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Childhood Anxiety and the Power of Relationship

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Running head: ANXIETY AND RELATIONSHIP

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Abstract

This study examined the effect of the group counseling experience, and the effectiveness of the use of Cognitive Behavioral Therapy techniques to control the signs and symptoms of anxiety. Third, Fourth and Fifth grade students (N=5) from a suburban Western New York school district, who have been identified as having a diagnosis of anxiety, were given a 10 week group experience facilitated by a Master's candidate from a Northeastern University. The SCARED (Screen for Childhood Anxiety Related Disorders) was given at the beginning and at the end of the study, to both the student as well as the parent/guardian. It has been postulated that students who experience anxiety would receive a reduction in their pre-recorded level of anxiety 10 sessions of group psychotherapy.

Childhood Anxiety and the Power of Relationship

Anxiety disorders are the most common mental illnesses in the United States, affecting approximately 19 million adults (NIMH, 2000). The Anxiety Disorders Association of America completed their 2005 survey on Stress and Anxiety Disorders and found that seven out of ten respondents said that they experience stress or anxiety in their daily lives (ADAA, 2005). Of those respondents who experience stress or anxiety, the majority indicated that the stress or anxiety they experience interferes in their lives at least moderately. 37% of respondents experience persistent stress or excessive anxiety in their daily lives. 32% of respondents have had an anxiety or panic attack. 27% of respondents have sought professional help for their stress and anxiety. However, only 7% have been diagnosed with an anxiety disorder and only 5% are currently undergoing treatment. (ADAA, 2005).

Etiology of Anxiety

The presence of anxiety as a defense mechanism is an integral part of the human condition. This "fight or flight" response to stress was first documented by Walter Cannon in 1929. This response to stress is characterized by physiological reactions in the sympathetic nervous system. The theory states that epinephrine, as well as norepinephrine, are released from the medulla of the adrenal glands when presented with an external stimuli. This influx of hormones creates an immediate physical reaction to the presenting stressor- often seen in the physical symptoms as an increase in heart rate and breathing, as well as the constriction of blood vessels in many parts of the body, but not in muscular tissues. The individual, under stress, or will either fight back when presented with an imminent threat, or to remove themselves from what they perceive as immediate

danger. All humans are predisposed to this "fight or flight." However, the individual that has been diagnosed with anxiety often perceives this danger to be greater then it may actually be.

The Surgeon General of the Untied States defined anxiety as the "pathological counterpart of normal fear, which is manifest by disturbances of mood, as well as of thinking, behavior, and physiological activity" (United States Office of the Surgeon General, 2006). The Diagnostic and Statistical Manual, Fourth Edition, Revised, defines generalized anxiety disorder (GAD) as six months of persistent and excessive anxiety and worry (American Psychiatric Association, 2000).

Children that have a family history of anxiety have a greater disposition to suffer from anxiety disorders. Anxiety has been attributed both to heredity as well as to environmental factors. Family studies not only indicated a strong genetic influence in the development of anxiety disorders, but also support the current classification system used by the *DSM-IV-TR*. If someone has a first-degree relative who has an anxiety disorder, they are about five times more likely to also have one than someone who has no anxiety disorder in the family (Hettema, 2006). Twin studies done in the Department of Psychiatry at Virginia Commonwealth University by Dr. Kendler and colleagues have shown that, not only do anxiety disorders run in families, but that the main reason for this is due to genetics. (Hettema, 2006).

Referencing an earlier study, Hettema also conducted another review and meta-analysis of the genetic epidemiology of anxiety disorders in a 2001 study, which explored the role of genetic and environmental factors in the etiology of anxiety. Hettema found that there was a 43 percent chance of having a panic disorder if your parent had a panic

disorder, or a 32 percent chance that you would develop generalized anxiety disorder, if one of your parents was diagnosed with an anxiety disorder (Hettema, Neale and Kendler, 2001).

There is considerable evidence that anxiety clusters within families (Black, Noyes, Goldestein, and Blum, 1992; Fyer, 1993; Last, Hersen, Kazden, Orvashel & Perrin, 1991; Martin, Cabrol, Bouvard, Lepine, & Mouren-Simeoni, 1999). Turner, Beidel, Robertson-Ney, and Tervo (2003), in the study, "Parenting behaviors in parents with anxiety disorders," come to the conclusion that although there is strong evidence supporting the role of genetics in producing children with anxiety, anxious parents were found to restrict their child's behavior and reported higher levels of distress then their non-anxious counterparts (Turner, et al, 2003).

Anxious parents are also known to be hypercritical (Hirshfield, Biederman, Brody, Faraone & Rosenbaum, 1997), show less positive regard, less affection, smile less, and be more critical and more catastrophizing during interactions with their children (Whaley, Pinto, & Sigman, 1999) and be less likely to encourage psychological autonomy. Autonomy was described as valuing the opinion of their child, tolerating differences of opinion, acknowledging and respecting the child's view, avoiding judgments, and encouraging independent thinking (Whaley, et al., 1999).

Hewitt, Caelian, Flett, Sherry, Collins, and Flynn (2002) also studied the concept of perfectionism in children, and the devastating effects of maladaptive behaviors in children, more specifically depression, anger, and anxiety. The researchers found that self-motivated perfectionism interacted with social stress to produce anxiety (Hewitt, Caelian, Flett, Sherry, Collins & Flynn , 2002). That same self-motivated perfectionism

also interacts with achievement stress and social stress to produce depression (Hewitt, et al, 2002).

Characteristics of Anxiety

Generalized Anxiety Disorder, or Overanxious Disorder of Childhood, is characterized by excessive anxiety and worry occurring more days than not for at least six months, and relates to events or activities, such as work or school (DSM-IV, TR; American Psychiatric Association, 2000). Anxiety disorders are characterized by an internal process of excessive worry, apprehensive expectation, and/or rumination about possible negative outcomes from perceived behavior (DSM-IV, TR; American Psychiatric Association, 2000). The person must find that it is difficult to control the worry, and is associated with three or more of the following six symptoms: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and/or sleep disturbance. The anxiety, worry, or physical symptoms must also cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000). This distress must also not be related to another medical condition or another psychiatric disorder.

Most individuals with anxiety disorder report that they have felt anxious or nervous most of their lives. The course of anxiety is chronic, and can often increase in severity during times of stress, which can be either internally or externally motivated (APA, 2000). Anxiety is a chronic and debilitating disorder, which if left untreated in childhood can have a direct impact on adult functioning later in life.

Research conducted by Weems, Hammond-Laurence, Silverman, and Ferguson (1997) discovered that a sensitivity to anxiety is positively related to depression in adults.

The comorbidity of depression with anxiety has been clearly documented in the National Comorbidity Survey, which was completed in 1994 (Kessler, McGonagle, Zhao, Hughes, Eshleman, Witchen, and Kendler, 1994). The study found that the prevalence of psychiatric disorders is higher than originally believed, with roughly one sixth of the population having a history of three or more comorbid disorders during their lifetime (Kessler, et al., 1994). Anxiety is often one of these disorders, and may often be seen as a symptom of a much larger psychological problem.

Anxiety sensitivity is defined as the "fear of anxiety." (Reiss, Peterson & Gursky, 1988). Therefore, it is important to address this anxiety during childhood, when the appropriate interventions and assistance can be provided to children to break the cycle of anxiety, which can be displaced from generation to generation. Anxiety can be a debilitating problem, which may cause emotional and physiological distress later in life, if left untreated (ADAA, 2005). In a meta-analysis conducted by Twenge at Case Western University, they found that Americans are admitted substantially higher levels of anxiety and neuroticism during recent decades (Twenge, 2000). It is imperative that mental health professionals utilize an upstream approach to assisting individuals who may be displaying the signs and symptoms of anxiety.

Anxiety In Children

All children experience some anxiety in their lives. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close (American Academy of Child and Adolescent Psychiatry, 2004). Young children may have short-lived fears, such as fear of the dark, storms, animals, or

strangers. This is a normal and expected part of the developmental process. (American Academy of Child and Adolescent Psychiatry, 2004). Disruptions in the caregiver-child relationship are often characterized as Separation Anxiety Disorder, or SAD, as described in the DSM-IV-TR. SAD is defined as developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

The Surgeon General's Conference on Children's Mental Health: A National Action Agenda, was held in Washington DC on September 18th-19th, 2000. This report clearly states that children's mental health is at 'crisis level' in America. According to the report, 10% of all children have mental health impairments enough to warrant treatment. This number is significant and warrants aggressive action on the part of professionals, school personnel and parents (Report of the Surgeon General's Conference on Children's Mental Health, 1999).

According to the report by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50%, to become one of the five most common causes of morbidity, mortality and disability among children (Report of the Surgeon General's Conference on Children's Mental Health, 1999). Anxiety disorders are the number one mental illness among children and adolescents (NIMH, 2000).

In young children, often the anxiety manifests itself through the fear of attending school or engaging in extracurricular activities such as sports or clubs. The National Association of School Psychologists, in a handout for parents on school refusal, states that school avoidance occurs in 2% of school aged children (National Association of School Psychologists, 1996). This exclusion often impacts the child’s quality of life, as

well as their ability to make friends and maintain positive relationships, both with other children as well as with adults and primary caregivers.

Although separation anxieties are normal among infants and toddlers, they are not appropriate for older children or adolescents (USOSG, 2006). Children with separation anxiety may cling to their parent and have difficulty falling asleep at night. When separated, they may fear that their parent will be involved in an accident or taken ill, or in some other way be "lost" to the child forever (NIMH, 2000).

Therapeutic Interventions for Childhood Anxiety

One specific study of anxious children (Prins & Hanewald, 1997) had closely examined the cognitions, or thoughts, of anxious children, versus their non-anxious counterparts. Four types of thoughts were monitored: positive, negative, coping and neutral. Overall, there were no group differences in the number of cognitions reported. In both studies, the children who were identified as being anxious showed more negative thoughts in anticipation, leading to a false perception of future failure (Alfano, Beidel, and Turner, 2002). However, once the task had been initiated, there was no perceived difference between the anxious children and their non-anxious counterparts. This fact supports the belief that cognitive behavioral therapy can assist anxious children in identifying the triggers to their worries through the group work process.

Cognitve Behavioral Therapy- The Gold Standard

Treadwell and Kendall (1996) also looked at the concept of cognitions among clinically anxious children, who received Cognitive Behavioral Therapy (CBT). They found that there was a higher frequency of negative thoughts, as opposed to differences in the number of positive thoughts. They have termed this perceived phenomena as "the

power of nonnegative thinking." CBT can be used to help change the thoughts of anxious children, over time. Bogels and Zigterman (2000) also completed a study of cognitive distortions in anxious children. Negative thoughts in anxious children were mostly found prior to the onset of a particular task then during the task itself.

The research has proven that Cognitive Behavioral Therapy (CBT) is the gold standard for working with children who have been diagnosed with Generalized Anxiety Disorder (GAD). In a study conducted by Barrett, Duffy, Dadds, and Rapee (2001), they evaluate the long-term effectiveness of CBT in children, ages 14-21 years old. In the study, they reevaluated children who had been treated with CBT an average of 6.17 years prior. These children were reassessed using diagnostic interviews, clinician rating, and self- and parent- report measures. Results indicated that 85.7 percent no longer fulfilled the diagnostic criteria for any anxiety disorder (Barrett, et al, 2001).

Researchers at Griffith University in Australia have also studied the effects of CBT on individuals diagnosed with Generalized Anxiety Disorder. The effectiveness of the interventions was evaluated at post-treatment and at 6 and 12 months follow-up. The results indicated that across treatment conditions, 69.8% of the children no longer fulfilled diagnostic criteria for an anxiety disorder, compared with 26% of the waiting-list children (Barrett, Dadds, & Rapee, 1996). At the 12-month follow-up, 70.3% of the children in the CBT group and 95.6% of the children in the CBT and family support group did not meet criteria. Comparisons of children receiving CBT with those receiving CBT and family support on self-report measures and clinician ratings indicated added benefits from CBT and family support treatment. Age and gender interacted with

treatment condition, with younger children and female participants responding better to the CBT and family support condition.

Treatment of Anxiety- the Group Approach

Group therapy and the power of relationship is an excellent tool in assisting those individuals who have been diagnosed with an anxiety disorder. Johnson, Burlingame, Olsen, Davies and Gleve (2005) examined the definitional and statistical overlap among four key group therapeutic relationship constructs—group climate, cohesion, alliance, and empathy—across member-member, member-group, and member-leader relationships. They found that group members distinguished among relationships primarily according to relationship quality rather than the status or role of others (Johnson, et al., 2005). This indicates that relationship is an important component of the ability of a group to work effectively and to come to cohesion.

Burlingame, Furiman, and Mosier (2003) also discuss the effectiveness of the group experience. Group therapy has a proven track record of effectiveness in treating a variety of psychiatric disorders, including anxiety. The group format is a logical choice for the delivery of preventive services, given the amount of time children and adolescents spend in groups with their peers, both in and out of the classroom (Kulic, Horne and Dagley, 2004). This is not surprising, given that children and adolescents spend a large part of their day in school. This is also an encouraging statistic, because it demonstrates that prevention research is taking place in our schools, one of the primary settings in which prevention services need to be implemented in order to reach the widest audience possible (Kulic, et al., 2004).

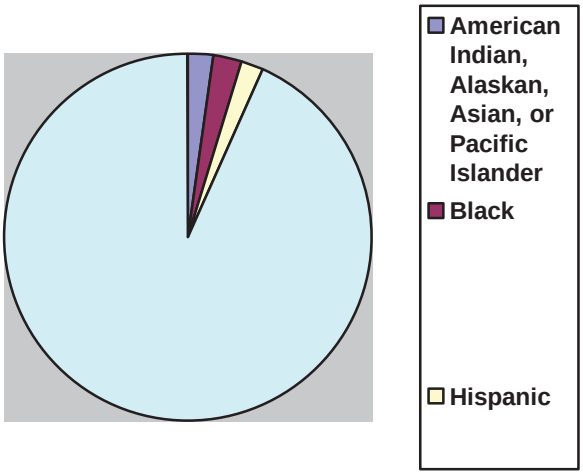
A study conducted by Manassis et al. (2002) also looked at the differences between group-based CBT and individual-based CBT. They found that both types of therapy proved almost equally beneficial to children with GAD (Manassis et al., 2002). Cognitive-behavioral therapy (CBT) has been the psychotherapy most-studied for treating Generalized Anxiety Disorder in children. In a controlled, randomized trial, Kendall et al. (1997) assessed the efficacy of CBT for children with anxiety disorders. Treatment components included recognition of anxious feelings and somatic sensations, clarification of cognitions related to feeling anxious, development of coping strategies to deal with anxiety, and self-reinforcement for successful use of these strategies. Behavioral components included role-play, relaxation training and homework assignments. Group cognitive-behavioral therapy has demonstrated similar efficacy (Silverman et al., 1999).

Methods

Demographic Information

This research study was completed at an elementary school, in a suburban school district in Western New York. The total population of the school district was 22,334, and the student enrollment for the 2005-2006 school year was 4,411 students. The annual average income of students residing in the school district was $53,259 per year, and the percentage of children who received free or reduced school lunches at this elementary school was 11.3 percent, with 11 to 20 percent of the children's parents receiving some kind of public assistance. Additional demographic information revealed that 40.55 percent of students residing in the school district were in single parent households, while 59.45 percent of households within the district were married. 32.36 percent of the

population had a college degree or better, while 66.03 percent of the population described their job as a "white collar" job (NYSED, 2005).



430 students were enrolled at the elementary school. The ethnic breakdown of the school itself was 2.1 percent American Indian, Alaskan, Asian, or Pacific Islander, 2.6 percent Black, 2.1 percent Hispanic, and 93.3 percent White (not Hispanic). This racial portrait was consistent with the other elementary schools in the district. The 2004-2005 school year statewide accountability report issued by the New York State Education Depertment of this particular school made the determination that the students are making "adequate yearly progress" (AYP) in English Language Arts, Mathematics and Science.

Purpose of Study

The purpose of this research project was to assess the impact that a small, psychotherapy group, of six students, which is based upon the tenets of Cognitive Behavioral Therapy (CBT) had upon third, fourth and fifth grade students in a suburban elementary school setting. The students in this project were identified as suffering from Generalized Anxiety Disorder (GAD), with the diagnosis made either by the school

psychologist and/or by the child's physician. The students were also referred to the school counselor for assistance and support either by their classroom teacher, school paraprofessionals (school counselor or by the school psychologist), or by the student's parents.

The diagnoses of GAD have been obtained and verified, either through the diagnosis of the school psychologist, or through the child's physician or psychiatrist, and have been evaluated through the Instructional Support Team (IST) mechanism of the elementary school setting. The Instructional Support Team is composed of the school psychologist, the school counselor, the principal, the occupational therapist, the classroom teacher, as well as any other support personnel that may work with the student in the school setting. Students who are referred to the IST have either exhibited social, emotional, or educational deficits that are having a profound impact on their educational success.

During the IST meeting, the members of the team brainstormed interventions and classroom accommodations that can be used to help the student to become successful both academically as well as emotionally. The potential for psychological or cognitive testing may also be discussed, as well as if the student may qualify for a referral to the Committee on Special Education for special education support services through the school district. This referral would ensure that the classroom accommodations that the student required for their academic success would be continuous throughout their academic career.

Collaboration is an integral piece in the completion of the research project. The students who participated in this study have been evaluated by the Instructional Support

Team and were evaluated to see if they would qualify for additional counseling intervention services. The IST came to a consensus that the six students identified by the IST were appropriate for a psychotherapy group on anxiety and would benefit from therapy to address their current anxiety.

The anxiety experienced by these students is pervasive and was interfering with their ability to participate in the educational process, and was affecting their potential for academic success, as dictated and concurred by the members of the Instructional Support Team, and were thus identified as requiring psycho-social intervention.

Description of Sample

The psychotherapy group consisted of five children, two girls and three boys, with a range in age from eight to ten years old. They were in third, fourth and fifth grade, and were all identified as being Caucasian in race. Of the five children who participated, all were from families where they were residing with their biological mother and father, with four of the five families being married, and one family residing in a common law marriage. It should also be noted that two of the five children have participated in individual therapy prior to the group began, yet neither had participated in group therapy prior to the commencement of the anxiety group.

The children who participated in the group experience were identified by parental survey, as well as through the identification of school administrators, counselors and teachers, as having the diagnosis of Generalized Anxiety Disorder (GAD).

Research Design

This psychotherapy group was held for 40 minutes in duration, one day a week, for a ten-week period. The group was held at the end of the school day, so that the

students would not miss any instructional time. Each student was provided with a spiral notebook, a copy of the "fear thermometer", (Appendix C) and was encouraged to draw or write, whenever they desired, during the group. Additional handouts were provided, as necessary, to communicate the theme of the day, or to provide the student a visual representation of the concepts involved.

This project utilized pre-test and post-test data, which was collected on each individual participant through the completion of the child and parent version of the Screen for Child Anxiety Related Emotional Disorders (SCARED). It was a 41-item child and parent self-report instrument that had five factors based on DSM-IV-TR criteria for anxiety disorders. It has shown good reliability and validity as a self-report screening instrument for GAD (Birmaher, Brenat, Chiapetta, Bridge, Monga, & Baugher, 1999).

This self-report assessment evaluated five key factors present in the anxious child: somatic/panic, general anxiety, separation anxiety, and social phobia. For the total score and for each of the five factors, both the child and parent SCARED demonstrated good internal consistency (alpha = .74 to .93), test-retest reliability (intraclass correlation coefficients = .70 to .90), discriminative validity (both between anxiety and other disorders and within anxiety disorders), and moderate parent-child agreement ($r = .20$ to .47, $p < .001$, all correlations). (Birmaher, Brenat, Chiapetta, Bridge, Monga, & Baugher, 1999)

The SCARED was developed by Birmaher, Khetarpal, Cully, Brent, and McKenzie (1995), from the Western Psychiatric Institute and Clinic at the University of Pittsburgh. It was developed as a diagnostic tool for clinicians to use as a self-report

screen for potential anxiety-related disorders, which measure not only the symptomology of the child, but also evaluates the parental evaluation of that symptomology.

So far, two studies have investigated the validity of the SCARED. In a clinical study, Birmaher et al. (1997) gathered evidence for the discriminant validity of the SCARED. These authors demonstrated that children with anxiety disorders exhibited the highest SCARED scores, children with disruptive disorders had the lowest SCARED scores, whereas children with depression scored in between. The SCARED is able to differentiate between anxiety disordered children, children with depression, and children with disruptive disorders. In addition, Birmaher et al. (1997) found that children suffering from a specific anxiety disorder display the expected profile of SCARED scores. For example, children with generalized anxiety disorder scored relatively high on the corresponding SCARED subscale.

In a second study, Muris and colleagues investigated the relationship between common childhood fears and SCARED scores in a sample of normal children. Children were given a shortened version of Fear Survey Schedule for Children (FSSC; Ollendick, 1983) which lists the 10 top intense childhood fears (e.g., death or dead people, getting lost in a strange place, spiders). Children were asked to indicate their level of fear (i.e., 'none', 'some', or 'a lot') of these items. Next, the relationships between children's FSSC ratings and SCARED scores were examined. For all FSSC items, the expected pattern of SCARED subscale scores emerged. For example, children who scored 'a lot' on FSSC item `getting lost in a strange place' exhibited significantly higher scores on SCARED separation anxiety disorder subscale than children who scored 'none', whereas children who scored 'some' fell in between.

Procedure

Week One: Completion of the SCARED and Overview of the Group Process

During the first week, the student researcher reviewed the directions for completing the 41-item "Screen for Childhood Anxiety Related Disorders," and administered the test. During the testing process, the student researcher read aloud the questions and encouraged the students to be as truthful as possible when completing the inventory, using a 1-3 likert-type scale to describe certain anxiety producing situations. The students were encouraged not to talk to each other or to discuss their answers during the test. This test was administered in the group setting, and lasted 30 minutes for completion.

Week Two: Child Consent Form Completion

The student researcher went over the group expectations and read aloud the child consent form, and had each student sign the consent form, if they agreed that they would like to participate in this research study. Any questions that had arisen from the items discussed were addressed, as needed. The one topic that yielded the most questions and discussion was the topic of confidentiality. All agreed that what was said within group should remain in the group, with only the following exceptions: if the student was thinking of harming himself, harming others, or if they were, in fact, being harmed. All agreed that this was the most serious part of the contract, and that the rules would be strictly adhered to, as the School Counselor was also present with the student researcher during the group session, and witnessed the student signatures as they were being signed.

Week Three: Introduction to the Fear Thermometer and Notebook

Aureen Pinto Wagner, Ph.D., in her work entitled, “Worried No More: Help and Hope for Anxious Children”, describes in child-friendly language the three components of anxiety covered in Cognitive Behavioral Therapy (CBT)- cognitions, physical symptoms and behaviors. According to Wagner, CBT is the most effective therapy for changing the factors of the anxiety triad that maintain that anxiety. CBT is an active, experiential form of learning, like bicycling or swimming, which are learned by doing, and for which practice is an essential element (Wagner 2002).

Wagner uses a devise called the Fear Thermometer, which helps children to “differentiate, qualify, and communicate levels of threat and anxiety” (Wagner 2002). It is a scale of 1-10, with one being a “piece of cake” and ten being “Out of control! Ballistic!” With this guideline, the student had the opportunity to evaluate and to confront any perceived threats within the safety of the group setting. Individual notebooks were handed out to each student, and the students were encouraged to write or to draw pictures at any time during the group session. Markers, crayons, pencils and erasers were available at any time for the student to use, and were located at the center of the table.

Week Four: Draw a Picture of Your Worry

It is postulated that often children who have difficulty voicing their worries can do so more effectively through the use of drawing and writing. Ever since Florence Goodenough created the “Draw-A-Man” test in 1926 in a book entitled, “Measurement of Intelligence by Drawings”, researchers have tried to use the medium of art to see into a child’s soul. It was under this premise that the student researcher utilized a simple direction: draw a picture of your worry. The students each drew what their worry looked like, and then explained it to the other children in the group. They discussed the pictures

themselves to the other students in the group, as well as to describe the colors that they chose to use in their drawing.

Week Five: What are you afraid of? - Part I

In week five, the student researcher continued on the same theme of worry, and asked the students to compile a list of what they are afraid of and some feelings associated with that worry. The students were encouraged to either make a list or to draw a picture of each thing they were worried about. After completing the list, the students would share their lists with the other students, and compare and contrast those lists with the lists compiled from the other students. There were a number of similarities and differences noted between the students answers, which they stated was surprising.

Week Six: What are you afraid of? – Part II

As the lists from week five were so extensive, I had the children whittle down their list to the top three things that they were afraid of, and to list them in rank order. These top three responses were then evaluated using the likert-type scale of the Fear Thermometer (1-10) and were then recorded in the notebook, along with some of the physical characteristics that they may experience of they had been exposed to this worry. The student researcher then began addressing termination, stated that we only had four more weeks before the group would be ending.

Week Seven: Antecedents and Worry Log

Now that the students understood the things that worry them the most, and could identify some of the physical characteristics of that worry, it was time to begin the exposure process. In CBT, the child will learn to overcome that fear through exposure, or in testing of their reality. According to Wagner, in order to overcome your fear, you must

face your fear until the reduction of that fear becomes a habit. This is called habituation. The following seven points about the concept of fear and habituation were communicated to the group:

- Anxiety is not fatal and can be lived through
- Anxiety is transient and passes away
- Avoidance strengthens anxiety
- Exposure strengthens anxiety
- Habituation is normal and automatic
- Exposure is necessary for habituation
- Anxiety in *anticipation* of exposure may be higher than anxiety *during* exposure (Wagner 2002)

After these seven points were communicated, the student researcher helped the students to understand the use of the worry log and how it might be used to help them to work through their worries. The students were alerted that there was only three weeks remaining in their time together.

Week Eight: From Worried Thinking to Calm Thinking

As stated earlier, Wagner argued for the use of a technique called gradual exposure. First, the student must identify their fears, and then rate the severity of their fears using the Fear Thermometer. The child is then required to rank order their fears on a hierarchy from the least to the most severe. The fear lowest on the hierarchy is chosen and exposure is begun on the selected fear. The student then helps the student to work through that fear, until habituation occurs. This process is continued until all of the child's anxiety has been alleviated. These worries are tracked on the sheet, "From

Worried Thinking to Calm Thinking" (Appendix G). With only two weeks remaining, the students were reminded of the group ending soon.

Week Nine: Worry Log- Theory to Practice

As a group, the students were led through the second part of the "Worried Thinking to Calm Thinking" worksheet, and an extensive discussion of the topic "Can you be absolutely sure that it will happen?" ensued. "What could you do to handle this?" as well as "What helpful things could you say to yourself now?" also created a lively discussion. As there was only one more week left of group, the student researcher discussed termination as well as the possibility of continuation, if the students wanted to do so, beyond the ten week period. As this was something to think about, the student researcher would check again the following week for group.

Week Ten: Letting my Worries Go- a Celebration

On the last day of group, each student was given a slip of paper, "Worries I want to let go" and a helium balloon. On the slip of paper, the students wrote the things that worry them the most that they would like to let go. The students then attached their "worries" to the balloon, which was then released to the skies above. The weather was warm and sunny, and the students ran after their balloons, staring up into the bright sky, trying not to lose sight of which balloon was theirs. The group then returned to the group room for a celebration of their accomplishments over the past ten weeks. A poem, entitled, "Dare to Be" (Appendix I) was read, and presented to each student at the end of the session. The students were then offered the opportunity to continue the worry group experience beyond the ten weeks covered in this research study. Of the five students who

participated, three of the five participants wanted to continue addressing their worries using the cognitive behavioral approach.

Results

The SCARED was administered to the five participants (N=5) prior to the beginning of the research project, to get a baseline of the current levels of anxiety that the students had experienced prior to the commencement of the research project. The pretest was administered, as a group, to the five participants. Each item was read aloud, and each student was encouraged to be as truthful and honest as possible, and to refrain from talking to each other, or looking on other student's papers during the test administration.

The students were instructed to choose from three choices for each of the sentences presented: "not true or hardly ever true", "somewhat true or sometimes true," or "very true or often true", with a likert-type scale of zero to three, with three being "very true or often true," and zero being "not true or hardly every true."

The initial correspondence containing the SCARED pre-test, as well as the parental consent form, was addressed to both the mother and the father of the participants. Instructions were given to complete the survey and to return the survey to the student researcher. The table below contains the pre-test scores of both the student report as well as the parental report of perceived anxiety for their child. A student who scores a score of 25 or higher may indicate the presence of an anxiety disorder:

Table 2: SCARED Pre-Test Comparison (Parent vs. Child Scores)

	Parent Report Pre-test	Student Report Pre-test	Difference
Student 1 (M)	16	7	-9
Student 2 (F)	40	10	-30
Student 3 (M)	X	8	X
Student 4 (F)	24	8	-13
Student 5 (M)	18	9	-9

The pre-test SCARED for Student 3 was not returned to the student researcher. Therefore, the results have not been included in the above- listed table, and the missing data has been replaced with an "X" to denote that the information is missing and cannot be evaluated.

Following the completion of the ten-week research study, the SCARED was again administered to the participating students. A score listed as a 25 or greater may indicate the possibility of an anxiety disorder. A comparison of the parental versus the student self-report post-test scores is presented in the below-listed table. Gender differences in pre-and post test analysis is also completed in table 4, and table five addresses the differences in student that had received previous therapy experience versus those who did not have any previous therapy prior to the ten week psychotherapy group.

Table 3: SCARED Post-Test Comparison (Parent vs. Child Scores)

	Parent Report Post-test	Student Report Post-test	Difference
Student 1(M)	6	5	-1
Student 2 (F)	40	26	-14
Student 3 (M)	31	1	-30
Student 4 (F)	33	21	-12
Student 5 (M)	13	13	0

Table 4: Gender Differences in Pre-and Post Test Analysis

	Parent Report Female Scores (Mean)	Parent Report Male Scores (Mean)	Difference
Pre-test	32	17	-15
Post-test	36.5	16.7	-19.7

Table 5: Differences in students who had received previous therapy versus those who had not received therapy

	Students with previous therapy experience (Mean)	Students with no past therapy experience (Mean)	Difference
Pre-test	14	8	-5
Post-test	17	13	-4

Discussion

Turner, Beidel, Robertson-Ney, and Tervo (2003), in the study, "Parenting behaviors in parents with anxiety disorders," come to the conclusion that although there is strong evidence supporting the role of genetics in producing children with anxiety, anxious parents were found to restrict their child's behavior and reported higher levels of distress then their non-anxious counterparts (Turner, et al, 2003). This was also found to be true during this research study. This discrepancy in self-reported scores versus parental reported scores was addressed above in Table 3.

It can be asserted that the parental reported anxiety for females was almost double the reported anxiety for the males in the research study. This was also consistent with the self-report measures that the two female students completed both pre and post- test. It should also be disclosed that even though the parental report questionnaires were addressed to both parents, the mother completed the SCARED and returned the assessment to the student researcher, in four out of the five instances of completion. It is important to add that since there were only two female children who participated in this study, that it would be unethical to try to generalize these results across all female children who may have been diagnosed with anxiety. However, the results for gender differences in the presentation of anxiety are consistent with other studies that have proven empirically that anxiety presents differently in females than in males.

Researchers have identified gender differences in the presentation of anxiety. The article entitled, "Gender differences in anxiety disorders and anxiety symptoms in adolescents," primarily concerns itself with the differences in anxiety patterns between males and female adolescents. 1,221 adolescents participated in this study. Of these participants, 47 currently had an anxiety disorder and 95 previously had an anxiety

disorder. After analyzing their results, the researchers found that female adolescents are twice as likely to have an anxiety disorder than are male adolescents (Lewinsohn, Gotlib, Lewinsohn, Seeley & Allen, 1998). Females are also more likely to develop anxiety disorders earlier than males. (Leibenluft, Oldham, Riba, 1999).

The World Health Organization (WHO) has also stated that women are at greater risk for depression and anxiety disorders than their male counterparts. These findings are consistent across a range of studies undertaken in different countries and settings (Desjarlais et al, 1995). It is in this vein that the WHO completed the Evidence-Based Review of the State of Women's Mental Health (2000). The first person accounts of the daily experiences of women support the hypothesis that anxiety is a major issue in the lives of women around the world.

It should also be asserted that both of the female children who participated in the study saw almost triple-fold increases in their self-reported pre-test and post-test scores, after ten weeks of a psychotherapy group. Student 2's scores went from 16 on the pre-test to 26 on the post-test with an increase in somatic concerns voiced (i.e. headaches, stomachaches, shakiness, sweating, choking, throwing up).

According to post-group interviews with both the child and her mother, both had reported a decrease in anxious symptoms and both stated that they had both observered and experienced therapeutic benefits from the ten week psycotherapy group. The mother also scored to the same (40), on the pre-test and the post-test, yet saw increases in some areas and decreases in others, yet stated that she felt that even though her daughter had participated in individual therapy for the past six years, this was the first time that she felt that her daughter had made significant progress. This may be due to the student being

more aware of what anxiety looks like, and feels like, for her, and is able to place a label on that anxiety, and the physical effect that it has on her body. Research has shown that women, in general, will often internalize their anxiety, resulting in physical concerns being voiced.

Student 4's scores also increased from a pre-test of 8, to a post-test of 21, citing a simular increase in somatic concerns (i.e. headaches, stomachaches, shakiness, sweating) voiced. Post-group conversations with the child's mother also stated that she had seen positive changes in her daughter's ability to react in stressful situations. In both cases, although the scores of the female students had increased significantly, it is due to the children becoming more aware of what anxiety both looks like and feels like for them. Identifying this anxiety is the first step in overcoming their fears and working through the discomfort. Wagner states that in order to overcome your fear, you must face your fear until the reduction of that fear becomes a habit (Wagner, 1999). This is called habituation. Both student 2 and student 4 are currently at the group stage when they may begin addressing those fears through the group process. It should also be added that both students have elected to continue the group beyond the ten-week research study.

Studies have revealed that there is a reversal of sex ratio of stress manifestation between boys and girl's due to conforming to traditional roles. They manifest more personality problems such as shyness, seriousness, jealousy, sensitivity and physical complaints. Girls have manifested five times more anxiety at the age of 13 (Rutter, et. al.1970) and higher anxiety in women after the age of 18 (Maccobey & Jacklin, 1974).

Gilliom and Shaw, in their study for disadvantaged boys found that on average, externalizing problems gradually decreased and internalizing problems gradually

increased as the child aged (Gilliom and Shaw, 2003). Externalizing problems of early childhood usually take the form of overt disruptive behaviors such as aggression, defiance, and hyperactivity. In contrast, early internalizing problems typically appear as anxiety, withdrawal, and sad affect (Campbell, 1995, 2002). This effect can be demonstrated in the female versus the male in response to a perceived danger, or anxiety.

The inverse was true of the male participants, who saw decreases in their self-perceived and parental-perceived levels of anxiety. General themes of the male students in the study revealed that the majority of respondents cited in increase in levels of anxiety regarding situations that involved "people I don't know well" (Survey questions 3,10, 26, 32, and 40) . This is an externalization of the presentation of anxiety and the effect that gender has upon the way that females and males present that fear and worry (Gilliom, et.al, 2003).

Of the three male children who participated in the research study, one male student has elected to continue the group beyond the ten-week period covered under this research project. It should also be noted that all three children (two females and one male), who have elected to continue the anxiety group beyond the ten week window received elevated scores in the pre-test versus the post-test phase of the research project. This increase has more to do with their awareness of their anxiety than an increase in symptomology.

Limitations

One of the most difficult obstacles to overcome in this research study was the issue of time. As the students were in three different grade levels, and four different teachers, it was difficult to find a time during the school day that all of the students would

be able to attend the psychotherapy group on a regular basis. It was paramount that the students not miss any instructional time during the school day, so the group was help one day a week, at the end of the school day.

The group sessions themselves were only ten sessions of 40 minutes each, and the student researcher was often pressed for time to complete the tasks required, as the original proposal requested 50-minute sessions. Ten minutes a day missed over the course of the study shorted the duration of the total group time by one hour and forty minutes. There were times when it seemed that the students had just settled in to work and it was time for the group to end.

It was also difficult for some teachers who had students participating in the study to see the "value" of a psychotherapy group based upon the tenets of CBT. Understanding that in order to for a child to succeed academically, it was important for their emotional needs to be met as well as the academic piece was difficult for some individuals. Many teachers are searching for a "quick fix" for students with anxiety, which does not exist. Anxiety is not something that can go away over night. It takes time to identify, and then to correct.

Recommendations

This study has deep implications for the field of counseling, specifically within the school setting. The ASCA and NYSSCA Comprehensive models state that as counselors, we have the duty to provide the school districts with whom we are employed, supporting the mission of the school by "promoting student achievement, career planning, and personal social development for every student" (NYSSCA, 2005). School counselors are the gatekeeper for student achievement and help to ensure that all students

have access to a "quality and equitable education" (NYSSCA, 2005). By employing best practices of research and pedagogy, we can help all students to succeed and to ensure that no child is left behind. School counselors work with all students, school staff, families, and community stakeholders as a critical component in the education of children. This comprehensive school counseling model offers content, process and accountability for the profession of school counseling. By contributing to the body of research in the area of anxiety, it only strengthens the case for elementary counselors as a mandatory component in the education of all students in New York State.

Implications for future research

There have been numerous studies done on the effectiveness of CBT in counseling children and adults with depression and anxiety-based disorders in the literature. However, there is little research done on the impact of group-work in CBT when dealing with small groups, especially when working with small groups of children. It would be helpful in the future for researchers to complete longitudinal studies in the effectiveness of CBT, both in the realm of group-work as well as in individual practice, to determine if the group experience has a synergistic effect on self-realization of anxiety symptology.

Conclusion

Group therapy has a proven track record of effectiveness in treating anxiety. The group format is a logical choice for the delivery of preventive services, given the amount of time children and adolescents spend in groups with their peers, both in and out of the classroom (Kulic, Horne and Dagley, 2004). One of the primary settings in which prevention services need to be implemented in order to reach the widest audience

possible is in the schools (Kulic, et al., 2004). This is the venue where counselors have the opportunity to reach the most children at any given time.

This idea also has been addressed in recent educational initiatives such as PBIS (Positive Behavioral Instructional Support) and in the New York State School Counseling Association's "New York State Model for Comprehensive K-12 Counseling Programs," which strives to meet the needs of all students, and not just the students who participate in enrichment programs (gifted and talented) or in special education services.

Cognitive Behavioral Therapy (CBT) is the Gold standard for working with individuals with anxiety-related disorders (Treadwell and Kendall, 1996). CBT can be used to help change the thoughts of anxious children, over time. Using the template of Wagner's research on working with children and anxiety, and her employment of the "Fear Thermometer", addressing cognitive distortions, as well as habituation, the counselor can be afforded the opportunity to address anxiety in children, and to begin to provide coping mechanisms for addressing their anxiety.

The use of CBT as employed by Wagner in the group setting provides a viable framework for children ages 8-11 in facing their fears in a supportive environment. This powerful strategy is strengthened by the power of camaraderie in the group experience. When children are given the opportunity to address their fears with individuals that have experienced those same fears, it creates a bond between those who share the same experience, and acts as a lightening rod for discussion among group members.

According to the NYSSCA website, counseling is "a process of helping people by assisting them in making changes and changing behavior." (NYSSCA, 2006). By contributing to the literature, and addressing the needs and limitations of CBT and group-

work in working with children with anxiety, future counselors can contribute to the mission of professional organizations, as well as to help the students in our care succeed both academically and emotionally.

APPENDIX A

November 30, 2005

Dear

My name is Samantha Golden, and I am the Counselor Intern here at Canal View Elementary School. I am currently finishing my Master's degree in Counselor Education at SUNY Brockport. For my final project, I will be working with a small group of six students in fourth and fifth grade, who have been diagnosed with anxiety. Anxiety is a persistent fear or worry that will not go away. A student with anxiety may avoid certain activities and may have physical reactions to their fears, such as sweating, cold palms, "racing" pulse, and shortness of breath. One of the main characteristics of anxious children is that they often feel that they are alone, and that no one else feels the same way that they do. It is my hope to provide these anxious students with the ability to form a bond with other students who also may have experienced the affects of anxiety and to allow the students to provide support to each other, with the guidance of the Counselor.

Starting on December 17, 2005, we will meet on Tuesday afternoons, from 4:00-5:00 pm, for a period of eleven weeks. There will be no group during Winter Recess, as the school will be closed. You will be responsible for transportation from the school at 5:00 pm. During these group meetings, the students will be allowed to talk about their anxiety with other children. It is my belief that when the child understands that they are not alone in their anxiety and that others have the same worries and fears, they will have the increased opportunities to address their anxiety and to work through their fear.

There is a short, 41-question survey about anxiety that I will ask both the student and the parent to fill out prior to beginning the 10-week group activity, and again at the end of the group activity. I will be following up this letter with a phone call in the coming week to help answer any questions you may have.

If you are interested in this opportunity for your child, please sign the attached consent form and return it in the enclosed envelope. Please feel free to contact me or with Edward Witkowski if you have any questions. I look forward to the possibility of working with you and your child in the near future.

Sincerely,

Samantha E Golden
Student Researcher
SUNY College at Brockport
(585) 278-3774

Edward Witkowski
School Counselor
Canal View Elementary
(585) 349-5740

Appendix B
Statement of Informed Consent- Child

You have been invited to join a group of six 4th and 5th graders from Canal View Elementary. The purpose of this group is to help you deal with anxiety, or worry. Worry is the trigger of your body's alarm system, and it often causes false alarms. Maybe a situation is a little bit risky or scary, but worry exaggerates your thoughts so much that you feel afraid to try anything at all. It's like your mind is seeing everything through worry glasses, and it makes you think of all the things that could go wrong.

Worry makes you feel like those bad things are *likely*, but just because you're *feeling* scared, doesn't mean the bad thing is going to happen. It's like you're reading a scary story-you're going to feel scared, but it doesn't mean that you are in danger. You can learn to label your worry thoughts and treat them differently from your smart or rational thoughts.

Once you learn how to recognize the sound of worry, you can begin to feel free to take the power away from it. Over time, you can turn down the volume on those worry thoughts and your brain will calm down and you will have a direct line to more calm, realistic thinking. If your mind tells you the true story about a situation, you will feel more confident approaching it because you know what the real risks are and that your worry thoughts are unlikely.

If you agree to participate in this group, you will be asked to answer a short series of questions about your current worries. We will meet weekly, for a period of ten weeks, on Tuesday afternoons, after school, from 4:00 pm to 5:00 pm, with five other children. Transportation on Tuesday afternoons at 5:00 pm is the responsibility of your parent or guardian.

This group will take place over a three-month period, beginning on December 19, 2005 and continuing until March 1, 2006. After the end of the ten sessions, you will be asked to answer the same short series of questions again. It does not cost you anything to be in this group.

An important part of any group is confidentiality. This means that it is important that what everyone says during group will not be talked about outside of the group. What you choose to say in the group will stay in the group, unless you want to hurt yourself, you want to harm others, or if you, in fact, are being harmed. I will discuss this with you at the beginning of the group.

Any information you provide to the Mrs. Golden remains a secret and will be known only to Mrs. Golden and Mr. Edward Witkowski, Counselor at Canal View Elementary, who will be helping Mrs. Golden complete her class project. The one exception that there could ever be to this is that if in talking to you, Mrs. Golden finds that there is something happening in your life that is an immediate

or serious danger to your health or physical safety. In that case, another professional might have to be contacted. Mrs. Golden would always talk to you about it first. Except for this consent form, all of your papers will be color-coded and your name will not be on them.

Your participation in this group is completely voluntary. Being in or refusing to be in this group will not affect your grades in school. You are free to change your mind or stop being in the group at any time and there will be no penalty.

You are being asked whether or not you want to participate in this group. If you wish to participate, and agree with the statement below, please sign in the space provided. Remember, you can change your mind at any point and stop coming to the group with no penalty.

I understand the information provided in this form and agree to participate as a subject in this group.

If you have any questions, you can contact:

Student Researcher	Mrs. Samantha E. Golden Canal View Elementary Spencerport Central School District (585) 278-3774 (cell) sgolden@spencerportschools.org
School Counselor	Mr. Edward Witkowski Canal View Elementary Spencerport Central School District ewitkowski@spencerportschools.org (585) 349-5740
Faculty Advisor	Dr. Thomas Hernandez Department of Counselor Education SUNY College at Brockport thernandez@Brockport.edu (585) 395-2258

_____ _____

Signature of Participant Date

_____

Birth date of Participant

_____ _____

Signature of a witness 18 years of age or older Date

APPENDIX C
Statement of Informed Consent- Parent/Guardian

This form describes a psychotherapy group being conducted with young people and their families. The purpose of this research project is to assess the impact that small group participation and the counseling experience has on fourth and fifth grade students in a suburban elementary school setting, who have been identified by teachers, paraprofessionals, or parents as displaying the physical and emotional signs and symptoms of anxiety (fear, distress and/or avoidance of activities). This anxiety may be pervasive and may be interfering with their ability to participate in the educational process, and may be affecting their potential for academic success.

If you agree to participate in this project, both you and your child will be asked to answer a short series of questions about your child's current levels of anxiety in different settings. After completion of the questionnaire, weekly 50-minute group counseling sessions will be held for a period of ten weeks, on Tuesday afternoons, after school, from 4:00 pm to 5:00 pm, with five other children. This project will take place over a three-month period, beginning on December 19, 2005 and continuing until March 1, 2006. After the end of the ten sessions, the parent and the child will be asked to complete the same short questionnaire, so the researcher may determine if there was a decrease in the student's level of anxiety, and in what area that decrease was achieved. There is no financial compensation for this project, and participation is free of charge. Transportation on Tuesday afternoons at 5:00 pm is the responsibility of the parent or guardian.

A possible risk of being in this project is the belief that some topics approached during the group sessions may provoke feelings of fear and distress. Before a child can conquer their anxiety, the child needs to address that anxiety and work through those unpleasant feelings. Your child has already been identified as having anxiety, thus this anxiety is already a part of your child's daily life experience. Another risk is disclosure of discussions by group members outside the group. It is understood that the group members will be made aware of the need for confidentiality. What they choose to say in the group will stay in the group, unless the following conditions should occur: the child says he/she wants to hurt himself/herself, the child says he/she wants to harm others, or if the child, in fact, says he/she is being harmed. These exceptions will be made known to group members before the commencement of the process group.

The possible benefit of participation in this project is a decrease in the level of anxiety experienced by the student, as well as a potential increase in academic performance. By helping 3rd, 4th and 5th graders to identify and to apply problem-solving principles to anxiety provoking situations, you are possibly providing the next generation with the tools to succeed emotionally.

Any information that you or your child provides to the researcher remains confidential and will be known only to the researcher and her direct supervisors, Mr. Edward Witkowski, Counselor at Canal View Elementary, or Dr. Thomas Hernandez, Associate Professor, Counselor Education at the State University of New York College at Brockport, both of whom will be monitoring the project. The only exception that there could ever be to this is that if in talking to you, or your child, the researcher finds that there is something happening in your child's life that is an immediate or serious danger to your child's health or physical safety. In that case, you and other professionals might have to be contacted. The researcher would always talk to the child and to you about this first. Except for this consent form, all questionnaires will be color-coded and your child's name will not be on them. If publications in scientific journals arise from this research, results will be given anonymously and in group-form only, so that your child cannot be identified.

Your child's participation in this project is completely voluntary. Being in or refusing to be in it will not affect your or your child's contact with any legal authorities, helping professionals, social service agencies, or the school district. Participating or not participating in this project will not affect your child's educational program and grades. You and your child are free to change your mind or stop being in the project at any time during it and there will be no penalty.

You are being asked whether or not you want your child to participate in this project. If you wish to participate, and have your child participate and agree with the statement below, please sign in the space provided. Remember, you and your child can change your minds at any point and withdraw from the project.

I understand the information provided in this form and agree that my child may participate in this project.

If you have any questions, you can contact:

Student Researcher	Mrs. Samantha E. Golden Canal View Elementary Spencerport Central School District (585) 278-3774 (cell) sgolden@spencerportschools.org
School Counselor	Mr. Edward Witkowski Canal View Elementary Spencerport Central School District ewitkowski@spencerportschools.org (585) 349-5740
Faculty Advisor	Dr. Thomas Hernandez

Department of Counselor Education
SUNY College at Brockport
thernandez@Brockport.edu
(585) 395-2258

_____ _____
Signature of Parent/Guardian Date

_____
Child's Name

Appendix D

Screen for Child Anxiety Related Disorders (SCARED)

Child Version−Pg. 1 of 2 (To be filled out by the CHILD)

Name:

Date:

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

1. When I feel frightened, it is hard to breathe.
2. I get headaches when I am at school.
3. I don't like to be with people I don't know well.
4. I get scared if I sleep away from home.
5. I worry about other people liking me.
6. When I get frightened, I feel like passing out.
7. I am nervous.
8. I follow my mother or father wherever they go.
9. People tell me that I look nervous.
10. I feel nervous with people I don't know well.
11. I get stomachaches at school.
12. When I get frightened, I feel like I am going crazy.
13. I worry about sleeping alone.
14. I worry about being as good as other kids.
15. When I get frightened, I feel like things are not real.
16. I have nightmares about something bad happening to my parents.
17. I worry about going to school.
18. When I get frightened, my heart beats fast.
19. I get shaky.
20. I have nightmares about something bad happening to me.
21. I worry about things working out for me.
22. When I get frightened, I sweat a lot.
23. I am a worrier.
24. I get really frightened for no reason at all.
25. I am afraid to be alone in the house.
26. It is hard for me to talk with people I don't know well.
27. When I get frightened, I feel like I am choking.
28. People tell me that I worry too much.
29. I don't like to be away from my family.
30. I am afraid of having anxiety (or panic) attacks.
31. I worry that something bad might happen to my parents.
32. I feel shy with people I don't know well.
33. I worry about what is going to happen in the future.
34. When I get frightened, I feel like throwing up.
35. I worry about how well I do things.
36. I am scared to go to school.
37. I worry about things that have already happened.
38. When I get frightened, I feel dizzy.
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.
41. I am shy.

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 30 are more specific.
A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.
A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.
A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.
A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.
A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.
**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the*
questionnaire sitting with an adult in case they have any questions.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western
Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: **birmaherb@msx.upmc.edu**

Appendix E

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version−Pg. 1 of 2 (To be filled out by the PARENT)

Name:

Date:

Directions:

Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

1. When my child feels frightened, it is hard for him/her to breathe.
2. My child gets headaches when he/she is at school.
3. My child doesn't like to be with people he/she doesn't know well.
4. My child gets scared if he/she sleeps away from home.
5. My child worries about other people liking him/her.
6. When my child gets frightened, he/she feels like passing out.
7. My child is nervous.
8. My child follows me wherever I go.
9. People tell me that my child looks nervous.
10. My child feels nervous with people he/she doesn't know well.
11. My child gets stomachaches at school.
12. When my child gets frightened, he/she feels like he/she is going crazy.
13. My child worries about sleeping alone.
14. My child worries about being as good as other kids.
15. When he/she gets frightened, he/she feels like things are not real.
16. My child has nightmares about something bad happening to his/her parents.
17. My child worries about going to school.
18. When my child gets frightened, his/her heart beats fast.
19. He/she gets shaky.
20. My child has nightmares about something bad happening to him/her.
21. My child worries about things working out for him/her.
22. When my child gets frightened, he/she sweats a lot.
23. My child is a worrier.
24. My child gets really frightened for no reason at all.
25. My child is afraid to be alone in the house.
26. It is hard for my child to talk with people he/she doesn't know well.
27. When my child gets frightened, he/she feels like he/she is choking.
28. People tell me that my child worries too much.
29. My child doesn't like to be away from his/her family.
30. My child is afraid of having anxiety (or panic) attacks.
31. My child worries that something bad might happen to his/her parents.
32. My child feels shy with people he/she doesn't know well.
33. My child worries about what is going to happen in the future.
34. When my child gets frightened, he/she feels like throwing up.
35. My child worries about how well he/she does things.
36. My child is scared to go to school.
37. My child worries about things that have already happened.

38. When my child gets frightened, he/she feels dizzy.
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.
41. My child is shy.

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra
McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Appendix F

Group Rules- a work in progress

1. No fighting
2. No talking when other people are talking
3. Treat people the way you want to be treated
4. Keep your hands and your feet to yourself
5. If it doesn't belong to you, don't touch it
6. What is said in here, stays in here.
7. Say appropriate words (no swearing)
8. Write appropriate words (no swearing)
9. Don't call people names (like anxiety girl)
10. Keep things to yourself (no throwing)
11. Listen to the teacher

Notes: Rules 1-6 were originally developed by the worry group on 1/23/06. rules 7 and 8 were adopted on 1/30/06, and rules 9-11 were added on 2/13/06.

APPENDIX G

Worry looks different to different people. What does your worry look like?

APPENDIX H

What are some of the things that make me feel worried?

APPENDIX I

Name:_____

Worry Lists Exercise

Please give a number, from 1-10, one being, Piece of Cake! And 10 being "Out of Control! For each worry listed below:

_____ Tests

_____ Going to Dad's house

_____ Drugs and/or alcohol use by people I love

_____ Getting up on stage and performing

_____ Singing in front of people

_____ Being alone

_____ Divorce/separated from my family

_____ Child abuse/ being hurt/ others being hurt

_____ Scary pets in the neighborhood

_____ Living in the "hood," "ghetto," "city"

_____ Guns

_____ Police in the neighborhood all the time

_____ Pets getting hurt by other animals

_____ Rabid animals

_____ Getting called to the Principal's office

After completing this exercise, What are your top three worries from this list?

1._____

2._____

3._____

APPENDIX J

From Worried Thinking to Calm thinking

What are you feeling? _____
_____
_____
_____

What is your fear temperature? _____

What are you worried about? _____
_____
_____
_____

Why are you worried about it? _____
_____
_____
_____

What are you saying to yourself? _____
_____
_____
_____

What are the chances it will happen (1 to 100)? _____

What clues do you have that it will happen? _____
_____

How many times has it happened before? _____
How many times has it not happened? _____
How many times has it happened to other kids? _____
How many times has it *not* happened to other kids? _____

Can you be absolutely sure it won't happen? Y or N (circle)

What else could happen? _____
_____
_____

What are the *real* chances it will happen? _____

What is the worst thing that could happen? _____
_____
_____

So what if it happens? _____
_____

Is this as bad as you thought it would be? Y or N (circle)

Have you had worse things happen to you before? Y or N (circle)

What could you do to handle this? _____
_____
_____

What helpful things could you say to yourself now? _____
_____
_____

How did you do? _____

What is your fear temperature right now? _____

How can you reward yourself? _____
_____
_____

APPENDIX K

The worries I want to let go…

The worries I want to let go…

Appendix L

DARE TO BE

By Steve Maraboli

When a new day begins,
dare to smile gratefully.

When there is darkness,
dare to be the first to shine a light.

When there is injustice,
dare to be the first to condemn it.

When something seems difficult,
dare to do it anyway.

When life seems to beat you down,
dare to fight back.

When there seems to be no hope,
dare to find some.

When you're feeling tired,
dare to keep going.

When times are tough,
dare to be tougher.

When love hurts you,
dare to love again.

When someone is hurting,
dare to help them heal.

When another is lost,
dare to help them find the way.

When a friend falls,
dare to be the first to extend a hand.

When you cross paths with another,
dare to make them smile.

When you feel great,
dare to help someone else feel great too.

When the day has ended,
dare to feel as you've done your best.

Dare to be the best you can -
At all times, Dare to be!

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