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Emotion Management in Children with Anxiety Disorders: A Focus on the Role of Emotion-related Socialization Processes

Cynthia M. Suveg

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EMOTION MANAGEMENT IN CHILDREN WITH ANXIETY DISORDERS:
A FOCUS ON THE ROLE OF EMOTION-RELATED
SOCIALIZATION PROCESSES

By

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B.S. The Pennsylvania State University, 1998

A THESIS

Submitted in Partial Fulfillment of the

Requirements for the Degree of

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(in Psychology)

The Graduate School

The University of Maine

August, 2003

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A FOCUS ON THE ROLE OF EMOTION-RELATED
SOCIALIZATION PRACTICES

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Thesis Advisor: Dr. Janice Zeman

An Abstract of the Thesis Presented
in Partial Fulfillment of the Requirements for the
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This study examined emotion management skills in anxious children and their mothers and investigated factors within the child and the parent, and the child-parent relationship that may relate to the development of adaptive emotion management. Three methods of emotion socialization were examined: parental reactions to children's emotions, discussion of emotion, and family expressivity. Children ages 8-11 years old were first screened for anxious symptomatology in their classrooms within the public school system. Children who scored in the clinical range on the self-report measure were then administered a semi-structured diagnostic interview. Those who met criteria for an anxiety disorder were included in the study. A total of 12 anxious boys and 13 anxious girls and their mothers, and a control group matched for sex and age, participated in the study.

Children were administered a variety of questionnaires that assessed their emotion management abilities, goals for emotion management, and perceptions of the family

emotional and social climate. Mothers completed questionnaires that assessed their own emotional expressivity, view of their child's emotion regulatory abilities, and perceptions of the family emotional and social climate. Children and their mothers also participated in an emotion-discussion task, in which they discussed a time the child felt negative emotions.

Data were analyzed using simple correlational, regression, and Multivariate (MANOVA) techniques. Overall, results indicated that anxious children have difficulty managing emotionally evocative experiences and that their difficulties in modulating the intensity of emotional experience and a lack of self-efficacy should be considered as factors that may produce, maintain, and/or exacerbate anxiety. Mothers of anxious children did not indicate more maladaptive emotion management than mothers of control children and there were no significant correlations between children's and mothers' patterns of emotion management. This study revealed a theme of control in families with an anxious child with respect to truncated emotional expression, mothers' reports of controlling behaviors, and observation of mothers' behavior during an emotion discussion task. The implications of these results to the treatment of childhood anxiety are discussed.

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INTRODUCTION

Emotional competence has been broadly defined as the ability to act efficaciously in emotionally arousing situations, which are invariably social in nature (Saarni, 1999). A considerable body of research has identified emotional competence as a crucial component in children's adaptive social functioning and psychological adjustment (Cicchetti, Ackerman, & Izard, 1995; Eisenberg & Fabes, 1992; Eisenberg, Fabes, & Losoya, 1997; Hubbard & Coie, 1994; Saarni, 1999). One skill posited to underlie emotionally competent functioning is the ability to manage emotion in a flexible and adaptive way in response to the demands of the social context (Brenner & Salovey, 1997; Campos, Mumme, Kermoian, & Campos, 1994; Saarni, 1999). Given the importance of emotion management to children's socioemotional well being, efforts have been made to understand the development of children's emotion management skills. Findings from this research indicate that parental socialization, both direct and indirect, is one of the primary ways that children learn to manage their emotions (Calkins, 1994; Kopp, 1989; Parke, 1994; Saarni, 1999). Although parents may socialize emotion in any number of ways, research has explicated three primary modes: (a) parental reactions to children's emotions, (b) discussion of emotion, and (c) family expressiveness (Eisenberg, Cumberland, & Spinrad, 1998).

Despite the considerable body of empirical research that has investigated emotion management skills in normative populations, a relatively small amount of research has examined these abilities in non-normative populations. Nevertheless, aspects of emotion management have been posited to play a role in most forms of psychopathology (Bradley, 1990, 2000; Casey, 1996; Cicchetti et al., 1995). With respect to childhood anxiety in

particular, research has typically investigated the course and correlates of anxiety, but has just begun to examine the role of specific emotion processes in anxiety. Examination of emotion management skills in anxious children may help identify emotion-related processes that contribute to the ontology and/or maintenance of childhood anxiety and consequently facilitate the development and/or refinement of prevention and intervention programs currently available.

Investigation of the familial components involved in the development of affect regulation skills in anxious children is important from both normative emotional development and childhood anxiety perspectives. First, given that parents are believed to be the primary agents through which emotion is socialized (Eisenberg et al., 1998; Saarni, 1999), study of emotion socialization practices within an atypical familial context may help to delineate processes or mechanisms necessary for both adaptive and maladaptive emotional functioning.

Second, although there is empirical support for a genetic component in anxiety disorders (Beidel & Turner, 1997; Kendler, Neale, Kessler, Heath, & Eaves, 1992), much of the variance is left unaccounted for suggesting that environmental factors also play an important role (Eley, 2001). Research has only begun to examine familial processes that may contribute to maladaptive ways of managing emotion (e.g., Barrett, Rapee, Dadds, & Ryan, 1996). Albeit preliminary, research suggests that parents of anxious children may impede the development of adaptive regulatory abilities through negative reinforcement, modeling, and overprotective and overcontrolling behaviors (Hibbs et al., 1991; Muris, Bogels, Meesters, van der Kamp, & van Oosten, 1996; Stubbe, Zahner, Goldstein, & Leckman, 1993). Examination of emotion socialization practices within the parent-child

relationship may help to explicate the underlying processes responsible for the strong familial component in anxiety disorders.

Lastly, examining the socialization of affect management skills in anxious children and their parents provides a rich context for gaining information on both normative and non-normative emotional development. From a developmental psychopathology perspective (Sroufe, 1990; Sroufe & Rutter, 1984), development is best informed by studying pathways that lead to both adaptation and maladaptation. Further examination of emotion management skills and the mechanisms through which such abilities develop in anxious children may serve to highlight processes within the parent-child dyad that are necessary for adaptive emotional development.

The goal of the present study is to investigate affect management skills in anxious children and to examine factors within the child and the parent, and the child-parent relationship that may impact the development of adaptive emotion management. Before proceeding to a detailed description of the present study, general information on childhood anxiety will be presented, followed by a theoretical rationale for conducting this study. Then, relevant literature examining the development of affect management skills in both normative and anxious children will be presented with a particular focus on the role of socialization practices. Lastly, the details and rationale for the present study will be outlined.

Childhood Anxiety

Anxiety disorders are among the most common forms of psychopathology in childhood (Anderson, 1994) that affect both clinic referred and nonreferred children. Estimates of prevalence rates for specific anxiety disorders vary. For example, separation anxiety disorder prevalence rates have been reported to range from 2% (Bowen, Offord, & Boyle, 1990) to 12.9% (Kashani & Orvaschel, 1990) in community samples, although the rates have been estimated up to 45% among clinic referred children (Last, Perrin, Hersen, & Kazdin, 1996). For overanxious disorder, currently known as Generalized Anxiety Disorder, estimates from community samples range from 2.7% (Anderson, Williams, McGee, & Silva, 1987) to 12.4% (Kashani & Orvaschel, 1990), and for clinic referred children, estimates up to 27% have been reported (Last, Perrin, Hersen, & Kazdin, 1992). In nonreferred children, estimated prevalence rates for simple phobia range from 2.4% (Anderson et al., 1987) to 9% (Costello, 1989) and in clinic referred children, prevalence rates up to 40% have been reported (Last et al., 1992).

Among the anxiety disorders, separation anxiety disorder is more prevalent among younger children, whereas overanxious and panic disorder are more likely to develop in prepubescent individuals (Cohen, Cohen, & Brook, 1993; Kashani & Orvaschel, 1990; Last & Strauss, 1989). With respect to gender differences, more girls than boys suffer from anxiety disorders (Kashani & Orvaschel, 1990), although the ratios for the specific anxiety disorders vary. Specifically, separation anxiety disorder and social and specific phobia are more common among girls than boys (Anderson et al., 1987; Kashani & Orvaschel, 1990). There appears to be no gender difference in overanxious disorder in early childhood, although the disorder becomes less prevalent in

boys as they grow older, thus, a greater number of girls exhibit overanxious disorder as they reach adolescence (Strauss, Lease, Last, & Francis, 1988). The research studies examining obsessive-compulsive disorder are equivocal; Last and Strauss (1989) found greater prevalence among referred males, whereas Whitaker et al. (1990) found greater prevalence in nonreferred girls.

Symptomatology in anxiety disordered children ranges from mild worry and distress to overwhelming, incapacitating anxiety that interferes with the ability to function (Bernstein & Kinlan, 1997). Anxious children have been shown to exhibit problematic family interactions (Dumas & LaFreniere, 1993), peer relations (Goodyer, Wright, & Altham, 1990; Panella & Henggeler, 1986; Strauss, Forehand, Smith, & Frame, 1986; Strauss, Frame, & Forehand, 1987; Strauss, Lahey, Frick, Frame, & Hynd, 1988), and lower academic achievement (Ialongo, Edelsohn, Werthamer-Larsson, Crockett, & Kellam, 1995). For example, using sociometric measures, Strauss, Lahey et al. (1988) compared the peer social status of anxiety-disordered children aged 6- to 13-years to a group of conduct-disordered children and a group of children with no psychiatric diagnosis. Results indicated that the anxiety-disordered children were as disliked by their peers as children with conduct disorders.

Comorbidity among the anxiety disorders is common in both nonreferred and clinical samples (Albano, Chorpita, & Barlow, 1996; Last, Strauss, & Francis, 1987). For example, Last et al. (1987) found that there was high diagnostic comorbidity among all of the disorders investigated; up to 80% of children diagnosed with separation and overanxious disorder and school phobia also had an additional diagnosis. Some researchers suggest that the high comorbidity found among the anxiety disorders may be

due to a lack of discriminant validity of the diagnostic categories, artificial boundaries, or developmental progression (Caron & Rutter, 1991; Perrin & Last, 1995), whereas others suggest that the high level of comorbidity may be due in part to the notion that the disorders share common etiological factors (Spence, 1997).

Anxiety disorders are frequently comorbid with depressive disorders and, to a lesser extent, externalizing disorders (Anderson et al., 1987; Bernstein & Kinlan, 1997; Brady & Kendall, 1992). With respect to depression, Strauss, Last, Hersen, and Kazdin (1988) found that 28% of children diagnosed with an anxiety disorder exhibited comorbid depression. In another study (Strauss, Lease et al., 1988), 50% of children aged 12-19 who had been diagnosed with an anxiety disorder evidenced a comorbid depressive disorder. In contrast, 20% of the children aged 5-11 years had comorbid depression. These findings, as well as others, suggest a temporal relationship between anxiety and depression such that anxiety may precede depression in children and adolescents (Cole, Peeke, Martin, Truglio, & Seroczynski, 1998; Kovacs, Gatsonis, Paulauskas, & Richards, 1989; Orvaschel, Lewinsohn, & Seeley, 1995). Although comorbid depression has not been linked with any specific anxiety disorder, it appears that older children and children with more severe anxious symptomatology are more likely to have a comorbid disorder (Barrios & O'Dell, 1998; Strauss, Last et al., 1988).

Vasey and Dadds (2001) suggest that to the extent that the anxiety disorders are distinct entities, they should be associated with a unique developmental pathway, although the influences of the pathway may also be components of the pathways to other forms of psychopathology (e.g., other anxiety disorders, depression). If the anxiety disorders represent distinct entities, it is not clear at this time whether the specificity of

the disorders is a result of one or more factors unique to a disorder or due to the organization and timing of the specific factors involved (Vasey & Dadds, 2001). Nonetheless, the high level of comorbidity among the childhood anxiety disorders may be, at least in part, the reason that research examining various aspects of childhood anxiety has at times combined data for children with any type of anxiety disorder into one group and compared them to a control group (e.g., Cobham, Dadds, & Spence, 1999; Dadds, Barrett, Rapee, & Ryan, 1996).

To summarize, anxiety disorders are one of the most common forms of psychopathology in childhood (Anderson, 1994) and have been associated with adverse outcomes including problematic family interactions (Dumas & LaFreniere, 1993), peer relations (Strauss, Forehand et al., 1988, Strauss, Lahey et al., 1988), and lower academic achievement (Ialongo et al., 1995). Comorbidity among the anxiety disorders and with depression is common (Albano et al., 1996), although is more likely to occur in older children and children with more severe levels of anxiety (Barrios & O'Dell, 1998). With respect to age differences, separation anxiety disorder is more prevalent among younger children, whereas overanxious and panic disorder are more common among older children and adolescents (Cohen et al., 1993). Although more girls than boys suffer from anxiety disorders, gender differences in the rates for the specific disorders vary: (a) separation anxiety disorder and social and specific phobia are more common among girls, (b) there are no gender differences in overanxious disorder until adolescence, when it becomes more common among girls, and (c) the findings for obsessive-compulsive

disorder are equivocal (Anderson et al., 1987; Last & Strauss, 1989; Strauss, Lease et al., 1988; Whitaker et al., 1990). In this study, children with any type of anxiety disorder were examined.

Theoretical Rationale

Bradley (2000) proposes a model of affect regulation that provides a theoretical rationale for examining emotion management in anxious children and the socialization processes involved in the development of emotion management. Consistent with emotion theorists (e.g., Cicchetti et al., 1995; Cole, Michel, & O'Donnell-Teti, 1994), Bradley proposes that difficulties with affect regulation are at the core of most forms of psychopathology. Specifically, a general vulnerability to high level of arousal is present that interacts with stressors to produce psychopathology. Indeed, Bradley (1990) posits that one reason different therapeutic modes are generally effective in treating psychopathology is because they target a reduction in arousal, albeit in different ways. For example, exposure strategies in behavior therapy ultimately serve to condition individuals to tolerate arousal and also to develop methods of managing arousal. Similarly, cognitive therapies improve affect modulation through restructuring maladaptive thoughts. In this model, arousal is used synonymously with general negative affect and refers to the activation of a system involved in affect regulation above a resting level. Bradley proposes that the experience of a specific negative emotion results from the individual's interpretation of the general negative affect or arousal.

According to this model, there are general risk factors common to various disorders (e.g., loss, trauma, abuse, stress reactivity) that tend to produce high levels of

attachment relationship, may not develop an anxiety disorder. In the context of an insecure attachment relationship (i.e., the stressor interacting with the vulnerability), however, an inhibited child may be more likely to develop an anxiety disorder. The same principles apply in the case of an experiential vulnerability to arousal, such as when a child is exposed to an environment in which a parent is emotionally incompetent. In the context of other supportive relationships, the child may develop into an emotionally healthy individual. However, without additional supportive relationships, such a child may go on to develop a disorder. Consequently, it is necessary to examine the context in which such deviant behavior develops. In this way, Bradley's model is consistent with a developmental psychopathology perspective (Sroufe & Rutter, 1984) in that she proposes that there are multiple pathways to an outcome and that examination of contextual factors is necessary in order to understand the development of a disorder.

In addition to genetic and environmental factors, Bradley posits that an individual's interpretation of an event can also produce increased levels of arousal. For example, a child who perceives an event as threatening and doubts his or her ability to cope with the stressor may experience elevated levels of arousal. In this way, attributions and schemas about the situation and the self are important aspects involved in learning to manage emotion in adaptive ways.

Implicit in the preceding discussion is the notion that affect regulation develops within the context of familial and other important relationships. Bradley (2000) states that, "To understand how the developing process of affect regulation can influence the development of psychopathology, we must examine this interaction and these transactions, exploring the individual within the system and also the many different levels

at which the transactions occur” (p. 30). In this way, Bradley’s model is consistent with emotion theorists who posit that development of emotion management is largely a function of the environmental experiences of the individual (Barrett & Campos, 1987; Kopp, 1989; Thompson & Calkins, 1996). For example, the Functionalist theory of emotion (Barrett & Campos, 1987; Campos et al., 1994) proposes that socialization practices influence (a) which emotions a child is likely to experience, (b) which events are interpreted as meaningful to the child (i.e., have the ability to cause increased arousal), (c) the tendency to display certain facial, vocal, and physiological patterns under arousing circumstances, and (d) the ability to respond in emotionally arousing situations.

Methods of Emotion Socialization

One of the primary ways that such emotion-related processes are socialized is through direct interaction with the caregiver, which impacts an individual’s schemas of relationships and the self (Dunsmore & Halberstadt, 1997). The socialization of emotion-related processes is believed to begin in infancy. For example, although the infant appears to have innate abilities to regulate distress, such as sucking behavior to self-soothe or gaze aversion to reduce negative stimulation (Cole & Kaslow, 1988; Kopp, 1989). These forms of emotion regulation ordinarily occur within the context of the infant-caregiver relationship (Cole et al., 1994). Typical infant-mother interactions involve coordinated and miscoordinated states that cycle back and forth and involve a wide range of affects (Tronick & Cohn, 1989). The ability to transition from a miscoordinated state to a coordinated state is viewed as the social-interactive mechanism that affects the child’s development. Specifically, successful transitions to a coordinated state result in positive affective states whereas unsuccessful transitions result in negative

affective states. The functional significance of reparation in typical mother-infant interaction is that the infant learns effective coping strategies, which sets the stage for developing more sophisticated coping methods and the understanding of interactive rules and conventions.

Although parent-child interaction in infancy sets the stage for developing emotion management skills, the socialization of emotion processes continues throughout childhood (Casey & Fuller, 1994; Saarni, 1999) and may occur through less direct methods (Casey & Fuller, 1994; Halberstadt, 1986; Thompson, 1990). For example, in social referencing, a child seeks out emotional information by examining his or her caregiver's facial expression and bodily behaviors to determine how he or she should interpret and respond to the event (Sorce, Emde, Campos, & Klinnert, 1985). Similarly, parents socialize emotion through the discussion of emotional experiences (Denham, 1998; Dunn, Brown, & Beardsall, 1991; Eisenberg et al., 1998; Kuebli, Butler, & Fivush, 1995). Through discussion with their parents, children may learn to use emotion-related language themselves (Dunn, Bretherton, & Munn, 1987) and ways of managing emotional experiences (Gottman, Katz, & Hooven, 1997).

Perhaps one of the most indirect methods of emotion socialization is through the emotional climate in the household (Halberstadt, Fox, & Jones, 1993; Thompson, 1990). Specifically, the general level of emotional expressiveness in the family, including the negative or positive quality of the expression, is an indirect method of socialization. Dunsmore and Halberstadt (1997) suggest that the "overall frequency, intensity, and duration of positive and negative emotional expressiveness in the family is important in the child's formation of schemas about emotionality, about expressiveness, and about the

world” (p. 53). For example, a child who learns that emotional expression is acceptable and valued may be more likely to openly express his or her emotions. In contrast, a family environment that discourages emotional expression might implicitly encourage the child to rely on affect-suppressing methods of managing emotional experience. Although functional in one context (i.e., the family), the same method of managing emotion may be maladaptive when utilized in another context (i.e., peers) (Jenkins & Oatley, 1998). In this way, it is imperative to consider that particular methods of managing emotional expressions (e.g., expressing, inhibiting, or exaggerating) are not in and of themselves maladaptive. Rather, the appropriateness of each method is determined by the context in which the emotional experience occurs (Cole & Kaslow, 1988). Dunsmore and Halberstadt (1997) suggest that one developmental task for children is to develop additional models of emotional expressiveness that they can use flexibly in response to the changing demands of the social context; an overreliance on a single strategy to regulate affect is one way in which maladaptive emotion management may be manifested.

Of primary interest to this study is the way in which socialization factors may be related to the development of atypical emotion management skills in anxious children. Research that has examined families of anxious children indicates that parents may exhibit behaviors that contribute to the anxious child’s socioemotional difficulties. Specifically, parents of anxious children have been shown to encourage maladaptive patterns of responding (Barrett et al., 1996; Dadds et al., 1996), exhibit over-controlling behaviors (Krohne & Hocke, 1991), and emotional over-involvement (Hibbs et al., 1991; Stubbe et al., 1993). These findings suggest that families of children with anxiety

disorders may be a useful population to examine because comparisons with a normative population may yield important findings regarding emotion-related socialization practices that encourage both adaptive and deviant development.

Next, the studies that have examined anxious children and their families will be reviewed. Consistent with a developmental psychopathology perspective, the development of affect regulation skills in normative samples will first be discussed, as an understanding of normal development is crucial to understanding the ways in which deviations from normality may occur (Cicchetti, 1993). Importantly, the review is framed within the context of socialization practices that influence the development of emotion management skills.

Development of Emotion Management Skills: The Role of Socialization

Although there are a number of methods in which parents may socialize emotion, Eisenberg et al. (1998) focus on three particular ways: (a) reactions to children's emotions, (b) discussion of emotion, and (c) parental expression of emotion. Such socialization practices are believed to vary as a function of the child's age, sex, and temperament, the parent's sex, emotion-related beliefs and behaviors, the context, and cultural factors. Consistent with Bradley's model of affect regulation, Eisenberg et al. (1998) posit that these socialization behaviors may be mediated by a child's level of arousal. Specifically, overarousal in an emotionally evocative situation may interfere with a child's ability to attend to important contextual information, including socialization behaviors. Eisenberg et al. (1998) similarly emphasize that parental socialization behaviors that are mildly arousing are likely to provide the optimal context for learning and internalizing parental values.

Parental Socialization of Emotion: Reactions to Children's Emotions

Normative populations. Evidence for the influence of parental reactions to children's emotions on the development of affect regulation comes from three primary sources: (a) observational studies of parents', primarily mothers', interactions with their children, (b) mother's self-reports of how they would react to their children's emotions, and (c) studies that examine children's expectations of outcome following emotional expression.

An observational study using mother-infant dyads (3- and 6-month-olds) illustrates one way in which parents may socialize affect management from an early age (Malatesta & Haviland, 1982). In this study, dyads were recorded for a 15-minute play period, after which the mother was instructed to leave the room and return after the infant had cried for 10 seconds. Results indicated that mothers' emotional expressions were primarily restricted to positive emotions (e.g., interest, enjoyment, surprise). Compared to the 3-month-old infants, the 6-month-old infants showed a reduction in negative expression, as well as a reduction in the frequency of expression changes during the interaction. Interestingly, mothers showed more contingent responding to older sons' smiles versus daughters' smiles and matched more male expressions while following female expressions with dissimilar responses. This suggests that mothers are more likely to encourage positive emotional expression in their sons, thus beginning the process of gender specific emotion socialization.

Eisenberg et al. (1992) reported on their program of research in which they demonstrated the influence of parental socialization on children's coping with their own and others' display of emotions, particularly distress. In one study, mothers of

kindergarten and 3rd-grade children were asked what they generally do when their children are distressed or anxious, whether they themselves demonstrate distress or sympathy, and what their children do when they feel sorry for a peer. In addition, general parental emotional expressiveness and parents' degree of encouragement or discouragement of expression of potentially hurtful emotions was assessed (referred to as leniency and restrictiveness, respectively). Overall, the findings indicated that the expression of positive and negative emotion in the home, mothers' expression of distress and sympathy, maternal reinforcement of sympathy and prosocial behaviors, and maternal lenience with respect to the expression of emotion, were positively associated with children's active attempts to help a peer. These findings were stronger for girls than for boys. In contrast, parental restrictiveness with respect to girls' emotional expression was positively related to their nonverbal expression of sympathy but negatively correlated with girls' active attempts to help a peer. The authors suggest that emotional expressivity in the home and encouragement of emotional displays may facilitate young children's helping behaviors.

In another study, Eisenberg et al. (1992) examined the influence of parents' reactions to their 3- to 5-year-old children's anger coping responses in a preschool setting. Parents' reactions to their children's negative emotions were assessed with a self-report questionnaire and coded into one of six categories: (a) distress reactions, (b) punitive responses, (c) emotional encouragement, (d) emotion-focused responses (e.g., strategies that encourage child to feel better such as thinking about happy things), (e) problem-focused responses (e.g., strategies that encourage child to solve the problems that made them upset), and (f) minimization responses (e.g., responses that attempt to

minimize the seriousness of the situation or devalue the children's problems or emotional expression). The coping behaviors were coded into one of six categories: (a) revenge (e.g., attempts to get back at the peer, such as hitting), (b) active resistance (e.g., attempts to get a toy back after it had been taken), (c) venting (e.g., expressing emotion without attempts to resolve the conflict (e.g., crying), (d) avoidance, (e) adult seeking, (f) expression of dislike (e.g., tells the peer that he or she cannot play with him or her because of what was done). In addition, social competence and popularity were assessed through teacher and sociometric status ratings, respectively.

The results revealed several interesting findings. Specifically, both problem- and emotion-focused coping by parents were negatively related to revengeful behaviors in the child and positively associated with children's popularity. Problem-focused coping was also positively related to the expression of dislike, whereas emotion-focused coping was positively related to social competence and negatively related to the child's overall frequency of anger episodes. In addition, parental encouragement of emotional expression was positively related to popularity and negatively associated with revenge and help seeking from adults. In contrast, punitive responses by the parent were associated with adult seeking, revenge, and avoidance. Parental responses that attempted to minimize or devalue the child's negative emotions were positively correlated with frequency of observed anger and negatively related to social competence. The findings reported by Eisenberg et al. (1992) are consistent with other research that has likewise found that restrictive or otherwise non-supportive parental reactions to children's negative emotions are positively associated with lower levels of both emotion regulation

and social competence (Eisenberg, Fabes, Schaller, Carlo, & Miller, 1991; Roberts & Strayer, 1987).

Further support for the effect of parental reactions to children's emotions on their regulatory abilities comes from a study by Casey and Fuller (1994). In this study, mothers and their 3-, 5-, 7-, and 9-year-old children were interviewed using hypothetical vignettes designed to elicit happiness, anger, sadness, and fear (e.g., someone teases or calls your son/daughter bad names). Children were asked how they would feel and respond, and mothers were asked what they would do, if anything, to intervene. Child temperament and family expressiveness were also assessed.

Findings indicated that children reported that anger was regulated more than happiness, sadness, or fear, and that the regulatory strategies used by mothers differed by type of emotion. For happiness situations, mothers reported matching children's emotions and using brief verbal comments without interactive discussion. An age by strategy type interaction for anger situations revealed that mothers reportedly used brief verbal comments more often with 9-year-olds than younger children and that pragmatic action was more likely used with 5- and 9-year-olds than 3- or 7-year-olds. For sadness situations, mothers reported they would be most likely to provide direct assistance, comforting, and discussion. For fear situations, comforting behavior was used more often with 3- and 7-year-old girls and 5-year-old boys, whereas instruction was cited more often by mothers of 9-year-old boys. Importantly, there was no decline in the use of directive strategies with child's age, suggesting that the regulation of expressive behavior remains an important parenting goal throughout middle-childhood.

Results that examined the role of family expressiveness also revealed interesting results. Mothers of negatively expressive families reported regulating their happiness more often than mothers of positively expressive families. In contrast, mothers from positively expressive families were no more likely to regulate emotionally negative situations than mothers from negatively expressive families. Further, mothers of negatively expressive families were less likely to match their children's emotional response to happiness situations than mothers from less negatively expressive families.

With respect to regulation strategies, children most often cited nonverbal means as the preferred method of regulating all types of emotions. Older children reported using more behavioral responses to fear than younger children, and in anger situations, older children were less likely to use proximity seeking than younger children. In sadness situations, gesturing was most often used by 3-year-olds but talking became increasingly more common from age 3- to 7-years. A gender difference indicated that girls were more behaviorally responsive than boys in happiness situations.

It is also possible to examine the role of parental reactions to children's emotions in the development of affect regulation using indirect methods; that is, research can examine children's expected consequences for expressing emotion. Indeed, Saarni (1999) posits that children develop a set of rules for expressing emotion based on the interpersonal consequences they expect to receive following the expression of an emotion. Fuchs and Thelen (1988) examined the relation between outcome expectancies following emotional expression of anger and sadness and children's likelihood of expressing their emotions to mothers and fathers. An affect induction procedure was used in which first-, fourth-, and sixth-grade children were asked to generate an incident

involving themselves and a good friend that made them angry or sad. The experimenter then asked the children questions that assessed their outcome expectancies for expressing their anger and sadness. Findings revealed that older children were more likely to regulate their emotional expression than younger children. Younger children reported that they would be more likely to express their emotions, and overall, expected more positive consequences when communicating sadness to mothers than fathers.

Interestingly, the oldest boys expected less positive expectancies for expressing sadness and were less likely to express sadness than girls. Girls reported less likelihood of expressing anger than boys and a greater likelihood of expressing sadness than anger.

Zeman and Garber (1996) examined children's decision to regulate anger, sadness, and pain as a function of audience (i.e., mother, father, peer, alone), age (i.e., 1st-3rd- and 5th-grade), and sex. Children were read hypothetical vignettes that varied as a function of audience figure and emotion. They were then asked a series of open-ended questions regarding whether or not the child would show his or her emotion, and then queried about their decision. Findings indicated that children overall were more likely to express pain than anger and sadness such that they expected to receive a supportive or sympathetic response following the expression of pain. Older children reported greater regulation of their emotions overall, especially for anger and sadness. With respect to audience figure, children were more likely to express emotion to either parent than to a peer because they expected negative interpersonal consequences (e.g., ridicule) from a peer. Girls reported expressing sadness and pain more than boys, but unlike the findings by Fuchs and Thelen (1988), girls were equally likely to express anger as boys.

In a study by Zeman and Shipman (1997), 8- and 11-year-old children's reasons and methods for regulating the emotions of sadness, anger, and pain were assessed as a function of the audience figure, (i.e., medium friend, best friend, mother, father), sex, and age of child. Children were instructed to imagine that they were the protagonist in each of the hypothetical vignettes that they were read. Each vignette portrayed a protagonist who experienced anger, sadness, or pain, and decided to not show his or her feelings. Children were then asked to indicate, in a forced-choice format, their reason for not showing the particular emotion including (a) relational goal (i.e., expect to receive a negative interpersonal reaction), (b) instrumental goal (i.e., expect to receive a negative consequence), (c) prosocial goal (i.e., not show the emotion because it will protect the audience figure's feelings), and (d) rule-oriented goal (i.e., do not show the emotion because you are not supposed to show how you feel).

Results revealed that children regulated their emotions more with peers than with parents because they expected negative interpersonal consequences. Children's goals for regulating their emotions differed as a function of audience figure. Specifically, children endorsed more instrumental, relational, and prosocial goals for regulating their emotions with peers than parents. Gender differences indicated that girls regulated feelings of anger and sadness in order to protect other's feelings, whereas boys regulated anger for prosocial reasons and regulated sadness because they expected a non-supportive interpersonal response. Both boys and girls indicated instrumental goals for regulating pain and in addition, girls cited regulating pain to protect other's feelings.

In summary, research with normative populations demonstrates that the socialization of emotion management through parental reactions to children's emotions

differs as a function of both age and sex. Second, parental efforts to minimize emotional expression and negative reactions to children's display of negative affects are likely to result in negative outcomes including lower levels of emotion regulation and social competence. Eisenberg and colleagues (Eisenberg et al., 1992, 1998) suggest that restrictive or punitive reactions to children's negative emotional expression may prompt children to inhibit or suppress their emotions. Consequently, the child may become overaroused and increasingly dysregulated (Eisenberg et al., 1998). In the long-term, when confronted with negative emotionally arousing situations, these children may become more physiologically aroused than other children as a result of the anticipated negative outcome expectancies for expressing negative emotion (Eisenberg et al., 1997). Gross and Levenson (1997) found evidence for the notion that inhibiting emotional expressive behavior produces increased sympathetic arousal, and, as a result, does not relieve individuals from the subjective experience of the distress. With respect to chronic inhibition as a way of managing emotionally expressive behavior, Gross and Levenson state, "It may impair the efficiency of cognitive processing, it may block adaptive action, and it may limit the ability of our social partners to accurately track (and thus respond to) our needs and plans" (p. 102).

Anxious populations. Observation studies of anxious children and their parents also provide evidence for the role of socialization in children's affect regulation behaviors. In a study by Dumas and LaFreniere (1993), mother-child dyads were observed while working on a challenging task. There were 30 preschool children in each group who were identified by their teacher as socially competent, average, anxious, or aggressive. In addition to working on a challenging task with his or her own mother,

each child worked on the task with an unfamiliar mother. Dyads were observed for positive interaction, affect, and reciprocation.

Interestingly, findings indicated that anxious dyads exhibited more aversive functioning than all other dyads, including the aggressive dyads. Anxious children did respond contingently with their own mothers but generally ignored, rejected, or were ambivalent toward unfamiliar mothers. This finding was interpreted within the context of the mother-child relationship. That is, mothers of anxious children exhibited the most aversive behavior and negative affect of all mothers, as well as a consistent pattern of negative reciprocity to their child, but did not exhibit these behaviors while interacting with others. Through their relationship with their mothers, it appears that anxious children are learning maladaptive ways of coping with social challenges.

In a similar study, Dumas, LaFreniere, and Serketich (1995) examined children aged 2.5- to 6.5-years in a laboratory task with their mothers. Children were identified by their teachers as socially competent, aggressive, or anxious. Mother and child behaviors were coded based on the following categories: (a) positive behavior (e.g., laughter, affectionate behavior), (b) positive affect (e.g., words of endearment, affectionate gestures), (c) aversiveness (e.g., critical, punishing, or aggressive behaviors), (d) aversive affect (e.g., expressions of aversive emotions, such as a loud or sarcastic tone), (e) control (i.e., clearly stated commands with which the person could comply or not comply), (f) compliance (i.e., compliance within 10 seconds of a control exchange), and (g) noncompliance (i.e., active refusal to comply with a control exchange within 10 seconds).

Results indicated that socially competent children and their mothers interacted in a generally positive way; they exhibited a coherent interactive style and although they

rarely relied on controlling behaviors, when they did, it was more often accompanied by positive rather than negative emotion. Aggressive dyads also interacted in a generally positive manner, although aggressive children frequently utilized coercive control, to which mothers responded in an indiscriminate manner. Further, mothers failed to oppose their children's coercive techniques of control. Anxious dyads were equally likely to be aversive as positive and demonstrated high levels of coercion, particularly by mothers. Mothers of anxious children were more controlling than all other mothers, and when they exhibited a control exchange, it was likely to be accompanied by aversive behavior or emotion. Interestingly, mothers of anxious children demonstrated a low level of compliance to their child's control exchanges, but overall, they were more likely to comply to aversive rather than positive control exchanges. Results also indicated that approximately one-half of children's control chains were coercive (a chain was defined as a sequence in which mother or child made one control attempt immediately followed by one or more control attempts made by the same person) and they refused to comply to 60% of their mother's coercive chains. Thus, in contrast to aggressive children, anxious children did not have control over their mothers; that is, mothers of anxious children ignored or actively refused to comply to their children's coercive exchanges.

Research that has examined anxious children's perceptions of their parent's behavior also lends support to the role of parental socialization. For example, Siqueland, Kendall, and Steinberg (1996) assessed perceptions of parenting behavior in anxiety-disordered children (ages ranged from 9- to 12.6-years) and their families. In addition, independent observers rated a family interaction task that required the mother and child, father and child, and mother, father, and child to discuss an emotionally provoking topic

(i.e., one that was the most prevalent and contentious for the mother, father, and second most contentious for the mother, respectively). Dyads were rated on (a) psychological autonomy, the degree to which the parent constrains or encourages the child's individuality through the use of inductive disciplinary procedures (e.g., acknowledges and respects child's views, and (b) warmth, the affective or emotional qualities of the parent-child relationship (e.g., demonstrates a mutual expression or recognition of feelings). Ratings of parent-child conflict, marital conflict, and parental self-report of psychopathology were also assessed.

Results indicated that independent observers rated parents of anxiety-disordered children as less granting of psychological autonomy than parents of control children. No differences on ratings of warmth in the observation task were found. The authors note, however, that the limited range of scores used to rate this construct resulted in most of the families being judged to be moderately warm. Further, anxiety-disordered children rated their mothers and fathers as significantly less accepting than control children rated their parents. There were no differences on ratings of marital conflict or level of parental psychopathology between the two groups. The authors suggest that parents of children with anxiety disorders may limit their children's activities or emotional expression through overinvolvement or overprotection, constructs traditionally believed to include behaviors such as excessive warmth or caring. For example, in one dyad, a boy was observed to disagree with his mother about cleaning his room everyday but then noticed a look of distress on her face; he then put his thumb in his mouth and lay his head in her lap saying "never mind" (p. 233).

In a study conducted by Suveg, Zeman, and Stegall (2001), outcome expectancies for emotional expression in children experiencing anxious symptomatology, as assessed through a self-report measure, were examined. In this study, children aged 9- to 11-years were read hypothetical vignettes designed through pilot testing to elicit the negative affects of fear, sadness, and anger and occurred in the presence of the mother. Children were instructed to imagine that they were the child in the story and to respond to questions that assessed (a) expectations of response if they did not show their emotions, (b) expectations regarding negative interpersonal consequences (i.e., if they expected to be teased or made fun of by their mothers as a result of expressing their emotions), and (c) expectations of somatic symptoms as a result of experiencing the emotion.

Results indicated that children experiencing greater levels of anxiety expected to feel worse than low anxious children if they did not show their angry feelings and expected to be teased for showing their emotions. High anxious children also expected to experience somatic symptoms as a result of experiencing negative emotions. These results lend support to other research that indicates anxious children tend to avoid or withdraw from emotionally arousing situations and rely on maladaptive methods of managing emotion (Barrett et al., 1996; Suveg, Zeman, & Stegall, 2001). It may be that such methods of coping may serve to decrease the arousal anxious children experience as a result of experiencing the negative emotion, and the anticipated consequences of showing emotions to others.

Parental Socialization of Emotion: Discussion of Emotion

Normative populations. The discussion of emotion may directly or indirectly influence a child's developing affect management skills in a number of ways (Denham,

1998; Eisenberg et al., 1998; Gottman et al., 1997; Kopp, 1989; Thompson, 1990). With respect to indirect influences, emotion-related discussions have been associated with children's ability to use emotion-related language themselves (Dunn et al., 1987) and children's understanding of emotion (Denham, Cook, & Zoller, 1992; Dunn et al., 1991). Children who are more skilled at using emotion-related language and understanding emotional experiences may be more adept at regulating their own arousal during distressing situations (Eisenberg et al., 1998). In a more direct manner, emotion-related discussion may affect the development of emotion management skills by explicitly teaching the child ways of understanding and managing emotional experiences (Barrett et al., 1996; Gottman et al., 1997). To the extent that the strategies themselves are generally adaptive, they will contribute to adaptive emotion management skills in the child.

Gottman et al. (1997) suggest that through the processes of "emotion-coaching," children demonstrate overall emotional well-being; children from emotion-coaching families are both more physiologically and behaviorally regulated. Further, they demonstrate greater academic achievement and more social competence. In contrast to "emotion-dismissing" families, emotion-coaching parents (a) are aware of the child's emotion, (b) see the child's emotion as an opportunity for intimacy or teaching, (c) help the child to verbally label the emotions that the child is experiencing, (d) empathize with or validate the child's emotion, and (e) help the child to problem solve.

In a longitudinal study, Gottman et al. (1997) recruited married couples with children between the ages of 4- to 6-years. Numerous emotion-related measures were taken in both the home and laboratory. In the laboratory, parents were interviewed individually about their own experience of sadness and anger, their philosophy of

emotional expression, and their feelings, attitudes, and responses to their children's anger and sadness. The interview was coded for parents' awareness and regulation of their own anger and sadness, and their awareness and coaching of their child's anger and sadness. A mildly challenging parent-child interaction task was coded for negative and positive parenting and a marital interaction task was observed and coded for problem solving behavior and emotional communication. In addition to dyadic tasks, children's facial reactions to emotionally-arousing films were observed and in addition, children's ability to pose facial expressions was examined. Children's physiological functioning was assessed by the child's heart rate and how much they were sweating under resting or baseline conditions, during parent-child interaction, and when watching the films. Vagal tone, skin conductance level, and stress-related hormones were also assessed. In the home, the child was audiotaped interacting in a 30-minute play period with a peer that the mother identified as the child's best friend. This interaction was coded for amount of negative affect and the overall quality of the play. Follow-up assessment was conducted when the children were 8-years-old and included the following measures. Peer interaction with a best friend was again assessed and in addition, teachers rated the degree to which the children used overt aggression while interacting with peers. Parents also completed a questionnaire about the frequency with which their child experienced negative emotions, and a questionnaire that assessed problem behaviors. Mothers also completed a questionnaire designed to assess the child's regulatory abilities.

Results indicated several interesting findings. Father's awareness of his own sadness was significantly related to his coaching of his child's anger and sadness, and it was also related to his wife's coaching of the child's anger and sadness. In contrast,

father's awareness of his own anger was related only to his coaching of his child's anger. For mothers, awareness of her own sadness was related to her sadness coaching with her child, and awareness of her own anger was significantly related to her coaching of her child's anger and sadness. Interestingly, for both mother and father, awareness of their own emotions was related to their awareness of the child's anger and sadness. In addition, the parenting dimension, Derogation (computed by combining the codes of intrusiveness, criticism, and derisive humor, humor at the child's expense), from the observation task, significantly predicted negative ratings of peer relations at age 8-years, as rated by the teacher, and more displays of negative affect when the child was playing with a best friend at 8-years. With respect to child's negative affectivity (as measured by teachers and mothers) and physical illness of the child at age 8-years, the parenting dimensions of Derogation and Scaffolding/Praising were significant predictors of child negative affectivity, but not of child physical illness. Derogation was also significantly related to increased child anger, disgust, sadness, and to a lesser extent, happy facial expressions shown during the emotion-eliciting films. In contrast, Scaffolding/Praising was related to fewer child disgust and sadness facial expressions. With respect to this particular finding, the authors note that learning to regulate facial display is an important development task of this age period; children whose parents are more negative and less positive may be delayed in the ability to inhibit one's emotional expression. The results indicated that academic performance in the child is impeded by parental intrusiveness, mockery and derision, and facilitated by maternal warmth in interaction and parenting Scaffolding/Praising.

In a study that specifically assessed the discussion of emotion, Fivush (1989) examined the emotional content of conversations between mothers and their children (30- to 35-months-old). Mothers were instructed to discuss a specific event with their child, although no specific instructions regarding emotion-related content were given. Conversations were coded for (a) the number of positive and negative emotion terms, (b) whether the emotion term related to the mother, child, or someone else, and (c) whether the conversations about emotion were attributional (i.e., discussed the emotional state itself but not the causes and consequences of the emotion), or explanatory (i.e., conversation includes discussion of the causes and consequences of the emotion).

Results indicated that mothers not only tended to focus on positive emotions with their daughters, but when negative emotions were discussed, they were attributed to persons external to the child. In contrast, conversations with sons included both positive and negative emotions and were just as likely to attribute both negative and positive emotions to the child. Mothers tended to discuss anger more often with their sons, but tended to discuss sadness more frequently with their daughters. In addition, mothers tended to discuss the emotion itself with their daughters but discussed the causes and consequences with their sons.

Denham (1998) reported on a series of studies (i.e., Denham & Auerbach, 1995; Denham et al., 1992) that demonstrated the link between emotion-related discussions and children's behavior in the preschool. In the lab, mothers and their children were instructed to look at and discuss pictures of infants who were displaying particular emotional expressions. After the conversation, the mother and child enacted the emotions displayed by the infants. The conversations were coded for the frequency,

function, and accuracy of the emotion language that was used by both mother and child. The following categories were used to code the function of emotion language: (a) commenting (e.g., “She has a surprise look on her face), (b) questioning (e.g., “She’s happy, isn’t she?”), (c) explaining (e.g., “He’s mad because he doesn’t like nobody to touch him.”), (d) moralizing (e.g., “It makes me sad to see [the baby] sad.”), and (e) guiding behavior (e.g., I’m gonna be angry if you do that ...”).

Results indicated strong correlations between maternal and child language, especially during the simulations, and children’s expressed emotions in the preschool. Further, particular aspects of the discussions appeared to relate to more adaptive behavior. For example, there was an association between mothers who explained their emotions during the emotion enactments and children who were less sad in the preschool setting. As Denham notes, “mothers who talked on and on about their distress during the simulations, but without explaining it, had children who looked more affectively *negative* in the classroom. These mothers “wallowed” in negative emotion via their language, conveying a negative emotional style. Their unrelenting, but equally unilluminating, harping on negative emotions was debilitating to the children” (p. 116).

Anxious populations. Studies of families of anxious children further contribute to the evidence that through discussion, parental practices influence the development of emotion management skills (Barrett et al., 1996; Dadds et al., 1996). In one study, Barrett et al. (1996) examined parental influence on 7- to 14-year-old anxious and aggressive children’s interpretation and subsequent solution to ambiguous situations. Following a diagnostic interview, children and their parents were separately presented with a number of ambiguous situations then interviewed about their interpretations and

possible solutions to these situations. Following the interview, the families engaged in two, 5-minute discussions in which parents were instructed to help the child decide how to cope with each ambiguous situation. The child was then asked to provide a final solution. Responses were coded for threat interpretations (overall, physical, and social threat) given by the parents and children in each group, and avoidance, aggressive, and proactive solutions to the situations.

Results indicated that both oppositional and anxious children interpreted the ambiguous situations in a more threatening manner than control children. Further, oppositional children endorsed more aggressive solutions to the situations, whereas anxious children responded with more avoidant solutions. Interestingly, parents of anxious and aggressive children also made more threat interpretations than mothers of control children. In addition, parents of anxious children predicted their children would select avoidant responses and mothers of aggressive children predicted their children would endorse aggressive responses. Further, avoidant and aggressive responses were greatly increased following the family discussion for anxious and aggressive children, respectively (referred to by the authors as the FEAR effect – family enhancement of avoidant and aggressive response). These findings suggest that through modeling or parental reinforcement, maladaptive patterns of responding may be learned and/or maintained. Dadds and Roth (2001) note that the findings from the Barrett et al. (1996) study demonstrate that familial processes have the ability to influence the expression of children's vulnerabilities, even in such a brief task as the one used in the study. By not helping the child to cope constructively with the emotionally arousing situation, the children were not provided with opportunities to master their anxiety; in this way, parents

may actually be reinforcing and modeling maladaptive behavior and poor regulatory strategies.

In an attempt to elaborate on the previously reviewed study, Dadds et al. (1996) examined a randomly selected subset of the larger sample in the Barrett et al. (1996) study. Sixty-six children ages 7- to 14-years who had been diagnosed with an anxiety disorder and for whom videotapes had been collected were utilized along with an aggressive and non-clinical control group. In addition to the previously mentioned procedures involving the discussion of ambiguous situations, each family discussion was coded for the (a) percentage of utterances where each person expressed agreement and listened (i.e., the process measures), and (b) percentage of intervals in which each person communicated threat descriptions, prosocial responses, aggressive responses, avoidant responses, positive consequences, and negative consequences (i.e., the content measures). Expressions of threat, avoidance, or negative consequences were collapsed into one category called Avoidance, whereas expressions of nonthreat descriptions, prosocial responses, or positive consequences were labeled Prosocial. Instances of reciprocation were also assessed.

Results indicated that mothers of both anxious and aggressive children agreed with their children less than mothers of non-clinical children. Further, mothers of anxious children listened less to their children than mothers of aggressive children. Although the groups could not be differentiated on the type of interpretation or solution generated, interesting findings emerged when conditional probabilities of behavior were examined. Specifically, parents of anxious children were more likely than parents of non-clinical children to respond to an avoidant communication from their child with their

own avoidant communication. The rate of avoidance in the child was positively related to the probability that the parents agreed to and listened to avoidance and the probability that they reciprocated the avoidant solution. In contrast, parents of non-clinical children were more likely than the aggressive or anxious groups to agree with and/or listen to a prosocial communication by their child. The frequency of child generated avoidant plans was negatively correlated with the probability that the parent would reciprocate and listen to the child's prosocial plans. Other research has similarly found support for the role of parental influences on childhood anxiety (Chorpita, Albano, & Barlow, 1996; Greco, Cadotte, & Morris, 2000).

Parental Socialization of Emotion: Family Expressiveness

Normative populations. The last category through which parental socialization may influence children's developing affect management abilities is family expressiveness. Eisenberg et al. (1998) suggest four primary ways in which family expressiveness affects children's functioning: (a) through processes of imitation and contagion, (b) as a mediator or correlate of other aspects of parenting that affect children's socioemotional competence, (c) through influences on children's abilities to interpret and understand other's emotional reactions, and (d) through processes such as shaping children's feelings about themselves, others, and the social world. Denham (1998) suggests that parents provide an emotional environment in which the child's emotional expressiveness is shaped to conform to family emotional expression rules. Many of the studies already reviewed provide support for the role of family expressiveness on children's affect management abilities, and in general, suggest that family expressiveness is related to more adaptive regulatory abilities and prosocial

behaviors in the child (e.g., Eisenberg et al., 1992; Gottman et al., 1997). The studies that follow examine family expressiveness and generally provide further support for the preceding conclusions.

A study by Denham and Grout (1992) assessed the relation between maternal emotional expressiveness and preschool children's emotional understanding. Mothers were instructed to keep a daily diary in which they described their emotional expressions. Mothers were then interviewed about the experiences recorded in the diaries, which yielded information about the type, intensity, and frequency, and mode of emotional expression. Children's understanding of emotion was assessed by having the children identify emotional expressions, which were drawn on the faces of puppets. Children's understanding of situations that might lead to the particular emotional expression was also measured.

Results indicated that family expression of happiness, sadness, and tension was positively related to children's emotional understanding. Maternal reports of expressing sadness over daily hassles and tension over their child's uncooperativeness were associated with higher levels of children's emotional understanding. The highest level of emotional understanding was demonstrated by children who responded to their mother's emotional expressions with verbal and behavioral strategies. Importantly, children's understanding of emotion was particularly low when mothers reported they suppressed their tension such that the children were unaware of their emotional state.

A study by Garner (1995) demonstrates a more direct influence of family expressiveness on emotion regulatory behaviors. In this study, 55 toddlers (mean age = 17.7 months) and their preschool-age siblings participated in a toddler-sibling and a

toddler-sibling-stranger interaction. Various toys were provided for the children and the stranger was instructed to read a magazine and ignore toddler bids for attention. During the interactions, the toddlers' facial expressions were coded as unratable, smiling, pleasant expression, moderate distress, and cryface. Measures of emotional lability and distress were created from the ratings. Emotional lability was defined as the number of intervals in which the ratings cycled from positive emotion to negative emotion and vice-versa. Latency to distress was defined as the number of intervals between the mother's departure and the first rating of distress in the toddler-sibling condition. In the toddler-sibling-stranger condition, latency to distress was defined as the number of intervals between the entry of the stranger and the first rating of distress. The frequency of self-soothing (e.g., rocking) or comfort-seeking (e.g., initiating proximity with the sibling or stranger) behaviors were also measured. Lastly, mothers completed the Family Expressiveness Questionnaire (FEQ; Halberstadt, 1986) in order to assess self-reported frequency of family expressiveness.

Results indicated that toddlers had a shorter latency to distress and more emotional lability in the toddler-sibling condition than when they were alone. Further, more self-soothing behavior was observed when the stranger was present. Importantly, mother's reports of positive emotional expressiveness within the family predicted toddlers' self-soothing behavior in the sibling alone condition. In contrast, mother's reports of expressivity of negative emotions were inversely related to toddler's self-soothing behaviors in both the toddler-sibling and toddler-sibling-stranger condition.

A longitudinal study by Denham et al. (2000) provides further support for the role of family expressiveness in children's regulatory behavior. In this study, children were

first assessed when they were between 48-61 months of age and again at two later time periods (i.e., mean age of children 7.0- and 9.7-years). Recruitment via newspaper ads and flyers sent to preschools and daycares targeted children who were difficult to manage (i.e., they recruited children exhibiting noncompliance, aggressiveness) as well as any children within the age range of study so as to maximize variability among them.

Children and their parents participated in dyadic and triadic interaction tasks that were chosen to create settings in which both positive and negative interactions could take place. Maternal and paternal behaviors were coded for supportive presence, limit setting, allowance of autonomy, negative affect, quality of instructions, and confidence.

Measures of parental restrictiveness and nurturance were also computed. In addition, maternal and paternal expressions of anger and happiness were coded, and both parents completed a self-report measure of hostility designed to assess the family's affective environment. Parents and teachers completed measures of the children's behavior. At Time 3, the children reported on their own behavior. Behavior problems in this study were viewed as indices of dysregulation.

Results indicated that observed mother's proactive parenting practices and mother's reported nurturance and nonrestrictiveness consistently predicted fewer externalizing problems in children over time. Parental anger was consistently related to children's behavior problems over time, and further, was most influential as a disorganizer of the behavior of those children already at risk. Thus, the authors emphasize the interaction of parental anger and a child's early vulnerability; parental negative affectivity served a dysregulatory or disorganizing role in the child's socioemotional development. In contrast, the role of constructive parenting, as assessed

through observation and self-report, in decreasing children's problematic behaviors was strongest for children who initially had many problems. Chronic negative emotional patterns, as assessed through self-reported parental hostility, significantly predicted later behavior problems. Positive emotion predicted fewer behavior problems in only one instance.

Anxious populations. The role of parental expressiveness in the development of emotion management skills in anxious children is somewhat less clear than that for typical children. Nonetheless, preliminary research suggests that expressed parental emotional overinvolvement, criticism, and control may directly and indirectly influence regulatory abilities of both anxious children and children at-risk for anxiety disorders (Dadds & Roth, 2001; Donovan & Spence, 2000; Hirshfeld, Biederman, Brody, Faraone, & Rosenbaum, 1997). For example, in a meta-analysis examining the relation between anxiety, depression, and perception of early parenting, Gerlsma, Emmelkamp, and Arrindel (1990) concluded that various types of phobic disorders were consistently related to a parenting style characterized by low levels of affection and high levels of control.

In a study by Stubbe et al. (1993), the association between expressed emotion and psychiatric disorders in 6- to 11-year-old preadolescent children was examined. Expressed emotion was evaluated using a 5-minute speech sample in which parents were instructed to talk about their thoughts and feelings about their child. The speech sample was coded for expressed critical comments (i.e., ratings of positive, negative, or neutral statements and frequency count of statements with critical tone or content) and emotional overinvolvement (e.g., statements of self-sacrificing, behavior or emotional outbursts

during the interview). Further, to examine whether the association between child diagnoses and expressed emotion was a function of the mother's current mental health status or reporting style, measures of depression, anxiety, and awareness and verbalization of her own mood and emotional states (referred to as introspectiveness) were included. To assess global family functioning, the conflict and expressiveness subscales of the Family Environment Scale (FES; Moos & Moos, 1981) were administered, as well as a measure of marital satisfaction. Child diagnoses were made based on a structured interview.

Results indicated that critical comments were significantly related to elevated rates of disruptive behavior disorders in children but unrelated to any measures of family functioning or maternal psychopathology. In contrast, emotional overinvolvement was significantly related to both anxiety disorders in children and several aspects of family functioning, including global family conflict, friction in the parental dyad, parent-child relations, and maternal neuroticism. These findings are consistent with research by Hibbs et al. (1991) that likewise found a relation between parental emotional overinvolvement and childhood anxiety disorders.

A study by Muris, Steerneman, Merckelbach, and Meesters (1996) examined the role of parental expression of fear in 9- to 12-year-old children's self-reported fears. Children were diagnosed with an anxiety, behavior, or depressive disorders, and both parents and children were administered a self-report inventory designed to assess an individual's level of fear in response to various stimuli and situations. A question that assessed the extent to which parents express their fear in the presence of the children was

added to the parental form. In addition, trait anxiety was assessed in both the mother and child.

Findings revealed a significant relationship between fearfulness of the mother and fearfulness of the child, which held after controlling for age, sex, and trait anxiety of both child and mother. Further, mothers who frequently expressed their fears had children who indicated the highest level of fears, mothers who sometimes expressed their fears had children who had a moderate number of fears, and mothers who never expressed their fears had children who reported the lowest level of fears. Importantly, expression of fear by the mother accounted for a unique proportion of variance in children's self-reported fearfulness. Although this study does not directly assess children's affect management skills, it nonetheless highlights the important role of socialization processes in children's emotional development. As this study demonstrates, children who are exposed to a fearful or anxiety-provoking environment are likely to internalize the fears themselves. Although symptoms of fear and anxiety are normal developmental phenomena (Bell-Dolan, Last, & Strauss, 1990), such symptoms may interfere with normal functioning (American Academy of Child and Adolescent Psychiatry, 1993; Ollendick & King, 1994). It is likely that an increasing number and intensity of fears will become more difficult to manage, contribute to increasing levels of arousal, and result in maladaptive efforts to reduce the arousal (e.g., avoidance).

Gender Differences in Emotion Socialization Practices

The influence of emotion socialization practices as a function of gender is an important component of the research findings examining the socialization of emotion in normative populations, and as such, these practices will be briefly highlighted here. With

respect to parental reactions to children's emotions, it was demonstrated that mothers are more likely to encourage positive emotional expression in their sons (Malatesta & Haviland, 1982). Similarly, boys tend to report that they expect to receive less positive expectancies for expressing sadness and are less likely to express sadness than girls (Fuchs & Thelen, 1988; Zeman & Garber, 1996). Findings for anger are equivocal; some research has found that girls report less likelihood of expressing anger, whereas other research has not (Fuchs & Thelen, 1988). Socialization practices involving the discussion of emotion also seem to vary according to gender. Specifically, research has demonstrated that during conversations with daughters, mothers tend to focus on positive emotions, and when negative emotions are discussed, they are attributed to persons external to the child. In contrast, conversations with sons include both positive and negative emotions and are just as likely to attribute both negative and positive emotions to the child (Fivush, 1989). In this same study, it was demonstrated that mothers tend to focus on the emotional experience itself with their daughters, but discuss the causes and consequences of the emotionally arousing event with their sons. Brody and Hall (2000) view such differences in emotion socialization practices in large part as a function of the specific characteristics of the family system (e.g., gender role attitudes, cultural and socioeconomic backgrounds, age of child). Given the wide variety of factors that may influence socialization practices within a family, it should not be surprising that gender differences are widely documented, yet sometimes the results yield contradictory or inconsistent findings.

There is a paucity of research, in general, on emotion socialization practices in families with an anxious child compared to normative populations. With respect to

gender differences specifically, the majority of studies have either found no gender differences (e.g., Dumas & LaFreniere, 1993) or none were reported (e.g., Dadds et al., 1996).

To summarize, the empirical research reviewed suggests that the development of emotion management skills occurs largely within the context of socialization experiences, particularly through parental reactions to children's emotions, the discussion of emotion, and family expressiveness. With respect to parental reactions to children's emotions, research demonstrates that parental efforts to minimize emotional expression and their negative reactions to children's displays of negative emotion are likely to result in negative outcomes including lower levels of emotion regulation and social competence (Eisenberg et al., 1995, 1998; Gottman et al., 1997). Parent-child emotion-related discussions have been linked to children's ability to use emotion-related language (Dunn et al., 1987), understanding of emotion (Denham et al., 1992; Dunn et al., 1987), and choice of coping strategies (Barrett et al., 1996). Children who are more skilled in using emotion language and understanding the causes and consequences of emotion are better able to manage their own emotional experiences. Regarding family expressivity, parental expression of positive emotion has been related to children's regulatory behaviors (Denham & Grout; 1992; Garner, 1995; Gottman et al., 1997), whereas the expression of chronic negative affectivity has been linked to both physiological and behavioral regulatory difficulties (Denham et al., 2000; Gottman et al., 1997). Further, it appears that parental reactions to children's emotions and the discussion of emotion vary as a function of the gender and age of the child (Fivush, 1989; Malatesta & Haviland, 1992). Similarly, children's emotion management decisions,

including expression and strategy for regulation, vary according to the particular emotion and audience figure present (Fuchs & Thelen, 1988; Zeman & Garber, 1996; Zeman & Shipman, 1997). These findings indicate that through socialization practices, children learn which emotional displays are likely to be accepted, and by whom.

Compared to research examining the role of socialization of emotion management in normative populations, there is little research that has examined these issues using atypical populations. With respect to anxious children specifically, few studies have explicitly examined the role of socialization practices in the development of emotion management skills. Nonetheless, from the research that is available with anxious children and their families, a few general conclusions can be drawn. Overall, it appears that parents of anxious children may respond in ways that model or reinforce maladaptive ways of responding (Dadds et al., 1996; Muris et al., 1996; Rapee, 1997). Specifically, research has found that anxious children and their mothers generally interact in an aversive and controlling manner (Dadds et al., 1996; Dumas & LaFreniere, 1993). Through discussion of potentially emotionally arousing situations, parents of anxious children have been shown to selectively reinforce avoidant, in contrast to prosocial, communications from their child. With respect to family expressiveness, overprotection and mother's expression of fear have been linked to anxiety in children (Hibbs et al., 1991; Muris et al., 1996; Stubbe et al., 1993). In this way, parents of anxious children may interfere with the development of adaptive regulatory abilities through negative reinforcement, modeling, and overprotecting and overcontrolling behaviors. Systematic examination of emotion management skills in anxious children, with a focus on the influence of socialization factors, will further contribute to an understanding of the ways

in which socialization practices may influence both typical and atypical emotional development. Further, this research will help to explicate the relations between emotion management and psychopathology, in general, and childhood anxiety, in particular.

The Present Study

From a developmental psychopathology perspective, development is best informed by studying pathways that lead to both adaptation and maladaptation (Sroufe & Rutter, 1984). Examination of socialization influences on emotion management within an atypical context may help delineate processes necessary for both normative and deviant development. The primary goal of the present study is to examine emotion management skills in anxious and control children and consider ways in which maternal emotion socialization practices may relate to children's regulatory abilities.

Contributions of the Present Study

This study contributes to the literature in several significant ways. Currently, the role of emotion regulatory processes in childhood anxiety is largely theoretical. Thus, systematic examination of emotion management in anxious children may help identify specific emotion-related difficulties that contribute to the etiology and/or maintenance of childhood anxiety.

Second, there is little research available that has examined family socialization factors that contribute to the socioemotional difficulties frequently experienced by anxious children. This study enhances our understanding of the ways in which emotion-related socialization processes influence emotion management skills in anxious children, and how deficits in regulatory abilities contribute to the development and maintenance of childhood anxiety.

Third, this study contributes to the existing literature by examining both child and maternal factors that may influence emotion management and emotion-related socialization practices, respectively. Specifically, this study assessed the role of intensity, self-efficacy beliefs, and goals in children's emotion management decisions. Further, the influence of maternal emotional expressivity and beliefs about appropriate emotion management were considered.

Lastly, the examination of emotion management patterns in anxious children and the socialization factors that may impact the development of regulatory abilities in anxious children, will facilitate the refinement of prevention and intervention programs currently available for childhood anxiety. Although treatments for childhood anxiety generally have a component that targets coping with stressful situations (e.g., Kendall, 1994), this research may help to identify specific areas related to emotion management that are in need of intervention among anxious children.

This study examined anger, sadness, and worry management in anxious children and investigated the influence of maternal reactions to children's emotion expression, emotion discussion, and family expressiveness on children's regulatory abilities. The specific negative emotions of sadness, worry, and anger were chosen because much of the research with anxious children has examined anxiety-provoking situations or emotions along more global dimensions. From a functionalist perspective, however, examination of discrete emotions is important given that each emotion serves a unique function (Barrett & Campos, 1987). Further, negative emotions have been posited to be more central to the development of psychopathology than positive emotions (Bradley, 2000). Research has identified worry, sadness, and anger as components of childhood

anxiety (APA, 1994; Blumberg & Izard, 1986; Suveg et al., 2001). The variable of gender is included given research that suggests that both children's emotion management decisions and emotion socialization practices vary according to the children's gender (Brody & Hall, 2000; Fuchs & Thelen, 1988; Zeman & Garber, 1996). Children in the 3rd- through 5th-grades were used because it is during middle childhood that children develop stylized ways of managing emotional experience and expression (Cole & Kaslow, 1988). Thus, it is expected that their responses will reflect enduring, in contrast to transient, methods of emotion management. Only mothers were included in this study because the vast majority of research on normative emotional development has examined emotion-related socialization behaviors of mothers (e.g., Casey & Fuller, 1994; Malatesta & Haviland, 1982). With respect to the anxiety literature, much of the research has either used mothers only or when both mothers and fathers have been used, results have not been reported separately as a function of parent (e.g., Barrett et al., 1996; Dumas & LaFreniere, 1993). Thus, although it would be interesting to include fathers in this research, it is important to establish a base of information from which to compare past to current findings and then expand the research to include fathers in the design and implementation of research studies.

Hypotheses

Parental reactions to children's emotions. With respect to parental reactions to children's emotions, research has demonstrated relations among attempts to minimize emotional expression, negative reactions to children's emotional expressions, and poor emotion management in children (Eisenberg et al., 1992, 1998). In this way, restrictive or punitive reactions to children's emotional expressions may subsequently prompt

children to inhibit their emotional expressions. Chronic suppression of emotional experience, however, is likely to result in increased arousal (Gross & Levenson, 1997) that may consequently lead to dysregulated (externalizing) methods of managing emotion (Eisenberg, 1998). Research examining anxious children's self-reports of parental rearing behavior indicates that anxious children typically perceive their mothers as less tolerant of emotional expressions than do control children (Siqueland et al., 1996; Suveg et al., 2001). Based on these findings, it was hypothesized that (a) anxious children would expect more negative consequences from their mothers as a result of expressing emotion than their nonanxious peers, (b) mothers of anxious children would indicate less supportive and more controlling responses to children's emotional expressions than mothers of control children, and (c) children's expectations of outcome following emotional expression and mothers' responses to children's emotional expressions would be related to children's emotion management decisions. Further, based on normative research that indicates the importance of the child's sex and emotion type in emotion management decisions and maternal socialization behaviors, it was predicted that children's expectations of outcome following emotional expression would vary as a function of emotion type and the child's sex, and maternal reactions to children's emotions will also vary as a function of the child's sex and emotion type. Specifically, it is hypothesized that (a) boys would report that they expected to receive less positive expectancies for expressing sadness than girls, and (b) mothers would be more accepting of sadness expression in girls than boys. Given that the majority of research with anxious populations that was reviewed has not specifically addressed gender differences, no

specific a priori hypotheses were generated about gender differences in anxious populations.

Discussion of emotion. Through discussions with their parents, children become more adept in using emotion-related language and in emotional understanding (e.g., the causes and consequences of emotion), both of which positively contribute to children's emotion management skills (Denham et al., 1992; Dunn et al., 1987). Further, mother-child discussions may directly impact children's regulatory abilities by discussing ways that children can manage stressful situations. To the extent that the strategies themselves are generally adaptive, they will contribute to adaptive emotion management skills in the child. However, discussions that encourage the use of strategies that may be maladaptive will likely contribute to deviant development of emotion management abilities. Research with anxious children and their families suggests that parents may inadvertently encourage the use of maladaptive strategies in their children during family discussions (Barrett et al., 1996; Dadds et al., 1996). Further, anxious children and their families have been shown to interact in generally aversive and controlling ways (Dumas & LaFreniere, 1993). Given these results, it was expected that mothers of anxious children, in contrast to mothers of control children, would (a) engage in less explanatory discussion of emotions (i.e., would spend less time discussing the causes and consequences of emotions with their children, and (b) discourage the discussion of emotions by their children. Further, it is hypothesized that anxious children would (a) engage in less explanatory discussion of emotion. Research with normative populations has found that mothers tend to focus on positive emotions during discussions with their daughters, whereas they discuss both positive and negative emotions with their sons (Fivush, 1989).

Further, Fivush (1989) also found that during discussions with their children, mothers tended to focus on the emotional experience itself more with their daughters than their sons, but discussed the causes and consequences of the emotionally arousing situation more with their sons than their daughters. Given these findings, it was hypothesized that mothers would (a) use more negative emotion-related words with their sons than their daughters, and (b) engage in more explanatory discussion with their sons than their daughters.

Family expressiveness. The general level of emotional expressiveness in the family, specifically the negative or positive quality of expressiveness, has been linked to children's emotion regulation abilities (Denham et al., 2000; Denham & Grout, 1992; Garner, 1995). Dunsmore and Halberstadt (1997) propose that emotional expressiveness in the family affects the formation of children's emotion-related schemas, which include beliefs about appropriate emotion management. With respect to anxiety, research has found a relation between anxiety disorders and low levels of expressed affection (Gerlsama et al., 1990). Further, research has also demonstrated a high level of expressed negative affect in mothers of children with anxiety disorders (Dumas & LaFreniere, 1993; Dumas et al., 1995). Accordingly, the following hypotheses were generated (a) mothers of anxious children would indicate less individual and less family emotional expressivity than mothers of control children, (b) anxious children would indicate less family expressivity and perceive their mothers as less accepting and more controlling than their nonanxious peers, and (c) maternal and family expressiveness would positively correlate with children's emotion management abilities.

Emotion Management. Research has consistently identified the role of emotion management in children's socioemotional adjustment; the inability to manage emotion in flexible ways in response to environmental demands has been posited to play a primary role in most forms of childhood psychopathology (Casey, 1996; Cole et al., 1994). Preliminary research with anxious children suggests that they tend to endorse a greater number of avoidant strategies in response to potentially emotionally arousing situations (Barrett et al., 1996). Further, research with anxious children and their families suggests that parents may inadvertently reinforce maladaptive ways of responding through processes including modeling and reinforcement (Barrett et al., 1996; Dadds et al., 1996; Siqueland et al., 1996). In accord with these theoretical tenets and empirical findings, it was expected that (a) anxious children would display more maladaptive patterns of emotion management in contrast to their nonanxious peers, (b) mothers of anxious children would display more maladaptive patterns of emotion management than mothers of control children, and (c) there would be a relation between patterns of emotion management among children and their mothers.

Eisenberg et al. (1998) state that the intensity of an emotional reaction is likely to impact emotion management behaviors. Specifically, emotional overarousal may lead to the over- or under-control of emotional experience, both of which are negatively associated with social and emotional competence. Given that there are relations among physiological hyperarousal, negative emotions, and anxiety, it seems that regulating emotional intensity may be difficult for anxious children, which may contribute to difficulties in emotion management. As such, it was hypothesized that (a) anxious children would report experiencing higher levels of emotional intensity than control

children in response to emotionally arousing vignettes, and (b) emotional intensity would be negatively related to children's reported adaptive emotion management decisions.

Self-efficacy is another factor that is likely to affect children's regulatory abilities in that children who have a sense of self-efficacy are likely to persevere (Bradley, 2000). When applied to emotion management, children with a low sense of efficacy may not be likely to try different methods of coping with emotionally arousing situations. Research has found trait anxiety in children to be associated with low levels of self-efficacy (Muris, 2002). Further research with anxious children suggests that they tend to withdraw from or avoid emotionally arousing situations, suggesting that they may not have a sense of self-efficacy in those situations. Further, through overprotective and controlling behaviors, parents of anxious children may not provide anxious children with opportunities to master stressful experiences and thus develop a sense of self-efficacy. Thus, it is expected that (a) anxious children would perceive themselves as less efficacious in emotionally arousing situations than their nonanxious peers, and (b) perceived self-efficacy would relate to children's emotion management decisions.

Another factor that is critical to understanding children's emotion management strategies is their goals in a particular situation (Thompson, 2001). Research with normative populations demonstrates relations between children's goals and strategies in particular situations (e.g., Zeman & Shipman, 1997, 1998). Research with normative samples further indicates that goals for regulating emotional expressions, expressions of sadness in particular, vary as a function of gender. Specifically, Zeman and Shipman (1997) found that girls reported regulating sadness in order to protect others' feelings, whereas boys regulated sadness because they expected a non-supportive interpersonal

response. Thus, it was expected that (a) girls would endorse more prosocial goals for regulating sadness than boys, and (b) boys would endorse more relational goals for regulating sadness than girls. Research with anxious children suggests that they may endorse different goals than control children in emotionally arousing situations because (a) anxious children expect to be teased or made fun of by their mothers following emotional expression (Suveg et al., 2001), (b) children who experience increased levels of arousal in situations may become overwhelmed by their own emotional experience and focus on their own state rather than others' feelings (Eisenberg et al., 1995, 1998), and (c) hyperarousal is a characteristic feature of anxiety (Laurent et al., 1999). Taken together, the following hypothesis, albeit speculative, was generated; (a) anxious children would tend to identify goals for emotion management that focus on reducing their own emotional arousal or avoiding negative consequences more often than their nonanxious peers.

METHOD

Participants

The control group included 12 boys (M age = 10 years, 4 months, SD = 12 months, range: 7 years, 7 months – 11 years, 7 months) and 13 girls (M age = 10 years, 8 month, SD = 8 months, range: 9 years, 4 months – 11 years, 5 months) who were recruited from public elementary schools and advertisements placed on local community bulletin boards and in family physician/pediatrician offices throughout the state of Maine. Mothers of children in the control group had a mean age of 36 years, 4 months (SD = 55 months) and a range of 29 years, 3 months – 45 years, 4 months. Children in the control group lived with both parents (girls = 11, boys = 8), mother alone (girls = 1, boys = 2), mother and step father (girls = 1, boys = 1), and other family constellation (girls = 1, boys = 1). All children in the control group scored within the normative range on the Children's Depression Inventory (CDI) and Revised Children's Manifest Anxiety Scale (RCMAS) and were free of any psychological disorders based on the ADIS-IV. None of the children in the control group were receiving mental health services (talking to the school guidance counselor was not considered to be formal treatment for the control group). All children in the anxious and control group were Caucasian.

The clinical group included 12 anxious boys (M age = 10 years, 1 month, SD = 10 months, range: 7 years, 8 months – 11 years, 8 months) and 13 anxious girls (M age = 10 years, 9 months, SD = 10 months, range: 9 years, 7 months – 12 years, 0 months) who were recruited from public elementary schools and advertisements placed on local community bulletin boards and in family physician/pediatrician offices throughout the state of Maine. Mothers or female guardians who had a primary parenting role for at

least 2 years were invited to participate in this study; all those who participated were biological mothers (M age = 37 years, 5 months, SD = 5 years, 9 months, range: 27 years, 10 months – 50 years, 11 months). Anxious children lived with both parents (girls = 9, boys = 5), mother alone (girls = 2, boys = 4), mother and step father (girls = 2, boys = 2), and other family constellation (girls = 0, boys = 2).

Psychological diagnoses were made using the Anxiety Disorder Interview Schedule for Children – IV (ADIS-IV). As suggested in the Clinician’s Manual for the Anxiety Disorder Interview Schedule for Children (ADIS-IV; Albano & Silverman, 1996), each child who receives a Clinician Severity Rating (CSR) of 4 or greater should be assigned a diagnosis, indicating that the disorder has caused significant interference in the child’s functioning. Anxious children in the sample had the following primary diagnoses: Separation Anxiety disorder (girls = 4, boys = 5), Social Phobia (girls = 6, boys = 1), Generalized Anxiety disorder (girls = 2, boys = 5), and Specific Phobia (girls = 1, boys = 1). Of the 13 girls in the clinical sample, nine had a comorbid anxiety diagnosis and two had a comorbid externalizing disorder. Of the 12 boys, eight had a comorbid anxiety diagnosis and three had a comorbid externalizing disorder (see Table 2.1). With respect to having received treatment services, for the clinical sample, 13 anxious children were never in treatment and not on a waitlist for services, one was never in treatment but on waitlist for services, two had treatment in the past and were on waitlist for services, five children had past treatment and were not on a waitlist for services, and two were in treatment with a school guidance counselor. Treatment history for 2 of the 25 children in the anxious group is unknown due to an experimenter oversight.

Table 2.1

Number of Secondary DSM-IV Diagnoses for Anxious Children by Sex

	Boys	Girls
SAD ^a	0	1
Specific Phobia	2	4
Social Phobia	3	0
ADHD ^b	1	0
ODD ^c	1	0
SAD, Specific Phobia	0	1
SAD, GAD ^d , ODD, ADHD	0	2
Specific Phobia, ODD	1	0

^aSeparation Anxiety Disorder. ^bAttention Deficit Hyperactivity Disorder. ^cOppositional Defiant Disorder. ^dGeneralized Anxiety Disorder.

Analyses of variance revealed no significant Group or Sex differences in children's WISC-III vocabulary scores, mother's ages or WAIS-III vocabulary scores, or family income as assessed by the Four Factor Index of Social Status (Hollingshead, 1975). On average, families in this study were of middle socioeconomic status (e.g., skilled craftsmen, clerical, or sales workers). A main effect for age indicated that girls ($M = 10$ years, 8 months, $SD = 8$ months) were significantly older than boys ($M = 10$ years, 2 months, $SD = 1$ year, 0 months), $F(1, 46) = 4.27, p = .04$. Analyses revealed that mothers of anxious children reported a significantly greater number of symptoms of psychopathology as assessed by the Symptom Checklist-90-Revised (SCL-90-R) than

mothers of control children, $F(1, 49) = 5.19, p = .03$. See Table 2.2 for mean values, standard deviations, and ranges.

Child Measures

Psychopathology. The initial screening for the presence of anxious symptomatology was assessed with the *Revised Children's Manifest Anxiety Scale* (RCMAS; Reynolds & Richmond, 1997). This measure is designed to assess manifest anxiety in children and adolescents ages 6- to 19-years. The RCMAS yields a total anxiety score as well as four subscales: Worry/Oversensitivity (11 items), Social Concerns/Concentration (7 items), Physiological Anxiety (10 items), and Social Desirability/Lie (9 items). The instrument requires a yes/no response and is designed to assess the presence or absence of various symptoms of chronic/state anxiety. The total number of yes responses are converted to a *T* score ($M = 50, SD = 10$) yielding the Total Anxiety score whereas the four subscales are standardized with a mean equal to 10 and standard deviation equal to three.

The psychometric properties of the RCMAS have been extensively studied. The internal consistency of the RCMAS has been shown to range from .79 to .95 (Lonigan, Carey, & Finch, 1994; Ollendick & Yule, 1990; Pela & Reynolds, 1982). Three-week test-retest reliability for the total anxiety scores have been reported at .97 for boys and .98 for girls (Pela & Reynolds, 1982), whereas a 9-month test-retest reliability for the total score indicated a coefficient of .68 (Reynolds, 1981). Numerous investigations have established the discriminant validity of the RCMAS with respect to differentiating between anxious and control children (e.g., Bell-Dolan et al., 1990; Last, 1991; Perrin &

Table 2.2

Means and Standard Deviations (in parentheses) for Descriptive Variables as a Function of Diagnostic Group and Sex

Variable	Anxious				Control			
	Girls		Boys		Girls		Boys	
	<i>M(SD)</i>	<i>Range</i>	<i>M(SD)</i>	<i>Range</i>	<i>M(SD)</i>	<i>Range</i>	<i>M(SD)</i>	<i>Range</i>
Child Vocabulary Score ^a	10.15 (3.78)	5-18	11.33 (3.56)	3-16	11.77 (2.35)	7-14	12.33 (3.42)	7-17
Mother Vocabulary Score ^b	11.00 (3.61)	7-17	11.27 (3.44)	7-15	10.77 (3.35)	7-16	11.25 (1.54)	9-13
Family Income ^c	3.18 (1.25)	0-5	3.80 (1.55)	0-5	3.83 (0.94)	2-5	3.64 (0.92)	2-5
SCL-90-R ^d	70.04 (66.65)	2.39-240	43.92 (40.05)	7-134	32.64 (28.14)	6-112	26.42(20.50)	4-82

^aAssessed with the Vocabulary subtest of the WISC-III.

^bAssessed with the Vocabulary subtest of the WAIS-III.

^cIndicating that, on average, families in this study were of middle socioeconomic status (e.g., skilled craftsmen, clerical, or sales workers).

^dSymptom Checklist-90-Revised

Last, 1992), however, the ability of the RCMAS to distinguish between anxiety disorders and other psychiatric disorders in children is relatively poor (Hodges, 1990; Lonigan et al., 1994; Wolfe et al., 1987). Thus, the RCMAS is best utilized as a screening rather than as a diagnostic instrument. The internal consistency of the RCMAS total scale for the screening part of this study was strong ($\alpha = .91$). Please refer to Appendix B for copies of all children's measures.

Children who scored at least one standard deviation above the mean (i.e., *T*-score greater than 60) were considered for inclusion into the anxious group and those who scored within the normative range were considered for inclusion into the control group. A 2 (Group: Anxious, Control) by 2 (Sex of Child) ANOVA indicated that children in the anxiety group ($M = 19.31, SD = 4.86$) scored significantly higher on the RCMAS than did children in the control group ($M = 9.37, SD = 6.1$), $F(1, 46) = 42.98, p < .001$. Further, girls ($M = 15.85, SD = 7.79$) indicated more anxiety symptoms than did boys ($M = 12.71, SD = 6.72$), $F(1, 46) = 4.33, p < .05$.

In order to screen out children with potential depressive disorders, children were administered the *Children's Depression Inventory* (CDI; Kovacs, 1992). The CDI is a 26-item questionnaire that assesses depressive symptomatology in children over the past two weeks. For each item, children are instructed to indicate the response that is most like them (e.g., "I am sad all the time," "I am sad many times," "I am sad once in a while"). Items are scored on a 3-point scale and summed to yield a total depression score that can range from 0 to 52. The item assessing suicide was omitted as a result of the controversy of administering this item in a school setting.

The psychometric properties of the CDI scale have been widely researched. Studies with both clinic and non-clinic referred samples indicate internal consistency coefficients that range from .70 to .86 (Carey, Gresham, Ruggiero, Faulstich, & Enyart, 1987; Kovacs, 1985). Adequate test-retest reliability over a 3-week period has also been established (Smucker, Craighead, Craighead, & Green, 1986). However, as with the RCMAS, the CDI is best used as a screening, rather than diagnostic, tool given the poor discriminant validity of the measure (Kovacs, 1985). Internal consistency for the CDI in the screening part of this study was strong ($\alpha = .89$).

The original goal of this study was to screen out children with comorbid depressive disorders. However, given the great difficulty of recruiting participants for this study in combination with the high correlation between anxiety and depressive disorders (Kovacs, 1985; Lonigan et al., 1994), children who scored in the clinical range on the CDI in addition to the RCMAS were included in the study. A total of seven girls and one boy scored in the clinical ranges on both the CDI and RCMAS. Children who scored in the clinical range on the CDI but in the normative range on the RCMAS were excluded from the study (girls = 2, boys = 1). A 2 (Group: Anxious, Control) by 2 (Sex of Child) ANOVA indicated children in the anxiety group ($M = 15.19$, $SD = 8.24$) scored significantly higher on the CDI than did children in the control group ($M = 6.72$, $SD = 5.91$), $F(1, 46) = 21.22$, $p < .001$. A main effect for sex emerged such that girls ($M = 13.19$, $SD = 9.86$) endorsed more depressive symptoms than did boys ($M = 8.54$, $SD = 4.54$), $F(1, 46) = 6.59$, $p < .05$.

Anxiety diagnoses were made during the *primary* part of this study using both the child and parent versions of the *Anxiety Disorders Interview Schedule for Children*

(ADIS-IV: C; Silverman & Albano, 1996). The child (ADIS-C) and parent (ADIS-P) versions are semi-structured interviews that were designed for use in clinical-research settings and in response to the low reliability coefficients that were previously found for childhood anxiety disorders using other structured interviews. The interviews assess anxiety disorders according to the Diagnostic and Statistical Manual of Mental Disorders DSM-IV criteria (4th-ed., 1994, American Psychiatric Association). They provide quantifiable data regarding anxious symptomatology, cause, course, and a functional analysis of the disorder (Silverman & Eisen, 1992). The interviews focus on anxiety and affect-related disorders, and thus permit the interviewer to rule out alternative diagnoses. Clinical judgment is required to determine the diagnosis and also to distinguish between primary and secondary diagnoses. Agreements and disagreements from the child and parent interview are compared and subsequently combined in order to form composite diagnoses that reflect both child and parent data. Discrepancies between child and parent data are resolved by considering severity rating and interference with functioning.

Examination of the psychometric properties of both the child and parent versions of the ADIS-IV indicate an overall kappa coefficient of .75 (Silverman & Nelles, 1988). Kappa coefficients for the specific anxiety disorders range from .64 (Overanxious Disorder) to 1.00 (Specific Phobia). Test-retest reliability has been reported from .64 (overanxious disorder) to .84 (specific phobia). Inter-rater reliability of the child and parent versions yield kappa coefficients ranging from .59 to .82 (Rapee, Barrett, Dadds, & Evans, 1994). Adequate validity has also been demonstrated (Rabian, Ginsburg, & Silverman, 1994, as cited in Silverman & Albano, 1996). Although the original goal of the study was to exclude children with comorbid depressive and externalizing disorders,

children who had secondary diagnoses were included for the same reasons as discussed previously in the section describing the CDI. Given the high comorbidity among the anxiety disorders (Albano et al., 1996), children with multiple anxiety disorders were included. A research assistant unaware of diagnostic status rated approximately one-third of randomly selected audiotaped interviews in order to establish diagnostic reliability. The kappa value for primary diagnosis was .89. Disagreements on diagnosis were resolved through discussion. Kappa for the CSR was also computed; ratings were considered in agreement if they fell within one point of one another (kappa = 1.00).

Emotion management. In order to assess children's emotion management and goals regarding emotion regulation, children were administered the child version of the *Emotion Regulation Interview* (ERI-C) that was designed for use in this study and modeled after previous research (e.g., Zeman & Garber, 1996; Zeman & Shipman, 1997). Children were read six vignettes that were designed through pilot testing to elicit worry, anger, and sadness. Following each vignette, children were asked a series of questions that assess emotional intensity (i.e., "How *worried*, *mad*, or *sad* would you feel in this situation?"), decisions regarding emotional expression (i.e., "Would you show how *worried*, *mad*, or *sad* you feel to your mother?"), outcome expectancies following emotional expression (i.e., "Would your mother make fun of or tease you if you show how *worried*, *mad*, or *sad* you feel?", "Would your mother understand how *worried*, *mad*, or *sad* you feel?"), outcome expectancies of experiencing the emotion (i.e., "How much would this situation make you sick, like make your stomach or head hurt?"), self-efficacy (i.e., "How much would you be able to make yourself feel better in this situation?"), emotion management strategies (i.e., "If this situation really happened to

you, what would you do?”), and goals regarding emotion management (i.e., “Why would you do that?”). For the first six questions, children responded using a Likert-type scale. The open-ended questions (i.e., 7, 8, and 9) were coded by a graduate student who was unaware of diagnostic status. Approximately one-third of the responses were coded for reliability by another graduate student who was also unaware of diagnostic status. Kappa values indicated good reliability (#7 = .69, #8 = .89, and #9 = .84). Please refer to Appendix D for coding instructions for the ERI-C.

In order to assess emotion management skills further, children were administered the *Children's Emotion Management Scales: Anger and Sadness* (CEMS). Using a 3-point Likert scale (1 = *hardly ever*, 2 = *sometimes*, 3 = *often*), the CEMS (Zeman, Shipman, & Penza-Clyve, 2001) assess the way that children manage feelings of anger (11-items) and sadness (12-items). Each scale is composed of three subscales, (a) Inhibition, suppression of emotional expression (e.g., “I get sad inside but I don’t show it.”); (b) Dysregulated Expression, children’s culturally inappropriate emotional expression (e.g., “I say mean things to others when I am mad.”); and (c) Emotion Regulation Coping, children’s adaptive methods of emotion management (e.g., “I try to calmly deal with what is making me feel mad.”).

Examination of the psychometric properties of the CEMS indicate coefficient alphas that range from .62 to .77 and test-retest reliability ranging from .61 to .80 for the six scales. Research has demonstrated construct validity for each of the factors using a normative sample and a sample of children with asthma and diabetes (Penza-Clyve, Zeman, & Sim, 1999). Although the measure was normed on children ages 9 - 12 years, the CEMS has been used with children as young as six years (Penza-Clyve et al., 1999).

For this study, internal consistency analyses yielded the following coefficients for the CEMS (coefficients for the anger scale are presented first, followed by the sadness scale): Inhibition = .47, .61, Dysregulation = .43, .55, and Coping = .67, .62. A Worry management scale that has a similar 3-factor structure was developed for use in this study, and yielded the following reliability coefficients: Inhibition: .67, Dysregulation: .58, Coping: .17).

Children participated in the *Mother-Child Emotion Interaction Task* in which they were asked to discuss, for 5-minutes with their mother, a time when they felt worried, mad, and sad. This task was included in order to examine ways in which emotion socialization may occur through the discussion of emotion. The discussion was tape-recorded and coded for the frequency of use of negative and positive emotion words and for the presence or absence of explanatory discussion. A research assistant who was unaware of diagnostic status coded the emotion discussion. Another research assistant who was also unaware of diagnostic status rated approximately one-third of randomly selected audiotaped discussions in order to establish inter-rater reliability. Inter-rater reliability analyses indicated the following kappa values: frequency of negative emotion words = .93, frequency of positive emotion words = 1.00, and presence/absence of explanatory discussion = .63. Disagreements were resolved through discussion. Please refer to Appendix D for coding instructions for this task.

Family expressiveness/beliefs about emotion management. Children completed the *Family Environment Scale* (FES; Moos & Moos, 1994) to assess their perceptions of the family social climate. This scale assesses 10 aspects of the family environment that generally reflect the quality of interpersonal relationships among family members,

personal growth, and efforts at family system maintenance (Moos, 1990). Only two subscales relevant to the present study were used (20 items) including the *Expressiveness* subscale that measures the degree of emotional expressiveness in the family and the *Control* subscale that reflects the degree of structure within the family.

Examination of the reliability and validity of the Expressiveness and Control subscales of the FES reveal adequate psychometric properties (Moos, 1990). Moos and Moos (1994) report alpha coefficients of .69 and .67 for the Expressiveness and Control subscales, respectively. In this study, alpha coefficients were .53 and .43 for the Expressiveness and Control subscales, respectively. Construct, content, and predictive validity have also been established (Moos, 1990). In addition to normative samples, the FES has also been used with depressed and alcoholic families (Moos & Moos, 1994).

Children were also asked to complete the *Family Expressiveness Questionnaire* (FEQ; Halberstadt, 1986) to assess their perceptions of the degree of emotional expressiveness in their home. Assessing the degree of expressiveness in the household is believed to reflect the norms and values of emotional expression within the family that act to either encourage or discourage emotional expression (Halberstadt, 1984). The FEQ is comprised of 40 items that individuals respond to on a 9-point Likert scale (1 = *not at all*, 9 = *very frequently*). Two factors of the FEQ, Positive and Negative Expressivity, were used in this study.

Psychometric data on the FEQ reveals adequate reliability and validity (Halberstadt, 1986) when examined with a college student population. Test-retest reliability coefficients ranging from .89 to .92 have been reported (Halberstadt, 1986). Internal consistency for this study was strong for the Positive subscale ($\alpha = .93$) but

lower for the Negative subscale ($\alpha = .73$). Validity research on the FEQ has established shared perceptions of expressiveness by family members, discriminant validity with respect to self-expression and shyness, and corroboration of self-reported expressiveness through laboratory observation (Halberstadt, 1986). All questionnaires were read to children; no children had difficulty answering the questions on this measure.

Children were administered the *Egna Minnen Beträffande Uppfostran för Children* (EMBU-C; Castro, Toro, van der Ende, & Arrindell, 1993) to assess their perceptions of parental warmth (e.g., “When you are unhappy, your parents console you and cheer you up.”), rejection (e.g., “Your parents wish that you were like somebody else.”), and overprotection (e.g., “Your parents want you to reveal your secrets to them.”). This scale was modified from the original adult version (Perris, Jacobsson, Lindstrom, von Knorring, & Perris, 1980) that was designed to assess retrospective reports of parental rearing behavior. Questions were modified from “parent” to “mother,” given that this study only examined maternal emotion related socialization practices. Responses on the EMBU have been related to both anxiety and depressive disorders (Arrindell, Emmelkamp, Monsma, & Brilman, 1983, Muris & Merckelbach, 1998; Perris et al., 1986), and hostility (Meesters, Muris, & Esselink, 1995). The EMBU-C was developed in response to criticisms that retrospective reports may be unreliable (Muris, Bosma, Meesters, & Schouten, 1998) and thus, allows measurement of current perceptions of parental rearing behaviors in children ages 8- through 18-years. The EMBU-C consists of 34 items that are answered on a 4-point Likert scale (1 = *No, never*, 4 = *Yes, most of the time*).

The EMBU-C has a 3-factor structure consisting of Emotional Warmth, Rejection, and Overprotection scales (Castro et al., 1993; Muris et al., 1998). Internal consistency estimates for the Emotional Warmth and Rejection factors are strong (ranging from .83 - .86 and from .78 -.80, respectively), whereas the reliability estimates for the Overprotection scale are moderate (ranging from .58 - .61) (Muris et al., 1998). For this study, internal consistency values were .83, .77, and .62 for the Warmth, Rejection, and Overprotection scales, respectively. Adequate validity has been established (Perris, Arrindell, & Eismann, 1994).

Intellectual functioning. Children were administered the *Vocabulary* subtest of the *Wechsler Intelligence Scale for Children* (WISC-III; Wechsler, 1991) to gain an estimate of the children's overall intellectual functioning. This measure was administered in order to consider the potential influence that overall intellectual functioning may have had on the dependent variables in this study. Although this subtest primarily serves as a measure of children's verbal ability, research suggests that it is the best estimate of general intelligence (Sattler, 1992) and exhibits a high correlation with the Full Scale IQ score ($r = .74$; Wechsler, 1991), and generally, has strong psychometric properties (Sattler, 1992). All children in this study, except for one anxious boy and one anxious girl, had at least an Average-level score on this subtest. The low score for these children was attributed to performance anxiety rather than below-average intelligence.

Mother Measures

Demographic information. A demographic information sheet was included in order to obtain information on mother's age, family constellation, and socioeconomic status.

Maternal psychopathology. To assess symptoms of psychopathology, mothers were administered the *Symptom Checklist-90-Revised* (SCL-90-R; Derogatis, 1994). This checklist consists of 90-items that assess current adult psychopathology (Derogatis, 1994). This measure was administered in order to consider the potential influence of psychopathological symptoms on mother's reporting about her own and her child's emotional functioning. Mothers were instructed to indicate on a 4-point Likert scale (0 = *not at all*, 4 = *extremely*) how much they were distressed by a variety of symptoms in the last week (e.g., "Having to check or double-check what you do," "Feeling very self-conscious with others."). This measure yields three global scores: (a) Global Severity Index, (b) Positive Symptom Distress Index, and (c) Positive Symptom Total. The SCL-90-R also yields nine subscales: (a) Somatization, (b) Obsessive-Compulsive, (c) Interpersonal Sensitivity, (d) Depression, (e) Anxiety, (f) Hostility, (g) Phobic Anxiety, (h) Paranoid Ideation, and (i) Psychoticism. Adequate reliability and validity have been established (Derogatis, 1993). Internal consistency for this study was strong ($\alpha = .98$). As noted previously in Table 2.2, analyses revealed that mothers of anxious children reported a significantly greater number of symptoms of psychopathology on this measure than mothers of control children, $F(1, 49) = 5.19, p = .03$. Please refer to Appendix B for copies of all mother measures.

Child psychopathology. Mothers were administered the *Anxiety Disorders Interview Schedule for Children – Parent Version* (ADIS-P) in order to assess their child's psychological functioning and to establish convergent validity of children's self-reports of their own symptomatology on the RCMAS, CDI, and ADIS-IV, Child Version.

Please see the discussion of this measure, including a review of its psychometric properties in the *Child Measures* section (p. 61).

Emotion management. To assess mothers' styles of emotion management, they were administered the *Parent's Emotion Management Scales – Anger and Sadness* (PEMS). These scales were modified from the Children's Emotion Management Scales that assess the manner in which children manage their anger and sadness experience and expression. Specifically, the wording was modified so that it would be more appropriate for adults. For example, "I whine/fuss about what's making me sad," was changed to "I complain/fuss about what's making me sad." The psychometric properties of the scales have been established with children (Zeman et al., 2001). A Worry scale that has a similar 3-factor structure was developed for use in this study. For this investigation, analyses indicated poor to good internal consistency for the PEMS (Worry, Anger, and Sadness scales, respectively): Inhibition (.76, .84, .69), Dysregulation (.52, .38, .36), and Coping (.77, .75, .34). Please refer to the discussion of the Emotion Management scales in the *Child Measures* section (p. 63).

Mothers were also administered the *Emotion Regulation Checklist* (ERC; Shields & Cicchetti, 1997) in order to assess perceptions of their children's regulatory abilities. This checklist consists of 24 items, rated on a 4-point Likert scale, that assess their child's typical methods of managing emotional experiences (1 = *never*, 4 = *always*). This checklist yields two subscales: (a) Emotion Regulation that measures appropriate emotional expression, empathy, and emotional self-awareness (e.g., "Can modulate

excitement in emotionally arousing situations”) and (b) Lability/Negativity that assesses inflexibility, lability, and dysregulated negative affect (e.g., “Exhibits wide mood swings.”).

Examination of the psychometric properties of this instrument reveal strong internal consistency for the overall scale ($\alpha = .89$) and for the two subscales Lability/Negativity = .96 and Regulation = .83) (Shields & Cicchetti, 1997). Validity has been established through positive correlations with observers’ ratings of children’s regulatory abilities ($r = .40 - .46$) and the proportion of expressed positive and negative affect (Shields & Cicchetti, 1997). Discriminant validity demonstrates that the ERC can reliably be differentiated from other emotion-related constructs (Shields & Cicchetti, 1997). Good internal consistency for the two subscales was also found in this study (Lability/Negativity = .91, Regulation = .65).

Family expressiveness/beliefs about emotion management. In order to assess mothers’ beliefs about appropriate emotional expression and management that may influence the development of children’s emotion management skills, they were administered the *Parent Attitude Toward Children’s Expressiveness Scale* (PACES; Saarni, 1989). This scale consists of 20 items that examine parental control-acceptance of school-aged children’s emotional expressivity. Parents are presented with hypothetical vignettes that portray an emotionally-evocative situation, in which both child and parent are present. Parents are instructed to choose one of four responses that reflect the way they would most likely respond to their child in the particular situation. The responses are coded from 1-4 based on the degree of acceptance versus control over the child’s emotional display. These scores are then summed to produce a total score in which

higher scores reflect more controlling responses by the parent. Adequate psychometric properties have been reported for this measure, including internal consistency estimates ($\alpha = .76$), 4-week test-retest reliability ($\alpha = .77$), and validity estimates (McDowell & Parke, 2000; Saarni, 1989). Internal consistency for this study was poor ($\alpha = .40$).

Mothers were also administered the *Expressiveness* and *Control* scales of the *Family Environment Scale* (FES; Moos & Moos, 1994) and the *Family Expressiveness Questionnaire* (FEQ; Halberstadt, 1986) in order to assess mothers' perceptions of the family's general social climate and family expressiveness. Please refer to the full description and discussion of the psychometric properties of these the FES and FEQ in the *Child Measures* section (pp. 65, 66). When administered to the parents, internal consistency was moderate ($\alpha = .56$) and poor ($\alpha = .33$) for the Expressiveness and Control subscales, respectively. For the FEQ, internal consistency was strong for both the Positive ($\alpha = .90$) and Negative ($\alpha = .89$) subscales.

To assess the potential role of mothers' emotional expressivity on children's affect management, the mothers were administered the *Emotional Expressivity Questionnaire* (EEQ; Kring, Smith, & Neale, 1994). The EEQ consists of 17-items that assess the degree to which individuals express emotions using a 5-point Likert scale (1 = *never true*, 5 = *always true*). This instrument has established psychometric properties including internal consistency ($\alpha = .91$), four-week test-retest reliability ($r = .90$), and construct validity (Kring et al., 1994). Strong internal consistency was found for this scale in this study ($\alpha = .90$). Positive correlations between the EES and the FEQ, affect intensity, and positive and negative emotional expressivity demonstrate the convergent validity of the EES. Discriminant validity is demonstrated through near zero correlations

between the EES and depression, stress, social desirability, and self-esteem. Further, the EES has been related to spontaneous facial and verbal expressiveness in the laboratory and to parent- and peer-report of child expressiveness (Kring et al., 1994).

Socialization of emotion management. In order to assess mothers' perceptions regarding appropriate emotion management by their children, they were administered the parent version of the *Emotion Regulation Interview* (ERI-P) that was designed for use in this study and modeled after previous research (e.g., Zeman & Garber, 1996; Zeman & Shipman, 1997). Mothers read six vignettes that were designed to elicit worry, anger, and sadness in their child. Following each vignette, mothers were asked a series of questions that assess their perceptions of their child's expected emotional intensity (i.e., "How *worried, mad, or sad* do you think your child would feel in this situation?"), beliefs regarding their child's emotional displays (i.e., "Do you think your child would show you how *worried, mad, or sad* he/she feels?"), anticipated reaction to their child's emotional expression (i.e., "Would you make fun of or tease your child if he/she showed you how *worried, mad, or sad* he/she feels?", "Would you understand how *worried, mad, or sad* your child feels?"), outcome expectancies as a result of the child experiencing the emotion (i.e., "How much do you think that this situation would make your child feel physically sick?), the child's efficacy in managing the emotion (i.e., "How much do you think that your child would be able to make himself/herself feel better in this situation?"), the child's emotion management strategies (i.e., "What would your child most likely do in this situation?"), and the child's goals regarding emotion management, (i.e., "Why would he/she do that?", "What would you tell your child to do in this situation?"). The open-ended questions (i.e., 7, 8, and 9) were coded by a graduate student who was

unaware of diagnostic status. Approximately one-third of the responses were coded for reliability by another graduate student who was also blind to diagnostic status and yielded the following kappa values: #7 = .90, #8 = .88, and #9 = .86. Please refer to Appendix D for coding instructions for the ERI-P.

Mothers participated in the *Mother-Child Interaction Task* in which they were asked to discuss with their child, for 5-minutes, a time when the child felt worried, angry, and sad. This discussion was tape-recorded and coded for frequency of use of positive and negative emotion words, the presence or absence of explanatory discussion, and positive and negative encouragement of emotion discussion by a graduate student unaware of diagnostic status. Another research assistant who was also unaware of diagnostic status rated approximately one-third of randomly selected audiotaped discussions in order to establish inter-rater reliability. Inter-rater reliability indicated the following kappa values: frequency of negative emotion words = .85, frequency of positive emotion words = 1.00, presence/absence of explanatory discussion = .76, positive encouragement of emotion discussion = .74, and discouragement of emotion discussion = .64. Disagreements were resolved through discussion. Please refer to Appendix D for coding instructions for this task.

Intellectual functioning. To consider potential influences of intellectual functioning on mothers' reporting about her own and her child's emotional functioning, the *Vocabulary* subtest of the *Wechsler Adult Intelligence Scale – Third Edition* (WAIS-III; Wechsler, 1997) was administered. This subtest consists of 33 words that provide an estimate of both verbal ability and general intelligence (Sattler, 1992). The Vocabulary subtest has established high reliability, provides the best measure of the general

intelligence factor of the scale, and has the highest correlation with the Full Scale IQ score of any other subtest included in the WAIS-III ($r = .84$; Wechsler, 1997). All mothers who participated in this study had at least an Average-level score on this subtest.

Procedure

This project consisted of two sessions. The purpose of the first session was to screen children into one of two groups: (a) those with a potential anxiety disorder, but not a depressive disorder, and (b) those without the presence of internalizing symptoms. For reasons discussed previously, however, children who indicated depressive symptoms were also considered. The purpose of the second session was to confirm diagnostic status of the children and to administer questionnaires to both the child and the mother. Please refer to Appendix A for copies of all maternal consent and child assent forms.

Initial screen. Within the public school system, children and mothers/guardians received an invitation to participate in the first stage of this project. Nearly every public elementary school in the state of Maine (100+) was contacted; a total of 15 schools agreed to participate. The 210 children across the 15 schools who were given written consent by their mothers/guardians and who provided verbal assent to participate, took part in the initial session to screen for psychopathology. The screening took place in a group setting in their classrooms and lasted approximately 30 minutes. At this time, children were administered the Revised Children's Manifest Anxiety Scale and the Children's Depression Inventory. Two research assistants attended each school screening. A third research assistant determined which children met initial screening requirements, as described in the Child Measures section, and called the mothers to solicit participation in the primary study. Given that the RCMAS and CDI are measures

of distress and not necessarily indicative of diagnostic status, an additional screening was conducted over the phone with the parent. The primary purpose of the additional screening was to exclude those with a false positive score on the anxiety measure. A total of 39 additional screenings were conducted. Of the 39 screenings, one girl and four boys met criteria for the study but refused to participate. An additional four girls and four boys did not meet criteria to participate in the study based on the additional screening. See Appendix A for a copy of this additional screening measure. The research assistant who contacted the parents did not participate in subsequent data collections as she was aware of potential diagnostic status.

In addition to recruiting participants through the public school system, an attempt was made to recruit participants through local bulletin-board advertisements. Further, pediatricians and family physicians throughout the state of Maine were sent a brief letter describing the study and asked to hang an advertisement in their offices. One mother responded to an ad, a screening was conducted over the phone, and subsequently participated in the primary study. The screening was conducted by the research assistant who determined which children met initial screening requirements in the schools.

Parents of children who exhibited elevated scores only on the depression measure were contacted and assisted in obtaining treatment services, if they so wished. Given that the CDI is a screening, not a diagnostic measure, it was explained to parents that an elevated score does not necessarily mean that their child is depressed. The significance of an elevated score must be determined by also considering other information about the child (e.g., Is the child already receiving services for emotional/behavioral difficulties?, Is

the child demonstrating social and/or academic difficulties?). Parents of the children who were diagnosed with an anxiety disorder were assisted in obtaining treatment services.

Primary study. Data were collected by four graduate students in the Developmental-Clinical Psychology doctoral program who were trained to administer the diagnostic interview and questionnaires and who were unaware of diagnostic status. Two research assistants attended the primary data collection; all data collections related to the primary study were conducted either at the participant's home (Anxious = 15, Control = 12) or in the research laboratory (Anxious = 10, Control = 13), depending on the family's preference. One research assistant administered the diagnostic interviews to the mother and child and the other assistant administered the questionnaires. Except for the mother-child interaction task, the mother and child were independently interviewed and completed the questionnaires separately.

Following a 5- to 10-minute rapport building period, mothers and their children took part in the *Mother-Child Interaction task*. This task was presented first to avoid the possibility that completing questionnaires about emotional expression would prime both mothers and children to respond in an atypical way to the discussion task. After the task was completed, the mother and child were administered the questionnaires separately. The child questionnaires were administered in a random order except that the *Emotion Regulation Interview* and the *Children's Emotion Management Scales* that assess management of specific emotions were administered consecutively. Specifically, the *Children's Emotion Management Scales-Worry* were administered immediately after the *Emotion Regulation Interview-Worry*, the *Children's Emotion Management Scales-Anger* were administered immediately after the *Emotion Regulation Interview-Anger*, and

the *Children's Emotion Management Scales-Sadness* were administered immediately after the *Emotion Regulation Interview-Sadness*. These measures were stapled together and administered randomly among the other measures. The same format was followed for administration of the mother's questionnaires. As suggested by the developers of the diagnostic interview (Silverman & Albano, 1996), the order of presentation of this interview to mother or child was done in random order.

The data collection lasted approximately 2 hours. Participants were given short breaks as necessary. At the end of the data collection, mothers were paid \$25.00 for their participation and children received a small, age-appropriate gift (i.e., folder or pencil).

RESULTS

Data were analyzed using simple correlation, Univariate Analyses of Variance (ANOVAs) or Multivariate Analyses of Variance (MANOVAs). Measures of effect size (i.e., eta-squared) were obtained for all analyses where appropriate and interpreted according to criteria suggested by Cohen (1988): (a) .01 - .05 = small effect, (b) .06 - .13 = medium effect, and (c) .14 or larger = large effect.

The Results section is organized according to the three methods of emotion socialization that this study examined including: Parental Reactions to Children's Emotions, Discussion of Emotion, and Family Expressiveness. Within each section, the hypotheses and statistical strategies to test them are presented followed by the results of the analyses. Finally, results regarding Emotion Management are presented.

Parental Reactions to Children's Emotions

It was hypothesized that anxious children would expect more negative consequences from their mothers as a result of expressing emotion than would control children. A 2 (Group: Anxious, Control) by 2 (Sex) MANOVA was conducted, with the dependent variables being the ERI-C questions assessing anticipated consequences (i.e., ERI-C #3 and #4) across the Worry, Anger, and Sadness scenarios. Sex was included as a variable to examine the hypothesis that boys would expect to receive less positive expectancies for expressing sadness than girls. All F tests reported represent Wilks' Lambda values.

For the question, "Would your mother make fun of or tease you if you show how *worried, mad, or sad* you feel?" (i.e., ERI-C #3), the multivariate effect for Sex approached significance, $F(3,44) = 2.51, p < .07, \eta^2 = .15$, with significant univariate

effects for anger $F(1,46) = 4.04, p < .05, \eta^2 = .08$, and sadness $F(1,46) = 4.74, p < .04, \eta^2 = .09$. Girls expected to be teased for showing their angry and sad feelings more than boys.

For the question, “Would your mother understand how *worried, mad, or sad* you feel? (i.e., ERI-C #4), Sex yielded a significant main effect, $F(3,44) = 3.39, p < .03, \eta^2 = .19$, with significant univariate effects for anger $F(1,46) = 9.67, p < .003, \eta^2 = .17$ and sadness $F(1,46) = 6.24, p < .02, \eta^2 = .12$. Univariate effects indicated that boys expected their mothers to understand how mad and sad they felt more than girls. See Table 3.1 for means and standard deviations.

To examine the hypotheses that mothers of anxious children would indicate less supportive responses to children’s emotional expression than mothers of control children, and that mothers overall would be more accepting of sadness expression in girls than boys, a 2 (Group: Mother of anxious child, Mother of control child) by 2 (Sex) MANOVA was conducted, using measures assessing expected consequences of emotional expression across the Worry, Anger, and Sadness scenarios of the ERIC-P as the dependent variables (i.e., ERI-P #3 and #4). All F tests reported represent Wilks’ Lambda values. For the question, “Would you make fun of or tease your child if he/she showed his/her *worried, mad, or sad* feelings?” (i.e., ERI-P #3), there were no significant between or within Group effects. For the question, “Would you understand how *worried, mad, or sad* your child feels? (i.e., ERI-P #4), there were no significant between or within Group effects. See Table 3.2 for means and standard deviations.

Table 3.1

Mean Scores and Standard Deviations (in parentheses) of Children's Anticipated Consequences for Emotional Expression

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
ERI-C #3				
Worry	3.69 (0.38)	3.95 (0.14)	3.73 (0.43)	3.83 (0.33)
Anger	3.58 (0.53) ^a	3.77 (0.39) ^b	3.73 (0.48) ^a	4.00 (0.00) ^b
Sadness	3.53 (0.59) ^a	3.79 (0.33) ^b	3.73 (0.48) ^a	4.00 (0.00) ^b
ERI-C #4				
Worry	1.53 (0.43)	1.50 (0.39)	1.66 (0.66)	1.33 (0.39)
Anger	1.73 (0.53) ^a	1.48 (0.48) ^b	1.92 (0.53) ^a	1.29 (0.45) ^b
Sadness	1.65 (0.47) ^a	1.42(0.56) ^b	1.81 (0.83) ^a	1.21(0.39) ^b

Note. Maximum score = 4.00 (1 = *Definitely Would*, 4 = *Definitely Would Not*). Means in the same row with different superscripts differ significantly at $p < .05$.

Table 3.2

Mothers' Mean Scores and Standard Deviations (in parentheses) for Reactions to Children's Emotional Expression

	Mother of Anxious Child		Mother of Control Child	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
ERI-P #3				
Worry	3.85 (0.43)	3.87 (0.43)	4.00 (0.00)	4.00 (0.00)
Anger	3.92 (0.28)	3.79 (0.40)	3.92 (0.28)	3.96 (0.14)
Sadness	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)	4.00 (0.00)
ERI-P #4				
Worry	1.26 (0.39)	1.30 (0.49)	1.23 (0.39)	1.13 (0.31)
Anger	1.73 (0.90)	1.50 (0.60)	1.26 (0.39)	1.25 (0.34)
Sadness	1.20 (0.33)	1.13 (0.31)	1.23 (0.48)	1.21 (0.39)

Correlational analyses were conducted separately by Group to examine the hypothesis that children's expectations of outcome would be related to their emotion management decisions. For these analyses, ERI-C#2 (i.e., "Would you show how *worried, mad, or sad* you feel to your mother?") was correlated separately with ERI-C#3 (i.e., "Would your mother understand how *worried, mad, or sad* you feel?") and ERI-C#4 ("Would your mother make fun of or tease you if you show how *worried, mad, or sad* you feel?"). Analyses were not conducted separately by Sex due to the large number of analyses conducted already, increasing the chance of Type I errors, and the lack of specific hypotheses for Sex. For the Anxious group, children were significantly more likely to show their worried ($r = .62, p < .01$) and sad ($r = .41, p < .05$) feelings if they thought their mothers would understand how they felt. For the Control group, none of the correlations were significant. See Table 3.3 for all correlations.

Correlational analyses were conducted separately by Group to examine the hypothesis that mothers' reported responses to children's emotional expressions would be related to children's emotion management decisions. For these analyses, ERI-C#2 (i.e., "Would you show how *worried, mad, or sad* you feel to your mother?") was correlated separately with ERI-P#3 (i.e., "Would you make fun of your child if she should you how *worried, mad, or sad* he/she feels?") and ERI-P#4 ("Would you understand how *worried, mad, or sad* your child feels?"). Analyses were not conducted separately by Sex for the same aforementioned reasons. No significant correlations were found for either the Anxious or Control groups. See Table 3.4 for all correlations.

Table 3.3

Correlations Between Children's Expectations for Emotional Expression and Emotion Management Decisions

	Anxious	Control
	<i>r</i>	<i>r</i>
ERI-C#3		
Worry	.04	.13
Anger	.08	-.06
Sadness	-.18	-.03
ERI-C #4		
Worry	.62**	.17
Anger	-.01	.28
Sadness	.41*	.26

* $p < .05$, ** $p < .001$

Table 3.4

Correlations Between Mothers' Responses to Children's Emotional Expression and Children's Emotion Management Decisions

	Anxious	Control
	<i>r</i>	<i>r</i>
ERI-C#3		
Worry	.30	
Anger	.08	-.19
Sadness		
ERI-C #4		
Worry	-.07	.01
Anger	.38 ⁺	-.09
Sadness	.14	.04

Note. Where blank, a correlation coefficient could not be computed as there was no variability in the mother's responses (i.e., they all indicated a "4," that they definitely would not tease their child. ⁺approached significance at $p < .08$

To examine whether mothers of anxious children indicated more controlling responses to children's emotional expressions than mothers of control children, a 2 (Group: Mother of anxious child, Mother of control child) by 2 (Sex of child) ANOVA was conducted using the total score from the PACES as the dependent variable. The finding that mothers of anxious children ($M = 41.88$, $SD = 5.66$) reported more controlling responses to children's emotional expressions than did mothers of control children ($M = 39.56$, $SD = 3.39$) approached significance, $F(1, 47) = 3.11$, $p = .08$, $\eta^2 = .06$. Neither significant differences for Sex nor interactive effects (i.e., Group by Sex) were found.

Discussion of Emotion

Child data from the emotion discussion task was analyzed using a 2 (Group: Anxious, Control) by 2 (Sex of child) MANOVA to examine the hypothesis that anxious children would engage in less explanatory discussion of emotion than control children. The total length of discussion, number of negative emotion-related words, number of positive emotion-related words, and presence of explanatory discussion of emotion were entered as the dependent variables. Results did not yield any significant findings. See Table 3.5 for means and standard deviations.

To examine the hypotheses that mothers of anxious children would engage in less explanatory discussion of emotion and discourage the discussion of emotion by their children, a 2 (Group: Mother of anxious child, Mother of control child) by 2 (Sex) MANOVA was conducted. The following mother-specific aspects of the mother-child interaction task were examined: (a) number of negative emotion-related words, (b) number of positive emotion-related words, (c) presence of explanatory discussion of

Table 3.5

Mean Scores and Standard Deviations (in parentheses) for Child-Specific Aspects of the Emotion Discussion Task

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
Total length of discussion ^a	2.65 (0.62)	3.13 (1.42)	3.26 (1.94)	3.23 (1.15)
Frequency of positive emotion words	0.01 (0.28)	0.18 (0.40)	0.17 (0.58)	0.25 (0.62)
Frequency of negative emotion words	5.38 (3.73)	4.00 (2.72)	4.92 (3.40)	4.48 (2.57)
Presence of explanatory discussion	0.54 (0.52)	0.64 (0.50)	0.67 (0.49)	0.67 (0.49)

^aMeasured in minutes.

emotion, (d) presence of facilitation of emotion discussion, and (e) presence of discouragement of emotion discussion. A multivariate effect for Group approached significance, $F(5, 40) = 2.24, p < .07, \eta^2 = .22$. Univariate results indicated that mothers of control children used a significantly greater number of positive emotion words during the emotion discussion task than mothers of anxious children, $F(1, 44) = 9.15, p < .004, \eta^2 = .17$, whereas mothers of anxious children discouraged the discussion of emotion more frequently than mothers of control children $F(1, 44) = 7.07, p < .01, \eta^2 = .14$. There were no significant differences by Group or Sex for explanatory discussion of emotion, facilitation of discussion, or frequency of negative emotion words. See Table 3.6 for means and standard deviations.

Table 3.6

Mean Scores and Standard Deviations (in parentheses) for Mother-Specific Aspects of the Emotion Discussion Task

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
Frequency of positive emotion words	0.01 (0.28) ^a	0.01 (0.30) ^a	0.58 (0.79) ^b	0.83 (1.11) ^b
Frequency of negative emotion words	4.00 (4.34)	9.36 (7.78)	6.75 (6.27)	10.08 (6.22)
Presence of explanatory discussion	0.38 (0.51)	0.73 (0.47)	0.75 (0.45)	0.75 (0.45)
Presence of discouragement of discussion	0.77 (0.44) ^a	0.55 (0.52) ^a	0.25 (0.45) ^b	0.33 (0.49) ^b
Presence of facilitation of discussion	0.46 (0.52)	0.73 (0.47)	0.75 (0.45)	0.83 (0.39)

Note. Means in the same row with different superscripts differ significantly at $p < .05$.

Family Expressiveness

To test the hypothesis that anxious children would perceive their mothers as less accepting and more controlling than their nonanxious peers, a MANOVA was calculated. The between-groups factors were Group (Anxious, Control) and Sex, and the dependent variables included children's perceptions of warmth, rejection, and overprotection (i.e., the three subscales of the EMBU-C). The multivariate effect for Group was not significant. A significant multivariate effect for Sex was found, $F(3, 44) = 3.92, p < .02, \eta^2 = .21$. A significant univariate effect for rejection indicated all girls perceived their mothers as more rejecting than did boys, $F(1, 46) = 7.68, p < .008, \eta^2 = .14$. The finding

that all girls perceived their mothers as less warm than boys approached significance, $F(1,46) = 3.89, p = .06, \eta^2 = .08$. No Group or Sex differences emerged on the Overprotection scale. See Table 3.7 for means and standard deviations for all three subscales.

Table 3.7

Mean Scores and Standard Deviations (in parentheses) of Children's Perceptions of Maternal Warmth, Rejection, and Overprotection

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
<hr/>				
EMBU-C subscales				
Warmth	44.69 (5.99)	48.81 (3.64)	46.85 (6.12)	48.67 (4.99)
Rejection	17.54 (4.09) ^a	13.83 (2.59) ^b	14.54 (3.13) ^a	13.17 (2.86) ^b
Overprotection	22.85 (6.54)	22.92 (3.82)	22.84 (3.19)	24.00 (4.18)

Note. Means in the same row with different superscripts differ significantly at $p < .05$.

To examine the hypothesis that child-perceived aspects of parenting behavior would relate to adaptive coping with emotional experience, a regression equation was computed. The predictor variables were the Warmth, Rejection, and Overprotection subscales of the EMBU-C and the mean global Coping score from the CEMS (i.e., mean of the Worry, Anger, and Sadness Coping subscales) was entered as

the criterion variable. Although specific Group differences were hypothesized for the individual EMBU-C factors, it was expected the factors would be significantly related to adaptive coping for both anxiety-disordered and control children. Further, there were no a priori Sex hypotheses. Therefore, one regression equation was computed that included all children in the sample. The overall model was significant, $F(3, 46) = 4.46, p < .008$, and accounted for 23% of the variance in coping scores. Rejection was inversely related to coping and accounted for 12% of the variance whereas overprotection was positively related to coping with emotion and accounted for 11% of the variance. Warmth did not significantly predict coping with emotion.

A separate MANOVA was performed to test the hypothesis that anxious children would indicate less family expressivity than control children. For this analysis, the independent variables were Group (Anxious, Control) and Sex, and the dependent variables were the Positive and Negative subscales of the FEQ. No significant Group or Sex differences were found on either scale. See Table 3.8 for means and standard deviations.

To further assess whether anxious children indicated less family expressivity and perceived their mothers as more controlling than their nonanxious peers, a 2 (Group: Anxious, Control) by 2 (Sex) MANOVA was calculated. The Expressiveness and Control subscales of the FES were entered as the dependent variables. The multivariate effect for Group was significant, $F(2, 45) = 4.23, p < .02, \eta^2 = .16$. The significant univariate finding revealed that control children ($M = 25.68, SD = 4.18$) perceived more expressiveness in their families than anxious children ($M = 23.30, SD = 3.02$), $F(1, 46) = 5.49, p < .03, \eta^2 = .11$. A multivariate effect for Sex approached significance, $F(2, 45) =$

Table 3.8

Mean Scores and Standard Deviations (in parentheses) of Children's Perceptions of Family Expressiveness as Assessed by the FEQ

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
Positive	127.00 (26.86)	115.02 (22.63)	119.38 (28.66)	122.08 (25.35)
Negative	89.31 (15.62)	83.79 (12.78)	87.31 (21.58)	80.25 (18.17)

2.98, $p < .06$, $\eta^2 = .12$. The significant univariate effect for Sex indicated that boys ($M = 29.79$, $SD = 3.93$) rated their family environments as more controlling than did girls ($M = 27.77$, $SD = 2.80$), $F(1, 46) = 4.44$, $p < .04$, $\eta^2 = .09$.

To test the hypothesis that mothers of anxious children would indicate less family expressivity than mothers of control children, 2 (Group: Mother of anxious child, Mother of control child) by 2 (Sex of child) MANOVAs were computed. Separate MANOVAs were conducted with the following dependent variables: (a) FEQ subscales (i.e., Positive and Negative) and (b) FES subscales (i.e., Control and Expressiveness). No significant Group or Sex differences were found on the Positive or Negative subscales of the FEQ. See Table 3.9 for means and standard deviations.

The MANOVA examining the FES subscales indicated a significant multivariate Group effect, $F(2, 47) = 6.62$, $p < .003$, $\eta^2 = .23$. Significant univariate effects indicated that mothers of control children ($M = 33.60$, $SD = 5.58$) reported more

Table 3.9

Mean Scores and Standard Deviations (in parentheses) of Mother's Perceptions of Family Expressivity as Assessed by the FEQ

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
Positive	132.69 (20.32)	132.92 (22.19)	132.76 (15.48)	133.75 (28.02)
Negative	95.17 (27.63)	84.35 (15.39)	82.38 (16.36)	79.42 (20.37)

expressiveness in their household than did mothers of anxious children ($M = 29.55$, $SD = 4.52$), $F(1, 46) = 11.76$, $p < .001$, $\eta^2 = .20$. No differences emerged between mothers of anxious ($M = 28.08$, $SD = 4.09$) and control ($M = 28.57$, $SD = 3.48$) children for the Control subscale.

To examine the hypothesis that mothers of anxious children would indicate less emotional expressivity than mothers of control children, a 2 (Group: Mother of anxious child, Mother of control child) by 2 (Sex) ANOVA was conducted using the total score for the EES as the dependent variable. Results revealed no significant differences in self-reported emotional expressivity between mothers of anxious ($M = 45.51$, $SD = 7.55$) and control ($M = 45.90$, $SD = 7.54$) children or between mothers of girls ($M = 44.67$, $SD = 6.54$) and mothers of boys ($M = 46.84$, $SD = 8.35$). There were no significant interaction effects.

To test the hypothesis that maternal and family expressiveness would positively relate to children's adaptive emotion management abilities, 12 separate regression models

were computed separately by Group status. The child predictor variables included total scores from the Expressiveness subscale of the FES and the Positive and Negative subscales of the FEQ. The mother predictor variables included the total scores from the Expressiveness subscale of the FES, Positive and Negative subscale of the FEQ, and the EES. The dependent variables included the Coping scores from the CEMS: Worry, Anger, and Sadness. None of the regression equations for the Anxious or Control groups were significant. See Tables 3.10 – 3.15 for unstandardized beta weights and standard errors for the variables.

Although there were no significant findings by Group when the coping scores of each emotion were entered as the dependent variables, when analyses were collapsed across Group and a mean global coping score was entered as the dependent variable, the overall model using the child's variables approached significance, $F(3, 49) = 2.61, p < .06$, and accounted for 15% of the variance in coping scores. Expression of negative emotions in the family was negatively associated with coping scores and accounted for 13% of the variance in coping scores.

When collapsed across groups and the mean global coping scores entered as the dependent variable, the regression equation using the mother's variables was significant, $F(4, 49) = 3.79, p < .01$, and accounted for 25% of the variance in coping scores. Family expressivity as assessed by the FES was positively related to coping scores and accounted for 17% of the variance.

Emotion Management

To examine the hypothesis that anxious children would report experiencing higher levels of emotional intensity than control children in response to emotionally arousing

Table 3.10

Summary of Regression Analyses for Child and Mother Variables Predicting Child
Worry Management for the Anxious Group

<u>Variable</u>	<u>R²</u>	<u>B</u>	<u>SEB</u>
Child	.029		
FES-E		-0.0141	.019
FEQ-P		-0.0002	.002
FEQ-N		0.0015	.004
Mother	.292		
FES-E		0.0083	.013
FEQ-P		0.0002	.003
FEQ-N		-0.0002	.002
EES		-0.0183	.007

Table 3.11

Summary of Regression Analyses for Child and Mother Variables Predicting Child Anger Management for the Anxious Group

<u>Variable</u>	<u>R²</u>	<u>B</u>	<u>SEB</u>
Child	.168		
FES-E		-0.0140	.030
FEQ-P		-0.0056	.004
FEQ-N		-0.0082	.006
Mother	.267		
FES-E		0.0230	.022
FEQ-P		-0.0028	.005
FEQ-N		-0.0092	.004
EES		-0.0110	.011

Table 3.12

Summary of Regression Analyses for Child and Mother Variables Predicting Child
Sadness Management for the Anxious Group

<u>Variable</u>	<u>R²</u>	<u>B</u>	<u>SEB</u>
Child	.083		
FES-E		-0.0300	.029
FEQ-P		-0.0008	.003
FEQ-N		-0.0035	.006
Mother	.178		
FES-E		0.0268	.022
FEQ-P		-0.0016	.005
FEQ-N		-0.0033	.004
EES		-0.0177	.011

Table 3.13

Summary of Regression Analyses for Child and Mother Variables Predicting Child Worry Management for the Control Group

<u>Variable</u>	<u>R²</u>	<u>B</u>	<u>SEB</u>
Child	.104		
FES-E		0.0164	.016
FEQ-P		-0.0007	.003
FEQ-N		-0.0039	.004
Mother	.148		
FES-E		0.0146	.018
FEQ-P		-0.0014	.003
FEQ-N		0.0017	.004
EES		0.0101	.009

Table 3.14

Summary of Regression Analyses for Child and Mother Variables Predicting Child Anger Management for the Control Group

<u>Variable</u>	<u>R²</u>	<u>B</u>	<u>SEB</u>
Child	.198		
FES-E		0.0036	.020
FEQ-P		0.0067	.004
FEQ-N		-0.0095	.005
Mother	.253		
FES-E		0.0050	.022
FEQ-P		-0.0016	.004
FEQ-N		-0.0011	.005
EES		-0.0161	.011

Table 3.15

Summary of Regression Analyses for Child and Mother Variables Predicting Child
Sadness Management for the Control Group

<u>Variable</u>	<u>R²</u>	<u>B</u>	<u>SEB</u>
Child	.115		
FES-E		0.0057	.019
FEQ-P		0.0027	.003
FEQ-N		-0.0074	.004
Mother	.132		
FES-E		0.0096	.022
FEQ-P		-0.0027	.004
FEQ-N		0.0025	.005
EES		0.0141	.011

situations, global intensity scores were computed for each of three emotions by obtaining a mean intensity score for the camp and sports scenarios. A 2 (Group: Anxious, Control) by 2 (Sex) MANOVA was conducted, using the global intensity score for each emotion as the dependent variable (i.e., ERI-C #1, “How *worried, mad, sad* would you feel?”). All F tests reported represent Wilks’ Lambda values. A significant multivariate effect for Group was found, $F(3, 44) = 4.46, p < .008, \eta^2 = .23$, with significant univariate effects for worry, $F(1, 46) = 6.46, p < .01, \eta^2 = .12$ and anger, $F(1, 46) = 11.28, p < .002, \eta^2 = .20$. For both of these emotions, anxious children reported that they would experience worry and anger more intensely than control children. See Table 3.16 for means and standard deviations for these emotions.

To examine the hypothesis that emotional intensity would be negatively related to children’s reported emotion management decisions, ERI-C#1 was correlated with ERI-C#2 (i.e., Would you show how *worried, mad, or sad* you feel to your mother?”). Analyses were conducted separately by Group status only as there were no specific hypotheses by Sex. For the Anxious group, significant correlations were found for the anger and sadness scenarios, whereas for the control group, all three scenarios yielded significant correlations. See Table 3.17 for the correlations.

Global self-efficacy scores were computed by obtaining a mean score for the camp and sports scenarios separately by emotion (i.e., ERI-C #6, “How much do you think you would be able to make yourself feel better in this situation?”) to test the hypothesis that anxious children would perceive themselves as less efficacious

Table 3.16

Means and Standard Deviations (in parentheses) of Children's Levels of Emotional Intensity by Emotion Type

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
ERI-C #1				
Worry	6.35 (1.47) ^a	6.17 (2.11) ^a	5.27 (1.78) ^b	4.54 (2.22) ^b
Anger	7.35 (2.15) ^a	7.16 (2.20) ^a	5.38 (1.37) ^b	5.12 (2.55) ^b
Sadness	6.62 (2.22)	6.75 (2.56)	6.38 (1.59)	5.21 (2.03)

Note. Maximum score = 10.00 (1 = *Not at All*, 10 = *Very*). Means in the same row with different superscripts differ significantly at $p < .05$.

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Table 3.19

Mean Number of Problem-Solving Responses and Standard Deviations (in parentheses)

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
Worry	0.92 (0.28)	0.67 (0.49)	0.92 (0.28)	1.00 (0.00)
Anger	0.92 (0.28) ^a	0.42 (0.51) ^b	0.69 (0.48) ^a	0.50 (0.52) ^b
Sadness	0.92 (0.28)	0.75 (0.45)	1.00 (0.00)	1.00 (0.00)

Note. Means in the same row with different superscripts differ significantly at $p < .05$.

by 2 (Sex) MANOVAs were computed. The dependent variable included responses to the question, “Why would you do that?” (ERI-C#8) that were coded into the relational or self-focused category of goals. Results did not reveal any significant Group or Sex differences for the worry, anger, or sadness scenarios.

To examine differences in overall maladaptive styles of coping (composed of support seeking, externalizing, other maladaptive, vague, and avoidance codes), a 2 (Group: Anxious, Control) by 2 (Sex) MANOVA was computed. The dependent variables were the coded response to the question, “If this situation really happened to you, what would you do?” (ERI-C #7) for each of the Worry, Anger, and Sadness scenarios and that fell into one of the aforementioned maladaptive categories. The multivariate effect for Group approached significance, $F(3, 44) = 2.31, p < .09, \eta^2 = .14$; thus, the following significant univariate effect should be interpreted with caution.

Results indicated that anxious children generated more maladaptive responses for the worried scenario than did control children, $F(1, 46) = 5.53, p < .02, \eta^2 = .11$. The finding that anxious children generated a greater number of maladaptive responses for the sadness scenario approached significance, $F(1, 46) = 3.80, p = .06, \eta^2 = .07$. See Table 3.20 for means and standard deviations for all emotions.

Table 3.20

Mean Number of Maladaptive Responses and Standard Deviations (in parentheses)

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
Worry	0.54 (0.52) ^a	0.75 (0.87) ^a	0.38 (0.65) ^b	0.01 (0.29) ^b
Anger	0.69 (0.63)	1.17 (0.58)	0.85 (0.81)	0.50 (0.52)
Sadness	0.38 (0.51)	0.67 (0.65)	0.23 (0.44)	0.25 (0.45)

Note. Means in the same row with different superscripts differ significantly at $p < .05$

In order to test the hypothesis that anxious children would display more maladaptive patterns of emotion management than their nonanxious peers, separate MANOVAs were computed. The between-groups factors were Group (Anxious, Control) and Sex with the dependent variables being the Inhibition, Dysregulation, and Coping subscales of the CEMS. Results for the MANOVA examining patterns of worry management revealed a significant multivariate effect for Group, $F(3,43) = 4.79, p <$

.006, $\eta^2 = .25$, with a significant univariate effect for Coping, $F(1, 45) = 9.93, p < .003, \eta^2 = .18$. Control children indicated more adaptive worry management than did anxious children. The finding that anxious children indicated more inhibited worry management than control children approached significance, $F(1, 45) = 3.43, p < .07, \eta^2 = .07$. A significant multivariate effect was found for Sex, $F(3, 43) = 3.86, p < .02, \eta^2 = .21$, with a significant univariate effect for Coping, $F(1, 45) = 9.76, p < .003, \eta^2 = .18$. Boys indicated more adaptive worry management than did girls. The findings that boys endorsed more dysregulated worry management than girls approached significance, $F(1, 45) = 3.62, p < .06, \eta^2 = .07$. See Table 3.21 for means and standard deviations for all subscales for sadness, anger, and worry.

Analyses examining patterns of anger management revealed significant multivariate effects for Group, $F(3, 43) = 4.89, p < .005, \eta^2 = .25$, with significant univariate effects for Dysregulation, $F(1, 45) = 4.31, p < .04, \eta^2 = .09$ and Coping $F(1, 45) = 12.47, p < .001, \eta^2 = .22$. Anxious children reported more dysregulated and less adaptive anger management than did control children. A significant multivariate effect for Sex approached significance, $F(3, 43) = 2.39, p < .08, \eta^2 = .14$. The significant univariate effect indicated that regardless of Group status, boys reported more adaptive anger management than did girls, $F(1, 45) = 5.00, p < .03, \eta^2 = .10$.

The MANOVA that examined patterns of sadness management revealed significant multivariate effects for Group, $F(3, 43) = 4.07, p < .01, \eta^2 = .22$, with a significant univariate effect for Coping, $F(1, 45) = 12.69, p < .001, \eta^2 = .22$. Control children indicated using more adaptive sadness management than anxious children. Sex also yielded a significant multivariate effect, $F(3, 43) = 9.56, p < .0001, \eta^2 = .40$, with

Table 3.21

Children's Mean Emotion Management Scores with Standard Deviations (in parentheses)

	Anxious		Control	
	Girls	Boys	Girls	Boys
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
CEMS: Worry				
Inhibition	2.21 (0.66)	2.24 (0.34)	1.98 (0.41)	1.92(0.59)
Dysregulation	1.69 (0.71)	1.44 (0.24)	1.52 (0.52)	1.25 (0.30)
Coping	1.93 (0.32) ^a	2.04 (0.25) ^b	2.05 (0.30) ^c	2.48 (0.35) ^d
CEMS: Anger				
Inhibition	1.71 (0.46)	1.82 (0.41)	1.83 (0.34)	1.96 (0.41)
Dysregulation	1.81 (0.48) ^a	1.60 (0.37) ^a	1.56 (0.48) ^b	1.33 (0.38) ^b
Coping	1.88 (0.39) ^a	2.13 (0.38) ^a	2.27 (0.37) ^b	2.51 (0.38) ^b
CEMS: Sadness				
Inhibition	1.73 (0.38) ^a	2.13 (0.42) ^b	1.90 (0.40) ^a	2.06 (0.44) ^b
Dysregulation	1.61 (0.63)	1.72 (0.57)	1.46 (0.42)	1.42 (0.38)
Coping	1.92 (0.29) ^a	2.28 (0.45) ^b	2.20 (0.27) ^c	2.67 (0.27) ^d

Note. Maximum score = 3.00. Means in the same row with different superscripts differ significantly at $p < .05$.

significant univariate effects for Inhibition, $F(1, 45) = 5.59, p < .02, \eta^2 = .11$, and Coping $F(1, 45) = 19.83, p < .0001, \eta^2 = .31$. Regardless of Group status, boys indicated more inhibition of sadness but also more adaptive sadness management than did girls. No significant interaction effects were found.

Separate MANOVAs were conducted to examine whether mothers of anxious children would display more maladaptive patterns of worry, anger, and sadness management. The between-groups factors were Group (Anxious, Control) and Sex and the dependent variables were the Inhibition, Dysregulation, and Coping subscales of the PEMS. Analyses did not yield any significant findings. See Table 3.22 for means and standard deviations for the subscales for worry, anger, and sadness.

A 2 (Group: Anxious, Control) by 2 (Sex) MANOVA was performed to examine mothers' report of children's regulatory abilities, using the Regulation and Negativity/Lability subscales of the ERC as the dependent variables. A significant multivariate effect Group was found, $F(2, 45) = 9.93, p < .001, \eta^2 = .31$ with significant univariate effects for both of the subscales. Results indicated that mothers of anxious children perceived their children as more inflexible, labile, and negative ($M = 2.24, SD = 0.52$) than mothers of control children ($M = 1.71, SD = 0.29$), $F(1, 46) = 19.59, p < .0001, \eta^2 = .31$. Mothers of anxious children also rated their children significantly lower on appropriate emotion expression and self-awareness ($M = 3.01, SD = 0.46$) than did mothers of control children ($M = 3.30, SD = 0.26$), $F(1, 46) = 6.83, p < .01, \eta^2 = .13$. No sex differences were found.

Table 3.22

Mothers' Mean Emotion Management Scores and Standard Deviations (in parentheses)

	Anxious	Control
	<i>M(SD)</i>	<i>M(SD)</i>
PEMS: Worried		
Inhibition	1.87 (0.29)	2.02 (0.34)
Dysregulation	1.39 (0.46)	1.16 (0.26)
Coping	2.23 (0.42)	2.33 (0.31)
PEMS: Anger		
Inhibition	2.00 (0.58)	1.86 (0.30)
Dysregulation	1.87 (0.31)	1.80 (0.36)
Coping	2.42 (0.47)	2.44 (0.42)
PEMS: Sadness		
Inhibition	1.94 (0.56)	1.90 (0.48)
Dysregulation	1.64 (0.41)	1.41 (0.36)
Coping	2.23 (0.45)	2.34 (0.38)

Note. Maximum score = 3.00.

Correlational analyses were conducted separately by Group and Sex to examine the hypothesis that there would be relations between patterns of emotion management among children and their mothers. For the anxious group, the relation between anger dysregulation for mothers and their children was significant, $r = .37, p = .03$. For the control group, there were no significant relations found for any pattern of management (i.e., Inhibition, Dysregulation, or Coping) for worry, anger, or sadness. See Tables 3.23 – 3.26 for correlations by Group and Sex.

Table 3.23

Correlations Between Emotion Management Subscales for Anxious Children and their

Mothers

Subscale	<i>r</i>
Worry	
Inhibition	-.30
Dysregulation	-.20
Coping	-.21
Anger	
Inhibition	-.09
Dysregulation	.37*
Coping	-.11
Sadness	
Inhibition	-.06
Dysregulation	.01
Coping	.22

* $p < .05$

Table 3.24

Correlations Between Emotion Management Subscales for Anxious Girls and Boys
and their Mothers

Subscale	Girls <i>r</i>	Boys <i>r</i>
Worry		
Inhibition	-.43	-.20
Dysregulation	-.27	-.05
Coping	-.21	-.26
Anger		
Inhibition	-.20	-.30
Dysregulation	.33	.48
Coping	.03	-.19
Sadness		
Inhibition	.07	-.20
Dysregulation	.05	-.02
Coping	-.18	.31

Table 3.25

Correlations Between Emotion Management Subscales for Control Children and their Mothers

Subscale	<i>r</i>
Worry	
Inhibition	-.22
Dysregulation	-.11
Coping	-.11
Anger	
Inhibition	-.01
Dysregulation	.16
Coping	.11
Sadness	
Inhibition	-.20
Dysregulation	-.25
Coping	-.16

Table 3.26

Correlations Between Emotion Management Subscales for Control Girls and Boys
and their Mothers

Subscale	Girls	Boys
	<i>r</i>	<i>r</i>
Worry		
Inhibition	-.16	-.30
Dysregulation	-.41	-.20
Coping	.02	.26
Anger		
Inhibition	-.24	.36
Dysregulation	.23	.01
Coping	.02	.11
Sadness		
Inhibition	-.26	-.01
Dysregulation	-.25	-.33
Coping	-.30	-.30

DISCUSSION

Although a considerable body of empirical research has examined emotion management abilities in normative populations, relatively little effort has been directed toward investigating such skills in non-normative populations. The developmental psychopathology perspective as first formulated by Sroufe and Rutter (1984), however, suggests that development is best informed by studying pathways that lead to both adaptation and maladaptation. With this perspective in mind, the primary goal of this study was to examine emotion management skills in anxious and nonanxious children and consider ways in which maternal emotion socialization practices may be related to children's regulatory abilities. Findings from this study document interesting differences between the two groups as well as important sex differences. The results of group differences are discussed first followed by results of sex differences within each method of emotion socialization that this project examined: Parental Reactions to Children's Emotions, Discussion of Emotion, and Family Expressiveness. Lastly, group and sex differences with respect to emotion management are discussed.

Parental Reactions to Children's Emotions

Research suggests that parental reactions to children's emotional expressions are one of the primary ways that parents may socialize emotion (Eisenberg et al., 1998). Parental efforts to minimize emotional expression and their negative reactions to children's displays of negative emotion are likely to result in negative outcomes including lower levels of emotion regulation and social competence (Eisenberg et al., 1995, 1998; Gottman et al., 1997). Saarni (1999) has suggested that children develop a set of rules for expressing emotion based on the interpersonal consequences they expect

to receive following the expression of an emotion. In this study, when anxious children expected that their mothers would not be understanding of their emotional experience, specifically with worry and sadness, they chose to inhibit its expression. In the short-term, inhibiting emotional expression may serve to decrease the immediate arousal experienced. In the long-term, however, these children may become increasingly overaroused and dysregulated (Esinberg et al., 1997), making them less likely to cope effectively with the situation. It is interesting to note that there was no correlation between children's expectations of mothers' understanding of their angry feelings and their decision to express or inhibit the emotion. One possible explanation is that their coping skills are less well-developed in general and thus, the anger is overwhelming and taxes their resources. Even if they know their mothers will not approve of their anger expression, they cannot control it. Another explanation is that because these children were anxious, expressing worried feelings led to stressful or otherwise negative interactions with their mothers at home in the past. As a result, anxious children are more aware of the anticipated reaction of their mothers as a way to avoid potentially negative consequences. These findings are consistent with other research that indicates that children's expectations of outcome following emotional expression is related to emotion management decisions (Zeman & Garber, 1996, Zeman & Shipman, 1996, 1997).

The hypothesis that mothers of anxious children would indicate more controlling responses to children's emotional expressions than mothers of control children was generally supported. These findings expand upon previous research that found mothers of anxious children display more controlling behaviors than mothers of nonanxious children during observational tasks (Dumas et al., 1995; Siqueland et al.,

1996) including both younger (e.g., Dumas, et al., 1995) and older (e.g., Siqueland et al., 1996) children. Although these studies did not examine control with respect to emotional expression specifically, they nonetheless demonstrate that control, in general, seems to be an observed characteristic of mothers of anxious children. The significance of these findings can be understood by considering research on normative emotional development. This research suggests that parental efforts to minimize emotional expression are likely to result in negative outcomes including lower levels of emotion regulation and social competence (Eisenberg et al., 1995, 1998; Gottman et al., 1997). Indeed, maternal control may be one factor that contributes to the emotion dysregulation (Barrett et al., 1996; Suveg et al., 2001) and peer difficulties (Goodyer et al., 1990) that anxious children experience.

Research suggests that emotion-related socialization practices vary according to sex (Broday & Hall, 2000; Fuchs & Thelen, 1988; Zeman & Garber, 1996). In contrast to previous research (Fuchs & Thelen, 1988; Zeman & Shipman, 1997), and the hypothesis that boys would expect to receive less positive expectancies for expressing sadness than girls, this study found that boys expected their parents to be more understanding of their anger and sadness expressions than did girls. Further, boys expected to be teased for showing their angry and sad feelings less than girls. Brody and Hall (2000) suggest that differences in emotion socialization vary in large part as a function of factors such as gender role attitude, cultural background, SES, etc. within the family. It could be that the 4-point Likert scale that was used in this study to assess children's expectations did not have enough variability to capture the differences. This is a plausible explanation given that both girls and boys scores on this question were relatively low.

In sum, when anxious children expected less understanding of their emotional displays by their mothers, they chose to inhibit their expression. Further, mothers of anxious children reported more controlling responses to children's emotional expressions than did control mothers. Taken together, these findings suggest that anxious children may not engage in some experiences either by choice (i.e., by purposely inhibiting their emotional expressions) or direct parental influence (i.e., parental control of expression) that research shows contributes to the development of adaptive emotion management abilities.

Discussion of Emotion

The discussion of emotion influences children's emotion regulatory abilities by increasing children's ability to use emotion-related language and understanding of emotion experiences (Denham et al., 1992; Dunn et al., 1987). Both of these skills are important facilitators of adaptive emotion management and may also explicitly teach the child ways of managing emotional experience (Barrett et al., 1996). During the emotional discussion task in this study, mothers of control children used a significantly greater number of positive emotion words during the emotion discussion task than did mothers of anxious children. This finding is consistent with previous research that found nonclinical mother-child dyads interact in a generally positive way (Dumas & LaFreniere, 1993, Dumas et al., 1995). In addition, mothers of anxious children discouraged the discussion of emotion more frequently than mothers of control children. That is, whereas mothers of control children allowed their child to discuss his or her emotion-related experiences, mothers of anxious children discouraged their child's emotion-related discussion by changing the topic, ignoring, or belittling the child. The

finding that mothers of control children gave their children more opportunity to discuss their experiences likely led to more positive interactions overall. Further, that mothers of anxious children discouraged their child's emotion-related discussion is consistent with controlling responses to their children's emotional expressions. This finding is consistent with previous research that examined potential mechanisms for the transmission of anxiety from parent to child and found that anxious parents exerted control during an observational task when the child expressed negative affect (Woodruff-Borden, Morrow, Bourland, & Cambron, 2002). In combination, these results suggest that it is likely that anxious children come to expect negative responses from their mothers when they attempt to express or discuss their emotional experiences. The expectation of a negative response may prompt them to inhibit their expressivity in the future. Not only does inhibiting these emotion behaviors lead to increased sympathetic arousal and subjective distress (Gross & Levenson, 1997), but it also precludes opportunities to learn adaptive emotion management.

The hypothesis that anxious children would engage in less explanatory discussion of emotion than control children was not supported. Surprisingly, no significant findings were revealed between anxious and control children on any of the child-related emotion discussion variables. Although the discussion task was vague by design, it could be that a more specific task that directed the child to speak for a specified period of time or about a designated topic would have been more sensitive to the presence of group differences. Another potential explanation may be that differences in emotion-related processes in children of this age are most observed in behavior, rather than language.

It appears from these results that emotional discussions in families with an anxiety-disordered and control child are qualitatively different. Whereas mothers with a control child allowed their children to discuss positive and negative emotional experiences freely, mothers with an anxious child did not. Not only did mothers of anxious children discourage the discussion of emotional experiences, they used positive emotion words significantly less during the discussion than did mothers of control children, suggesting that the discussions overall, were less pleasant. Given that parent-child emotional discussions are one of the key avenues by which children learn to manage emotional experiences adaptively, these findings suggest that anxious children are likely to be at a disadvantage in acquiring these skills.

Family Expressiveness

The most indirect method of emotion socialization that this study examined is the emotional climate in the household. Family expressiveness is important in shaping children's beliefs about their own and other's emotionality specifically, and the world more generally (Dunsmore & Halberstadt, 1997). One way that the family environment was assessed in this study was by examining children's perceptions of their mothers. Contrary to predictions, anxious children did not perceive their mothers as less accepting than control children. The negative finding could be that the measures used to assess control did not have very strong reliability.

Interestingly, regardless of Group status, children's perceptions of parental rejection and overprotection significantly predicted coping with negative emotion (i.e., coping subscales of the CEMS collapsed across emotion) in children. Whereas parental rejection was negatively related to coping, overprotection was positively related to

coping. When the analyses were conducted by Group status, the results did not hold. This is surprising given previous research that has linked rejecting and emotionally overinvolved parental behaviors to anxiety disorders in children (Hibbs et al., 1991; Stubbe et al., 1993). Further, developmental research has indicated that rejecting and otherwise non-supportive behavior in parents is important when considering children's emotional development and has been associated with lower levels of adaptive coping in both normative (e.g., Eisenberg et al., 1991, 1992) and nonnormative populations (e.g., Hibbs et al., 1991). It could be that there were not enough participants in each group to replicate these findings.

With respect to overprotection, one might expect this parental characteristic to be inversely related to children's adaptive coping with emotion; overprotecting children might prevent them engaging in challenging experiences that when mastered, provide them with a sense of self-efficacy, and better coping in future situations. Indeed, research has found links between emotional overinvolvement, a related concept to overprotection, and anxiety disorders in children (Stubbe et al., 1993). In this study, overprotection scores were relatively low suggesting that the children in this study did not perceive their parents as being overprotective. Perhaps this level of parental protection is conducive to adaptive coping with emotion.

As expected, this study found that anxious children and their mothers indicated lower levels of family emotional expressivity than control children and their mothers. Interestingly, group differences were nonsignificant when positive and negative affectivity were specifically assessed. It appears that the range of both positive and negative

emotional expressivity may be truncated in families with an anxious child. It also may be that there was insufficient power to be sensitive enough to detect group differences.

Research with normative populations has linked positive emotional expressiveness in the family to children's adaptive regulatory abilities (Denham et al., 2000; Denham & Grout, 1992; Garner, 1995) and negative emotional expressivity with more maladaptive regulatory skills in children (Denham et al., 2000; Muris et al., 1996). The hypothesis that maternal and family expressiveness would relate to children's adaptive emotion management abilities was partially supported in this study. When analyses were run separately by Group status for each emotion of worry, sadness, and anger, maternal and family expressiveness variables did not significantly predict coping in children. However, when the groups were collapsed and a global measure of coping was used, general family expressiveness significantly predicted children's adaptive coping. Further, frequent expression of negative emotionality in the family approached significance and was negatively related to adaptive coping with emotion.

When considering sex differences, both anxious and control girls perceived their mothers as more rejecting than boys. One possible explanation could be that the girls in this study were approaching early adolescence – a time when one might expect increased conflict with parents. However, developmental research suggests that while adolescents overall tend to engage in more conflict with their mothers than fathers, there are generally no significant sex differences in how girls and boys get along with their parents (Russell & Saebel, 1997). The finding could also be due to the particular way in which the child-parent relationship was assessed in this study (i.e., assessing children's perceptions of feelings of rejection versus child-parent report on how they get along).

Although anxious children did not perceive their mothers as more controlling than did control children, anxious children and their mothers indicated less family expressivity than control children and their mothers. Further, given that this study found maternal and family expressivity to be related to adaptive coping for both anxious and normative populations, truncated expressivity in families of anxious children should be considered a potential contributor to the difficulties with emotion management that anxious children experience.

Emotion Management

One skill posited to underlie emotionally competent functioning is the ability to manage emotional experiences in a flexible and adaptive way in response to the demands of the social context (Brenner & Salovey, 1997; Campos et al., 1994). Not surprisingly, difficulties with emotion management have been posited to play a role in most forms of psychopathology (Bradley, 1990; 2000; Casey, 1996; Cicchetti et al., 1995). Eisenberg et al. (1998) suggest that the intensity of an emotional reaction is likely to impact emotion management behaviors. Specifically, arousal beyond a certain level may interfere with an individual's ability to respond adaptively in an emotionally evocative situation (Bradley, 1990; Cole et al., 1994). As hypothesized, anxious children reported that they would experience worry and anger more intensely than control children. This is not surprising given that hyperarousal is a distinguishing feature of anxiety (Clark & Watson, 1991). Further, for the anxious group, intensity of emotional experience was positively related to the decision to show their angry and sad feelings whereas for the control group of children, emotional intensity was positively related to the decision to show worried, angry, and sad feelings. Indeed, this is consistent with previous research that found that

children endorse high emotional intensity as a good reason to express their emotions (Saarni, 1999). When collapsed across groups and a global coping measure was used, intensity of emotional experience was significantly negatively related to coping in children. Thus, the more intense the emotional experience, the greater difficulty children reported having managing the experience.

The hypothesis that anxious children would perceive themselves as less efficacious than control children across the worry, sadness, and anger scenarios was supported. This result provides an explanation for research that has found that anxious children tend to withdraw from or avoid emotionally arousing situations (Barrett et al., 1996; Suveg et al., 2001). Children who have a sense of self-efficacy are likely to persevere in difficult situations and develop more adaptive coping skills (Bradley, 2000). In this study, self-efficacy predicted adaptive coping with negative emotional experience when combining all group data, suggesting that this variable is important for both typical and atypical populations.

When the frequency of problem-solving responses was examined, no Group differences emerged. However, when global maladaptive responses were examined, anxious children indicated a greater number of responses when managing worried feelings than did control children. These results lend support to other research that indicates that anxious children tend to rely on maladaptive methods of managing emotion (Barrett et al., 1996; Suveg et al., 2001).

Contrary to predictions, there were no group differences for goal identification (i.e., reducing their own emotional arousal, avoiding negative consequences). That anxious children did not identify reducing their own arousal as a goal more often than

control children is somewhat surprising given that anxious children indicated experiencing emotions more intensely than control children in this study. One explanation for this finding might be that the actual language used in phrasing the question was too broad and perhaps, vague. That is, after responding to what they would do in a situation, the research assistant asked them, “Why would you do that?”. It was clear that some children either did not understand the question or did not have the cognitive and/or language abilities necessary to provide responses that were codeable. For example, many of the children responded to the question of why they would do a particular act by reiterating the emotion itself (e.g., “I would do that because I’m mad!”) and could not provide an underlying rationale for their decision.

The hypothesis that anxious children would indicate more maladaptive patterns of emotion management than their nonanxious peers was partially supported. Anxiety-disordered children indicated less adaptive sadness, anger, and worry management and more dysregulated anger management than did control children. This is consistent with previous research that found that children experiencing anxious symptomatology reported using less constructive ways of managing their negative emotions than nonanxious children (Suveg et al., 2001). Deficits in emotion management as indicated in previous research and this study should be considered a potential correlate of the difficulties that anxiety-disordered children experience in terms of social functioning (Goodyer et al., 1990).

The hypothesis that mothers of anxious children would indicate more maladaptive patterns of emotion management than would mothers of control children was not supported. In part, the absence of group differences could be due to the fact that the

measures used to assess patterns of emotion management were initially developed for use with children and modified in this study for use with mothers. As such, the validity and reliability of the parent-adapted measure has not been established.

One method of assessing socialization effects was to examine the strength of relationship between patterns of emotion management among children and their mothers. Surprisingly, there was only one significant correlation that was found - patterns of anger dysregulation were significantly correlated for the Anxious group. A few potential explanations for this finding are offered. First, the reliability coefficients for several of the subscales were poor for both the mother (Sadness Dysregulation = .38) and the child questionnaires (e.g., Anger Inhibition = .47). Further, while the Anger and Sadness scales have been validated, the Worry scale was developed for use this study and has not yet been validated on children.

A second explanation for the lack of association between mother and child emotion management patterns concerns a possible response set by mothers, and perhaps, by the children. It would be quite obvious to most adults which items reflect acceptable methods of emotion management. The questions were designed to be used with younger children, and, as such, it is possible that socially desirable responding may have skewed the results. However, when mean scores are examined, children's scores in this study are quite similar to those that have been published (Zeman et al., 2001). Thus, socially desirable responding by the children, at least for this measure, is not a plausible explanation.

With respect to sex differences in emotion management, an unexpected finding emerged. In the vignette measure, girls indicated more problem-solving responses than

boys in the anger scenario. One explanation is that girls accurately report that they are better at managing their emotional behavior in arousing situations than are boys.

Research has found that girls may be better at suppressing negative emotional expressions than boys and thus, may be more skilled at regulating emotion (Davis, 1995).

Another explanation is that girls were more aware of socially desirable responding than were boys. Whereas boys stated what they would do whether or not they believed it was socially appropriate, girls might have given responses that they believed to be more socially acceptable.

On the emotion management measure, boys indicated inhibiting sadness more than girls. This finding is consistent with literature that indicates boys are less likely to express sadness than girls because they expect to receive negative consequences for sadness expression (Fuchs & Thelen, 1988; Zeman & Garber, 1996; Zeman & Shipman, 1997). In this study, boys reported that they would use adaptive coping with worry and sadness more than girls. Brody and Hall (1993) suggest that in Western society, females are generally associated with factors such as affiliation, vulnerability, and self-consciousness. As such, they would be expected to display emotions such as warmth, happiness, shame, fear, etc. because those emotions would be consistent with their role. In contrast, the emotions of anger, pride, and confidence are often associated with the male role. It could be that because boys are socialized from an early age to regulate the emotions of sadness and potentially worry, they become more skilled than girls at managing these emotions, or they are embarrassed to acknowledge difficulty with managing them.

These results suggest that anxious children have difficulties managing emotional experiences adaptively. One potential correlate of this finding is that anxious children experience at least some of their emotions quite intensely, which makes the experience harder to manage. Secondly, anxious children perceive themselves as less self-efficacious than control children, suggesting that they do not have the self-confidence necessary to face a challenging emotional experience in a constructive way. Differences in emotion management abilities also seem to vary by sex. Whereas girls report better problem-solving in anger situations and in response to open-ended questions, boys report more adaptive worry and sadness management than girls in response to forced-choice format questions.

Limitations

Although this study yielded some very interesting findings, several limitations need to be addressed. First, the sample size was small and that may have hampered efforts to detect group differences. As noted in the Method section, however, a very rigorous recruitment process was used for this study that ensured that all participants were correctly placed in the Anxious or Control group. Access to a more densely populated area may have provided a larger sample from which to recruit participants.

Second, the sample was very homogenous in terms of ethnicity (i.e., Caucasian) and SES (i.e., middle class), limiting the generalizability of the findings. This is an important limitation to consider given that childhood anxiety disorders can be found in diverse samples of the population. However, participants did reflect rural versus urban settings.

A third limitation to consider is that some of the questionnaires utilized in this study had been developed for this study and thus, have not been validated. As such, some of the scales produced poor or moderate internal consistency. Given that the measures that yielded strong internal reliability coefficients (i.e., ERC) indicated strong findings, it is likely that at least some of the null or weak findings could be attributed to the poor reliability of the measures. Relatedly, a social desirability measure should have been included, particularly for the mothers, in order to determine its effect on the responses.

Fourth, this study coded children's emotion management behaviors into one of several theoretically predetermined categories. The danger in using this approach is that if the context surrounding the behavior is not considered, then one may erroneously conclude that the child is not demonstrating adaptive emotion management strategies. That is, the function of the child's behavior in context needs to be examined, rather than assuming a priori what is "adaptive" or "maladaptive" for that particular child. Although this limitation is readily acknowledged, this study attempted to make the situations as relevant to the child as possible by rigorously pilot testing the vignettes. Further, the vignettes were administered individually, providing the child more opportunity to discuss his or her responses.

Finally, the sample only included mothers. Given that we know that fathers certainly take a role in children's emotional development (Goodman, Brogan, Lynch, & Fielding, 1993), it will be important to include them in future research studies. Although the inclusion of fathers was considered for this study, establishing an initial base of

information from which to compare past to current findings was considered of primary concern.

Future Directions

Future research should include a larger and more diverse sample of anxiety-disordered children in terms of ethnicity and SES. Including more diverse samples is especially important given that anxiety disorders in children are found across various ethnic groups and levels of SES. However, without validated assessment devices that accurately capture emotion-related processes, recruiting larger and more diverse samples is a futile endeavor. This leads into perhaps the most important direction for future research – developing and validating emotion measures. Emotion researchers need to continue to develop and rigorously validate questionnaires and other methods to assess aspects of both individual- and family-related emotion processes. As was the case in this study, questionnaires that have not been validated impede accurate assessment and blur research results.

Lastly, given that emotional development in children occurs largely in the context of family systems, family members, in addition to parents, should be included in future research programs.

The goal of the present study was to investigate emotion management skills in anxious children and examine factors within the child and the parent, and the child-parent relationship that may impact the development of adaptive emotion management. Despite the aforementioned limitations, findings from this study not only contribute to previously documented research, but also offer new insights. Overall, this study found that anxious children have difficulty managing emotionally evocative experiences. Not only did

anxious children in this study report more maladaptive worry management, but they also indicated more maladaptive anger and sadness regulation. With respect to child factors that may contribute to the difficulties that anxious children experience, this study suggests that the inability to modulate intensity of emotional experience and a lack of self-efficacy should be considered. This study revealed a theme of control in families with an anxious child with respect to children's perception of control, mothers' reports of controlling behaviors, and observation of mothers' behaviors during an emotion discussion task. When considering parent- and child-parent factors that contribute to the development of emotion management skills, this study suggests that control, whether it be in general, or more specific emotion-related terms, is a potential correlate of the difficulties that anxious children have managing their emotions.

These findings are significant and suggest further areas for intervention with anxious children and families with an anxious child. Treatments currently available for anxiety-disordered children include some focus on emotion management skills (e.g., Kendall, 1994; Kendall & Southam-Gerow, 1996) and parental involvement (e.g., Barrett, Dadds, & Rapee, 1996). However, Ginsburg and Schlossberg (2002) argue for more family-based models of treatment. This study offers some specific areas that may be targeted in such family-based interventions. For instance, parent education regarding the importance of emotion-related discussions with their children to children's developing emotion management abilities should be included. Providing parents an opportunity to actually engage in such discussions with their child while in treatment in order to receive constructive feedback might also be helpful.

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Appendix A

Parent Consent and Child Assent Forms

1. Mother Consent Form (Session I: School Screening)
2. Child Assent Form (Session I: School Screening)
3. Mother Consent Form (Session II)
4. Child Assent Form (Session II)

Session I: Parent/Guardian Consent Form (For School Screening)

Mothers and their children are invited to participate in a research project that is being conducted by a graduate student, Cynthia Suveg, and her faculty sponsor, Janice Zeman, in the Department of Psychology at the University of Maine. Female guardians who have had a parenting role for at least 2 years are also invited to participate. Types of anxiety (e.g., fears, worrying) are common in elementary school-age children, and we are interested in learning how anxiety affects children's ability to control their feelings. We are also interested in maternal attitudes and beliefs about expressing emotions, like anger and sadness. Participation in this study is voluntary.

What's involved? If you agree to participate, your child will first take part in a 30-minute session at school, in which he or she will fill out 3 brief questionnaires. Although your child will be in a group setting, he or she will be given file folders to use as a shield so that his or her answers will be private. These surveys ask about feelings of anxiety and depression that your child may be feeling (e.g., "I worry about things that may happen.", "I am sad once in a while.").

We are looking for children who are experiencing few distressing feelings, children who appear to be very distressed, and children who fall somewhere in the middle. If your child meets the criteria for this study based on the forms that he or she will fill out in school, we will call you within a month, and see if both you and your child would be willing to participate in the second part of the study.

What will I have to do? The second part of the study will involve a two-hour session at your home, or if you prefer you can come into our office at the University. You and your child will talk about times when your child felt some different emotions. Then you and your child will be interviewed separately about feelings of anxiety and depression that your child may be having. Both the emotion discussion and the anxiety interview will be audiotaped. Following this, you will (separately from your child) complete a series of brief forms that ask about your and your child's emotional experiences. The first form will ask about how you view your child's emotional behavior (e.g., "Is your child prone to angry outbursts?"). The next few forms ask about ways that you manage your feelings (e.g., "I hold my anger in.", "I show my sadness.", "Other people aren't easily able to observe what I am feeling.") and how you respond to your child's emotional expressions (e.g., "If my child shouts at me in anger after I accidentally throw away her favorite comic book, I would: a.) apologize; b) send her/him to her/his room, etc.). Then you will be asked about different feelings that you may be having (e.g., "In the last week I was distressed by nervousness or shakiness inside.", "In the last week I was distressed by feelings of guilt.") and lastly, you will be asked to define some words.

What will my child have to do? Following the discussion described above, your child will complete forms that look at children's beliefs about showing their feelings. A few short stories will be read to your child (e.g., A child is worried that he or she is not good enough to make the soccer team). After each story, your child will be asked questions that ask why he or she would or would not show angry, sad, and worried feelings. The

next form looks at ways that your child copes with his or her feelings (e.g., “When I’m sad, I try not to show it.”, “I show my anger.”). Another form will ask your child about his or her family (e.g., “How often does someone in your family praise a family member for good work?”). The last form will ask your child to define some words.

Will our answers be private? Any information obtained from you or your child will be kept strictly confidential and used only for research purposes. Both your and your child’s name will not be associated with answers at any time, rather, identification numbers will be used on all pieces of information we collect. The list linking you and your child’s name to the information, and the actual information, will be stored in a locked office and destroyed at the end of the study. The audiotapes will also be stored in the locked office and destroyed approximately one-year after the study. Confidentiality of your child’s answers will be broken if your child obtains a score on the anxiety or depression measure that indicates a concern in this area. At this time, we will contact you.

Risks and benefits. The only risk to participating is that you or your child may feel uncomfortable answering questions about beliefs and attitudes about emotion, a potentially sensitive topic. For this reason, you may skip any question you do not want to answer and you may stop participating at any time. At the end of the session, you will be paid \$25.00 for your participation and your child will receive a small gift of his or her choice (e.g., folder, pencil, or stickers). If you have more than one child in the 3rd-through 5th-grades, you will be paid an additional \$5.00 for each child who participates. We will contact you if your child has a high score on the anxiety or depression measure, and if you so wish, we will assist you in identifying appropriate referrals. It is important to know, however, that an elevated score does not necessarily mean that your child is anxious or depressed. The significance of an elevated score must be determined by also considering other information about your child (e.g., your observations as well as those of your child’s teacher).

What do I need to do now? Please fill out and return the form at the bottom of the next page to your child’s classroom teacher **as soon as possible**.

If you have any questions or concerns, feel free to contact myself or Janice Zeman at the addresses or phone numbers listed below.

Sincerely,

Cynthia Suveg, B.S.

Address: 301 Little Hall
University of Maine
Orono, ME 04469
Phone: 581-2058

E-Mail: cynthia.suveg@umit.maine.edu

Janice Zeman, Ph.D., Associate Professor

301 Little Hall
University of Maine
Orono, ME 04469
581-2037

zeman@maine.maine.edu

Consent Form for the University of Maine research project conducted by Cynthia Suveg and Janice Zeman

_____ Yes, I agree to let my child participate in the initial school project and consent to being called if my child meets criteria for the second part of the study. By signing this form, I am not agreeing to participate in the second part of the study, only to consider it.

_____ No, my child may not participate

Parent/Guardian Signature

Date

Child's Name and Grade

Teacher's Name

Phone Number

Best Times to Call

Session I: Child Assent Form (For School Screening)

Hello:

You are invited to be in a project that wants to learn about different feelings that kids might have sometimes, like anger and sadness. If you agree to be in the project, we will help you complete three short forms, which will take about a half-hour. There are no right or wrong answers. We are just interested in how kids think about things. At the end of the project you will get to pick a small gift of your choice (e.g., stickers, pencil, or folder).

Because the questions ask you about your feelings, sometimes you may not want to answer them. So, you can skip any questions that you do not want to answer and you may stop participating at any time. You do not have to let anyone know if you do not want to fill out the rest of the forms. You can keep your folder up and just stop filling out the forms. You can also work on something else or just sit in your seat quietly until the rest of the kids are finished. If you become upset when you answer any of the questions, someone will be here for you to talk to. If it seems by your answers that you are very worried and sad about a lot of things, we will talk to your mom or dad about your concerns. Also, we may be calling your mom/guardian at a later time anyway, to see if she would be willing to help us out with the second part of this project that would invite both you and your mom to take part.

Do you have any questions? Would you be willing to do the project with us?

Session II: Parent/Guardian Consent Form

I agree and give consent for my child _____ to participate in the research project that is examining how mothers/guardians and children manage their emotions, which is being conducted by a graduate student, Cynthia Suveg, and her faculty sponsor, Janice Zeman, in the Department of Psychology at the University of Maine. I understand that I don't have to be in this study and that my child and I can leave the study at any time without giving any reason.

For participating in this study, I will be paid \$25.00 for my participation and my child will receive a small age-appropriate gift. If I have more than one child that qualifies to be in the project, I will be paid an additional \$5.00 for each child who participates.

If I agree to participate, my child and I will be interviewed about feelings of anxiety and depression that my child may be having. Then, we will be asked to talk about times when my child felt different emotions. I understand that the part when my child and I are interviewed about my child's feelings of anxiety and depression will be tape-recorded. The part when my child and I talk about different feelings will also be tape-recorded. Following this, I will (independently from my child) complete a series of brief forms that primarily ask about both my and my child's emotional experiences. The first form will ask about how I view my child's emotional behavior (e.g., "Is your child prone to angry outbursts?"). The next few forms ask about ways that I manage my feelings (e.g., "I hold my anger in.", "I show my sadness.", "Other people aren't easily able to observe what I am feeling.") and how I respond to my child's emotional expressions (e.g., "If my child shouts at me in anger after I accidentally throw away her favorite comic book, I would: a.) apologize; b) send her/him to her/his room, etc.). Then I will be asked about different feelings that I may be having (e.g., "In the last week I was distressed by nervousness or shakiness inside.", "In the last week I was distressed by feelings of guilt.") and lastly, I will be asked to define some words.

Following the emotion discussion task, my child will complete forms that look at children's beliefs about expressing emotion. A few short stories will be read to my child (e.g., A child is worried that he or she is not good enough to make the soccer team). After each story, my child will be asked questions about why he or she would or would not express angry, sad, and worried feelings. The next form looks at ways that my child copes with his or her feelings (e.g., "When I'm sad, I try not to show it.", "I show my anger."). Another form will ask my child about his or her perception of our family (e.g., "How often does someone in your family praise a family member for good work?", "When you are unhappy, your parents try to console you and cheer you up."). The last form will ask my child to define some words.

Any information obtained from my child and me will be kept strictly confidential and used only for research purposes. Our names will not be associated with answers at any time, rather, identification numbers will be used on all pieces of information we collect. The information will be stored in a locked office and destroyed when the study is over. The audiotapes will be destroyed after approximately one-year.

If my child or I feel uncomfortable answering questions about our beliefs and attitudes about emotions, we can skip any questions we do not want to answer and may stop participating at any time. The only risk to participating in this study is that we may feel uncomfortable answering questions about our beliefs and attitudes about emotions, a potentially sensitive topic. If I choose, the researchers conducting this project will provide referrals for my child if he or she meets criteria for an anxiety disorder.

If you have any questions or concerns, feel free to ask them now or contact myself or Janice Zeman at the addresses or phone numbers listed below.

Sincerely,

Cynthia Suveg, B.S.

Address: 301 Little Hall
University of Maine
Orono, ME 04469

Phone: 581-2058

E-Mail: cynthia.suveg@umit.maine.edu

Janice Zeman, Ph.D., Associate Professor

301 Little Hall
University of Maine
Orono, ME 04469

581-2037

zeman@maine.maine.edu

Yes, I agree to participate in this project. It has been explained to me that I may withdraw from participation at any time.

Parent/Guardian Signature

Date

Researcher Signature

Date

Session II: Child Assent Form

Dear Child:

You are invited to be in a project that wants to learn about how children show their feelings, like anger and sadness, and also what kids do when they are having these feelings. There are no right or wrong answers. We are just interested in how kids think about things. At the end of the session you will get to pick small gift of your choice (e.g., stickers, pencil, or folder).

When we first begin, you will be asked to talk with your mom for a few minutes about a time when you felt mad, sad, or nervous. We will tape-record your talk. After the talk is over, you will be asked about any nervous or sad feelings that you may be having. Then, you will complete forms that ask you about children's beliefs about showing their feelings. You will be read a few short stories (e.g., You are worried that you might not make the soccer team.). After each story, you will be asked, "Would you show how nervous you feel to your mother?" and other questions that look at why you would or would not show your mad, sad, and worried feelings. The next form looks at ways that you deal with your feelings (e.g., "When I'm sad, I try not to show it," "I show my anger"). Another form will ask you about your family (e.g., "How often does someone in your family praise a family member for good work?", "When you are unhappy, do your parents try to console you and cheer you up."). The last form will ask you what some words mean.

Because the questions ask you about your feelings, sometimes you may not want to answer them. For this reason, you can skip any questions you do not want to answer and you may stop participating at any time. If you become upset when you answer any of the questions, someone will be here for you to talk to.

Do you have any questions? Would you be willing to do the project with us?

Appendix B

Child Measures*

1. Revised Children's Manifest Anxiety Scale (RCMAS)
2. Children's Depression Inventory (CDI)
3. Emotion Regulation Interview-Child Version (ERI-C)
4. Children's Emotion Management Scales (CEMS: Sadness, Anger, Worry)
5. Family Environment Scale (FES: Control, Expressiveness)
6. Family Expressivity Questionnaire (FEQ)
7. Egna Minnen Beträffande Uppfostran for Children (EMBU-C)
8. Vocabulary subtest of the Wechsler Intelligence Scale for Children-Third Edition (WISC-III)

*Anxiety Disorders Interview Schedule for Children (4th-ed.; ADIS-IV) available upon request.

ID# _____

RCMAS

- | | | |
|-----|----|--|
| Yes | No | 1. I have trouble making up my mind. |
| Yes | No | 2. I get nervous when things do not go the right way for me. |
| Yes | No | 3. Others seem to do things easier than I can. |
| Yes | No | 4. I like everyone I know. |
| Yes | No | 5. Often I have trouble getting my breath. |
| Yes | No | 6. I worry a lot of the time. |
| Yes | No | 7. I am afraid of a lot of things. |
| Yes | No | 8. I am always kind. |
| Yes | No | 9. I get mad easily. |
| Yes | No | 10. I worry about what my parents will say to me. |
| Yes | No | 11. I feel that others do not like the way I do things. |
| Yes | No | 12. I always have good manners. |
| Yes | No | 13. It is hard for me to get to sleep at night. |
| Yes | No | 14. I worry about what other people think about me. |
| Yes | No | 15. I feel alone even when there are other people with me. |
| Yes | No | 16. I am always good. |
| Yes | No | 17. Often I feel sick in my stomach. |
| Yes | No | 18. My feelings get hurt easily. |
| Yes | No | 19. My hands feel sweaty. |
| Yes | No | 20. I am always nice to everyone. |
| Yes | No | 21. I am tired a lot. |
| Yes | No | 22. I worry about what is going to happen. |
| Yes | No | 23. Other people are happier than I. |
| Yes | No | 24. I tell the truth every single time. |
| Yes | No | 25. I have bad dreams. |
| Yes | No | 26. My feelings get hurt easily when I am fussed at. |
| Yes | No | 27. I feel someone will tell me I do things the wrong way. |
| Yes | No | 28. I never get angry. |
| Yes | No | 29. I wake up scared some of the time. |
| Yes | No | 30. I worry when I go to bed at night. |
| Yes | No | 31. It's hard for me to keep my mind on my schoolwork. |
| Yes | No | 32. I never say things I shouldn't. |
| Yes | No | 33. I wiggle in my seat a lot. |
| Yes | No | 34. I am nervous. |
| Yes | No | 35. A lot of people are against me. |

- | | | |
|-----|----|--|
| Yes | No | 36. I never lie. |
| Yes | No | 37. I often worry about something bad happening to me. |

CDI

From each group of three sentences, pick one sentence that best describes you for the past two weeks. There is no right or wrong answer. Just pick the sentence that best describes the way you have been recently.

Item 1

- I am sad once in a while.
- I am sad many times.
- I am sad all the time.

Item 2

- Nothing will ever work out for me.
- I am not sure if things will work out for me.
- Things will work out for me O.K.

Item 3

- I do most things O.K.
- I do many things wrong.
- I do everything wrong.

Item 4

- I have fun in many things.
- I have fun in some things.
- Nothing is fun at all.

Item 5

- I am bad all the time.
- I am bad many times.
- I am bad once in a while.

Item 6

- I think about bad things happening to me once in a while.
- I worry that bad things will happen to me.
- I am sure that terrible things will happen to me.

Item 7

- I hate myself.
- I do not like myself.
- I like myself.

Item 8

- All bad things are my fault.
- Many bad things are my fault.
- Bad things are not usually my fault.

Item 10

- I feel like crying every day.
- I feel like crying many days.
- I feel like crying once in a while.

Item 11

- Things bother me all the time.
- Things bother me many times.
- Things bother me once in a while.

Item 12

- I like being with people.
- I do not like being with people many times.
- I do not want to be with people at all.

Item 13

- I cannot make up my mind about things.
- It is hard to make up my mind about things.
- I make up my mind about things easily.

Item 14

- I look O.K.
- There are some bad things about my looks.
- I look ugly.

Item 15

- I have to push myself all the time to do my schoolwork.
- I have to push myself many times to do my schoolwork.
- Doing schoolwork is not a big problem.

Item 16

- I have trouble sleeping every night.
- I have trouble sleeping many nights.
- I sleep pretty well.

Item 17

- I am tired once in a while.
- I am tired many days.
- I am tired all the time.

Item 18

- Most days I do not feel like eating.
- Many days I do not feel like eating.
- I eat pretty well.

Item 19

- I do not worry about aches and pains.
- I worry about aches and pains many times.
- I worry about aches and pains all the time.

Item 20

- I do not feel alone.
- I feel alone many times.
- I feel alone all the time.

Item 21

- I never have fun at school.
- I have fun at school only once in a while.
- I have fun at school many times.

Item 22

- I have plenty of friends.
- I have some friends but I wish I had more.
- I do not have any friends.

Item 23

- My schoolwork is alright.
- My schoolwork is not as good as before.
- I do very badly in subjects I used to be good in.

Item 24

- I can never be as good as other kids.
- I can be as good as other kids if I want to.
- I am just as good as other kids.

Item 25

- Nobody really loves me.
- I am not sure if anybody loves me.
- I am sure that somebody loves me.

Item 26

- I usually do what I am told.
- I do not do what I am told most times.
- I never do what I am told.

Item 27

- I get along with people.
- I get into fights many times.
- I get into fights all the time.

ID# _____

ERI-C-SW

You really want to be on the soccer team so you decide to try out. Your mother goes with you to the try-outs. During the try-outs, you think that there are a lot of kids who are really good at soccer. You are not sure if you are good enough to make the team. This makes you feel **WORRIED**.

1. How worried would you feel? (show picture of emotion thermometer here)

2. Would you show how worried you feel to your mother?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

3. Would your mother make fun of or tease you if you show how worried you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

4. Would your mother understand how worried you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

5. How much would this situation make you sick (like make your stomach or head hurt)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think you would be able to make yourself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. If this situation really happened to you, What would you do? (Query 3 times) Which of these things would you **most likely** do?

8. Why would you do that?

9. If this situation really happened to you, what would your mother tell you to do? (Query 3 times).

ERI-C-SS

You really want to be on the soccer team so you decide to try-out. The next day your mother goes with you to check the bulletin board where the names of kids who made the team are listed. When you get there you find out that you didn't make the team but that your friends did. This makes you feel **SAD**.

1. How sad would you feel? (show picture of emotion thermometer here)

2. Would you show how sad you feel to your mother?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

3. Would your mother make fun of or tease you if you show how sad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

4. Would your mother understand how sad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

5. How much would this situation make you sick (like make your stomach or head hurt)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think you would be able to make yourself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. If this situation really happened to you, what would you do? (Query 3 times) Which of these things would you **most likely** do?

8. Why would you do that?

9. If this situation really happened to you, what would your mother tell you to do? (Query 3 times).

ID# _____

ERI-C-SM

You really want to be on the soccer team so you decide to try-out. Your mother goes with you to the try-outs. During the try-outs you practice kicking the ball back and forth with another child who purposely kicks the ball away from you so that you cannot kick the ball back. This makes you feel **MAD**.

1. How mad would you feel? (show picture of emotion thermometer here)

2. Would you show how mad you feel to your mother?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

3. Would your mother make fun of or tease you if you show how mad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

4. Would your mother understand how mad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

5. How much would this situation make you sick (like make your stomach or head hurt)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think you would be able to make yourself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. If this situation really happened to you, what would you do? (Query 3 times) Which of these things would you **most likely** do?

8. Why would you do that?

9. If this situation really happened to you, what would your mother tell you to do? (Query 3 times).

ID# _____

ERI-C-CW

Your mother takes you to meet the bus on the first day of summer camp. You are planning to share a seat on the bus and a cabin at camp with your best friend who is planning to meet you there. When you arrive at the bus stop you find out that your best friend is unable to go to camp. You don't know any of the other kids that are going, but they all seem to know each other. This makes you feel **WORRIED**.

1. How worried would you feel? (show picture of emotion thermometer here)

2. Would you show how worried you feel to your mother?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

3. Would your mother make fun of or tease you if you show how worried you feel?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

4. Would your mother understand how worried you feel?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

5. How much would this situation make you sick (like make your stomach or head hurt)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think you would be able to make yourself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. If this situation really happened to you, What would you do? (Query 3 times) Which of these things would you **most likely** do?

8. Why would you do that?

9. If this situation really happened to you, what would your mother tell you to do? (Query 3 times).

ERI-C-CS

Your mother is taking you to meet the bus on the first day of summer camp. When you arrive you find out that some of your friends are going but that your best friend got sick at the last minute and can't go. This makes you feel **SAD**.

1. How sad would you feel? (show picture of emotion thermometer here)

2. Would you show how sad you feel to your mother?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

3. Would your mother make fun of or tease you if you show how sad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

4. Would your mother understand how sad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

5. How much would this situation make you sick (like make your stomach or head hurt)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think you would be able to make yourself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. If this situation really happened to you, What would you do? (Query 3 times) Which of these things would you **most likely** do?

8. Why would you do that?

9. If this situation really happened to you, what would your mother tell you to do? (Query 3 times).

ID# _____

ERI-C-CM

Your mother takes you to meet the bus on the first day of summer camp. You are glad that you get to be third in line because you will get a good seat on the bus. All of a sudden another kid purposely pushes you out of line, which causes you to have to move to the end of the line. This makes you feel **MAD**.

1. How mad would you feel? (show picture of emotion thermometer here)

2. Would you show how mad you feel to your mother?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

3. Would your mother make fun of or tease you if you show how mad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

4. Would your mother understand how mad you feel?

1	2	3	4
Definitely	Probably	Probably	Definitely
Would	Would	Would Not	Would Not

5. How much would this situation make you sick (like make your stomach or head hurt)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think you would be able to make yourself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. If this situation really happened to you, What would you do? (Query 3 times) Which of these things would you **most likely** do?

8. Why would you do that?

9. If this situation really happened to you, what would your mother tell you to do? (Query 3 times).

ID# _____

CEMS: Anger

1. When I'm feeling mad, I can control my temper.	Hardly ever 1	Sometimes 2	Often 3
2. I hold my anger in.	Hardly ever 1	Sometimes 2	Often 3
3. I stay calm and keep my cool when I'm feeling mad.	Hardly ever 1	Sometimes 2	Often 3
4. I do things like to slam doors when I'm mad.	Hardly ever 1	Sometimes 2	Often 3
5. I hide my anger.	Hardly ever 1	Sometimes 2	Often 3
6. I attack whatever it is that makes me very angry.	Hardly ever 1	Sometimes 2	Often 3
7. I get mad inside but I don't show it.	Hardly ever 1	Sometimes 2	Often 3
8. I can stop myself from losing my temper when I'm mad.	Hardly ever 1	Sometimes 2	Often 3
9. I say mean things to others when I'm mad.	Hardly ever 1	Sometimes 2	Often 3
10. I try to calmly deal with what is making me mad.	Hardly ever 1	Sometimes 2	Often 3
11. I'm afraid to show my anger.	Hardly ever 1	Sometimes 2	Often 3

ID# _____

CEMS: Sadness

1. When I'm sad, I can control my crying and carrying on.	Hardly ever 1	Sometimes 2	Often 3
2. I hold my sad feelings in.	Hardly ever 1	Sometimes 2	Often 3
3. I stay calm and don't let sad things get to me.	Hardly ever 1	Sometimes 2	Often 3
4. I whine/fuss about what's making me sad.	Hardly ever 1	Sometimes 2	Often 3
5. I hide my sadness.	Hardly ever 1	Sometimes 2	Often 3
6. When I'm sad, I do something totally different until I calm down.	Hardly ever 1	Sometimes 2	Often 3
7. I get sad inside but don't show it.	Hardly ever 1	Sometimes 2	Often 3
8. I can stop myself from losing control of my sad feelings.	Hardly ever 1	Sometimes 2	Often 3
9. I cry and carry on when I'm sad.	Hardly ever 1	Sometimes 2	Often 3
10. I try to calmly deal with what is making me sad.	Hardly ever 1	Sometimes 2	Often 3
11. I do things like mope around when I'm sad.	Hardly ever 1	Sometimes 2	Often 3
12. I'm afraid to show my sadness.	Hardly ever 1	Sometimes 2	Often 3

ID# _____

CEMS: Worried

1. I keep myself from losing control of my worried feelings.	Hardly ever 1	Sometimes 2	Often 3
2. I show my worried feelings.	Hardly ever 1	Sometimes 2	Often 3
3. I hold my worried feelings in.	Hardly ever 1	Sometimes 2	Often 3
4. I talk to someone until I feel better when I'm feeling worried.	Hardly ever 1	Sometimes 2	Often 3
5. I do things like cry and carry on when I'm worried.	Hardly ever 1	Sometimes 2	Often 3
6. I hide my worried feelings.	Hardly ever 1	Sometimes 2	Often 3
7. I stay calm when I'm feeling worried.	Hardly ever 1	Sometimes 2	Often 3
8. I avoid whatever it is that makes me feel very worried.	Hardly ever 1	Sometimes 2	Often 3
9. I get worried inside but don't show it.	Hardly ever 1	Sometimes 2	Often 3
10. When I feel worried I do something totally different until I calm down.	Hardly ever 1	Sometimes 2	Often 3
11. I keep whining about how worried I am.	Hardly ever 1	Sometimes 2	Often 3
12. I can't stop myself from acting really worried.	Hardly ever 1	Sometimes 2	Often 3
13. I try to calmly settle the problem when I feel worried.	Hardly ever 1	Sometimes 2	Often 3
14. I cry and carry on when I'm worried.	Hardly ever 1	Sometimes 2	Often 3
15. I'm afraid to show it when I'm worried.	Hardly ever 1	Sometimes 2	Often 3

ID# _____

FES-Control

1. Family members are rarely ordered around.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
2. There are very few rules to follow in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
3. There is one family member who makes most of the decisions.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
4. There are set ways of doing things at home.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
5. There is a strong emphasis on following rules in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
6. Everyone has an equal say in family decisions.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
7. We can do whatever we want to in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
8. Rules are pretty inflexible in our household.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
9. You can't get away with much in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	

ID# _____

FES-Expressiveness

1. Family members often keep their feelings to themselves.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

2. We say anything we want to around home.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

3. It's hard to "blow off steam" at home without upsetting someone.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

4. We tell each other about our personal problems.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

5. If we feel like doing something on the spur of the moment we often just pick up and go.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

6. Someone usually gets upset if you complain in our family.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

7. Money and paying bills is openly talked about in our family.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

8. We are usually careful about what we say to each other.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

9. There are a lot of spontaneous discussions in our family.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

ID# _____

Family Expressivity Questionnaire (FEQ)

Instructions: This is a questionnaire about family expressiveness. We'd like to know more about the degree of expressiveness shown in different families. Therefore, we'd like you to tell us about the frequency of expression in your family. By frequency we mean, "How often does this situation occur in your family in comparison to other families?" Circle a number on the rating scale from 1 (not at all frequently in my family) to 9 (very frequently in my family) that indicates how frequently that activity occurs.

1. Showing forgiveness to someone who broke a favorite possession.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

2. Thanking family members for something they have done.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

3. Exclaiming over a beautiful day.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

4. Showing contempt (disgust) for another's actions.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

5. Expressing dissatisfaction with someone else's behavior.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

6. Praising someone for good work.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

7. Expressing anger at someone else's carelessness.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

8. Sulking over unfair treatment by a family member.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

9. Blaming one another for family troubles.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

10. Crying after an unpleasant disagreement.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

11. Putting down other people's interests.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

12. Showing dislike for someone.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

13. Seeking approval for an action.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

14. Expressing embarrassment over stupid mistake.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

15. Going to pieces when tension builds up.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

16. Expressing exhilaration/excitement after an unexpected triumph.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

17. Expressing excitement over one's future plans.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

18. Demonstrating admiration.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

19. Expressing sorrow when a pet dies.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

20. Expressing disappointment over something that didn't work out.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

21. Telling someone how nice they look.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

22. Expressing sympathy for someone's troubles.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

23. Expressing deep affection or love for someone.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

24. Quarreling with a family member.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

25. Crying when someone leaves.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

26. Spontaneously hugging a family member.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

27. Expressing momentary anger over a trivial irritation.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

28. Expressing concern for the success of other family members.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

29. Apologizing for being late.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

30. Offering to do somebody a favor.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

31. Snuggling up to a family member.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

32. Crying for being punished.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

33. Trying to cheer up someone who is sad.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

34. Telling a family member how hurt you are.

1	2	3	4	5	6	7	8	9
not at all				somewhat	frequently			very frequently
in my family				in my family				in my family

35. Telling family members how happy you are.

1	2	3	4	5	6	7	8	9
not at all				somewhat	frequently			very frequently
in my family				in my family				in my family

36. Threatening someone.

1	2	3	4	5	6	7	8	9
not at all				somewhat	frequently			very frequently
in my family				in my family				in my family

37. Criticizing someone for being late.

1	2	3	4	5	6	7	8	9
not at all				somewhat	frequently			very frequently
in my family				in my family				in my family

38. Expressing gratitude for a favor.

1	2	3	4	5	6	7	8	9
not at all				somewhat	frequently			very frequently
in my family				in my family				in my family

39. Surprising someone with a little gift or favor.

1	2	3	4	5	6	7	8	9
not at all				somewhat	frequently			very frequently
in my family				in my family				in my family

40. Saying "I'm sorry" when one realizes one was wrong.

1	2	3	4	5	6	7	8	9
not at all				somewhat	frequently			very frequently
in my family				in my family				in my family

ID# _____

EMBU-C

1. When you come home, you have to tell your mother what you've been doing.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

2. When you are unhappy, your mother consoles you and cheers you up.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

3. Your mother wants you to reveal your secrets to her.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

4. Your mother tells you that she doesn't like your behavior at home.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

5. Your mother likes you just the way you are.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

6. Your mother tells you things like: "If you do that, you will make me sad".

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

7. Your mother plays with you and are interested in your hobbies.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

8. Your mother treats you unfairly.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

9. Your mother worries about what you are doing after school is out.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

10. Your mother listens to you and considers your opinions.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

11. Your mother wishes that you were like somebody else.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

12. You feel guilty when you have behaved in a way that your mother disapproves of.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

13. You are treated as the “black sheep” of the family; you are blamed for everything that goes wrong.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

14. Your mother punishes you for no reason.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

15. Your mother wants to be with you.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

16. Your mother wants to decide how you should be dressed or how you should look.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

17. Your mother shows that she love you.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

18. Your mother criticizes you in front of others.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

19. Your mother is scared that something might happen to you.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

20. Your mother encourages you to enjoy yourself and learn things.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

21. You feel disappointed because your mother doesn't give you what you want.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

22. Your mother doesn't give you everything because she doesn't want you to become a spoiled child.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

23. When things aren't going well for you, your mother tries to console or help you.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

24. You feel that your mother and you like each other.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

25. You think that your mother is mean and grudging towards you.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

26. Your mother not only tells you that she loves you, but she also hugs and kisses you.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

27. When you've done something stupid, you can make it up with your mother.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

28. Your mother beats you for no reason.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

29. Your mother forbids you to do things, because she is afraid that something bad might happen to you.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

30. Your mother gives you compliments.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

31. You are the one whom your mother blames if anything happens at home.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

32. When you have done something which isn't allowed, your mother looks so sad that you feel guilty.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

33. Your mother helps you when you have to do something difficult.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

34. Your mother trusts you and allows you to make your own decisions.

1	2	3	4
No	Yes, seldom	Yes, often	Yes, most of the time

ID# _____

Vocabulary

Children will be asked what the following words mean according to instructions specified in the WISC-III manual. Discontinue after 4 consecutive failures.

1. Clock
2. Hat
3. Umbrella
4. Bicycle
5. Cow
6. Alphabet
7. Donkey
8. Thief
9. Leave
10. Brave
11. Island
12. Ancient
13. Nonsense
14. Absorb
15. Fable
16. Precise
17. Migrate

18. Mimic
19. Transparent
20. Strenuous
21. Boast
22. Unanimous
23. Seclude
24. Rivalry
25. Amendment
26. Compel
27. Affliction
28. Imminent
29. Aberration
30. Dilatory

Total Score _____

Appendix C

Mother Measures*

1. Phone Script
2. Demographic Information
3. Emotion Regulation Interview-Parent Version (ERI-P)
4. Emotion Regulation Checklist (ERC)
5. Parent's Emotion Management Scales (PEMS: Sadness, Anger, Fear)
6. Emotional Expressivity Scale (EEQ)
7. Family Expressivity Questionnaire (FEQ)
8. Family Environment Scale – Control and Expressivity Subscales (FES: Control, Expressiveness)
9. Parent Attitude Toward Child Expressiveness Scale (PACES)
10. Symptom Checklist-90-Revised (SCL-90-R)
11. Vocabulary Subtest of the Wechsler Adult Intelligence Scale-Third Edition (WAIS-III)

*Anxiety Disorders Interview Schedule for Children (4th-ed.; ADIS-IV) available upon request.

Phone Script for Calling Parents of Children with High Anxiety Scores

- 1) As soon as parent responds affirmatively to **ONE** of the questions below, you can stop there and go to **PART B** of script.
- 2) If parent responds no to all of the above questions, go to **PART C** of script.

PART A

Ask for Mom – if she is not home just say you will call back.

Hi, my name is _____ and I am calling from the University of Maine in regard to the project that your daughter/son, _____, recently participated in at school. Is this a good time to talk for about 10 minutes? **If no, ask when would be a good time to call back. If yes, proceed with script.**

As you know, CHILD'S NAME filled out a brief form at school that measures anxiety. Based on CHILD'S NAME answers to the questions on this measure, his/her score falls above other kids his/her age. However, just because he/she had a high score on this anxiety measure, it does not necessarily mean that CHILD'S NAME has an anxiety problem. Sometimes these measures give inaccurate results. So, I am calling to get your input and ask you a few questions that will help determine whether or not CHILD'S NAME likely has an anxiety problem. If it appears by your answers that CHILD'S NAME does have an anxiety problem, we will ask you if you would be willing to participate in the second part of the study. Does this sound ok? Ok, then let me ask you a few questions about CHILD'S NAME.

1. Does CHILD'S NAME get very nervous or scared about having to go to school?

Yes No
2. When CHILD'S NAME is not with you, does he/she let you know, or have you noticed, that he/she feels really scared or worried and does whatever he/she can to be with you?

Yes No
3. When CHILD'S NAME is in certain social situations with other people in school, in restaurants, at parties, or when meeting new people, has he/she told you, or have you noticed, that he/she is afraid that people might think something he/she does is stupid or dumb or that they might laugh at him/her?

Yes No
4. Many kids feel very scared and uncomfortable, so much so that they might want to stay away from certain, specific things. I want to know if CHILD'S NAME is more afraid of some things than are other kids his/her age. Does this sound like CHILD'S NAME?

Yes No

5. Occasionally, some people feel very frightened for no reason at all. They are not in a frightening situation, there is nothing to scare them, and they are not thinking frightening thoughts. But suddenly, out of the blue, they feel really frightened and they don't know why. Has your child ever told you, or have you ever noticed, that his happened to CHILD'S NAME?
- Yes No
6. Some children always seem to be worrying. They might worry about school and how well they are doing; they worry about things that can happen in the future; they worry about their friends, or family, or other things. Do you think that CHILD'S NAME has been worrying a lot about such things?
- Yes No
7. Does CHILD'S NAME complain of feeling anxious or uncomfortable if he/she cannot do the same thing over and over in a special order or manner? Like washing his/her hands over and over again?
- Yes No
8. Has CHILD'S NAME ever felt depressed. Depressed is a feeling that some people have when they are extremely sad, it is not like the temporary sadness children experience when they lose a pet or move away from good friends.
- Yes No

PART B: Parent answered yes to one of the above questions.

Ok, well it seems based on both your and CHILD'S NAME responses, that he/she would qualify for the second part of the study. As you might recall, the second part of the study will involve both you and CHILD'S NAME and last for approximately 2-hours. At the end, your child will receive a small age-appropriate gift and you will receive \$25. Would you be willing to help us out? If so, schedule a time. Once you and your child come into the lab, we will be asking both of you in more detail about the difficulties that CHILD'S NAME may be experiencing.

IF THE PARENT ASKS ABOUT SERVICES, SAY: When you come for the second part of the study, we will have a better idea of the most appropriate services for your child if you would like for us to help you find services.

PART C: Parent answered no to all of the above questions.

It seems by your answers to the above questions that the form CHILD'S NAME filled out in school might have overestimated his/her anxiety difficulties. Does your child exhibit any other behaviors other than those I already asked you about that might lead you to think that he/she does have anxiety problems?

If yes, ask for a brief description and set up an appointment if seems reasonable.

If no, proceed with script.

Thank you for your time. Please feel free to call us if you think of any other information that you think might be helpful.

Phone Script for Calling Parents of Children with High Anxiety and Depression Scores

- 1) As soon as parent responds affirmatively to **ONE** of the questions below, you can stop there and go to **PART B** of script.
- 2) If parent responds no to all of the above questions, go to **PART C** of script.
- 3) If parent responds yes to only #8 (the question about depression), then go to **PART D** of the script.

PART A

Ask for Mom – if she is not home just say you will call back.

Hi, my name is _____ and I am calling from the University of Maine in regard to the project that your daughter/son, _____, recently participated in at school. Is this a good time to talk for about 10 minutes? **If no, ask when would be a good time to call back. If yes, proceed with script.**

As you know, CHILD'S NAME filled out a brief form at school that measures anxiety and depression. Based on CHILD'S NAME answers to the questions on this measure, his/her scores falls above other kids his/her age. However, just because he/she had a high score on these measures, it does not necessarily mean that CHILD'S NAME has an anxiety or depression problem. Sometimes these measures give inaccurate results. So, I am calling to get your input and ask you a few questions that will help determine whether or not CHILD'S NAME likely has a problem. If it appears by your answers that CHILD'S NAME does have an anxiety problem, we will ask you if you would be willing to participate in the second part of the study. Does this sound ok? Ok, then let me ask you a few questions about CHILD'S NAME.

1. Does CHILD'S NAME get very nervous or scared about having to go to school?

Yes No

2. When CHILD'S NAME is not with you, does he/she let you know, or have you noticed, that he/she feels really scared or worried and does whatever he/she can to be with you?

Yes No

3. When CHILD'S NAME is in certain social situations with other people in school, in restaurants, at parties, or when meeting new people, has he/she told you, or have you noticed, that he/she is afraid that people might think something he/she does is stupid or dumb or that they might laugh at him/her?

Yes No

4. Many kids feel very scared and uncomfortable, so much so that they might want to stay away from certain, specific things. I want to know if CHILD'S NAME is more afraid of some things than are other kids his/her age. Does this sound like CHILD'S NAME?
- Yes No
5. Occasionally, some people feel very frightened for no reason at all. They are not in a frightening situation, there is nothing to scare them, and they are not thinking frightening thoughts. But suddenly, out of the blue, they feel really frightened and they don't know why. Has you child ever told you, or have you ever noticed, that his happened to CHILD'S NAME?
- Yes No
6. Some children always seem to be worrying. They might worry about school and how well they are doing; they worry about things that can happen in the future; they worry about their friends, or family, or other things. Do you think that CHILD'S NAME has been worrying a lot about such things?
- Yes No
7. Does CHILD'S NAME complain of feeling anxious or uncomfortable if he/she cannot do the same thing over and over in a special order or manner? Like washing his/her hands over and over again?
- Yes No
8. Has CHILD'S NAME ever felt depressed. Depressed is a feeling that some people have when they are extremely sad, it is not like the temporary sadness children experience when they lose a pet or move away from good friends.
- Yes No

PART B: Parent answered yes to one of the above questions.

Ok, well it seems based on both your and CHILD'S NAME responses, that he/she would qualify for the second part of the study. As you might recall, the second part of the study will involve both you and CHILD'S NAME and last for approximately 2-hours. At the end, your child will receive a small age-appropriate gift and you will receive \$25. Would you be willing to help us out? If so, schedule a time. Once you and your child come into the lab, we will be asking both of you in more detail about the difficulties that CHILD'S NAME may be experiencing.

IF THE PARENT ASKS ABOUT SERVICES, SAY: When you come for the second part of the study, we will have a better idea of the most appropriate services for your child if you would like for us to help you find services.

PART C: Parent answered no to all of the above questions.

It seems by your answers to the above questions that the form CHILD'S NAME filled out in school might have overestimated his/her anxiety difficulties. Does your child exhibit any other behaviors other than those I already asked you about that might lead you to think that he/she does have anxiety problems?

If yes, ask for a brief description and set up an appointment if seems reasonable.

If no, proceed with script.

Thank you for your time. Please feel free to call us if you think of any other information that you think might be helpful.

PART D: Parent answered yes only to the depression question.

Well, it seems by your answers that your child may be experiencing depression. Although our follow-up study is only including children with depression and anxiety, we would still like to help you locate services for your child if you are interested.

**IF PARENT SAYS YES, THEN GIVE HER PRIMARY INVESTIGATOR'S NUMBER (581-2058) AND ASK HER TO LEAVE A CONFIDENTIAL MESSAGE ON THE ANSWERING MACHINE IF I'M NOT THERE. TELL HER CINDY WILL GET BACK TO HER WITHIN A FEW DAYS.
IF PARENT SAYS NO, THEN TELL HER IF SHE CHANGES HER MIND TO CALL PRIMARY INVESTIGATOR AND GIVE HER THE REST OF THE INFORMATION ABOVE.**

Demographic Information

ID#: _____

Birthdate (M/D/Yr): _____

Child's Birthdate (M/D/Yr): _____

**Please list all individuals living:
in your home** _____

Marital Status: _____

Occupation: _____

Highest Level of Education: _____

Spouse's Occupation: _____

**Spouse's Level of Education:
(if applicable)** _____

Race: _____

ID# _____

ERI-P-SW

Your child really wants to be on the soccer team so he or she decides to try-out. You go with him/her to the try-outs. During the try-outs, your child thinks that there are a lot of other kids who are really good at soccer and he/she is not sure if he/she is good enough to make the team. This makes your child feel **WORRIED**.

1. How worried do you think your child would feel in this situation?

1	2	3	4	5	6	7	8	9	10
A little bit									Extremely Worried

2. Do you think your child would show you how worried he/she feels?

1	2	3	4
Definitely Should	Probably Should	Probably Should Not	Definitely Should Not

3. Would you make fun of or tease your child if he/she showed his/her worried feelings?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

4. Would you understand how worried your child feels?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

5. How much do you think that this situation would make your child feel physically sick (e.g., get a stomachache or headache)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think that your child would be able to make him/herself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. What would you tell your child to do in this situation?
 8. What would your child most likely do in this situation?
 9. Why do you think he/she would do that?

ID# _____

ERI-P-SS

Your child wants to be on the soccer team so he/she decides to try-out. The next day you go with him/her to check the bulletin board where the names of kids who made the team are listed. When your child gets there he/she finds out that he/she didn't make the team but that his/her friends did. This makes your child feel **SAD**.

1. How sad do you think your child would feel in this situation?

1	2	3	4	5	6	7	8	9	10
A little bit									Extremely Worried

2. Do you think your child would show you how sad he/she feels?

1	2	3	4
Definitely Should	Probably Should	Probably Should Not	Definitely Should Not

3. Would you make fun of or tease your child if he/she showed his/her sad feelings?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

4. Would you understand how sad your child feels?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

5. How much do you think that this situation would make your child feel physically sick (e.g., get a stomachache or headache)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think that your child would be able to make his/herself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. What would you tell your child to do in this situation?
 8. What would your child most likely do in this situation?
 9. Why do you think he/she would do that?

ID# _____

ERI-P-SM

Your child really wants to be on the soccer team so he/she decides to try-out. You go with him/her to the try-outs. During the try-outs, your child practices kicking the ball back and forth with another child who purposely kicks the ball away from your child so that your child cannot kick the ball back. This makes your child feel **MAD**.

1. How mad do you think your child would feel in this situation?

1	2	3	4	5	6	7	8	9	10
A little bit									Extremely Worried

2. Do you think your child would show you how mad he/she feels?

1	2	3	4
Definitely Should	Probably Should	Probably Should Not	Definitely Should Not

3. Would you make fun of or tease your child if he/she showed his/her mad feelings?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

4. Would you understand how mad your child feels?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

5. How much do you think that this situation would make your child feel physically sick (e.g., get a stomachache or headache)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think that your child would be able to make his/herself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. What would you tell your child to do in this situation?
 8. What would your child most likely do in this situation?
 9. Why do you think he/she would do that?

ID# _____

ERI-P-CW

You take your child to meet the bus on the first day of summer camp. Your child is planning to share a seat on the bus and a cabin at camp with his/her best friend who is supposed to meet him/her there. When you arrive at the bus stop, your child finds out that her best friend is unable to go to camp. Your child doesn't know ANY of the other children who are going but they all seem to know each other. This makes your child feel **WORRIED**.

1. How worried do you think your child would feel in this situation?

1	2	3	4	5	6	7	8	9	10
A little bit									Extremely Worried

2. Do you think your child would show you how worried he/she feels?

1	2	3	4
Definitely Should	Probably Should	Probably Should Not	Definitely Should Not

3. Would you make fun of or tease your child if he/she showed his/her worried feelings?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

4. Would you understand how worried your child feels?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

5. How much do you think that this situation would make your child feel physically sick (e.g., get a stomachache or headache)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think that your child would be able to make his/herself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. What would you tell your child to do in this situation?
 8. What would your child most likely do in this situation?
 9. Why do you think he/she would do that?

ID# _____

ERI-P-CS

You take your child to meet the bus on the first day of summer camp. When they arrive, your child finds out that some of his/her friends are going but that his/her best friend got sick at the last minute and can't go. This makes your child feel **SAD**.

1. How sad do you think your child would feel in this situation?

1	2	3	4	5	6	7	8	9	10
A little bit									Extremely Worried

2. Do you think your child would show you how sad he/she feels?

1	2	3	4
Definitely Should	Probably Should	Probably Should Not	Definitely Should Not

3. Would you make fun of or tease your child if he/she showed his/her sad feelings?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

4. Would you understand how sad your child feels?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

5. How much do you think that this situation would make your child feel physically sick (e.g., get a stomachache or headache)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think that your child would be able to make his/herself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. What would you tell your child to do in this situation?
 8. What would your child most likely do in this situation?
 9. Why do you think he/she would do that?

ID# _____

ERI-P-CM

You take your child to meet the bus on the first day of summer camp. Your child is glad that he/she gets to be third in line because he/she will get a good seat on the bus. All of a sudden, another child purposely pushes him/her out of line, which causes your child to have to move to the end of the line. This makes your child feel **MAD**.

1. How mad do you think your child would feel in this situation?

1	2	3	4	5	6	7	8	9	10
A little bit									Extremely Worried

2. Do you think your child would show you how mad he/she feels?

1	2	3	4
Definitely Should	Probably Should	Probably Should Not	Definitely Should Not

3. Would you make fun of or tease your child if he/she showed his/her mad feelings?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

4. Would you understand how mad your child feels?

1	2	3	4
Definitely Would	Probably Would	Probably Would Not	Definitely Would Not

5. How much do you think that this situation would make your child feel physically sick (e.g., get a stomachache or headache)?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

6. How much do you think that your child would be able to make his/herself feel better in this situation?

1	2	3	4
Not At All	A Little Bit	Some	A Lot

7. What would you tell your child to do in this situation?
 8. What would your child most likely do in this situation?
 9. Why do you think he/she would do that?

ID# _____

ERC

1. Is a cheerful child.

1	2	3	4
Never	Sometimes	Often	Always

2. Exhibits wide mood swings (for example, the child's emotional state is difficult to anticipate because s/he moves quickly from a very positive or neutral to very negative emotional states).

1	2	3	4
Never	Sometimes	Often	Always

3. Responds positively to neutral or friendly overtures by adults.

1	2	3	4
Never	Sometimes	Often	Always

4. Transitions well from one activity to another (for example, does not become anxious, angry, or overly excited when moving from one activity to another).

1	2	3	4
Never	Sometimes	Often	Always

5. Can recover quickly from episodes of upset or distress (for example, does not pout or remain sullen, anxious or, sad after emotionally distressing events).

1	2	3	4
Never	Sometimes	Often	Always

6. Is easily frustrated.

1	2	3	4
Never	Sometimes	Often	Always

7. Responds positively to neutral or friendly overtures by peers.

1	2	3	4
Never	Sometimes	Often	Always

8. Is prone to angry outbursts/tantrums easily.

1	2	3	4
Never	Sometimes	Often	Always

9. Is able to delay gratification.

1	2	3	4
Never	Sometimes	Often	Always

10. Takes pleasure in the distress of others (for example, laughs when another person gets hurt or punished: enjoys teasing others).

1	2	3	4
Never	Sometimes	Often	Always

11. Can modulate excitement in emotionally arousing situations (for example, does not get 'carried away' in high energy play situations, or overly excited in inappropriate contexts).

1	2	3	4
Never	Sometimes	Often	Always

12. Is whiny or clingy with adults.

1	2	3	4
Never	Sometimes	Often	Always

13. Is prone to disruptive outbursts of energy or exuberance.

1	2	3	4
Never	Sometimes	Often	Always

14. Responds angrily to limit-setting by adults.

1	2	3	4
Never	Sometimes	Often	Always

15. Can say when s/he is feeling sad, angry or mad, fearful or afraid.

1	2	3	4
Never	Sometimes	Often	Always

16. Seems sad or listless.

1	2	3	4
Never	Sometimes	Often	Always

17. Is overly exuberant/excitable when attempting to engage others in play.

1	2	3	4
Never	Sometimes	Often	Always

18. Displays flat affect/emotion (for example, expression is vacant and unexpressive; child seems emotionally absent).

1	2	3	4
Never	Sometimes	Often	Always

19. Responds negatively to neutral or friendly overtures by peers (for example, speaks in an angry tone of voice; or responds angrily).

1	2	3	4
Never	Sometimes	Often	Always

20. Is impulsive (responds quickly without thinking).

1	2	3	4
Never	Sometimes	Often	Always

21. Is empathic towards others; shows concern or sadness when others are upset or distressed.

1	2	3	4
Never	Sometimes	Often	Always

22. Displays excessive energy or excitement that others find intrusive or disruptive.

1	2	3	4
Never	Sometimes	Often	Always

23. Displays appropriate negative emotion (for example, anger, fear, frustration, distress) in response to hostile, aggressive, or intrusive acts by peers.

1	2	3	4
Never	Sometimes	Often	Always

24. Displays negative emotion when attempting to engage others in play.

1	2	3	4
Never	Sometimes	Often	Always

ID# _____

PEMS: Sadness

1. I can control my crying and being upset.	Hardly ever 1	Sometimes 2	Often 3
2. I hold my sad feelings in.	Hardly ever 1	Sometimes 2	Often 3
3. I stay calm and don't let sad things get to me.	Hardly ever 1	Sometimes 2	Often 3
4. I complain/fuss about what's making me sad.	Hardly ever 1	Sometimes 2	Often 3
5. I hide my sadness.	Hardly ever 1	Sometimes 2	Often 3
6. I do something totally different until I calm down.	Hardly ever 1	Sometimes 2	Often 3
7. I get sad but don't show it.	Hardly ever 1	Sometimes 2	Often 3
8. I can stop myself from losing control of my sad feelings.	Hardly ever 1	Sometimes 2	Often 3
9. I cry and carry on when I'm sad.	Hardly ever 1	Sometimes 2	Often 3
10. I try to calmly deal with what is making me sad.	Hardly ever 1	Sometimes 2	Often 3
11. I do things like mope around when I'm sad.	Hardly ever 1	Sometimes 2	Often 3
12. I'm afraid to show my sadness.	Hardly ever 1	Sometimes 2	Often 3

ID# _____

PEMS: Anger

1. When I'm feeling mad, I can control my temper.	Hardly ever 1	Sometimes 2	Often 3
2. I hold my anger in.	Hardly ever 1	Sometimes 2	Often 3
3. I stay calm and keep my cool when I'm feeling mad.	Hardly ever 1	Sometimes 2	Often 3
4. I do things like slam doors when I'm mad.	Hardly ever 1	Sometimes 2	Often 3
5. I hide my anger.	Hardly ever 1	Sometimes 2	Often 3
6. I confront whatever it is that makes me very angry.	Hardly ever 1	Sometimes 2	Often 3
7. I get mad but don't show it.	Hardly ever 1	Sometimes 2	Often 3
8. I can stop myself from losing my temper.	Hardly ever 1	Sometimes 2	Often 3
9. I say mean things when I'm mad.	Hardly ever 1	Sometimes 2	Often 3
10. I try to calmly deal settle the problem.	Hardly ever 1	Sometimes 2	Often 3
11. I'm afraid to show my anger.	Hardly ever 1	Sometimes 2	Often 3

ID# _____

PEMS: Worried

1. I keep myself from losing control of my worried feelings.	Hardly ever 1	Sometimes 2	Often 3
2. I show it when I am worried.	Hardly ever 1	Sometimes 2	Often 3
3. I hold my worried feelings in.	Hardly ever 1	Sometimes 2	Often 3
4. I talk to someone until I feel better when I'm feeling worried.	Hardly ever 1	Sometimes 2	Often 3
5. I do things like cry and carry on when I'm worried.	Hardly ever 1	Sometimes 2	Often 3
6. I hide my worried feelings.	Hardly ever 1	Sometimes 2	Often 3
7. I stay calm when I am feeling worried.	Hardly ever 1	Sometimes 2	Often 3
8. I avoid whatever it is that makes me feel very worried.	Hardly ever 1	Sometimes 2	Often 3
9. I get worried but I don't show it.	Hardly ever 1	Sometimes 2	Often 3
10. When I feel worried, I do something totally different until I calm down.	Hardly ever 1	Sometimes 2	Often 3
11. I keep complaining about how worried I am.	Hardly ever 1	Sometimes 2	Often 3
12. I can stop myself from acting really worried.	Hardly ever 1	Sometimes 2	Often 3
13. I try to calmly settle the problem when I feel worried.	Hardly ever 1	Sometimes 2	Often 3
14. I cry and carry on when I'm worried.	Hardly ever 1	Sometimes 2	Often 3
15. I'm afraid to show my worried feelings.	Hardly ever 1	Sometimes 2	Often 3

ID# _____

EES

1. I don't show my feelings to other people.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

2. Even when I have strong feelings on the inside, I don't show them on the outside.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

3. Other people think I am very emotional.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

4. People can tell how I feel.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

5. I keep my feelings to myself.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

6. It isn't easy for other people to tell how I'm feeling.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

7. I show my feelings to other people.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

8. People think I am an unemotional person.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

9. I don't like to let other people see how I'm feeling.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

10. I can't hide the way I'm feeling.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

11. I don't show my feelings very much.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

12. People often think nothing bothers me.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

13. I think its ok to cry in front of other people.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

14. Even when I have strong feelings, I keep them inside.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

15. I think that I usually show how I feel.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

16. The way I feel inside is different from how other people think I feel.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

17. I hold my feelings in.

1	2	3	4
Never True	Sometimes True	Usually True	Always True

ID# _____

FEQ

Instructions: This is a questionnaire about family expressiveness. We'd like to know more about the degree of expressiveness shown in different families. Therefore, we'd like you to tell us about the frequency of expression in your family. By frequency we mean, "How often does this situation occur in your family in comparison to other families?" Circle a number on the rating scale from 1 (not at all frequently in my family to 9 (very frequently in my family) that indicates how frequently that activity occurs. Some items may be difficult to judge, but it is important to answer every item. Try to respond quickly but not randomly.

1. Showing forgiveness to someone who broke a favorite possession.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

2. Thanking family members for something they have done.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

3. Exclaiming over a beautiful day.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

4. Showing contempt (disgust) for another's actions.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

5. Expressing dissatisfaction with someone else's behavior.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

6. Praising someone for good work.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

7. Expressing anger at someone else's carelessness.

1	2	3	4	5	6	7	8	9
not at all			somewhat frequently			very frequently		
in my family			in my family			in my family		

8. Sulking over unfair treatment by a family member.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

9. Blaming one another for family troubles.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

10. Crying after an unpleasant disagreement.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

11. Putting down other people's interests.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

12. Showing dislike for someone.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

13. Seeking approval for an action.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

14. Expressing embarrassment over stupid mistake.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

15. Going to pieces when tension builds up.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

16. Expressing exhilaration/excitement after an unexpected triumph.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

17. Expressing excitement over one's future plans.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

18. Demonstrating admiration.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

19. Expressing sorrow when a pet dies.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

20. Expressing disappointment over something that didn't work out.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

21. Telling someone how nice they look.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

22. Expressing sympathy for someone's troubles.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

23. Expressing deep affection or love for someone.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

24. Quarreling with a family member.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

25. Crying when someone leaves.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

26. Spontaneously hugging a family member.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

27. Expressing momentary anger over a trivial irritation.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

28. Expressing concern for the success of other family members.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

29. Apologizing for being late.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

30. Offering to do somebody a favor.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

31. Snuggling up to a family member.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

32. Crying for being punished.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

33. Trying to cheer up someone who is sad.

1	2	3	4	5	6	7	8	9
not at all in my family				somewhat frequently in my family			very frequently in my family	

34. Telling a family member how hurt you are.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

35. Telling family members how happy you are.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

36. Threatening someone.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

37. Criticizing someone for being late.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

38. Expressing gratitude for a favor.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

39. Surprising someone with a little gift or favor.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

40. Saying "I'm sorry" when one realizes one was wrong.

1	2	3	4	5	6	7	8	9
not at all				somewhat frequently				very frequently
in my family				in my family				in my family

ID# _____

FES-Control

1. Family members are rarely ordered around.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
2. There are very few rules to follow in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
3. There is one family member who makes most of the decisions.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
4. There are set ways of doing things at home.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
5. There is a strong emphasis on following rules in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
6. Everyone has an equal say in family decisions.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
7. We can do whatever we want to in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
8. Rules are pretty inflexible in our household.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	
9. You can't get away with much in our family.

1	2	3	4	5
Not at all			Frequently in	
in my family			my family	

ID# _____

FES-Expressiveness

1. Family members often keep their feelings to themselves.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
2. We say anything we want to around home.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
3. It's hard to "blow off steam" at home without upsetting someone.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
4. We tell each other about our personal problems.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
5. If we feel like doing something on the spur of the moment we often just pick up and go.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
6. Someone usually gets upset if you complain in our family.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
7. Money and paying bills is openly talked about in our family.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
8. We are usually careful about what we say to each other.

1	2	3	4	5
Not at all				Frequently in
in my family				my family
9. There are a lot of spontaneous discussions in our family.

1	2	3	4	5
Not at all				Frequently in
in my family				my family

ID# _____

PACES

Instructions: In the following multiple-choice questions, please circle only the one response that seems most similar to what you would be likely to do in the situation described.

1. If my school-age child is bragging about her skills in some activity to another child, proceeds to goof up and hurt herself, and then comes to me for aid, I would:
 - a. tell her that she looks foolish for being so upset after bragging
 - b. attend to her a little but with some annoyance
 - c. comfort her about the injury and ignore the bragging
 - d. give comfort but also mildly chide her about the bragging

2. If my school-age child receives an undesirable birthday gift from a family friend or relative and looks obviously disappointed, even annoyed, after opening it in the presence of the person giving the gift, I would:
 - a. be annoyed with my child for being rude
 - b. look the other way
 - c. remind my child to say thank you
 - d. say that it was really too bad that she did not get what she wanted

3. If my school-age child is very shy around adults who come to visit our home and prefers to stay in the bedroom during the visit, I would:
 - a. let my child do as she pleases
 - b. reproach my child about behaving like a mouse
 - c. tell my child that she must stay in the living room and visit with the guest
 - d. remind my child to be polite

4. If during a bus ride my school-age child continues to look at someone who's head is covered with scar tissue, I would:
 - a. nudge my child and tell her to mind her own business
 - b. permit the looking
 - c. tell my child it is impolite to stare
 - d. ask what she is doing

5. If my school-age child starts to giggle during a funeral, I would:
 - a. ignore it
 - b. smile understandingly at my child
 - c. frown at my child
 - d. frown and also ask my child to be quiet

6. If my school-age child is afraid of injections and becomes shaky while waiting for her turn for a shot, I would:
 - a. comfort her before and after the shot
 - b. tell her not to embarrass me by crying while getting a shot
 - c. tell her to try to get more under control
 - d. tell her that the pain lies more in the fear than in the actual shot

7. If my school-age child shouts at me in anger after I accidentally throw away her favorite comic book, I would:
 - a. apologize
 - b. give her a piece of my mind about the disrespect shown to me and tell her to go to her room
 - c. apologize but tell her to stop yelling at me
 - d. send her to her room to cool off, then apologize later

8. If my school-age child carelessly loses some prized (but inexpensive) possession and reacts with tears, I would:
 - a. tell her not to get so upset about it
 - b. tell her how unhappy I am about the loss, too
 - c. remind her to be more careful next time
 - d. say that she should not feel so sorry for herself because she was so careless as to lose it in the first place

9. If my school-age child is about to appear on a local television program and inquiries with visible nervousness about how many people will be watching the show, I would:
 - a. say to get herself under control and try not to show her nervousness
 - b. reassure and comfort my child
 - c. suggest thinking about something relaxing so that the nervousness will not be so obvious
 - d. tell my child to get a grip on herself if she wants a good performance

10. If my school-age child attends a family birthday dinner in a nice restaurant and excitedly jumps out of his chair and shouts, "Happy Birthday!" I would":
 - a. smile but also tell my child to try not to act so excited
 - b. say nothing
 - c. smile understandingly about my child's feeling so happy
 - d. say that proper restaurant behavior requires sitting down and speaking quietly, despite feeling happy and excited

11. If my school-age child becomes very angry at her sibling and begins to shout and stomp around the room, and if I am nearby, I would:
 - a. tell my child to speak civilly and apologize as well
 - b. not intervene
 - c. try to find out what the problem was all about
 - d. tell my child to cool down

12. If my school-age child has some unfounded fear (e.g., of the dark or of dogs) and gets panicky in the feared situation, I would:
 - a. reach out and touch and assure her that I was there to help
 - b. give assurance that I was there to help but that it was time for her to realize that she had no real reason to be afraid
 - c. tell the child that she is being silly and will embarrass herself someday by being so afraid
 - d. tell her to control herself better so that she will feel less afraid

13. If my school-age child is teased and called names by another youngster on the way home from school and arrives home trembling and tearful, I would:
 - a. say, "If you don't want to be called a sissy, scaredy-cat, or whatever, you should stick up more for yourself"
 - b. feel concerned myself and also comfort and reassure my child
 - c. tell my child to keep a stiff upper lip and not let the other child see her so upset
 - d. reassure my child but also say that showing one's fear to others sometimes causes problems

14. If my school-age child rather obviously watches a mentally retarded person as we ride the bus, I would:
 - a. permit the staring
 - b. nudge my child and say to mind her own business
 - c. ask what she is doing
 - d. tell my child that it is impolite to stare

15. If my school-age child wins a race in a track meet and after receiving everyone's congratulations continues to jump gleefully and exclaim over the victory, I would:
 - a. say nothing
 - b. smile approvingly and offer more congratulations
 - c. frown at the display and say that real winners do not keep "crowing" (showing off)
 - d. suggest that she is overdoing it and to calm down

16. If my school-age child appears to be quite afraid during an amusement park ride and other accompanying youngsters do not seem to be afraid, I would:
 - a. tell my child to shape up or she will be teased by the other kids
 - b. comfort and reassure my child
 - c. let her cope with the fear without my intervening
 - d. tell my child to get better control of herself

17. If my school-age child is in a recital (e.g., dance, music, or gymnastics) and during a solo makes an error and proceeds to look as if on the verge of tears, afterward I would:
 - a. say the performance was fine, but it would have been better if she had not looked so upset about the mistake
 - b. compliment the performance and say nothing about the mistake
 - c. compliment the performance and say that the concern on her face after the mistake showed the audience that she really wanted to do well
 - d. say that no one would have paid attention to the mistake if she had not acted so babyish about it

18. If my school-age child comes home from school very angry about something the teacher has done and proceeds to slam doors, mutter dire threats, and scowl fiercely, I would:
 - a. reprimand my child for being so out of control and behaving inappropriately in the house
 - b. ask what happened
 - c. tell my child that her behavior is disruptive
 - d. tell my child that I just hope that she doesn't act this way at school

19. If my school-age child is staring with interest at a woman breast-feeding her baby, I would:
 - a. permit the looking
 - b. nudge my child and say to mind her own business
 - c. ask my child what she is doing
 - d. tell my child that staring is impolite

20. If my school-age child mutters "yecchh" and grimaces (makes a face) when grandma serves some of the casserole on her plate, I would:
 - a. remind my child to be more polite
 - b. tell my child to apologize and shape up immediately or leave the table
 - c. smile rather nervously and ask my child, "Well, what do you think it is?"
 - d. frown at my child while asking her to apologize for the poor manners

ID# _____

Symptom Checklist-90-Revised (SCL-90-R)

Below is a list of problems people sometimes have. Please read each one carefully, and circle the response that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one response for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

1. Headaches

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

2. Nervousness or shakiness inside

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

3. Repeated unpleasant thoughts that won't leave your mind

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

4. Faintness or dizziness

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

5. Loss of sexual interest or pleasure

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

6. Feeling critical of others

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

7. The idea that someone else can control your thoughts

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

8. Feeling others are to blame for most of your troubles

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

9. Trouble remembering things

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

10. Worried about sloppiness or carelessness
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
11. Feeling easily annoyed or irritated
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
12. Pains in heart or chest
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
13. Feeling afraid in open spaces or on the streets
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
14. Feeling low in energy or slowed down
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
15. Thoughts of ending your life
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
16. Hearing voices that other people do not hear
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
17. Trembling
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
18. Feeling that most people cannot be trusted
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
19. Poor appetite
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
20. Crying easily
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |

21. Feeling shy or uneasy with the opposite sex
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
22. Feelings of being trapped or caught
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
23. Suddenly scared for no reason
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
24. Temper outbursts that you could not control
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
25. Feeling afraid to go out of your house alone
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
26. Blaming yourself for things
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
27. Pains in lower back
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
28. Feeling blocked in getting things done
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
29. Feeling lonely
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
30. Feeling blue
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
31. Worrying too much about things
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |

32. Feeling no interest in things
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
33. Feeling fearful
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
34. Your feelings being easily hurt
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
35. Other people being aware of your private thoughts
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
36. Feeling others do not understand you or are unsympathetic
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
37. Feeling that people are unfriendly or dislike you
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
38. Having to do things very slowly to insure correctness
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
39. Heart pounding or racing
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
40. Nausea or upset stomach
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
41. Feeling inferior to others
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
42. Soreness of your muscles
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |

43. Feeling that you are watched or talked about by others
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
44. Trouble falling asleep
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
45. Hot or cold spells
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
46. Having to avoid certain things, places, or activities because they frighten you
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
47. Feeling afraid to travel on buses, subways, or trains
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
48. Trouble getting your breath
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
49. Hot or cold spells
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
50. Having to avoid certain things, places, or activities because they frighten you
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
51. Your mind going blank
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
52. Numbness or tingling in parts of your body
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
53. A lump in your throat
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |

54. Feeling hopeless about the future

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

55. Trouble concentrating

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

56. Feeling weak in parts of your body

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

57. Feeling tense or keyed up

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

58. Heavy feelings in your arms or legs

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

59. Thoughts of death or dying

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

60. Overeating

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

61. Feeling uneasy when people are watching or talking about you

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

62. Having thoughts that are not your own

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

63. Having urges to beat, injure, or harm someone

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

64. Awakening in the early morning

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

65. Having to repeat the same actions such as touching, counting, or washing
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
66. Sleep that is restless or disturbed
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
67. Having urges to break or smash things
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
68. Having ideas or beliefs that others do not share
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
69. Feeling very self-conscious with others
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
70. Feeling uneasy in crowds, such as shopping or at a movie
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
71. Feeling everything is an effort
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
72. Spells of terror or panic
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
73. Feeling uncomfortable about eating or drinking in public
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
74. Getting into frequent arguments
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
75. Feeling nervous when you are left alone
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |

76. Others not giving you proper credit for your achievements
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
77. Feeling lonely even when you are with people
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
78. Feeling so restless you couldn't sit still
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
79. Feelings of worthlessness
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
80. The feeling that something bad is going to happen to you
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
81. Shouting or throwing things
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
82. Feeling afraid you will faint in public
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
83. Feeling that people will take advantage of you if you let them
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
84. Having thoughts about sex that bother you a lot
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
85. The idea that you should be punished for your sins
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |
86. Thoughts and images of a frightening nature
- | | | | | |
|------------|--------------|------------|-------------|-----------|
| 0 | 1 | 2 | 3 | 4 |
| Not at all | A Little Bit | Moderately | Quite a bit | Extremely |

87. The idea that something serious is wrong with your body

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

88. Never feeling close to another person

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

89. Feelings of guilt

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

90. The idea that something is wrong with your mind.

0	1	2	3	4
Not at all	A Little Bit	Moderately	Quite a bit	Extremely

ID# _____

Vocabulary

Mothers/guardians will be asked what the following words mean according to instructions specified in the WAIS-III manual. Discontinue after 6 consecutive failures. Score of 0 or 1 on item 4 or 5, reverse sequence until two consecutive perfect scores are obtained.

- | | Score |
|----------------|--------------|
| 1. Bed | |
| 2. Ship | |
| 3. Penny | |
| 4. Winter | |
| 5. Breakfast | |
| 6. Repair | |
| 7. Assemble | |
| 8. Yesterday | |
| 9. Terminate | |
| 10. Consume | |
| 11. Sentence | |
| 12. Confide | |
| 13. Remorse | |
| 14. Ponder | |
| 15. Compassion | |
| 16. Tranquil | |

17.Sanctuary

18.Designate

19.Reluctant

20.Colony

21.Generate

22.Ballad

23.Pout

24.Plagiarize

25.Diverse

26.Evolve

27.Tangible

28.Fortitude

29.Epic

30.Audacious

31.Ominous

32.Encumber

33.Tirade

Total Score _____

Appendix D

Coding Instructions

1. Mother-Child Interaction Task
2. Emotion Regulation Interview
 - (a) Child's affect management strategies and goals
 - (b) Maternal affect management strategies and goals

Coding Instructions for the Mother-Child Interaction Task

1. Length of Discussion

Total length of discussion.

2. Emotion Words

Mother

A. Frequency of use of negative emotion-related words:

e.g., sad, down, disappointed, upset, mad, angry, scared, afraid, ashamed, embarrassed

B. Frequency of use of positive emotion-related words:

e.g., happy, joyful, good, proud, excited, cheerful

Child

A. Frequency of use of negative emotion-related words:

e.g., sad, down, disappointed, upset, mad, angry, scared, afraid, ashamed, embarrassed

B. Frequency of use of positive emotion-related words:

e.g., happy, joyful, good, proud, excited, cheerful

3. Content of discussion

Mother

A. Presence or absence of explanatory discussion; defined as any discussion relevant to the causes, consequences of emotion

Child

A. Presence or absence of explanatory discussion; defined as any discussion relevant to the causes or consequences

4. Facilitation**Mother**

- A. Presence or absence of positive encouragement- mother encourages the child discuss emotion-related experiences.
- B. Presence or absence of discouragement-mother discourages child's emotion-related discussion by changing the topic, ignoring, or belittling the child

Coding Instructions for the ERI-C

1. **Management Decisions**

Question #7: If this situation really happened to you, what would you do?
(Query 2 times).

Which of these things would you **most likely** do? Code the most likely response.

Question #9: If this situation really happened to you, what would your mom tell you to do?

(Query 2 times). Which one would she most likely tell you to do? Code the most likely response.

- A. **Problem-Solving Strategy:** The child attempts cognitive or behavioral strategies to constructively manage his or her feelings or indicates his/her mother would encourage him/her to use these strategies (e.g., “If I was worried about not making the soccer team, I would just try as hard as I could and if I didn’t make it this year, I could try again next year,” or “My mom would just tell me to try as hard as I could and if I didn’t make the team this year, I could try again next year.”).
- B. **Support-Seeking:** The child attempts to seek outside help to cope with his or her feelings or the child indicates that his/her mother would suggest he/she use support-seeking strategies (e.g., “I would go tell the camp counselor if I was worried that I didn’t know anyone else at camp,” or “My mom would tell me to tell the camp counselor if I was worried that I didn’t know anyone else at camp.”).
- C. **Avoidance:** The child attempts to avoid or distance him- or herself from the situation or indicates that his/her mother would suggest he/she use avoidance strategies (e.g., “If I was worried because my friend could not go to camp with me and I didn’t know anyone else who was going, then I wouldn’t go either,” or “If I was worried because my friend could not go to camp with me and I didn’t know anyone else who was going, then my mom would tell me not to go either.”).
- D. **Externalizing:** The child endorses revengeful or other behaviorally or relationally aggressive strategies or indicates that his/her mother would suggest the use of externalizing strategies (e.g., “If another kid bumped into me and knocked me out of line while I was waiting for the bus to come, I would go ahead and push her back,” or “If another kid bumped into me and knocked me out of line while I was waiting for the bus to come, my mom would tell me to just push her back.”).

- E. Other Maladaptive: Any strategy that does not fit into any of the above categories, but is clearly a maladaptive response (e.g., “If I was worried about going to camp because I didn’t know any of the other kids there, I would stay home and tell myself what a baby I am,” or “If I was worried about going to camp because I didn’t know any of the other kids there, my mom would tell me I should stay home and then think about what a baby I am.”).
- D. Other - the response does not fit into any of the above categories
- E. Unscorable - response is unscorable because the child indicates he/she does not know

2. Goals for Management Decision

Question #8: (in response to the child’s emotion management strategy), Why would you do that?

- A. Relational Goal: The response indicates an attempt to avoid negative consequences (e.g., belittling, punishment).
- B. Rule-Oriented Goal: The response demonstrates adherence to cultural expectations (e.g., “because that’s what you *should* do when you’re feeling sad.”)
- C. Prosocial: The response indicates an attempt to protect another’s feelings.
- D. Self-Focused: The response indicates a need to make one self feel better.
- E. Other - the response does not fit into any of the above categories
- F. Unscorable - response is unscorable because the child indicates he/she does not know

Coding Instructions for the ERI-P

1. **Management Decisions**

Question #7: What would you tell your son to do in this situation?

Question #9: What would your son most likely do in this situation?

- A. **Problem-Solving Strategy:** The mother encourages cognitive or behavioral strategies to constructively manage his or her feelings (or the mother believes the child will use cognitive or behavioral strategies).
- B. **Support-Seeking:** The mother encourages her child to seek outside help to cope with his or her feelings (or the mother believes her child will seek outside help).
- C. **Avoidance:** The mother encourages her child to avoid or distance him- or herself from the situation (or the mother believes her child will attempt to avoid the situation).
- D. **Externalizing:** The mother encourages revengeful or other behaviorally or relationally aggressive strategies (or the mother believes her child will engage in externalizing strategies).
- E. **Other Maladaptive:** Any strategy that does not fit into any of the above categories, but is clearly a maladaptive response.
- F. **Other -** the response does not fit into any of the above categories
- G. **Unscorable -** response is unscorable because the child indicates he/she does not know

2. **Goals for Management Decision**

Question #8: (in response to the child's emotion management strategy), Why do you think she/he would do that?

- A. **Relational Goal:** The response indicates an attempt to avoid negative consequences (e.g., belittling, punishment).
- B. **Rule-Oriented Goal:** The response demonstrates adherence to cultural expectations (e.g., "because that's what you *should* do when you're feeling sad.")
- C. **Prosocial:** The response indicates an attempt to protect another's feelings.

- D. Self-Focused: The response indicates a need to make one self feel better.
- E. Other - the response does not fit into any of the above categories
- F. Unscorable - response is unscorable because the child indicates he/she does not know

Appendix E

Diagnostic Criteria for Anxiety Disorders*

1. Separation Anxiety Disorder
 2. Generalized Anxiety Disorder
(formerly Overanxious Disorder in children)
 3. Specific Phobia
(formerly Simple Phobia)
 4. Social Phobia
(Social Anxiety Disorder)
 5. Panic Disorder
 6. Obsessive-Compulsive Disorder
 7. Posttraumatic Stress Disorder
-

* American Psychiatric Association, 1994

Diagnostic criteria for Separation Anxiety Disorder

- A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
- (1) recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
 - (2) persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
 - (3) persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
 - (4) persistent reluctance or refusal to go to school or elsewhere because of fear of separation
 - (5) persistently and excessively fearful or reluctant to be alone or without significant adults in other settings
 - (6) persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
 - (7) repeated nightmares involving the theme of separation
 - (8) repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder, and in adolescents and adults, is not better accounted for by Panic Disorder without Agoraphobia.

Specify if:

Early Onset: if onset occurs before age 6 years.

Diagnostic criteria for Generalized Anxiety Disorder
(formerly Overanxious Disorder in children)

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety or worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required for children.
 - (1) restlessness or feeling keyed up or on edge
 - (2) being easily fatigued
 - (3) difficulty concentrating or mind going blank
 - (4) irritability
 - (5) muscle tension
 - (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas or functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Diagnostic criteria for Specific Phobia
(formerly simple phobia)

- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving and injection, seeing blood).
- B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. If the individual is under age 18 years, the duration is at least 6 months.
- G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

Specify type:

Animal Type

Natural Environment Type (e.g., heights, storms, water)

Blood-Injection-Injury Type

Situational Type (e.g., airplanes, elevators, enclosed places)

Other Type (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

Diagnostic criteria for Social Phobia
(Social Anxiety Disorder)

- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings not just in interaction with adults.
- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- C. The person recognized that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Specify if:

- Generalized: if the fears include most social situation (also consider the additional diagnosis of Avoidant Personality Disorder)

Diagnostic criteria for Panic Disorder Without Agoraphobia

- A. Both (1) and (2):
 - (1) recurrent unexpected Panic Attacks (see below)
 - (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
 - (a) persistent concern about having additional attacks
 - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)
 - (c) a significant change in behavior related to the attacks
- B. Absence of Agoraphobia
- C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
- D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Criteria for Panic Attack

Note: A Panic Attack is not a codable disorder. Code the specific diagnosis in which the Panic Attack occurs.

A discrete period of intense discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- (1) palpitations, pounding heart, or accelerated heart rate
- (2) sweating
- (3) trembling or shaking
- (4) sensations of shortness of breath or smothering
- (5) feeling of choking
- (6) chest pain or discomfort
- (7) nausea or abdominal distress
- (8) feeling dizzy, unsteady, lightheaded, or faint
- (9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
- (10) fear of losing control or going crazy
- (11) fear of dying
- (12) paresthesias (numbness or tingling sensations)
- (13) chills or hot flashes

Diagnostic criteria for Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

- (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
- (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems
- (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
- (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

- (1) repetitive behavior (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
- (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded events or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

- B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.
- C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
- D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty rumination in the presence of Major Depressive Disorder).

- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Posttraumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, traum-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
 - (2) irritability or outbursts of anger
 - (3) difficulty concentrating
 - (4) hypervigilance
 - (5) exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With delayed onset: if onset of symptoms is at least 6 months after the stressor

BIOGRAPHY OF THE AUTHOR

Cynthia Suveg was born in Phillipsburg, New Jersey on March 19, 1972. She was raised in Weatherly, Pennsylvania and graduated from Weatherly Area High School in 1990. She attended The Pennsylvania State University and graduated in 1998 with a Bachelor of Science degree in Psychology. She entered the Clinical Psychology graduate program, Developmental-Clinical Track, at The University of Maine, in August of 1998. During her graduate training, Cynthia presented several peer-reviewed posters at national conferences and published one manuscript. She is a member of several professional societies, including the Society for Research in Child Development, Association for the Advancement of Behavior Therapy, and the American Psychological Association.

After receiving her degree, Cynthia will be working as a Postdoctoral Research Assistant in the Department of Psychology at Temple University. Cynthia is a candidate for the Doctor of Philosophy degree in Psychology from The University of Maine in August, 2003.