helpful when making decisions about applications within specific schools.

An informed decision should firstly be made around whether FFL is delivered as a universal or targeted intervention. The literature highlights that promising effects can be found for all students, however, there is evidence that students with higher anxiety at baseline show the largest improvements. A consideration needs to be made which balances financial and time implications of offering FFL to universal samples versus individuals with highest anxiety levels. Briesch et al., (2010) reported that the mean effect size of FFL with students with anxiety disorders (ES = 0.84) is within the average range reported for individualised CBT (Compton et al., 2004). With increasing demands placed on mental health services, FFL delivered in schools may provide an alternative way of supporting students with high anxiety. Educational Psychologists (EPs) could assist with making well informed and ethical decisions about students who may benefit greatly from FFL, rather than devising arbitrary groups through student self-report alone.

Consideration should also be given to who implements FFL. Although training teachers offers a potentially convenient low-cost option, implementor experience and knowledge of CBT may improve effectiveness. Supervision may be an important factor and protocol fidelity may be more important for teachers/school staff than professionals. Educational Psychologists (EP)

are well placed to run FFL, provide support to implementors, and could provide supervision that may improve FFL's effectiveness.

Before implementing FFL, it is important to decide upon how to measure impact. It is useful to use a multi-informant approach to obtain data, as solely relying on self-report can induce bias, threaten validity and does not generate a holistic understanding of the child. Additionally, using follow up measures is important for capturing impact as often sleeper effects may occur, and, ensuring booster sessions and parent sessions are included should improve the generalisation of skills.

Studies with specialised populations also highlight the importance of using mixed methodologies to capture impact. Research suggests that FFL can be adapted for the needs of students with HFA and emotional and behavioural disorders. EPs are well placed to assist in running FFL for these populations or may offer support in adapting the intervention using experience and evidence from the literature (e.g. Attwood, 2004; Rossiter & Holmes, 2013).

Overall, FFL is a well evaluated and evidence-based intervention. FFL can be run at a low cost and schools have shown to be effective places for its delivery. Furthermore, FFL is well liked by students, teachers and parents and can be adapted for selected populations. Considerations should be made about who implements FFL, measurement of impact and selected students on a school by school basis, and EPs are well placed to provide support.

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Appendix

Systematic Search Strategy

Using the 'PICOS' framework (Higgins & Green, 2011), the key search terms were identified (see Table 1 below) to answer the research question *"how effective is 'FRIENDS for Life' in improving anxiety for primary aged children (8-11)?".* 'PsycINFO' and 'ERIC' databases were chosen databases for this search due to the focus on education and psychology, as well as a wider scoping search on 'Google Scholar' and references obtained through completing the 'FRIENDS for Life' training.

Table 1: *Search terms identified using the PICOS framework*

	Search Terms
Population (P)	child* OR young person OR young people
Intervention (I)	"FRIENDS for Life" OR "friends for life" OR "friends intervention"
Comparison (C)	N/A
Outcome (O)	anx*
Setting (S)	N/A

**Search strategy: ("FRIENDS for Life" OR "FRIENDS for life" OR "FRIENDS intervention") AND anx* AND (child* OR young person OR young people)*

This systematic search was conducted throughout March 2020.

Inclusion Criteria

Studies that were conducted using specifically the 'FRIENDS for Life' intervention were used. Also, studies whose participants were primary aged children (mean age from 8-11) were included as this is the intended age group for the intervention. The studies included also had to measure anxiety and studies had to be published materials to be included.

Exclusion Criteria

Studies that did not deliver the specific 'FRIENDS for Life' intervention and used 'Fun Friends' or 'My FRIENDS Youth' were excluded. Additionally, studies which did not measure anxiety were excluded from this critique as well as unpublished literature and grey literature. These exclusions were made at the title/abstract screen phase. Studies whose participants' mean age was outside of the 8-11 age range were excluded during the full text screen phase. See PRISMA diagram in Figure 1 for details.

PRISMA Recording Flow Chart (Moher, Tetzlaff & Altman, 2009)

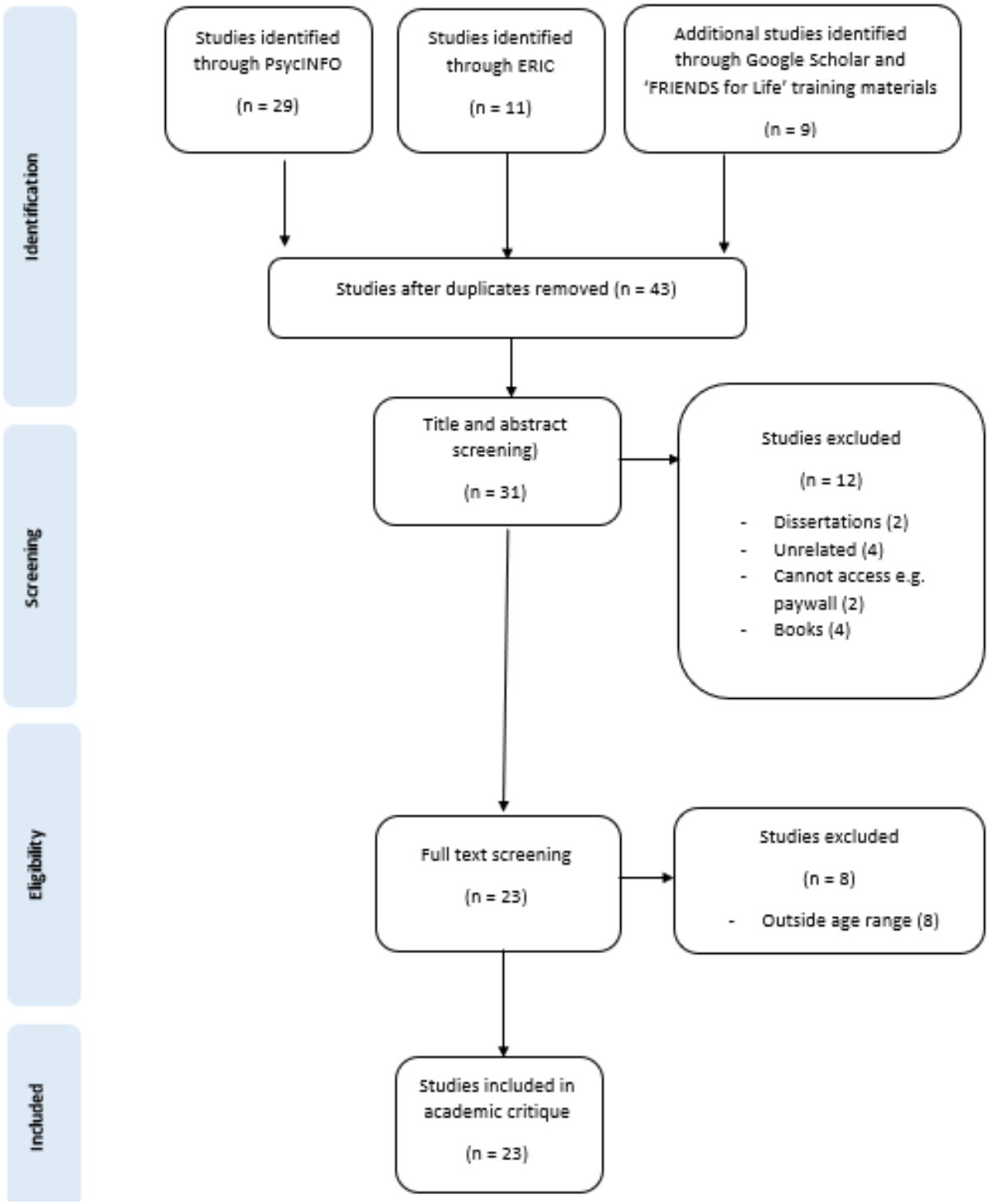

Figure 1. PRISMA Recording Flow Chart.