Childhood Anxiety: How Schools Identify, Assess, Provide Resources to and Refer Students with Anxiety

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ABSTRACT

Anxiety disorders are one of the most common reasons children are referred to a mental health professional (Tomb & Hunter, 2004). Between 3% and 20% of children suffer from anxiety symptoms or disorders. Anxiety disorders are defined as unreasonable fear often accompanied by physiological signs that exceed what is considered typical and age appropriate. Children diagnosed with anxiety disorders are more likely to have depression, trouble paying attention, lower self-esteem, and a difficult time maintaining friendships and developing positive social behaviors. McLoone, Hudson, and Rapee (2006) stated that many children who suffer from anxiety are not identified and therefore their symptoms often go untreated. Providing appropriate services for children who suffer from anxiety is critical to their success in school and therefore should be a high priority for school counselors, school psychologist and other school professionals.

This literature review will analyze how schools identify students who have symptoms of anxiety, how students are assessed, what resources are available to students and parents and how students are referred for community services.

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Chapter I: Introduction

Anxiety disorders are one of the most common reasons children are referred to a mental health professional (Tomb & Hunter, 2004). Between 3% and 20% of children suffer from anxiety symptoms or disorders. According to McLoone, Hudson and Rapee (2006), anxiety may affect at least 10% of children and adolescents. Anxiety disorders are defined as unreasonable fear, often accompanied by physiological signs that exceed what is considered typical and age appropriate. Children diagnosed with anxiety disorders are more likely to have depression, trouble paying attention, lower self-esteem, and a difficult time maintaining friendships and developing positive social behaviors. Children with anxiety also tend to have anxiety and other mental health issues when they become adults. McLoone, Hudson, and Rapee (2006) stated that many children who suffer from anxiety are not identified and therefore their symptoms often go untreated.

Anxiety in children can manifest itself in a variety of ways. Some behaviors related to anxiety may include: having difficulty leaving the car and going into the school building, missing school on a regular basis, visiting the school nurse complaining of not feeling well, and/or having trouble sharing their knowledge in class participation or on tests (Walkup & Ginsburg, 2002). Walkup and Ginsburg (2002) stated that it is important for parents and professionals to understand different treatment options and know which ones have been successful. Therefore, identifying children who suffer from anxiety is important.

Causes of anxiety have been the basis for debate. The possible causes as seen in one article are genetics, parenting, social issues, and trauma (Moore, Whaley, & Sigman, 2004). Moore, Whaley, and Sigman (2004) stated that studies have shown certain types

of parenting styles relate to higher anxiety levels in at least one family member. Some of the parenting behaviors that may contribute to the development of anxiety in children include over control, low warmth or high criticism, and parental worrying. Researchers have studied the interactions between children and their mothers and the variables that may affect the child's level of anxiety. Anxiety rates have also been looked at in relationship to gender, age, and socioeconomic status (Strauss, 1990).

With the high rate of anxiety in children, it is very important that professionals who are involved with children on a daily basis have the skills to recognize, assess, treat, and refer children appropriately (McLoone, Hudson, & Rapee, 2006). Schools have a variety of options available to help identify children with anxiety. However, the tools utilized to identify students with anxiety seem to be dependent on the school's resources, such as finances and available staff, the prevention or intervention focus, and the abilities of those who are doing the assessment.

The ability to identify and treat children with anxiety is crucial to the child's school performance and social development. Wood (2006) explained that if a child's anxiety is reduced, s/he may be able to participate more fully in school and therefore improve her/his school performance. There may also be some improvement of social development. Parents, teachers, and school counselors need to be aware of the possibility that anxiety may be affecting a child's performance both academically and socially. Being aware of and able to identify anxiety as a possible issue will allow a child to get the treatment s/he needs to be successful throughout her/his life.

Services available to a child suffering from anxiety include in-school counseling and psychotherapy. Cognitive Behavioral Therapy (CBT) has been shown to be effective

in decreasing anxiety in children (Bernstein, Layne, Egan, & Tennison, 2005). CBT has been successful when used individually, in groups, with parents involved, and with siblings involved. According to Bernstein et al. (2005), there was a significant increase in effectiveness of CBT with parental involvement. This finding demonstrates the importance of working as a team to help and support children within the educational system.

Parents with a child, who has anxiety often feel isolated, have difficulty dealing with their child, and feel like they need more information about helping their child (Ruffolo, Kuhm, & Evans, 2006). Developing a relationship between parents and school professionals may provide this support to the parents and increase the likelihood a child with anxiety will be identified and receive appropriate and effective treatment. This relationship will also help parents feel more in control and able to help their child more effectively.

The focus of this paper will include three types of anxiety disorders: separation anxiety disorder, social phobia, and generalized anxiety disorder. Separation anxiety disorder is seen when a parent or primary caregiver drops the child off at school and the child refuses to go to school and may cry throughout the drop-off time period (McLoone, Hudson, & Rapee, 2006). Some children may also cry at different times throughout the day. This type of behavior usually decreases as a child gets older. Social phobia is a fear of social situations where a child may fear s/he will become the center of attention for a negative reason. A child with social phobia worries about being embarrassed and, as a result, does not want to participate in social events. Generalized anxiety disorder is characterized by a child's display of extreme worry about many different aspects of

her/his life. A child with generalized anxiety disorder worries about such things as how s/he does in school, health issues, and/or family issues.

Statement of the Problem

Childhood anxiety is a reality for up to 20% of the students in the educational system today (McLoone, Hudson & Rapee, 2006). Childhood anxiety can lead to other social and academic problems throughout childhood and into adulthood. Identifying, assessing, treating, and referring students for anxiety as early as possible are important to help students achieve success in the classroom and in life.

Purpose Statement

The purpose of this paper is to investigate how school staff identify children with anxiety disorders at the elementary school level and examine what services are provided to children and their families. A definition of anxiety will be established and the characteristics and symptoms children with anxiety may experience will be discussed. Next, a discussion of who is responsible for identifying children and making referrals will be presented. Finally an in-depth look at the most effective treatment strategies for helping children cope with their anxiety in order to be successful academically will be researched.

Research Questions

The following questions will be addressed in this literature review:

1. What types of anxiety disorders are prevalent among elementary school children?
2. What characteristics do children with anxiety display?
3. What is the origin(s) of anxiety disorders in children?

4. Who is responsible for identifying children who may have anxiety symptoms?

5. What resources are available to children through the educational system?

6. Who is responsible for providing children/families with resource information?

7. How do school professionals and parents work together to help a child cope with her/his anxiety?

Definition of Terms

There are several terms that need to be defined for reader clarification:

General Anxiety disorder: abnormal trepidation and fear often accompanied by physiological signs (McLoone, Hudson, & Rapee, 2006).

Separation anxiety disorder: extreme levels of anxiety when separated or going to be separated from a main attachment figure, most commonly the child's parents (McLoone, Hudson, & Rapee, 2006).

Social phobia: fear of social situations and frequently avoiding situations where social behavior is needed. These social situations may include interactions with other people where the child may become the center of attention (McLoone, Hudson, & Rapee, 2006).

Assumptions

It is assumed that an exhaustive search of the current literature will be conducted. A second assumption is that the literature will not only be current, but it will also be valid and empirically based. Third, it is assumed that the research will be thoroughly and objectively examined, setting subjectivity and bias aside. However, limiting factors must be considered.

Limitations

One limitation of this research will be the lack of specific information about how school staff identifies students with anxiety and who is responsible for identifying children and finding help for those children and their parents. A second limitation to this research is the lack of longitudinal studies of children suffering from anxiety and the treatment that helps those children because the focus of anxiety in children is a relatively new area of research. All research on the topic will not be investigated. It is possible that the author's interpretations and perspective may impact the paper to some degree. Lastly, although empirical research may be sought, it may be difficult to find and outdated at times.

Chapter II: Literature Review

Introduction

Anxiety disorders are defined as unreasonable fear, often accompanied by physiological signs that exceed what is considered typical and age appropriate (McLoone, Hudson & Rapee, 2006). According to these researchers, anxiety may affect at least 10% of children and adolescents. Anxiety is related to elevated rates of depression, attention and concentration difficulties, low self-esteem, difficulty developing friendships, and displaying inappropriate social behaviors. This shows how critical it is to have people involved in the lives of children and adolescents who are prepared to recognize, assess, treat and refer children with anxiety issues.

This chapter will investigate three areas of child anxiety. The first area will examine three types of anxiety: general anxiety disorder (GAD), separation anxiety disorder (SAD), and social phobia (So Ph); as well as the causes, symptoms, and characteristics of children with these types of anxieties. The second area will look at how children are identified as having anxiety, what assessments are completed, and who is involved in the identification and assessment process. The third area will discuss what interventions are provided and referrals made on behalf of the child and her/his family.

Causes, Symptoms and Characteristics of Children with Anxiety

Childhood anxiety is very complex and may have many different causal factors related to a diagnosis (Zubrick, Silburn, Burton, & Blair, 2000). Genetic, biological, and environmental influences have all been investigated throughout history. Most research indicates that there is a positive correlation between a family history of anxiety and a child developing anxiety sometime during her/his life (Merikangas, Lieb, Wittchen, &

Avenevoli, 2003). A child is two to three times more likely to develop social anxiety disorder if her/his parents suffer from it. A child is 10 times more likely to develop generalized anxiety disorder if her/his parents suffer from the disorder. The genetic influence is there, however, researchers have not located a gene related to anxiety at this time.

Some environmental factors that may cause anxiety include, watching movies and television, social learning such as witnessing bullying on the playground or being a target of bullying, cultural norms, parental behavior and expectations, and uncontrollable and unpredictable stress (Mineka & Zinbarg, 2006). Mineka and Zinbarg (2006) suggest that a child who watches something scary in movies and on television may fear a similar situation in real life. This seems to go hand-in-hand with a child witnessing another child being bullied. A child may feel fear at the time s/he is witnessing the incident and then fear it will happen again. After a few times a child may feel the anxiety without the stimulus that caused the fear in the first place.

Cultural norms may also contribute to the development of anxiety (Mineka & Zinbarg, 2006). In some cultures a child is taught not to make eye contact, to guess what another person is feeling, and be sensitive to the individual. A child may therefore feel a sense of social anxiety disorder (SAD) when s/he is unable to follow through on the cultural norms that are expected. Palapattu, Kingery, and Ginsburg (2006), investigated the levels of anxiety among African American adolescents and found that within the African American community gender roles are more fluid and therefore male and female adolescents possess both male and female traits; meaning they both possess caring, warmth, empathy and kindness which are typically female traits, along with assertiveness

and confidence which are typically male traits. Having assertiveness and confidence seems to decrease anxiety symptoms because s/he feels more in control and able to handle the situation. The most frequent and most researched environmental factor for developing anxiety is parental behavior.

Parental behavior seems to be related to an increase of anxiety in children (Moore, Whaley, & Sigman, 2004). A mother's behavior has been predominantly studied when looking at why children develop anxiety disorders. Moore, Whaley, and Sigman (2004) stated that research has shown that anxious mothers have less warm interactions with their children and allow their children less independence when their children display anxious behavior. The parenting behaviors discussed by Moore, Whaley, and Sigman (2004) include: over control, low warmth, or high criticism. The over control behavior of a parent decreases the exposure a child has to learning situations. Therefore, a child may internalize the idea s/he is not able to handle difficult situations because mom or dad do not allow her/him to experience them. The low warmth or high criticism expresses to the child that the world is a dangerous place and when facing difficult situations s/he will not be supported and, therefore, s/he is unable to handle the situation. Feng, Shaw, and Silk (2008) explained this as parental negative control. A parent is attempting to protect the child from the feelings of anxiety when in reality the parent is depriving the child of learning to cope with the emotion.

The researchers found that a parent modeling anxious behavior can increase a child's likelihood of developing an anxiety disorder (Moore, Whaley, & Sigman, 2004). For example, a parent may worry and talk about something bad happening in front of the child and the child internalizes this fear and imitates her/his parent causing the

development of anxiety. Feng, Shaw, and Silk (2008) stated that a parent who suffers from depression and models avoidance, withdrawn, or passive behaviors may reinforce these behaviors in her/his child and increase the child's tendency to develop anxiety.

According to Palapattu, Kingery and Ginsburg (2006), the incidence of anxiety symptoms and fears are higher for females than males especially during adolescents. These researchers indicate that girls may be more susceptible to anxiety due to their hormonal changes, androgen levels in their brain and may be socialized differently meaning girls are raised to have different interests, attitudes and values related to being feminine. Boys are socialized to be assertive, confident and to be masculine. Palapattu et al. (2006) refer to this as gender role orientation and indicate that girls are socialized to express fearfulness and anxiety whereas boys are taught to confront their fears, become problem solvers, and cope with their feelings. Palapattu et al. (2006) found that anxiety levels were higher in adolescents who possessed more feminine traits such as empathy, compassion, warmth, and kindness. Therefore, anxiety levels may increase based on a person's gender role orientation instead of her/his actual gender.

Palapattu et al. (2006) discussed the relevance of self-esteem on levels of anxiety in adolescents. Self-esteem is looked at as a masculine trait along with confidence and assertiveness. The researchers indicate that levels of self-esteem may affect an individual's level of anxiety and her/his gender role orientation. If a child has high levels of self-esteem s/he may possess adaptive qualities such as effective coping strategies which would decrease her/his anxiety. Therefore, the level of anxiety a child is feeling would not depend on the child being male or female. Palapattu et al. (2006) concluded that there are gender differences in relation to anxiety symptoms. A child who is

socialized with feminine traits without self-esteem is more likely to experience anxiety symptoms. As a result, it is important for a child who possesses more feminine traits to increase or maintain her/his levels of self-esteem in order to decrease the likelihood of suffering from anxiety.

Chronic health conditions in children may contribute to anxiety symptoms. Gupta, S., Mitchell, I., Giuffre, R., and Crawford, S. (2001), researched the fears and anxiety symptoms children with asthma and congenital heart disease have. They found that anxiety was 2-2.5 times higher in children with chronic conditions than the normal population. Both children with asthma and congenital heart disease scored higher on medical fears, fears of small animals, fear of injury, fear of the unknown and fear of not being able to breathe. Children with chronic conditions may also have more anxious parents increasing their likelihood of experiencing anxiety symptoms, may be frequently absent from school, and may fear they will not be able to keep up physically with their peer group.

Another environmental factor found to be related to anxiety is violence. Ward, Martin, Theron and Distiller, (2007) conducted a study related to children being exposed to violence and found that both witnessing and being a victim of violence increased a child's risk of developing anxiety. According to Menesini, Modena, & Tani, (2009) there is a connection between bullying, being a victim of bullying, and developing psychological disorders. Being a victim of bullying had the greatest effect on developing internalizing symptoms such as anxiety, depression, and low self-esteem. A child who is a victim of bullying at an early age and continues being bullied over time may have a

greater chance of developing a psychological disorder such as anxiety. The researchers did not find any link between gender and developing anxiety when being bullied.

The symptoms and characteristics of children vary depending on the type of anxiety with which they are dealing. Children with social phobia (So Pho) may have physical symptoms that include rapid heart rate, trembling, trouble breathing, sweating, abdominal pain, and/or cognitive symptoms, which include negative thoughts and beliefs about social situations that cause an increase in anxiety when placed in a social setting (Rosenthal, Jacobs, Marcus, & Katzman, 2007). So Pho can be broken down into generalized social phobia and non-generalized social phobia. Generalized social phobia is more severe because it is more generalized to a child's whole life. Non-generalized social phobia is less common and is usually a fear of one or two situations, such as reading out loud in class. Social Phobia may start in childhood, but often times peaks in adolescence. The primary characteristic of a child with So Pho is her/his intense fear of social situations. The child may refuse to participate in certain activities and will probably avoid the feared situation. Farndale, Burton-Smith, Montgomery, and Shute, (2003) investigated social phobia levels among adolescents whose parents were divorced or separated. These adolescents experienced higher levels of social phobia than those whose parents' were still married or had strong relationships. Farndale et al. (2003) found that other types of anxiety, however, were not affected by a parents' marital status. According to Pasnau and Bystritsky (1990), So Pho is thought to be a learned or conditioned behavior.

A child with generalized anxiety disorder (GAD) has characteristics of excessive worrying about many areas of her/his life. Some of these areas include the unknown of

unfamiliar situations, school performance, family issues, and social concerns (McLoone, Hudson, & Rapee, 2006). A child may find it difficult to control the amount s/he worries and will experience one of the following symptoms within six months: agitation, exhaustion, trouble concentrating, irritability, muscle soreness, or trouble sleeping. A child who suffers from GAD may complain that s/he cannot sit still or relax. The parents of a child with GAD indicate that their child is irritable and gets upset easily. At school the child may display an intense worry about her/his work not being good enough and may look for reassurance from her/his teachers, friends, and parents. A child may not participate in age-appropriate activities such as sleepovers or going to camp if the situation is unfamiliar to her/him. The strongest predictor of general anxiety during adolescence was low acceptance by peer group followed by lack of attachment to a father figure. According to Pasnau and Bystritsky (1990), GAD is usually a consequence of biological vulnerability and psychosocial stress.

A third type of anxiety is Separation Anxiety Disorder (SAD). SAD occurs when a child displays extreme levels of anxiety when separated from her/his parents or primary caregiver (McLoone, Hudson, & Rapee, 2006). Some of these behaviors may include clinging to her/his parent/caregiver, crying, and/or screaming. A diagnosis of SAD is made when this type of anxiety is excessive and outside of the normal developmental stages. In a school setting a child may cry and misbehave when being dropped off at school, then have physiological symptoms such as a headache or a stomachache. The child may worry that something bad is going to happen to her/his parents and s/he will never see them again. A child may not be able to sleep over at a friend's house or go to camp overnight because s/he does not want to be separated from her/his

parents/caregivers. SAD tends to be seen in younger children and decreases as the child gets older.

The Identification of Children With Anxiety and the Assessment Process

Due to the number of children suffering from a mental health disorder, policymakers and mental health professionals believe that it is important to proactively screen children with the hopes of identifying children with a mental health disorder sooner (Nemeroff, Mass Levitt, Faul, Wonpat-Borja, Bufferd, Setterberg, & Jensen, 2008). By identifying the child sooner s/he can receive the needed services faster. According to Nemeroff et al. (2008), the primary care physicians, juvenile justice system, and school settings are the targeted environments to identify children with mental health issues. The school system provides the maximum potential for identifying children early because the school professionals assess children in large numbers, and see the children and families on a daily basis throughout the year. However, even though the school system seems the most logical place to assess children for mental health issues, there is limited research available about school-based mental health services

McLoone, Hudson, and Rapee (2006), state that a child who has high levels of anxiety can be identified within the school setting in many ways. The way in which a school decides to screen a child for anxiety depends on the resources available. The research that is available about school-based screening tools indicates that many obstacles need to be overcome before early identification programs can be readily available in the school setting (Nemeroff et al. 2008). One obstacle is developing a screening program within the school setting that is acceptable to school staff and effective for connecting students who suffer from anxiety with the treatment services

available. A second obstacle would be having trained staff and appropriate tools available at all times to evaluate children who display anxiety symptoms as soon as possible. Due to the cost involved in both of these areas having an early identification program available may be limited depending on the school district.

Nemeroff et al. (2008) conducted a study to determine if it is realistic to have an early identification program to identify mental health issues in children within the school setting. Nemeroff et al. (2008) found that early identification programs in the school setting help students in a variety of ways. One way is to identify students suffering from a mental health disorder sooner, which allows a student to receive help when the impact of that help is the greatest. Another finding in this study is that parents of students are more willing to see medical help if the school professional recommends it. Early identification programs also positively affect the communication between the school and the mental health system because the school professional can send the preliminary assessment to the mental health professional which will initiate the intake process and decrease the time to develop a treatment plan (Nemeroff et al., 2008). Overall Nemeroff et al. (2008) showed the importance of having an early identification program in the school environment.

Some types of assessment approaches used are: structured clinical interviews, self-report inventories, parent and teacher questionnaires, direct observations and the physiological index (Strause, 1990). According to McLoone, Hudson, and Rapee, (2006), self-report inventories are the most cost effective and easy to administer. School personnel can use these tools with very little training and the tool comes with clear directions on scoring and interpreting the data. The self-report inventories accurately assess the severity of the symptoms, determine if the symptoms are clinical or non-

clinical in nature, and distinguish between anxiety and other childhood disorders. One drawback of this type of assessment is that children can sometimes fake their way through the test, hiding their anxiety. Some inventories also provide a parent questionnaire which is useful but takes cooperation from the parents to complete and return the questionnaire. Examples of these assessments are Spence Children's Anxiety Scale (SCAS), the Screen for Child Anxiety and Related Emotional Disorders, (SCARED) and the Multidimensional Anxiety Scale for Children (MASC)

Clinical interviews are also used to assess children in schools for anxiety (McLoone, Hudson, & Rapee, 2006). Clinical interviews allow a professional to assess a child personally so that the professional can identify the type of anxiety a child has and how much the child is impaired because of the anxiety. This type of assessment, however, is time consuming and takes a great deal of training therefore it is not used a great deal in the school setting. The most common clinical interview used is the Anxiety disorders Interview Schedule for Children (ADIS)

Teacher observation is also used to identify children with anxiety within the school setting (McLoone, Hudson, & Rapee, 2006). Classroom teachers are able to observe their students within the classroom and on the playground on a daily basis. Experienced teachers are able to identify behaviors that may not be typical of a child at a certain age. However, a teacher's attention is often directed towards the child who is exhibiting more externalizing behaviors therefore it is important to use a teacher's observations with other forms of assessment tools which will increase the validity and reliability of the overall assessment.

Strauss (1990) also writes about assessing a child's anxiety using physiological measurement. Physiological measurements are tests of a student's blood pressure and heart rate during stressful situations such as giving a speech in class. The history of this type of assessment has been inconsistent but recent findings show that these assessments are more valid than in years past. Physiological measurements can provide important information about how a student responds to stressful stimuli that may not be discovered using the other types of assessments.

There are several different types of assessment options available to assess children for anxiety (McLoone, Hudson, & Rapee, 2006) School professionals are in a position to investigate the limitations and advantages of each assessment technique and decide what will be the most effective way to help the children in their school district. At this point, there is not a single technique that is best to assess for anxiety in the school setting. The costs of the assessments, both financial and time requirements, need to be considered. School professionals also need to remember the parents and their reaction to these assessments. Being sensitive to the parent's needs and privacy concerns, obtaining proper informed consent, and providing good assessment information will be important.

The Interventions Provided and Referrals Made

Cognitive-Behavioral therapy (CBT) has been consistently recommended as the first treatment option for children suffering from anxiety (Bernstein, Layne, Egan, & Tennison, (2005). Bernstein et al. (2005) studied CBT with children individually, in groups, and as a family treatment option. The results showed that all forms of CBT were effective over the no treatment group. However, individual CBT and CBT plus family involvement were more successful in decreasing a child's anxiety and maintaining these

benefits three, six, and twelve months after treatment. Bernstein et al. (2005) found that CBT plus family involvement was more successful than individual CBT. However, after six years both types of treatment had equal results.

According to Velting, Setzer and Albano (2004), CBT for anxiety disorders consists of six parts: psycho-education, somatic management, cognitive restructuring, and problem solving, exposure, and relapse prevention. Psychoeducation informs the child and the family about anxiety and how high levels of anxiety are learned and maintained. Counselors who approach anxiety using the cognitive behavioral technique believe that anxiety is a natural and normal emotion that an individual uses to protect and motivate her/him. For example, feelings of anxiety tell us to avoid strangers or to complete a homework assignment. It is explained to the child and family that for whatever reason some people have a higher level of anxiety in situations where it is not necessary. CBT can be used to help the child respond to fearful situations with less fear and more confidence. CBT is not used to "wipe-out" anxiety completely or make one's life free from all stress (Velting et al. 2004) Instead CBT teaches a child how to deal with her/his fear and be proactive in dealing with daily frustrations. A child is often taught how to build a "toolbox" of skills to help manage her/his anxiety.

Somatic management techniques may include some form of relaxation training (Velting et al. 2004). These relaxation techniques vary depending on the type of anxiety disorder and its severity. Diaphragmatic breathing is used because it is convenient and always available to calm an anxious response to a situation. Progressive muscle relaxation can also be used for General Anxiety Disorder and Separation Anxiety. It is not used for Social Phobia because for this type of anxiety an individual needs to learn

how to deal with the rise in her/his anxiety. An example of somatic management is the use of a relaxation technique to help a child go to sleep in her/his own bed.

Cognitive restructuring involves identifying anxiety producing thoughts and changing these thoughts into questions that challenge the original thought (Velting et al. 2004). For example, a child may think if dad does not pick her/him up after baseball practice on time dad must have been in a car accident. Cognitive restructuring would teach the child how to come up with other reasons that her/his dad is late. For example, he left work late or he was stuck in traffic. The child focuses on these non-anxiety producing alternatives and continues with her/his deep breathing to help him/her relax. Parents are taught to help the child with this step by asking questions which allow the child to think about her/his answers instead of the parent just providing the answer for the child.

Problem solving is when a child uses a step-by-step process to cope with a specific problem situation. The first step is to identify the problem, then generate ideas about how to solve the problem without discarding any idea. Then, the child looks at every solution and determines the solution that would work best. If the first solution does not work then s/he can choose another option from the list. When teaching problem solving skills it is best to start with a problem that is very tangible but unrelated to the child's anxiety. For example the child lost her/his baseball mitt somewhere around her/his house. If the child experiences anxiety while problem solving remind the child to use the somatic management techniques learned earlier.

Exposure is the primary element of anxiety disorder treatment (Velting et al. 2004). Exposure involves exposing a child to her/his feared situation in a well controlled,

systematic and graduated way. The use of somatic management, problem-solving, and cognitive restructuring skills should be practiced and used during this phase. The pace of this step is dependent on the individual and should be carefully monitored to avoid early drop-out from the program. This process of exposing a child to what causes her/his anxiety will provide new information to the child and help her/him cope with her/his anxiety. At times, this step may not be completed during the school hours because the anxiety the child is experiencing is not related to school (McLoone, Hudson & Rapee, 2006). In this instance, a parent or guardian may need to complete the challenge with the child. This may create a barrier. For example, a parent may not wish to place her/his child in the same situation which caused the fear or the parent may have her/his own anxiety issues and be unable to model non-anxious behavior. When this occurs, the parents may need to have strategies available to handle their own anxiety in order to help their children.

The last step is the relapse prevention (Velting et al., 2004). This step is focused on combining all of the skills the child has learned throughout this program. Encouraging the child to keep a journal about her/his experiences with anxiety and how s/he managed the situation may be helpful. Velting et al. (2004) suggest making a video tape of all the techniques the child learned perhaps changing roles with the counselor and having the student explain what s/he has learned.

Velting et al. (2004) indicate that "The Coping Cat" program was one of the first treatment options available to treat childhood anxiety. There are other CBT manuals that have been developed and used with individuals, groups, and families. CBT protocols can be used by individuals with different theoretical and professional backgrounds and still be

effective. The key is that whoever is administering the program needs to be well trained in the program being administered.

Another Cognitive Behavioral Therapy program that has been used is "Being Brave: A Program for coping with Anxiety for Young Children and Their Parents" (Hirshfeld-Becker, Masek, Henin, Blakely, Rettew, Dufton, Segool, & Biederman, 2008). This treatment comes with a manual and can be offered up to 20 weekly, 50 minute sessions for parents and children. This treatment was adapted for the Kendall's Coping Cat program, which treats symptoms of generalized anxiety disorder, separation anxiety disorder, and social phobia. Hirshfeld-Becker et al. (2008) showed in their research that the CBT used with older children and adults can be adjusted for pre-school and elementary school children. There would need to be more parental involvement the younger the child is. Hirshfeld-Becker et al. found that children in pre-school were suffering from anxiety disorders and identifying and treating them as soon as possible allowed the children to learn to cope with their anxiety, therefore, reducing the impact the anxiety had on the child's academic and social growth.

The second part of first line treatments for anxiety disorders in children is pharmacotherapy (Liashko & Manassis, 2003) Clinicians seem to use the following criteria when deciding to use or not use medications to treat anxiety disorders: the availability of Cognitive-Behavioral Therapy, if a child is unable to participate in CBT due to language barrier or a cognitive impairment, if parents are not willing to use medications, when environmental factors exist that affect a child's life such as family conflict, and when a child has externalizing behaviors that affect those around her/him. Liashako and Manassis (2003) found there were not a lot of differences between the

medicated groups of children being treated for anxiety disorders versus non-medicated. There were however a greater number of medicated children who exhibited a secondary diagnosis. The medicated group also exhibited more parental frustration than un-medicated children. However, when CBT was part of the treatment both groups appeared to improve their overall functioning.

McLoone, Hudson, and Rapee (2006) reviewed three treatment CBT programs that were evaluated in a school environment; The Cool Kids Program, the Friends Program and the Skills for Social and Academic Success Program. The data indicates that 50-80% of children who participated in these CBT groups were symptom-free from their primary anxiety diagnosis after the treatment As the earlier research cited above suggested the treatment benefits from CBT seem to remain stable over a period of time after treatment. These programs are typically led by a school counselor, school psychologist or a specialist. These programs are targeted to groups of children with different needs.

The FRIENDS program is a prevention program that can be part of the whole school curriculum (McLoone, Hudson & Rapee, 2006). It is implemented within the classroom setting in both primary and secondary settings and is intended to prevent anxiety symptoms in children and adolescents. The FRIENDS Program has many benefits including: all children participate which decreases the chance of a child being teased because s/he is pulled out of class, it can help every child regardless of her/his risk of anxiety, it can integrate peer counseling and modeling of behavior because the whole class is learning the information together and it takes away the need to screen and assess children because everyone participates. The FRIENDS program includes ten, one hour

weekly sessions during the school day and two follow-up sessions, one and three months after the core set of sessions. The program is facilitated by a trained school teacher. There are also three sessions for the parents that are held during school hours at a time that is convenient for the parents. The parents are given information about what their children are learning in the first two sessions and the parents are taught child-management skills during the last session.

The FRIENDS program includes sessions on cognitive strategies, exposure exercises, relaxation techniques, and preparations for unplanned times of anxiety (McLoone, Hudson & Rapee, 2006). Interactive work with peers is a large part of this program including encouraging peer support and making friends. Research has shown that the FRIENDS program has indicated decreased clinical levels of anxiety symptoms in 75.3% of participants whereas in the control group only 45.2% had lower anxiety.

The Cool Kids program is a program that treats children with anxiety symptoms or children who are at risk for developing anxiety within a small group setting (McLoone, Hudson & Rapee, 2006). The group consists of up to six children who have been identified through a screening process to have anxiety or are at risk of developing anxiety. A trained school counselor leads the group through ten weekly one hour sessions typically during the school day. The program can be held at other times if necessary. There are two follow-up sessions for the children and two sessions for the parents. The parent sessions are used to involve the parents in learning how to help their children at home.

The Cool Kids program is designed for seven to sixteen year old children (McLoone, Hudson & Rapee, 2006). The program is designed to include psycho-

education, cognitive restructuring, child management strategies and exposure to anxiety-provoking situations. The goal of this program is to teach the children how to manage their anxiety better and face formerly feared situations independently. McLoone, Hudson and Rapee (2006) indicate that children who participated in this program had a significant decrease in anxiety symptoms based on child, teacher, and parent reports.

The Skills for Social and Academic Success program (SSAS) is purposely designed to treat social phobia (McLoone, Hudson & Rapee, 2006). Children are selected for this group by using three self-report measures and teacher nominations. The group is facilitated by a clinical psychologist trained in the delivery of this program. The program consists of 12, 45 minute group sessions during the school day, two individual sessions and two follow-up sessions. Parents and school staff also participate in this program each having two sessions. There are also four weekend events that include social activities for the participants and a "peer assistant", who is a fellow classmate, where the participant can practice the skills s/he is learning in a social environment. The SASS program is based off of the principles of Cognitive Behavioral Therapy and focuses on psycho-education, realistic thinking, social skills training, exposure, and relapse prevention.

The SASS program has shown to improve social anxiety symptoms in 67% of the participants versus six percent in a control group (McLoone, Hudson, and Rapee, 2006). The results may show that learning in a real-world environment is beneficial. A child learning skills within her/his school environment provides opportunities to learn the skills in real- life situations and the teachers can be available to support and encourage the child.

McLoone, Hudson, and Rapee (2006) show there are positive results from these programs being provided in a school environment instead of a clinical setting. Even with the positive results the need for justification of such programs in the school system is great. Schools are required to provide certain education to students however services for anxiety management is not mandated at this time. One limitation of the research of these programs, however, is that they were developed for white, middle-class students. There is not a great deal of research on how these programs work with other ethnic populations.

The benefits of providing anxiety treatment along with other mental health resources in the school setting are many. One benefit is that treatment programs decrease the barriers for the children to receive help (McLoone, Hudson, and Rapee, 2006). School professionals are able to screen and treat children earlier, provide a real-life setting to practice their skills, decrease their anxiety and increase the likelihood the child will get treatment because issues of cost, transportation and long waiting lists will not be an issue. School-based interventions also lessen the amount of shame a child may feel when receiving mental health services.

There are some limitations to having mental health services within the school setting (McLoone, Hudson, and Rapee, 2006). These programs are expensive and the schools do not have the funds to purchase the programs. Schools also have to train staff to be facilitators of these programs and a lot of times the school does not want to pay for this or the school professional is so busy with other commitments that it is difficult to attend the training.

Parents can also influence if a child receives anxiety treatment within the school setting. Parents may not know their child suffers from anxiety. If the parents do know

they may disagree with treatment due to the stigma that may be attached. The parents worry their child will be labeled, teased or bullied if other students or teachers find out the child is receiving help for anxiety. What parents need to know, however, is that if a child's anxiety is not treated s/he may have trouble with depression, alcohol and drug abuse, and/or poor school and work achievement throughout her/his lives.

According to Wood (2006) reducing a child's anxiety will improve her/his academic performance and social functioning in school. Wood (2006) completed a longitudinal study using multiple methods of assessment and independent raters. He found that by decreasing a child's anxiety the child is able to focus and increase her /his attention ability which allows the child to pay close attention to instruction of the teacher and performing on tests. Decreasing anxiety also positively influenced the child's social functioning in this study. This information is important for school counselors, parents, and teachers to know in order to identify anxiety early and avoid academic and social problems in school.

Many children who suffer from anxiety seem to go through the school system undetected (Tomb & Hunter, 2004). Anxiety has shown to have significant negative effects on a child throughout her/his life. School staff faces a challenging task of identifying and treating children who suffer from anxiety symptoms, however, they also are in a position to implement preventative programs to improve the school environment for many children. Research shows that the earlier the intervention is started the more positive the outcomes are for children who suffer from anxiety.

According to Tomb and Hunter, (2004) the school environment is the ideal place to implement preventive interventions for anxiety. Prevention is defined as "interventions

that occur before the onset of a clinically diagnosable disorder that aim to reduce the numbers of new cases of that disorder" (Tomb & Hunter, 2004, p. 89). Teaching a child coping skills will help her/him develop strategies to deal with her/his stress; therefore, decreasing her/his anxiety. Using an Early Screening Program (ESP) to identify children who are at risk of developing anxiety is one method discussed by Tomb and Hunter (2004). Within this program, the teachers are trained to identify symptoms of both internalizing and externalizing behaviors in children. The teacher ranks the top ten children in her/his class that exhibit these characteristics. The top three children in each category are then identified and evaluated using clinical questionnaires. The children who meet criteria off of the questionnaires are further assessed and observed by the school practitioner both in the classroom and on the playground. ESP has shown to have high satisfaction levels and positive outcomes in helping children who suffer from anxiety symptoms

Many of the interventions for anxiety need teacher and other school staff involvement (Tomb & Hunter, 2004). School based practitioners, such as school counselors and school psychologists, need to provide training to the school staff to increase the staff's knowledge about anxiety. School-based practitioners also need to prove the program's effectiveness by providing substantial measurements of improvement information to the school administrators and school board. This practice will promote interest and continued support for these programs. When deciding on which program to use within the school, the practitioner will need to look at the demographics and population being served such as, socioeconomic status, parental involvement and cultural make-up of the school.

Childhood anxiety is a real problem in our schools today. Research indicates that between 3% - 20% of children may suffer from anxiety symptoms (Tomb & Hunter, 2004). Anxiety has many negative effects on children including, lower achievement in learning, social problems, attention seeking, and low self-concept. School practitioners have the ability to implement preventive programs to improve the school environment and reduce the risk for students to develop anxiety disorders. To help children who suffer from anxiety it is important for school counselors, parents, and teachers to be aware of the signs and symptoms of anxiety (Wood, 2004). Identifying anxiety early will help children avoid academic and social problems in school and have a more positive and successful experience.

Chapter III: Critical Analysis

This chapter will include a critical analysis of all of the literature summarized within this paper. This chapter will address the possible limitations of the current research available about childhood anxiety and how anxiety is identified, assessed, and treated. This chapter will conclude by providing recommendations for future research on the best methods for helping children within the school system to decrease their symptoms of anxiety.

Analysis of Literature Review

Anxiety is a valid problem for up to 20% of the children in school (Tomb & Hunter, 2004). Anxiety can be caused by environmental factors, genetics, chronic health conditions and exposure to violence. Children who suffer from anxiety may exhibit signs of depression, inability to pay attention, have lower self-esteem, have difficulty maintaining friendships and developing positive social behaviors. It is known that anxiety, if not treated, can cause mental health disorders later in life. Policy makers have expressed a desire for the school system to screen children early so they can receive help as soon as possible. Three types of anxiety were explored in this paper: general anxiety disorder (GAD), separation anxiety disorder (SAD) and social phobia (So Pho). These types of anxiety generally begin in childhood and peak in adolescence. Anxiety does exist and can affect children in a variety of ways during childhood and into adulthood. Screening and treating children who suffer from anxiety is important for lifelong learning and health.

GAD is one type of anxiety that is characterized by an individual worrying excessively about such things as her/his school performance, family issues and/or social

concerns. For example, when a child is learning to read and write and starts to cry because s/he did not say the word right or erases her/his paper many times to write the word perfectly may be exhibiting signs of GAD. So Pho is another type of anxiety that can cause physical symptoms such as a rapid heart rate or a stomach ache when a child is in a social setting. A child who sits alone quietly during kindergarten free time may be experiencing So Pho because s/he does not know how to interact in an open social situation. So Pho can be characterized as generalized and non-generalized. Generalized So Pho is where a person has physical symptoms of anxiety in any social situation whereas non-generalized is within one setting such as reading out loud during class. The third type of anxiety discussed is SAD, where a child may experience extreme anxiety when separated from his/her parents or primary caregiver. When a parent is dropping her/his child off at school and the child refuses to leave the vehicle and the parent needs to drag the child into the building kicking and screaming this may be a sign the child is experiencing symptoms of SAD. Understanding all of these types of anxiety and what causes the anxiety are important in order to teach a child how to become successful at decreasing her/his anxiety symptoms.

The causes of anxiety can be environmental, genetic and biological. Environmental factors include; watching television and movies, being a target of or witnessing bullying, adverse cultural norms and expectations, parental behavior, and uncontrolled or unpredictable stress. All of these environmental factors may affect a child because of her/his lack of ability to separate reality from fiction. A child may have a lack of knowledge of how to deal with a situation if it does happen and the inability or fear of talking about what is worrying her/him. For example a child begins to worry about

her/his good friend being bullied at school s/he does not know who to talk to about the situation and is worried about her/his friend, and what if the bully targets her/him instead. The child then may experience symptoms of anxiety and refuses to go to school or finds it difficult to concentrate on school work because recess is in ten minutes.

Biological causes include gender differences. Researchers investigated anxiety levels between female and male students. Females generally suffer from anxiety more than males which could be due to hormonal changes a female may experience. Research shows however anxiety symptoms may be caused by her/his gender orientation. Females tend to display care giving, non-assertive traits whereas males tend to exhibit assertive and control type traits. What researchers found is what traits a person identify with effects her/his anxiety levels

Genetic causes include family history of anxiety. A child is two to three times more likely to suffer from social phobia (So Pho) and ten times more likely to experience generalized anxiety disorder (GAD) if her/his parents experience So Pho and/or GAD. Researchers have not found a particular gene that is the cause of anxiety being transferred from parent to child but the research has shown this significant link. The parenting behaviors discussed in this paper include: over control, low warmth, and high criticism (Moore, Whaley, and Sigman, 2004). These behaviors teach a child s/he does not have the ability to handle difficult situations and denies the child the opportunity to try. The parents therefore are teaching the child that the world is a dangerous place and when facing difficult situations the child will not be supported and, therefore, s/he will not be able to handle the situation. Parental negative control is when a parent attempts to protect her/his child from the feelings of anxiety, when in reality the parent deprives the child of

learning to cope with the emotion (Feng, Shaw, and Silk, 2008). Whether these parental behaviors are genetic or an environmental influence on the child is unknown but the behavior does increase the chance the child will develop anxiety at some point (Moore, Whaley, & Sigman, 2004).

There are many factors affecting children today that can increase the likelihood they will experience anxiety symptoms within their school experience. The benefits of providing screening and treatment in the school setting are numerous. Screening children in the school environment allows for more children to be assessed than through outpatient mental health service agencies. Children therefore have a better chance of receiving the help they need to address their anxiety appropriately. Furthermore, the school environment provides children with real-life situations in order to practice the skills they need to decrease their anxiety. If screening and treatment were provided within the school setting it would decrease the barriers of getting help for many children. Some of these barriers include the cost of treatment, transportation issues and long waiting lists within a clinical setting. Treating children's anxiety will improve their academic performance and social functioning, therefore making their school experience a positive one (Wood, 2006).

There are several assessments schools can use to assess children for anxiety including structured clinical interviews, self-report inventories, parent-teacher questionnaires, direct observations, and physiological indexes. Some of these assessments can be used on a large number of students at one time and other assessments are more appropriate for individual assessment. It is recommended that school counselors research the assessments available and select assessments based upon what would work best for their school(s) or school districts.

Treatment options for anxiety are also numerous and can be administered to a group or individual depending on the treatment chosen. Some treatments require the professional to be specifically trained to provide the treatment. Other treatments come with a facilitator manual and can be facilitated by a professional who is familiar with the program. Cognitive behavioral treatment is the most well known and effective treatment for anxiety at this time. There are many different programs available; however, only a few were discussed in this paper. The school counselor should research the available programs and decide which program would be the best for her/his school and/or school district (Tomb & Hunter, 2004).

Providing screening and treatment for anxiety within the schools does have some obstacles that need to be considered. Programs for screening and treatment are expensive. School districts would likely be required to pay for the programs and train the staff to administer the programs. At this time schools are struggling financially and therefore the effectiveness of these interventions would need to be established. There also may be a lack of time for staff to be trained or to provide the service during the school day. Parents also need to be involved and agreeable to screening and treatment for their children. Some parents may have doubts or fears and will not allow the screening or treatment for their child.

Childhood anxiety does exist and needs to be addressed within the school environment. We need to think about screening for anxiety as much as we screen for eye sight and hearing because it can have devastating effects on how a child learns and succeeds in school. Parents, teachers and other school professionals need to work together to develop a plan for the school or school district to assess, treat and refer

children who have anxiety. Helping children identify their anxiety and giving them the tools to decrease their anxiety will help children be more empowered and successful throughout their educational journey.

Limitations of Current Research

The limitations of this research include current information about how schools are assessing, treating and referring children with anxiety today. There seems to be a lack of information regarding the current protocols used within the school environment. Most research addressed defining childhood anxiety and what screening tools and treatment options are available. The research did not specifically explain how to establish programs within the school environment. There was limited research on how to identify children who may have anxiety symptoms and more clear direction on who should be assessing children for anxiety is needed. School personnel may consider conducting small scale studies of their students to further identify the needs of students regarding anxiety treatment and referrals.

There is limited information about how anxiety is treated across cultures. Most research has been done on white middle-class people. In the United States, schools have a diverse population of students. It would be important for school counselors and other school professionals to know what different treatment options and screening tools would benefit different cultures.

Current research includes information about the role a mother plays in a child developing anxiety but has limited research on the effects a dad has on a child's anxiety. This information would be beneficial because children are spending a lot more time with their dad's as their primary caregiver.

Recommendations for Future Research

There is a need for further research of childhood anxiety. If children who suffer from anxiety were identified, assessed, and treated they would hopefully have a more positive school experience and be more successful academically. Also when the children grow up there would potentially be less depression and other mental health issues in their adult lives. This in turn would benefit society as a whole.

Further research regarding screening tools and treatment options in the school environment would be helpful and determining what age anxiety screening and treatment would be the most effective. More involved research on different cultures and anxiety would be helpful. Perhaps research could give direction to school counselors and school psychologists on how to help the children they serve the best way possible.

Research on the communication between the parents and school professionals would be useful in practice. Providing information on the barriers to communication and how to overcome barriers to best serve the child would be valuable.

Investigating how treating anxiety does help children academically and socially within the school environment would be helpful when pursuing a program for individual school districts. Having this information available to give to the school board showing the importance of having a way to help up to 20% of the school children within the school district would be useful.

Implications for Practice

As a school counselor implications for practice include having the information available to develop a protocol within the school environment to identify, assess, treat and refer children who are experiencing anxiety. In developing the protocol, school

counselors will need to educate the other staff about identifying anxiety in children and then staff will need to know what to do with this information. School counselors will need to be trained to provide Cognitive Behavioral Treatment within the school setting. This may take grant writing or writing a proposal to the school board and educating the board members about the need for anxiety resources within the school environment.

Communication between children, parents, counselors, school staff and community agencies is very important. School counselors could facilitate the communication among all of these groups and help build relationships in the best interest of helping the child experience success in school and essentially in life.

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