Treatment of bullying experiences through Imagery Rescripting (ImRs); a pilot study using a quasi-experimental design.

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This research aims to investigate imaginary rescripting (ImRs) as a 'stand alone' intervention in clients aged eight to twelve years, in which bullying experiences have led to complaint behaviour (emotional problems, depressive complaints...

Ethical review	Approved WMO
Status	Recruitment stopped
Health condition type	Other condition
Study type	Interventional

Summary

ID

NL-OMON49681

Source
ToetsingOnline

Brief title
The Bullying Study

Condition

- Other condition

Synonym
PTSD related symptoms

Health condition

PTSS gerelateerde klachten.

Research involving

Human

Sponsors and support

Primary sponsor: Karakter
Source(s) of monetary or material Support: geen financiering

Intervention

Keyword: Bullying experiences, Imagery Rescripting, PTSD, Trauma

Outcome measures

Primary outcome

The intake questionnaire Karakter (version 2012) is used for client screening.

In this questionnaire, in addition to other important matters relating to the reason for registration, bullying experiences and/or other traumatic events are asked. Parents/carers indicate whether their child has been bullied and in what way (the Karakter intake questionnaire explains what bullying is and what forms of bullying there are).

The Children's Revised Impact of Event Scale

The Children's Revised Impact of Event Scale (CRIES-13, Children and War Foundation, 1998) is a brief, self-report questionnaire designed to screen for PTSD in children aged 8 years and older (and a version for parents/carers).It consists of thirteen questions to assess posttraumatic intrusions, avoidances, and arousal. Children rate the frequency with which they have experienced each of the items during the past week using a four-point Likert-scale (0=not at all, 1=rarely, 3=sometimes, 5=often). Psychometric properties have been previously reported (Verlinden et al., 2014), showing the CRIES-13 to be a

valid measure of posttraumatic stress. In this study, the internal consistency of the CRIES-13 was a=0.89. In this study the CRIES-13 will be used to measure posttraumatic stress symptoms between each session during the course of treatment

Secondary outcome

Secondary outcome measures are mapped by means of the KIDSCREEN-27, the Child Behavior Checklist, or CBCL, the Outcome Rating Scale, or ORS and the Revised Child Anxiety and Depression Scale, or RCADS.

Kidscreen-27 (parents).

The KIDSCREEN-27 (The KIDSCREEN Group Europe, 2006) is generic health-related quality of life (HRQOL) questionnaire for children and adolescents applicable for healthy and chronically ill children and adolescents aged between 8 and 18 years. There are two versions of the questionnaire: a self-complete (child/adolescent) and proxy (parent/proxy). The KIDSCREEN-27 consists of 27 items that measure five dimensions: physical Well-being, psychological Well-being, parent relations & autonomy, social support & peers and school Environment. Items are answered on a five-point Likert-type scale assessing frequency: never (1), seldom (2), sometimes (3), often (4), and always (5), or intensity: not at all (1), slightly (2), moderately (3), very (4), and extremely (5), with a 1-week recall period. Scores are coded from 1 to 5, negatively formulated items are recoded, and the sum scores for respective dimensions are transformed to T scores with a mean of 50 and a standard deviation (SD) of 10. Higher scores indicate better HRQOL. The KIDSCREEN-27 has

been shown to have robust psychometric properties. The internal consistency of the domains was between 0.81 and 0.84, and the test-retest reliability of the domains ranged from 0.61 to 0.74 (Ravens-Sieberer et al., 2008).

Child Behavior Checklist (CBCL 6-18) (parents).

The Dutch parent report version of the Child Behavior Checklist 6*18*years (CBCL) assesses a wide range of children's emotional and behavioral problems, aimed to identify children at high risk of a psychiatric disorder (Achenbach et al., 2008; Verhulst & Van der Ende, 2013). The CBCL/6*18 comprises 120 items assessing behavioral and emotional problems that are answered on a 3-point Likert-type scale (0 = not true, 1 = somewhat or sometimes true, 2 = very true or often true) by parents. The scores will displays eight problem scales: withdrawn (1); somatic (2); anxious (3); social (4); thought (5); attention (6); rule-breaking (7); aggressive (8); and other problems, the sum of the problem scale 1,2 and 3 form the scale *internalizing behavior*; 7 and 8 form *externalizing behavior*. All subscales together count for the total problem scale. Some items contribute to more than one problem scale. T scores are computed from raw scores; higher scores on the syndrome scales indicate greater severity of problems. A T score of 63 (90th percentile) demarcates the clinical range, which is an indication that a child needs professional help. For the competence scales, lower scores indicate greater severity. A T score <37 indicates the clinical range. The CBCL/6*18 has well-established psychometric properties in clinical, nonclinical, and cross-cultural populations (Verhulst & Van der Ende, 2013).

Outcome Rating Scale (ORS)

To collect client feedback, we will use a brief questionnaires, the Outcome Rating Scale (ORS), that can be easily be administered on a regular basis during treatment (Miller & Duncan, 2004). This allows treatment sessions to be evaluated at any time to ascertain whether individual treatments are *on the right track* to successful outcome, or not. The ORS is primarily focused on the wellbeing of the client and is administered at the beginning of the treatment session. The outcomes of the questionnaires are reflected in a graph per interview to allow the height of the score and progress to be visualised during the sessions. The ORS has a high internal consistency and an average correlation with other outcome measurements.

Anxiety (Revised Anxiety and Depression Scale; RCADS)

The Revised Child Anxiety and Depression Scale (RCADS) is a 47-item, youth self-report questionnaire (Chorpita et al., 2000) with subscales including: separation anxiety disorder (SAD), social phobia (SP), generalized anxiety disorder (GAD), panic disorder (PD), obsessive compulsive disorder (OCD), and major depressive disorder (MDD). It also yields a Total Anxiety Scale (sum of the 5 anxiety subscales) and a Total Internalizing Scale (sum of all 6 subscales). Items are rated on a 4-point Likert-scale from 0 (*never*) to 3 (*always*). Additionally, The Revised Child Anxiety and Depression Scale * Parent Version (RCADS-P) similarly assesses parent report of youth*s symptoms of anxiety and depression across the same six subscales.

Study description

Background summary

Children regularly experience unpleasant events. However, these events are not always considered traumatic (Jonkman et al., 2014). In the DSM 5, a traumatic event can be considered when an event involves actual or imminent death, serious injury or sexual violence, i.e. when the so-called 'A-criterium' of life threatening is met (American Psychiatric Association, 2013). Bullying is not seen as a 'A-criterium'. Unfortunately, in our population, bullying experiences are frequently reported, especially within the group of clients aged eight to twelve years old. During January 2017 to January 2018, a total of 721 intakes were seen at Karakter, Child and adolescent psychiatry. Approximately 111 parents/children indicated that they had been bullied (Source; intake questionnaire Karakter). Other studies have estimated the prevalence of bullying (especially at school) over 30% (Solberg and Olweus, 2003), suggesting a significant stressor for children and adolescents.

Studies examining the psychological consequences of bullying in both children/adolescents and adults show that bullying has a major impact on the development of both somatic and psychological complaints such as anxiety and mood problems, sleep problems, increased irritability, concentration problems (Arseneault, Bowes, & Shakoor, 2010; Bowling & Beehr, 2006; Nielsen & Einarsen, 2012). These symptoms are similar to those associated with PTSD, (Kreiner, Sulyok, & Rothenhausler, 2008; Leymann & Gustafsson, 1996; Matthiesen & Einarsen, 2004; Tehrani, 2004).

Nielsen and colleagues (2015) showed in a meta-analysis that bullying victims frequently report PTSD symptoms and that the bullying experience itself is indeed considered traumatic by victims. However, based on the DSM 5 criteria a diagnosis of PTSD does not occur in this group. As a result, they often do not receive treatment. A very recent international study among adolescents in 48 countries showed that the risk of suicide attempts among bullying victims is three times higher than among non-bullying adolescents (5.9% suicide attempts within the group of non-bullying adolescents versus 32.7% suicide attempts within the group of bullying children).

Many ('provisionally approved') treatment methods have been developed in the Netherlands for the prevention/prevention of bullying, namely: Alles Kidzzz, Kanjertraining, KiVa, Plezier op School, PRIMA, Porgramma Alternatieve Denkstrategieen (PAD), Sta Sterk training, Taakspel en Vreedzame School (NJI, 2015).

Treatment methods have also been developed for the consequences of bullying, particularly aimed at improving a negative self-image, namely; COMET training

(Competitive Memory Training, Korrelboom 2011) and/or *EMDR clockwise* (Beer & De Roos, 2017). Both interventions are techniques are based on integrated cognitive behavioural therapy, directly or indirectly re-evaluate the emotional meaning of a US/UR presentation, (within the so-called meaning analysis) (Korrelboom & Ten Broeke, 2014). COMET focuses on strengthening positive memory, by (1) making positive personal characteristics more emotionally salient, (2) repeatedly activating them and (3) eventually linking them to the negatively charged stimulus (Korrelboom & Ten Broeke, 2014). *EMDR clockwise* focuses on reducing negative memory representations, by editing three to five memories from learning history that still prove worthless (or any other negative core view) to the client (ten Broeke et al., 2014).

Practice shows that clients with prolonged bullying experiences often have an all-encompassing negative self-image, which can be expressed in a statement/conception about oneself as a person; 'I am worthless'. These clients are incapable of naming a single only credible positive attribute that contradicts his/her negative self-image, which, according to the authors of COMET, is an important condition for the success of the intervention. Research also shows that COMET is still one step too far for this group (Ten Broeke, Van der Heiden, Meijer & Hamelink, 2008). Also *EMDR clockwise* may seem promising, but research results on this treatment intervention have so far not yet sufficiently demonstrated its efficacy (Griffioen, 2017). Among other things, research shows that *EMDR clockwise* the arousel level of the evoked target images that provide 'evidence' for the emergence and survival of the client's view of himself is usually too low to achieve maximum processing (Littel et al., 2017).

Imaginary rescripting (ImRs) seems to be able to remove both of these obstacles and thus provide a solution for this group of clients. Imaginary rescripting (hereinafter referred to as ImRs) is a processing technique aimed at re-evaluating painful memories. This technique therefore appears to be extremely suitable for the processing of bullying experiences among that group of clients who have developed PTSD complaints as a result of these bullying experiences.

ImRs is an experiential (experiential) intervention that is already frequently applied within the schematic cognitive behavioural therapy in, among others, adults with personality disorders, but also in adolescents with developing personality disorders (Loose et al., 2015). ImRs is not a complete treatment, but forms part of a broader package of interventions. Within the ImRs, negative 'old' experiences in particular are reassessed, which are assumed to have contributed to the emergence and still contribute to the maintenance of the problems for which the client is now seeking help (Arntz, 2011). The traumatic memory (e.g. memories of bullying experiences) are activated during the ImRs and actively experienced again by the client, after which the client (or, in the case of young people, the therapist) must actively change the evoked memory. ImRs is not (yet) regarded as a proven effective intervention for the

treatment of PTSD, which is why this method is generally not primarily used in the case of PTSD and/or PTSD-related complaints. In clinical practice, however, this intervention is frequently used as a 'stand alone' intervention, and its effectiveness is shown by scientific research and several 'single case studies' (including Kunze, 2018; Arntz, Sofi & van Breukelen, 2015; Raabe, Ehring, Marquenie, Olff & Kindt, 2015; Arntz, Tiesema & Kindt, 2007; Grunert, Weis, Smucker & Christianson, 2007).

Study objective

This research aims to investigate imaginary rescripting (ImRs) as a 'stand alone' intervention in clients aged eight to twelve years, in which bullying experiences have led to complaint behaviour (emotional problems, depressive complaints, anxiety complaints, physical complaints and/or low self-confidence).

Study design

The research can be typified as 'quasi-experimental', by means of a 'pretest-posttest' design. Within this design, reported PTSD-related complaints are measured both before and after the intervention and in the control group, in order to be able to map out any changes in complaints by comparing the results of pre- and post-test questionnaires.

Intervention

Following Korrelboom and Ten Broeke (2014), the intervention will be applied as follows and, following Loose and colleagues (2015), adapted for children/young people;

Patients will follow a short-term treatment program consisting of five ImRs sessions of sixty minutes each, in which the intervention will be applied to the most fraught bullying experiences (based on an SUD score). An audio recording is made of the ImRs sessions (by telephone or voice recorder) which the client listens to three times a week between sessions at home.

As part of this research, a protocol ImRs will be developed for the participating therapists containing the adapted ImRs variant for children and adolescents. This adaptation consists mainly of active rescripting by the therapist as opposed to rescripting by the client himself (as is usual with ImRs adults). Children and adolescents are still (strongly) dependent on the adults around them for help in everyday life. Loose and colleagues therefore advise therapists to actively offer protection during rescripting (imaginary) by standing up for the child as an adult against the bullies.

Study burden and risks

Low burden.
Low risk.

Enrolled patients (children aged 8-12 years) follow a short-term treatment consisting of five ImRs sessions of sixty minutes each, applying the intervention to the most adverse bullying experiences (using an SUD score). Parents complete a number of short questionnaires. Furthermore, during the sessions, children are asked to complete a number of short questionnaires. These questionnaires are frequently used during treatments and are minimally burdensome for young people and parents.

Contacts

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Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Children (2-11 years)

Inclusion criteria

All registered patients within Karakter in the age range of eight to twelve

years where bullying experiences are reported on the intake questionnaire and/or during the intake and PTSD related symptoms are reported.

Willingness to cooperate in the study (informed consent).

Exclusion criteria

- A diagnosis of PTSD according to DSM 5 criteria including the A-criterium.
- Suicidal behaviours for which admittance is indicated.
- Serious psychiatric problems requiring (direct) and/or other treatment.
- Following another evidence-based trauma focussed (psycho)therapy during the intervention.
- IQ <75
- An autism spectrum disorder (ASD) with an emphatic impediment to imagination.

Study design

Design

Study type:	Interventional
Intervention model:	Other
Allocation:	Non-randomized controlled trial
Masking:	Open (masking not used)

Primary purpose: Treatment

Recruitment

NL

Recruitment status:	Recruitment stopped
Start date (anticipated):	01-11-2019
Enrollment:	34
Type:	Actual

Ethics review

Approved WMO

Date:	06-07-2020

Application type:	First submission
Review commission:	CMO regio Arnhem-Nijmegen (Nijmegen)

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
CCMO	NL73603.091.20