COGNITIVE BEHAVIORAL THERAPY WITH CHILDREN AND ADOLESCENTS WHO HAVE AN ANXIETY DISORDER

BY

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A Practicum submitted to
the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements for the Degree of

MASTER OF SOCIAL WORK

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University of Manitoba
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Abstract

This practicum reviews the use of Cognitive Behavioral Therapy with children and adolescents diagnosed with an anxiety disorder. The study takes place at the Human Resource Centre at the Lord Selkirk School Division, and directs the intervention to nine participants, and their families. Data for this practicum was collected using the "What I Think and Feel" (RCMAS), as well as the Revised Behavior Problem Checklist. Detailed descriptions and evaluations were conducted for three cases, with an overview of the remaining six participants. An outline and discussion of the achieved learning and intervention goals are described.

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Chapter 1- Objectives and Rationale

This practicum focused on gaining experience and knowledge in cognitive behavioral therapy with children and adolescents who were diagnosed with an anxiety disorder. The Human Resource Centre of the Lord Selkirk School Division, located in Selkirk, Manitoba, was the site for this practicum. The evaluation of this practicum was a single-systems design, and allowed the student to assess progress of the practicum goals, and outcome of the therapy sessions.

Learning Goals

1. To gain experience and counselling skills in working with children, adolescents, and their families.
2. To increase knowledge of cognitive behavioral therapy.
3. To gain assessment and clinical skill in the area of children and adolescents who are diagnosed with an anxiety disorder.
4. To implement and evaluate an intervention plan with children/ adolescents, and their parents/guardians.

Intervention Goals

Process Goals

1. To discuss an intervention plan during the assessment session.
2. Establish a rapport with the client and their family.
3. Assess the problem from the perspective of the client, family, peers, and/or education system.
4. Assist the client in setting a goal of where they would be comfortable with their level of anxiety by the end of the intervention stage.

5. To provide education about the nature of the anxiety disorders and the cognitive behavioral model.
6. Implement appropriate cognitive behavioral coping strategies for child and adolescent anxiety (i.e. cognitive restructuring, relaxation, exposure, social skills, etc.).
7. Prepare and educate parents of weekly goals, skills, and to practice these skills between weekly sessions.
8. Prepare the client, family, and school for possible relapse.
9. Provide the client with weekly questionnaires, and their parents with pre- and post- treatment questionnaires.
10. Establish a booster session with the client and family four weeks following the eleventh treatment session is to ensure continued success in the treatment.

Outcome Goals

1. The goal of the client developing the skills to cope with the anxiety is achieved and maintained.
2. Improvement in the client's anxiety symptoms conveyed from the perspective of both of the client and family.
3. Parents, peers, education system, etc. have developed skills and/or knowledge of anxiety and aid in the client's improvement of anxiety symptoms.
4. Experience and knowledge in using cognitive behavioural therapy is established.
5. Experience and knowledge in child and adolescent anxiety is achieved by the Social Worker.

6. Use of assessment and clinical skills for children and adolescents diagnosed with an anxiety disorder.

Rationale

Child and adolescent anxiety disorders are more visible in the school system today. It is therefore important for social workers to have knowledge of the disorder and the techniques used to help improve the client's well being. The method of intervention used in this practicum was Cognitive Behavioral Therapy, which is described in Chapter 2 as an effective form of treatment with an anxiety disorder. This practicum also focused on the client's environment at home as well as school to aid in the outcome of the treatment.

Chapter 2 - Literature Review

The practicum was specifically aimed at working with children and adolescents who had been diagnosed with an anxiety disorder; therefore, the chapter reviews the literature concerning this group. A section within this chapter will also address the current research in both cognitive behavioural therapy (CBT) and child and adolescent anxiety.

Anxiety Disorders

Overview

Experiencing some anxiety, which is commonly known as worry, or feeling uneasy is a normal part of development for most children (Miller, Barrett, and Hampe, 1974). More specifically, anxiety disorders are psychiatric disorders that are typically diagnosed using the Diagnostic and Statistical Manual of Mental Disorders. The current edition of this manual commonly referred to as the DSM-IV.

The prevalence in the United States of formal anxiety disorders is approximately ten percent in the general population. There are up to twenty-five percent of patients seen by general practitioners have significant anxiety symptoms. Anxiety is more common in women than in men and it tends to present itself in early adulthood but may surface at any age (Davies, 2000).

It is found that older children complain of fewer symptoms than younger children. This could be due to cognitive development, maturation, or simply because it is not socially acceptable for an older child to complain of fears. Girls have consistently reported more fears than boys (Morris and Kratochwill, 1983). However, children in general, in the lower socioeconomic status show lower frequency of fears (Fonseca,

1993). Children in poorer families express more fears of violence, rats, and cockroaches, where higher socioeconomic status children express fears of heights, accidents, dangerous animals, and poisonous insects.

According to The Mental Health Resource Guide (2001), anxiety disorders affect about twenty-five percent of Canadians. As well, three to five percent of all children and adolescents are clinically diagnosed as having anxiety disorders. These data do not include obsessive-compulsive disorder, which affects another .5-1.0 percent of children. More than fifty percent of the youths affected with anxiety will also experience a major depressive episode (Costello and Angold, 1995), which increases the morbidity and perhaps mortality. Anxiety disorders, however, are the most treatable of all mental illnesses according to MHERC- Mental Health Issues (2004). This study also states that cognitive behavioural therapy is 80-90% effective with this treatment group. However, they did not state if this applied to children or adults.

There are disorders that contain components of anxiety; however, the DSM-IV classifies specific anxiety disorders. The descriptions of these anxiety disorders can be seen in Appendix A.

As stated earlier, experiencing fear and anxiety is a normal part of growing up for most children. Treatment is indicated, however, when these experiences begin to persist in duration, increase in intensity, and interfere with everyday life. If the child does not receive treatment, he or she may continue to have an anxiety disorder in adulthood (Rapee, Wignall, Hudson, and Schniering, 2000).

Social Work practice includes consideration of the impact of race and culture. There is limited research on this topic for CBT, however, findings by Chavira, Stein,

Bailey, and Stein (2003), found that when they randomly selected and surveyed 180 parents of children (8-17 years) from a paediatric primary care setting, white parents were more accepting of medication and counselling. They also found that white parents in comparison to non-white parents perceived counselling as more practical.

A study by Kendall and Sugarman (1997) found that whereas socioeconomic status and parental educational levels were not associated with ending treatment prematurely, being from a single-parent home and being a member of an ethnic minority group were associated with terminating rather than completing treatment.

Cognitive Behavioural Therapy

Overview

Psychologists have primarily used cognitive behavioural therapy. It is assumed in cognitive behavioural therapy that the client is responding to the way their thoughts represent their environment. Their feelings and behaviours are causally interrelated to their cognitions. Therefore, the client's attitude, expectancies, attributions, and other cognitive actions are the focus of the intervention. The therapist is there to assist the client in changing her or his maladaptive cognitive processing and learn ways to alter these thoughts into more functional ones (Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Secca, and Siqueland, 1992).

Historical Development

The earliest cognitive behavioural therapies emerged in the 1960s (Ellis, 1962), however it was not recorded in major texts until the 1970s (Kendall and Hollon, 1979; Mahoney, 1974; Meichenbaum, 1977).

The behavioural tradition is built on the work of Thorndike, Pavlov, Watson, Skinner, and Bandura (Barett and Jonson, 1995). Thorndike, a psychologist in the early 1900s investigated the law of effects. Skinner presented a modern version of this theory in which he focused on human behaviour and the probability that behaviour will occur again in the future (Skinner, 1971). These behaviours are manipulated by using the classical conditioning theory, which is the basis for such components of cognitive behavioral therapy as progressive relaxation, systematic desensitization, and assertiveness training.

Pavlov, a psychologist in the early 1900s was concerned with the salivary reflexes of dogs. Watson and Rayer (1920) later brought this about to human responses, with a baby's fear response to rats. Emphasis was placed on the importance of learning about behaviour and placing understanding to it, as well as understanding how a person selects behaviours based on the consequences that are attached to these behaviours.

Since that time, many forms of CBT had been used. One variety was a "power therapy" which is a form of brief therapy. When considering the length of treatment, cognitive behavioural therapy has its downfalls when used in a "power therapy" approach. Brief therapy is reinforced by the achievement of "power therapies" and successful reduction in the length of CBT without loss of effectiveness (Clark, Salkovski, Hackmann, Wells, Ludgate and Gelder, 1999). It is tempting to say that CBT is a 'power therapy' because even small doses can bring about significant changes. The problem with this is that evidence for the efficacy of brief treatment is weak concerning long-term follow-up with representative clinical samples, and it relies for its credibility on an oversimplification of the process of change (Durham, Swan and Fisher, 2000).

March and Albano (2002) found that virtually all cognitive-behavioural interventions share four qualities:

> 1) emphasis on psycho-education, 2) a detailed behavioural analysis of the problem and the factors that maintain or extinguish it, 3) problem-specific treatment interventions designed to ameliorate the symptoms of concern, and 4) relapse prevention and generalization training at the end of treatment. (p. 420)

Cognitive Behavioural Therapy & Social Work

Davies (2000) stated that due fact that the cognitive-behavioral approach is psychology-based it is:

> ...limited in what it can achieve in the face of life difficulties that confront so many social work clients. Consequently, the cognitive-behavioural social worker needs many other kinds of skills and knowledge: law, welfare rights, understanding of physical and mental health issues, and much more. It is this mix of skills and knowledge that distinguished the cognitive-behavioural social worker from similarly oriented colleagues in other helping professions. (p.65)

One of the major limitations of the cognitive behavioural approach is its inability to go beyond the clients themselves. Therapy is conducted in one to one sessions, with the hopes that the client will make the necessary changes to cope in his or her world. However, social workers and a few psychologists have broadened this approach and included the environment into the equation. The social work approach to cognitive behavioural therapy includes how the person's environment, such as the family, school, or workplace, affects his or her functioning. A social worker integrates environmental

and social forces into his or her work. This is a powerful tool to have, because people do not live in a bubble, they interact and respond to things around them.

A major social factor these social workers need to be aware of when working with their client is their cultural background and how that plays into a person's interaction with things around them. The idea that the environment is playing a role in the individual's problem indicates that the cognitive behavioural theory is consistent with social work's history of working with oppressed populations. However, the fact that behavioural theory disregards the factors of race, ethnicity, gender, sexual orientation, and social class, indicates that there is a problem with it fitting with social work ethics and values (Robbins, Chatterjee, and Canda, 1998).

University of Michigan was the birthplace of behavioural social work in the 1960s. Edwin Thomas launched behavioural social work in a symposium that resulted in his publication of *The Socio-Behavioural Approach and Applications to Social Work* (Thomas, 1967). Werner (1965) introduced cognitive theory to social work practice, and Berlin (1983) was one of the first writers to adapt cognitive-behavioural theory to social work practice. He believed that changing cognitions, behaviour, affect, or interpersonal and social situations could change our functioning. Edwards and Hopps (1995) stated the following:

> Berlin's work involved a nine-step sequence of problem solving, including developing awareness of early warning signals; scrutinizing one's expectations for realism; defining the problem; and formulating and implementing solution alternatives using cognitive, behavioural, and affective strategies. (p.1398)

A limitation to the social work field of cognitive behavioural therapy is its lack of empirical evidence. Cognitive behavioural therapy has been around for many years in the psychology field, and an abundance of research has been conducted using this approach. However, due to social work's recent adaptation of the theory there is limited empirical evidence in this realm.

Another limitation of the psychology cognitive behavioural therapy approach is its focus on the relevant symptoms that are defined in the DSM-IV instead of the problem (anxiety). The therapy is designed to reduce the symptoms that are defined in the DSM-IV that make up the anxiety disorder. Social work addresses this limitation by expanding the psychology field by assessing what the problem is, and focusing the treatment on the symptoms and on the environment that is involved in the problem.

Cognitive Behavioural Therapy with Children and Adolescents

Cognitive behavioural therapy with youth uses role-play, performance-based procedures as well as interventions to generate changes in thinking, feeling, and behaviour (Kendall, 2000).

There are special factors to take into consideration when working with children and adolescents. These according to Dobson (2001) include:

1. The need for careful attention to a young client's level of cognitive and affective development
2. Use of age-appropriate modes of delivery of the therapy content
3. The recognition of the differences in how young clients come to treatment
4. Recognition of the extent to which a young client is embedded in his or her social context. (pp. 249-250)

These considerations are important because children do not process information the same way as adults. The delivery of the therapy must be explained in a language that is age appropriate so that the child understands what is being taught, and made visibly exciting to ensure that the child's attention to the therapy is maintained.

Cognitive restructuring helps clients to be aware of self-statements, expectancies, or beliefs that reflect their way of thinking. Young children, however, may find this difficult until they are old enough to develop worldviews. The therapist can aid the child in thinking of their cognitions by having cartoon figures with thought bubbles over their head, (Kendall and Chansky, 1992). The therapist can design the therapy in a detective-like format for older children and adolescents, with statements such as "What's the evidence to support this view?" "Is there another way of looking at this"? The therapist can also ask "What if…" type questions (Stark, Sander, Yance, Bronik and Hoke, 2000).

Self-control/self-regulation is taught to children who are anxious by having them become more aware of internal arousal and reactions. The goal is to link the behavioural approach to their cognitions. They are taught to monitor early signs of distress and use their emotional signals to enact coping skills (Kendall, 2000).

Educating the child about his or her disorder is an important component of CBT. In some cases, the child/adolescent may be aware of how they are emotionally but may not have the vocabulary to describe these experiences. There are workbook manuals that are developed for specific childhood disorders. Kendall (1992) developed the "Coping Cat Workbook" which helps the client to examine their emotions and connect their thoughts and feelings of their anxiety in a concrete manner. Barrett, Webster and Turner

(2000) also developed a "Friends" workbook to help anxious children and adolescents in a group setting.

Relaxation training is taught in many forms depending on the child's developmental level. Relaxation may be discussed as tensing various muscle groups and enacting their relaxation procedures for older youth. The adolescent will be conscious of the tense vs. relaxed muscles. The "robot-rag doll game" may be played for younger children (Kendall and Braswell, 1993). The robot is stiff and tight, where as a rag doll flops around and arms and legs are loose and hang by the child's sides.

Role-playing may be helpful to the therapist to detect any gaps in knowledge or incomplete behavioural information that was provided to the child. The role-playing can take place in session and be age-appropriate. Videotapes can also be used for feedback.

Behavioural incidents are effective in decreasing unwanted behaviors or increasing wanted behaviors. A reward system for younger children has meaning they can relate too. As children get older, they still want social approval but mastery incentives become more important.

Effectiveness

Cognitive Behavioural Therapy & Anxiety Disorders

Generally, the literature pertaining to comparison of psychotherapies for various disorders has concluded that most treatments are roughly equivalent in effectiveness (Shapiro, Barkham, Rees and Hardy, 1994). However, there are also studies that maintain that cognitive and cognitive-behavioural therapy methods are more effective than other treatments for a variety of conditions (Brown 1997). A few of these studies state that whether the treatment is individual or group, cognitive therapy is effective in

reducing symptoms of depression and anxiety by increasing assertiveness (Lumpkin, Silverman, Weems, Markham and Kurtines, 2002; Scogin, Hamblin and Beutler, 1987). Children who receive CBT compared to waiting list control groups also improve significantly in school attendance, self-reported fear, anxiety, depression, and coping. Improvements for this study were found in the caregiver reports and clinician ratings as well (King, Tonge, Heyne, Pritchard, Rollings, Young, Myerson and Ollendick, 1998). When there are differences in research, it is important to view who is conducting the research because they may be self-serving.

Cognitive behavioural therapy also favours well when compared to pharmacotherapy. Historically, research on cognitive therapy has been viewed to be equal to or sometimes superior when compared to pharmacotherapy (Blackburn, Eunson and Bishop, 1986). It has also been found that cognitive therapy has lower rates of relapse than antidepressant medications, which are used for treating anxiety (Hollon, 1996). Cognitive behavioural therapy may not be as fast acting as medication for some conditions however; it may have longer lasting effects (Tian and Alice, 1999). Research has also shown that cognitive therapy has lower drop out rates compared to pharmacotherapy alone (Murphy, Simons, Wetzet, and Lustman, 1984).

Barlow, O'Brien and Last (1984) found that cognitive therapy outperformed behavioural therapy in treatment of patients with anxiety. Chambless and Gillis (1993) have also established cognitive behavioural therapy for anxiety to be an effective form of treatment. Most of the research has shown successful treatment over the control groups when using coping-skills in combination with behavioural techniques such as exposure, imagery, relaxation, and contingent reward.

Cognitive behavioural therapy has proven to be an effective form of therapy for a variety of conditions however, it cannot be said that cognitive therapy is equally effective for all individuals. Therapy efficacy is influenced by a variety of characteristics such as the clients coping style, complexity, and severity of problem.

A client's coping style is his or her usual way of minimizing the negative symptoms of anxiety. Cognitive therapy has been found to be most effective among clients who "exhibit an inhibited, controlled, inner-directed, and internalizing coping style" (Dobson, 2001, p. 152). However, client characteristics such as internalizing and resistance to direction, were indicators for poor long-term outcomes of cognitive therapy (Beutler, Mohr, Grawe, Engle and MacDonald, 1991)

Cognitive therapy is less effective with more complex and severe problems. These are associated with co-morbidity, enduring personality disturbances, and chronicity of the condition. Beutler, Mohr, et al. (1991) found that insight- based treatments do better than cognitive therapies for people who do not have strong impulsive, externalizing traits. As well, Durham, Swan and Fisher (2000) found that there is evidence from both psychotherapy outcome research and epidemiological psychiatry that higher symptom severity, economic difficulty (chronic indebtedness, low socio-economic status, unemployment) and social disadvantages (absence in intimate confiding relationships, chronic social difficulties and low support) are associated with a poor long-term outcome, irrespective of treatment provided.

Age has been shown to be a strong predictor in improvement of anxiety symptoms. Roth & Fonagy (1996) report that "96% of treated children under 11 improved, compared with 57% of the waiting-list cases; for children over 11, the figures

were 20% and 17% respectively," (pp. 293-294). Other studies (Bannett and Gibbons, 2000; Epstein, Schlesinger and Dryden, 1988) show that CBT was more effective for adolescents and older elementary children than for younger elementary school aged children for intervention in antisocial behaviour. In a two-year follow-up, the children who improved in therapy remained doing well, and those that had not responded in the beginning had started to improve. Only seven percent of those who were phobic remained anxious in this study.

The client's age as seen above is important for the effectiveness of CBT. However, the modifications made for these younger groups are also responsible for the efficacy of CBT. The principles of CBT with developmental modifications that apply to adult disorders can apply to children. Children with psychological problems make systematic errors in thinking (cognitive distortions) and have skill deficits that maintain the problem. The cognitive model proposes that a person's thinking influences his or her mood. Therefore, modifications to thinking will result in changes in mood and behaviour.

Brewin (1996) states that cognitive approaches should treat symptoms based on verbally accessible cognitions, and behavioural interventions can make use of single or repeated exposures when anxiety reflects the unconscious memory. "The differing combinations and strengths of maladaptive beliefs and neutralizing behaviours and the different relations between them dictate that CBT be comprehensive and flexible if it is to be effective" (Brewin, 1996, p.49) especially with children and adolescents. The therapist should implement relatively straightforward strategies to lessen symptoms and reduce avoidant behaviour. "A critical element of therapy is to increase exposure to the

stimuli or situations that provoke anxiety. Without such therapeutic assistance, the sufferer typically withdraws from anxiety-inducing situations, inadvertently reinforcing avoidant or escape behaviour," (Mental Health: A Report of the Surgeon General- CH 4, par. 4 under Treatment of Anxiety Disorders).

Parental Involvement

An important component of the social work perspective of CBT is that it incorporates significant others within the child's life, such as parents, school counsellors, and peers. When significant others (peers, teachers, and parents) provide positive feedback for children's efforts and change their perceptions and attributes about the child, the child's behavioural change is likely to be maintained (Kendall, 1993).

Consistency is key and the most difficult component for parents when managing components of the child's behaviour. Rapee, Wignall, Hudson, and Schniering (2000), report that there are many ways to be inconsistent. When a child misbehaves, parents often threaten with punishment, which is not carried out. The opposite is also true. The parents often loose their patience with their children, and give into their screaming and crying, which in turn rewards their child for misbehaving. Parents may also be vague in their instructions, which will complicate the child's thinking.

Children who participated in treatment programs often improved. However, according to parent report measures, children with a co-morbid condition did not do as children without a co-morbid condition. This was contradictory to the children's self-report measurement where children who had a co-morbid condition felt they were doing better than the other group (Rapee, 2003).

Mendlowitz, Manassis, Bradley, Scapillato, Miezitis and Shaw (1999) found that parents involved in their child's treatment reported their child as using of more active coping strategies and showing greater improvement in their emotional well being as compared to parents' reports within parent-only or child-only treatment conditions.

There is, however, contradictory research on parental involvement in the child's treatment. When examining changes in child, parent, and family functioning over the course of child cognitive-behavioural therapy among children who completed outpatient treatment, results showed that children significantly improved in functioning over the course of therapy. The parent and family functioning, although not focused on directly, also significantly improved (Kazdin and Wessell, 2000).

Other interesting research reported by Cobham, Dadds and Spence (1998), found that when they split their testing groups to child-focused CBT or child-focused CBT plus parental anxiety management, 82% of the children within the CBT only group improved in treatment compared to 80% of children in CBT and parental anxiety management. However, when child and parent had anxiety, 39% of children improved in the CBT compared to 77% who received CBT and parental anxiety management.

This research is somewhat inconsistent in that it states parent and child intervention used more active coping strategies. This is compared to child only or parent only treatment, when the child is diagnosed with anxiety and depression, (Mendlowitz et al., 1999). Other research such as Knox, Albano and Barlow (1996), state that parental involvement shows promise in treatment of children diagnosed with OCD.

Parenting styles can have an influence on the child's anxiety. It is found that parental control during parent-child interaction was consistent with child shyness, and

child anxiety disorders (Wood, McLeod, Sigman, Hwang and Chu, 2003). Mothers of anxious children were more critical and granted less autonomy than mothers of non-anxious children. Their diagnosis of anxiety was the best predictor of maternal damaging behaviour (Moore, 2003). These mothers were also less warm, more critical, and more controlling than mothers of non-anxious children. Other research shows that children who reported significant distress in their own level of anxiety also reported that their mothers as less psychologically controlling. Children who did not have significant improvement reported changes in mothers' psychological control. Parents did not report any changes in their level of control (Gosch, 1998).

There is inconsistent research when viewing child and parental reports of the child's improvement in anxiety symptoms through treatment. Rapee, Barrett, Dadds and Evans (1994) reported that parent-child agreement was poor. This is consistent with research by Vance, Costin, Barnett, Luk, Maruff and Tonge (2002) who also found that there was no significant association between the child and parent reports of anxiety. However, Howard (1995) showed that children whose families participated in treatment showed improvement in child-report, parent-report, and teacher-report measures.

The therapist appearing in alignment with one of the family members could be another difficulty when working with the family instead of the client only. Unknown to the therapist, he/she might have defined the problem in a way that aligns with one person in the family (Roth and Fonagy, 1996). According to Epstein, Schlesinger and Dryden (1988):

> Cognitive behavioural techniques require families to learn a number of skills and to build a repertoire of responses which together redirect crucial aspects of family

functioning. Limited intellectual capacity in families may impede the learning process that characterizes these approaches and may reduce the techniques' effectiveness. (p.41)

Regardless of the skills that a therapist brings, he or she still faces several potential hazards. According to Ellis & Bernard (1983), some of these problems are under-diagnosing the extent of irrational thinking of family members. Parents and children may try to present themselves as the best possible light. There is also the possibility that the therapist will become enmeshed in the family's miss-perception of the problem.

According to Goldfried (1995), instead of concluding that the fearful individual was "not ready to change," sometimes the therapists create hierarchies of increasingly more anxiety-producing situations that would allow for an ongoing progressive reduction in anxiety. However, the higher the magnification, the narrower the field of vision. Thus, it fails to look at behaviour patterns that may differentiate at times and settings of a client's life. As well, the therapist's objectivity can be compromised when judging what is rational and which cognitions need to be changed (Spinelli, 1994). This may be a problem if the wrong cognitions are focused on, therefore hindering success of the treatment. Nevertheless, Person (1989) concluded that a therapist who is empathetic, genuine, and warm is important in a helpful therapeutic relationship.

Cognitive Behavioral therapy has evolved over the years from research with animals, to humans, and from psychology to social work. The research shows that CBT is an effective form of treatment when used with children and adolescents who have been diagnosed with an anxiety disorder. Including significant others is beneficial to

treatment. This is because the child's behavioral changes are encouraged, and maintained when the therapist is not present. Therefore, Cognitive Behavioral Therapy was used with individual children and adolescents who have been diagnosed with an anxiety disorder. As well their, parents/guardians and significant school personnel were involved in the practicum treatment program.

Chapter 3 - Implementation of the Practicum

Setting Description

Human Resource Centre of the Lord Selkirk School Division.

The Human Resource Centre (HRC) is part of the Lord Selkirk School Division and provides clinical services to students and their families within the school district. It is located within Daerwood School, in Selkirk, Manitoba. The staff at HRC offers several different family/school oriented services including individual and family counselling. The therapy is provided to a variety of client populations with regard to an assortment of family and school related issues. All services are free of charge.

Client

Cognitive behavioral therapy with children and adolescents who have been diagnosed with an anxiety disorder was the focus of this practicum. The clients were referred to the Human Resource Centre from the schools, parents, and the local community Child and Adolescent Mental Health services. The treatment and practicum provided through the HRC is voluntary. Children and adolescents who participated in the practicum were accepted based on their declaration of being diagnosed with an anxiety disorder, and agreement to maintain weekly contact for the full twelve sessions. Children and adolescents were not accepted into this program, and directed to appropriate resources, if they did not meet the criteria of having diagnosed anxiety disorder. Children were excluded if their family were unwilling to partake in the full practicum procedure; or if there was drug or alcohol dependency, as well as the ability to complete the program in the time allotted.

Recording

The practicum student kept session notes for each client contact. These records were set up for the clinician to make notes on each session or contact the student had with the client, family, peers, or school. The date and type of contact were also recorded.

The pre-consult form was collected prior to agreeing to work together in the practicum. The pre-consult form enquires identifying information about the client, as well as the reason for the possible referral. The referral form, which also asks for identifying information about the client, was gathered after the agreement between the client, parents, and practicum student was made to participate in the practicum. The assessment form included an in-depth description of the client's anxiety from birth to present.

The practicum student kept a daily journal, which covers the day of contact and who the contact was with. There is also a brief description of the events of each meeting. These notes illustrate any concerns of the client that the writer wished to discuss later with the supervisor, as well as concerns of the practicum procedure.

The supervisor and practicum student met every second week to discuss each case in detail, learning objectives, concerns, and need for improvement. Additional consult meetings were available when the student requested. In addition to written records, sessions with two clients were audio taped for review by the student and/or supervisor and advisor.

Supervision and Consultation

Mrs. Toni Cascegna, a school psychologist of the Lord Selkirk School Division, provided student supervision. Mr. Brian Lee, a school psychologist of the Lord Selkirk School Division, also provided supervision upon request. Mrs. Cascegna and Mr. Lee have extensive experience in the area of working with individuals and their families within the school division. Supervision with Mrs. Cascegna consisted of meetings every second week in which the student and supervisor discussed case-related issues and student progress. Less formal supervision was also available for brief consultations throughout the week. During the commencement of the practicum, supervision focused primarily on the student conceptualising, and planning for work with the newly acquired cases. As the practicum progressed, supervision progressively focused on various therapeutic tools and techniques that could enhance the student's work with clients. The provided supervision was invaluable to the student's development as a new practitioner of cognitive behavioural therapy.

Professor Ranjan Roy of the Faculty of social work at the University of Manitoba was available for consultation of the practicum proposal and final practicum report. He had also made himself available to observe and participate in the oral presentation of the practicum by this writer.

The student's advisor, Dr. Frankel Associate Dean of the Faculty of Social Work at the University of Manitoba, also provided supervision. Dr. Frankel made his services available when the student felt clarification was needed for the practicum to succeed, aid in proposal and final practicum paper writing, as well as over all support. Contact was

made primarily through e-mails, and individual consultations were planned mid way through the practicum as well as at the end of the practicum experience.

Approval for this practicum has also been obtained from the Foint-Faculty Research Ethics Board (JFREB) (Appendix F).

The participants and their parents/guardians read and signed the consent forms prior to commencing this practicum. A copy of the participant and parental consent forms are in Appendix B and C.

The Cognitive Behavioral treatment program for this practicum consisted of twelve sessions for each client (Rapee, Wignall, Hudson and Schniering, 2000). Sessions were scheduled weekly at the school or at the student's home when requested. Sessions one through eleven were weekly with a four week break between the eleventh session and the twelfth session to provide follow-up.

Cognitive Behavioural Intervention

The assessment meeting was designed to consider how the therapy would best suit the child and their anxiety. Herbert (1994) has suggested seven key steps in assessment:

1. Identify the target problem.
2. Identify setting in which the behaviours occur (person, places, times, situation).
3. Set parameters (frequency, intensity, number, duration, and sense/meaning).
4. Identify the organism variables (age, sex, congenital-genetic factors, brain functioning, personality and arousal, health and physical impairment, temperament, autonomic reactivity, stress proneness, cognition-IQ, and achievement level).
5. Identify the antecedents to the event (distal antecedents, proximal antecedents).

6. Identify consequent events (proximal outcomes, distal outcomes).
7. Identify diagnostic implications (personal (emotional), and social such as attitudes towards the self, integration, reality-orientation, autonomy, and perception of reality; ongoing development such as growth, development, and self-actualization; learning such as environmental mastery; and others).

The child filled out weekly questionnaires at the commencement of each week's therapy sessions, and parents completing a questionnaire pre and post treatment.

Duration of Intervention with Each Client

According to Rapee, Wignall, Hudson and Schneiring, 2000, a typical twelve-week program resembling the following was used in the practicum:

1. Rapport building; linking thoughts and feelings; nature of anxiety
2. Introduction to cognitive restructuring
3. Cognitive restructuring practice; self-rewards
4. Introduction to relaxation; practice techniques
5. Practice of relaxation and cognitive techniques
6. Commencement of graded exposure
7. Review of techniques
8. Review use of techniques; introduction social-skills practice
9. Review use of techniques; discuss assertiveness and teasing
10. Review use of techniques
11. Termination issues; closure
12. Booster session.

Family therapy is highly recommended when working with anxious children, (Rapee et al., 2000). This is true because parents help the child practice the skills learned in the sessions. In a sense, they are a 24hour per day therapist. This does not mean that parents had to be present during the treatment sessions, due to practicality reasons. However, the caregivers were informed of the program being taught to the child. It was highly recommended that both parents attend to ensure that one parent does not undermine the treatment procedure.

Time allocation

On average, the student spent time on regularly occurring tasks such as:

1. Planning for each client session: 30 minutes
2. Travel time: 10-40 minutes per client
3. Client sessions: 30-60 minutes
4. Written records following each session: 10 minutes
5. Consultation with parents: 10-60 minutes
6. Preparation for supervision: 30 minutes
7. Supervision sessions- 1-2 hours

These additional tasks were also performed:

1. Client services, i.e. meeting with the school personnel, arranging appointment times, telephone contacts, seeking information
2. Additional consultations
3. Planning and administering seminars for school personnel in the division
4. Attending seminars in the area of child and adolescent counselling, and anxiety disorders.

Chapter 4- Evaluation

The evaluation for this practicum involved multiple measurements of this student's learning and outcome goals. The use of these measures gave the researcher greater confidence in the data. This assurance was due to the collection of information from multiple perspectives about the targeted problem (Bloom, Fischer, & Orme, 1999).

Evaluation Procedure

Two measures used in this practicum were the "What I Think and Feel" scale (Reynolds and Richmond, 2000) (Appendix D), and the Revised Behavior Problem Checklist (Quay and Peterson, 1987) (Appendix E). The Human Resource Centre purchases the "What I Think and Feel" scale therefore, consent for its use had been obtained. Only the anxiety portion of the Revised Behavior Problem Checklist was used for this practicum, and was obtained from the practicum advisor at the University of Manitoba.

The self-report measure used was the "What I Think and Feel" scale (RCMAS) (Reynolds et al., 2000). It consisted of thirty-seven yes/no questions relating to worry and oversensitivity, physiological anxiety, and social concerns/ concentration. It was designed for children age five to nineteen, and took approximately five to ten minutes to complete. Instructions for the RCMAS were provided prior to the children reading the questions. They were told there was no right or wrong answers, and asked to answer the questions that best fit how they have felt in the past week. All children were able to read the questions; therefore, they did not have the questions read to them.

The internal consistency coefficients for this measure varied from .78 to .85 across age, and the test-retest coefficients ranged from .69 to .98. Concurrent and

construct validity were recognized through correlations of .85 between the RCMAS and the A-Trait scale on the STAIC (James, Reynolds and Dunbar, 1994).

One of the difficulties with scoring this questionnaire was that it was developed in the United States and provides three categories of race to score under (White, Black, & Combined). The difficulty was that there were aboriginal children in this study and they did not fall under any of the categories. Therefore, I had to choose the category of White to be able to score them, because of the three categories to choose from I felt that this one best represented them.

The students found the questionnaire easy to complete. However, when administering the same questionnaire for fifteen weeks, some children had memorized the questions and were not reading the questions but circling the answers that they circled in previous weeks.

Overall, I would say that this questionnaire was helpful in analyzing the client's anxiety from a number of viewpoints (physiological, oversensitivity, concentration & lie). The Physiological subscale is an indicator of the child's expression of physical symptom of anxiety. A high score on this suggests that certain kinds of physiological responses are typical during times of anxiety. The Oversensitivity subscale suggests that the person is afraid, nervous, or in some way oversensitive to their environment. A high score on this suggests that the child is internalizing the anxiety experiences and may be overloaded with trying to relieve this. The social concerns/concentration subscale conveys a concern about oneself with other people or express difficulty with concentration.

This scale uses Standard Deviations (SD) as a form of scoring the total anxiety. According to Bloom, Fischer and Orme (1999):

> The standard deviation tells us the average amount by which the scores in a given distribution deviate from the mean of the distribution. The SD is important not only because it is used in a variety of other statistics, but because knowing the SD tells us the exact percentage of scores above and below the mean. (564-565)

I would recommend this questionnaire to clinicians who would like to follow improvement in anxiety symptoms. I however, would be cautious as to how often I administer the questionnaire, and how close together I administer them, for fear of memorization of the questions.

A second measure used in this evaluation was the Revised Behavior Problem Checklist (Quay and Peterson, 1987). This checklist, which was designed to be used for children between the grades of kindergarten to twelve, consisted of 89 problem behaviors that were rated on a three-point scale by a teacher or parent. This study required only parents to complete the scale. This checklist evaluated four major areas: conduct disorder, socialized aggression, attention problems- immaturity, and anxiety-withdrawal. Due to the focus of this practicum being child and adolescent anxiety, only the anxiety section (AW) was evaluated. The anxiety sub-scale included items that related to such DSM-III categories as separation anxiety, avoidant disorder, overanxious disorder, and dysthymic disorder.

The reliability coefficients for the AW scale in six samples ranged from .74 to .89. Studies have reported inter-rater reliability coefficients ranging from .61 to .70. A variety of test-retest findings were found, however, a mean correlation coefficient of .79

(2 months) was found when using the same teacher. A lower correlation coefficient was found .32 when obtained using different teachers, and when testing 7, 12, and 17 months apart. External validity of four major DSM-III diagnostic categories found that parents' ratings were not significantly different among three groups (anxiety disorders, ADHD, and a co-morbid ADHD and conduct disorder). There were sufficient differences between the children with anxiety disorders and a symptom free control group using the AW scale.

The RCMAS was administered weekly to the child/adolescent at the beginning of each session. The questionnaires that were completed in the first eleven sessions provided an intervention phase measurement. Following the eleventh session, a four-week break from therapy was provided although weekly questionnaires continued to be administered. The twelfth session followed this break, at which time a final questionnaire was completed and involvement was terminated. The combination of the four-week break and session twelve made up the baseline phase.

The Revised Behavior Problem Checklist was administered in a pre-test, post-test format due to inability to meet with parents in person weekly. The questionnaires were provided to parents to complete in the assessment session, as well as the follow-up/termination session.

Overall, I would use this checklist again in the future. However, I would use it with a more detailed analysis of the questions that were circled to be severe in nature. I would also focus more on the differences between parents and child checklists, to bring out perception differences of the same situation.

Evaluation of Learning Goals

The practicum intervention and overall practicum experience was evaluated through a combination of self-evaluation, feedback from this writer's onsite supervisor, along with feedback from the clients themselves. The following will explain the forms and feedback questions that were gathered.

This writer kept a journal of daily activities to allow for personal reflection. This process allowed the student to document the practicum experience and observe if progress had been made toward achieving the learning objectives or if there were areas that needed greater improvement. These were later discussed with the onsite supervisor. Baird (2002) provided an intern evaluation form for both the supervisor and intern. These evaluation forms consisted of seven sections. Each section contained several points of assessment. These points were rated on a scale from one (Far Below Expectations- needs much improvement to form a judgement) to five (Far Above Expectations- a definite strength, performs well beyond average levels for interns), by the student and supervisor. A rating of NA (Not Applicable) was also available to this evaluation. The section headings for this evaluation are as follows:

1. Basic Work Requirements
2. Ethical Awareness and Conduct
3. Knowledge and Learning
4. Response to Supervision
5. Interactions with Clients
6. Interactions with Co-workers
7. Work Products

The onsite supervisor, as well as the student completed a mid-term review of the student's progress, as well as a final evaluation. The mid-term review was beneficial for both the student and supervisor in terms of whether progress was made and what areas needed further development. The final evaluation provided an indication of whether the supervisor and the student felt the practicum interventions were completed satisfactorily and whether learning objectives were met. Any section that was assigned a rating of three or lower was considered by the student as an area for further development. Copies of the mid-term and final evaluations were provided to both Dr. Frankel and Professor Ranjan Roy for review and feedback to the student.

Evaluation was also based on audiotapes of a few clients weekly sessions. Both students as well as their guardian agreed to have them audio taped. At first, they appeared nervous by looking at the cassette player, and asking a few times who would be listening to the tapes and where they would be going after the practicum. They appeared relaxed about the recording after receiving reassurance that only the supervisors of this practicum would hear the tapes and then they would be destroyed following the practicum. These tapes were available to this student's onsite supervisor as well as the advisor. Clients and their parents in the twelfth session were also asked to reflect and comment about their experience with this student, cognitive-behavioral therapy, and anxiety.

Chapter 5 – Case Examples and Evaluation Results

This chapter examines the cases involved in this practicum as well as evaluates the results developed over this period. It begins with a brief overview of the results obtained from the questionnaires, discussion of the instruments themselves, and the clinical value of each. Secondly, this chapter focuses on three cases in detail to demonstrate how this student used the assessment and cognitive behavioral therapy intervention. These case descriptions involve an in-depth discussion of each session, the goals and outcomes of each session, and therapist's reasoning behind case intervention. Each of these cases end with the client, family, and therapist statement concerning case outcomes. There is also detailed case evaluation information.

Overview of the Clients and their Families

Nine families initially signed up to participate in this practicum. Meetings were set up with the child/adolescent for weekly therapy sessions, as well as weekly phone conversations with the parents. All of these families participated in the assessment process, completed the pre-test parental questionnaire Revised Child Behavior Checklist (Quay and Peterson, 1987), and started the therapy process. Eight students went on to complete the twelve sessions. One student was asked to leave after the fourth session due to issues that fell into the exclusion criteria to participate in practicum.

Of the nine families, five had immediate family member(s) diagnosed with an anxiety disorder, and one did not have immediate family members but had extended family diagnosed with anxiety. One of these family members was female, and five were male. Of the nine families, four parents also displayed other mental health disorders, and one child in this study was diagnosed with a co-morbid disorder.

Family dynamics and their socio-economic status also played a role in this practicum. Four of the nine students were affected by their parents' separation or divorce, and two of these parents have since re-married. Two of the students lived in a single-parent home; however, seven of the nine families had at least one if not two of the parents working. Four families were considered to be in high socio-economic status, one family in middle class, and four families in low social economic status. The family's low socio-economic status became a source of anxiety for some of the participants throughout the sessions because they felt they could not provide themselves with the same things as their friends/neighbours.

The focus of this practicum was child and adolescent anxiety disorders however; a child having a single disorder is often not the case. Around eighty percent of children treated for anxiety disorders (the most problematic disorder in their life) will have at least one other disorder (Rapee, Wignall, Hudson and Schniering, 2000). Most often, this is another anxiety disorder. Depression is also commonly associated with anxiety disorders. The National Institute of Mental Health (2004) reported that approximately 42% of people with depression also have anxiety traits. They also reported that 43% of people who have bipolar disorder also exhibit PTSD symptoms. These studies showed that people with severe anxiety are at a high risk of suicide.

In this practicum, all students were diagnosed with an anxiety disorder. One girl was examined for ADHD. A boy in this study had been diagnosed as having bipolar disorder. As well, two girls had discussed thinking of suicide at a point in their treatment.

Case Examples

The clients who were referred to participate in this program were primarily referred by their school. Two of the students however were referred by the local Child and Adolescent Mental Health agency. All of the clients were diagnosed with an anxiety disorder and were seeking treatment for their anxiety or their parents were seeking treatment for them.

Parents of these clients were provided with a package of information, which included a description of what anxiety looks like, and a detailed description of each Cognitive Behavioral therapy session. Parents were contacted weekly to review this information as well as to provide information as to how they could best help their child each week with practicing coping strategies.

The following case reviews are based on three of the clients who participated in the program. The case examples start with a description of the client who made the greatest gains. The second case example has a description of the client who made the least gains. The last case is of the client who taught me the most from participating in this program. The chapter concludes with a brief overview of the six remaining clients.

"Vince"

Vince was an adolescent male referred to the practicum by his school counsellor. The counsellor was concerned with his social anxiety getting in the way of attending classes, and with his aggression and timidity. Vince lives with his parents, brother and sister who moved to this community from a small northern reserve a few years prior. This move had a significant impact on his anxiety. His forwarding school had

approximately two to three hundred students all together, and his current school is five times that amount. Therefore, this contributed to his fear of crowded places.

The assessment session took place at Vince's home due to expulsion from school. This session included Vince, his mother, and brother. Prior to obtaining information, Vince and his parents completed a consent form to participate in the program. A copy of the consent forms are in Appendix B & C. There was a discussion of the parental information package, as well as an overview of what each session would look like. We also discussed the signs and symptoms of anxiety and, ways Vince had tried to reduce his anxiety.

In the initial meeting, we also completed an assessment of the anxiety. This student was afraid of large public places such as the crowded hallways at his school, crowded malls, and skating rinks. His anxiety heightened prior to attending school for fear of what was to come. This anxiety happened every school day, was moderate in intensity, and would persist until he could get himself into a smaller environment such as the classroom.

When assessing Vince's personal variables there were no congenital-genetic problems. He was of normal intelligence; he was in good health and had a shy personality.

He could foresee problems approaching with his social anxiety, when he starts back to school, as well as Christmas season when he will have to go into a mall. These places were a problem because he would have to face large groups of people. Vince and his mom describe him as not having a lot of self-confidence, and having a hard time making friends.

Vince had tried anti-anxiety medication at one time however; he felt that he could overcome his anxiety without the aid of medication. He also felt that his most common automatic thought when he was anxious was that he would embarrass himself. Both the parents and Vince completed the questionnaires before leaving. They appeared to be eager to start, awaiting the possible coping strategies that the therapy could provide.

The first session, which focused on the cognitive restructuring portion of this therapy, took place in Vince's home. We started with the questionnaire and began to discuss positive vs. negative thinking.

The goal of this session was to make Vince aware of how worried thinking leads to worried feelings, which lead to negative behaviors. The goal was to teach him to find calming thoughts of a situation that would lead to calmer feelings and end with positive behaviors. Vince often had negative thoughts in the hallways of the school. These thoughts mainly consisted of thinking that people were looking at him, and thinking negatively of him. He also thought that everyone else was confident and he was the only one who doubted himself.

The hope of this session was to help Vince turn the negative thinking into positive thinking. He was able to do this by focusing on the fact that other people may be thinking of their own lives instead of him. He also thought when people look at him it may just be a casual glance and not a stare. He in addition thought that other students have difficulties as well such as school tests, family issues, or friendship problems. This would allow him to walk the hallways with a more confident feeling like he is not the only one feeling stress, and that he may be misinterpreting the social cues: The

anticipation was, with practice, this would lead to behaviors that are less avoidant of crowded environments.

Vince's homework assignment for session one was to think positively when he was feeling anxious. He also needed to be reflective of how his positive thinking or negative thinking made him feel, and to what type of day that would lead.

The second session was in Vince's home, and addressed the second half of the cognitive restructuring section of this therapy. We first followed up with Vince's homework assignment. He felt that thinking positively did make a huge impact on how he felt, but that doing this was hard work. We discussed the more he used this technique the more it would become second nature.

For this session, we started with a questionnaire and then focused on the goal of this session. We addressed reasons for his stress possibly being his ability to overestimate the probability or overestimate the consequences of an action. Once Vince realized that he often overestimates the probability that people will laugh at him or think bad thoughts about him we then looked at past evidence to warrant these thoughts. He had no confrontations with people making fun of him in the past. This was just his perception. We re-examined alternative explanations for the social cues that he was focusing on, and discussed a role reversal. In the role reversal we visualised if he was standing in the hallway of the school, he could see that he would be casually looking at people as they walked by. He realized that this did not mean he was thinking negatively about them, as he thought they were thinking of him.

We also looked at the probability of his worst-case scenario, and challenged his thinking. These were such things as "how bad is it really?" "It is not the end of the

world." "Not everyone has to like me." "I am a good person, and it's a shame that they don't get to know me". By focusing on the alternatives, and past evidence, the hope was that Vince would come to the understanding that his fears may not be happening. Instead, he could be oversensitive to the environment. It is easier for Vince, or any client, to make changes within himself than it would to change everyone around him.

Vince's homework this week was to practice the above-named challengers to his thinking, and to evaluate the evidence.

The third session took place in the home with Vince and his parents. We began the meeting with the questionnaire and a review of the pervious sessions. Vince reported that he had been using the positive thinking and that it was beginning to get easier to use. However, he said that he still needed to work at it.

The focus of this session was to look at self-rewards for the client and child management techniques for parents to assist in decreasing anxious symptoms and behaviors. The goal of this meeting was to encourage the parents to use child behavior management to reduce the attention towards Vince's unwanted behaviors and encourage the wanted behaviors by providing attention. Secondly, they could praise Vince for being courageous with not avoiding the anxiety. They needed to be clear and specific in what it was that they were praising. The parents were also encouraged to reward Vince for non-anxious behavior. This reward could be in the form of candy, presents or even hugs, and spending time together. Lastly, ignoring or removing attention from the unwanted behaviors was taught to the parents. Since many of the practicum participants had anxious parents, they were to model the appropriate behavior in front of their children. Most importantly, they also needed to be consistent. They were also promoted to not

give empty threats, not give into rewarding the child because they were worn down, not to be vague in instructions, and to have consistency between parents.

Vince and I came up with ways to accomplish a small goal of his by identifying manageable steps towards the goal. Once each step was completed, he was encouraged to reward himself with self-rewards such as praise, extra TV time, or buying a favourite magazine. This particular client focused on getting himself back to school because he could not think of a smaller goal.

The fourth session started with a questionnaire, and followed with a review of last session's homework. Vince's goal was to return to school therefore, he signed himself up for school, and had a meeting with the school administrators, school counsellors and his parents. It was encouraged at this meeting that he remain at the specialized self-paced school he was currently attending until his anxiety reduced even more. The prospect was of him returning to school in the fall. His parents encouraged him to keep trying and not look at this as a failure to attend school, but an opportunity to become stronger before facing this anxiety-arousing environment again. These parents were unique in that they were less involved in directing their son in his life path, but supportive in whatever he wished to do with his life.

In this session, we focused on learning relaxation therapy. The goal was to help Vince become calm, reduce headaches and stomachaches, be able to concentrate, and to have a more peaceful sleep. We did this by focusing on the difference between having a tense body versus relaxed body. Vince was encouraged to practice his relaxation in a quiet room where he would not be disturbed. A relaxation tape was provided to him. This was a recording of the therapist's voice walking him through tensing his entire body

and then relaxing the body muscles from feet to their head (Rapee, Spence, Cobham and Wignal, 2000). For practicing purposes, this adolescent chose to lie down on the couch while listening to the tape, closed his eyes and followed the instructions on the tape. The tape was approximately fifteen minutes in length. Following the tape Vince reported that he felt very relaxed and sleepy, which was the goal of the session.

Vince's homework was to listen to the tape throughout the week when he was feeling symptoms of anxiety. Then he was to report how he was feeling before the tape and after.

The fifth session was a review of the previous sessions. After completing the questionnaire, Vince reported that he felt more relaxed as if his anxiety had been reduced. He stated that he listened to the relaxation tape from the previous week and it helped him to fall asleep.

Through this session, Vince constantly asked how I thought he was doing. I discovered he enjoys receiving positive reinforcement. Therefore, I let him know he was doing well with practicing the techniques I was teaching him. He followed through with the suggestions I made, was eager to reduce his anxiety, and was looking for anything to help him. He acknowledged that, of all the cognitive restructuring statements; he found it easiest to think, "How bad is it really?" He reinforced himself, by saying "each time I face my anxiety it will get easier". He also used his relaxation tape 5/7 days, and was feeling comfortable to look for alternative-soothing tapes before this one became too repetitive. Vince's father also felt his son was getting better because he was going out more to play hockey with his friends.

The homework for this week was for Vince to continue using the previously taught coping skills.

The sixth session took place in Vince's home. We started the session with a questionnaire and an introduction to exposure therapy. Vince reported that his anxiety was still dropping and was feeling much better about himself.

The goal of this session was to have Vince face his fears gradually, stay in the feared situation for longer periods, or practice repetitions of the anxious state. His parents were reminded that their support and encouragement is helpful in this step, and they should refrain from trying to step in and rescuing Vince from the anxious situation.

We identified the behavior to focus this session on. Vince made a list of things that were really hard to do, things that were a little hard to do, and things that made him a little worried. Once this was completed, the really hard behaviors were focused on. This was identified as being able to stay in large crowds (especially hallways in his school), without feeling the need to escape. Vince also felt that his anxiety amplified when walking to school, because of what he thought he was going to face.

Once his goal was identified, a list of steps to help accomplish this was established. While Vince was out of "normal school hours", he was to start practicing getting up and ready for school at the times he would at his previous school. Next, he would add on walking to school and come back home. Subsequently, he would add walking into the school doors and out. Then he would walk into the school to the office and leave a note. Lastly, we would walk around the hallways together, and then he would walk by himself.

These steps were completed at the clients pace. For instance he would walk to school every day until his anxiety was low enough that he felt he could move on to the next step. He began this process of getting up and ready in the morning, however he did not practice walking to school because it was too cold outside, and was not motivated to go out just to walk back home. Therefore, he jumped to the step where we would walk the hallways (with the principal's permission) for as long as he wanted. We did this weekly along with our other sessions. He felt from week to week that his anxiety was reducing which. The writer also observed this. The first time we walked the halls Vince did not say a thing and walked quickly. The last time he walked the halls it was at a "normal" speed and he stopped to talk to a few of his old friends. As well, with each trial, he wanted to walk for longer periods.

Vince was encouraged to work out a reward system with his parents for pushing himself through the anxiety. He did come up with the list of rewards but did not follow through with receiving them. He said that the feeling of accomplishment was enough of a reward.

<u>The seventh session</u> was a review session, which took place in Vince's old school. We started with the questionnaire, and then walked the hallways of the school to practice the exposure therapy. Vince reflected on how his body was feeling when walking the halls. He stated it was tight in the chest when he first started walking, but became more relaxed as we continued.

He was also thinking that some of the people in the hallway were pushing and shoving and did this intentionally. We focused on how his thinking could be misinterpreted, and that many kids in high school act immaturely and like to roughhouse.

We discussed when someone bumps into him it may be an accident, but many adolescents don't have that maturity to say "sorry", therefore allowing him to know that it was an accident.

Given that Vince could not enter his old school without supervision, he could not practice the exposure therapy between sessions. Therefore, his homework was to visualize himself walking through the hallways, focusing on how other people would be acting, and how he would like to act when in this situation.

The eighth session took place in the school. We started with the questionnaire and walking through the hallways. This time Vince walked slower than the previous week, and wanted to walk for a longer period. He reported again that he was feeling a bit anxious but much less than last week.

This week's session focused on social skills. We discussed three basic skills (Rapee, et al. 2000):

1. Body language- eye contact, posture, and facial expression
2. Voice quality- tone, pitch, volume, rate, and clarity
3. Conversation skills- greetings and introductions, and holding a conversation

Vince was already practicing good social skills in comfortable situations, as would most people. He also displayed good social skills in some uncomfortable situations. However, Vince needed to work on having an open posture, walking with his head held up, making eye contact with people as he walked by, and casually smiling if he knew someone. He also needed help on the volume of his voice. He, like many anxious people, talked quietly in nervous situations. We focused on how loud to talk in different

crowds, and at different distances, or settings. He was appropriate for tone, pitch, rate, and clarity.

We also discussed holding a conversation. Vince knew how to start a conversation and introduce himself. However, when the conversation came to a lull he did not know what to say, and became uncomfortable. Therefore, we discussed a variety of questions he could ask when the conversation stopped. These were such things as "have you seen any good movies lately?" "How did you find that test?" We discussed the difference between a close-ended question (a question that is answered with a yes or no), and an open-ended question (a question which keeps the person talking). Most people like to talk about themselves, so we focused discussions on asking people about them. Therefore, the next time he saw someone he had previously talked to he could ask them something about them he learned in the last conversation.

Once again, Vince could not practice these social skills in his school. Therefore, he would practice them when he went out to play hockey with his friends. This is a much more comfortable situation; however, his friends would often bring new people along to play. This gave him a good opportunity to use his social skills.

The ninth session once again took place in Vince's school. We started with a questionnaire and walked through the hallways. This time I walked slightly behind Vince so that he felt he was walking alone. It also gave me an opportunity to see if he was keeping his head up or glancing at other students in the halls. He appeared much more confident this time, and even tapped a friend and said "hi" as he passed by. He also reported that he had approached a new person at hockey this week and held a good conversation.

This week's session focused on assertiveness training. Vince stated that he feels he is a passive person when anxious and will avoid the uncomfortable situation. However, his school counsellor, and parents also provided me with instances where he became aggressive when anxious. We discussed how a passive person and an aggressive person would present themselves. However, our goal was for Vince to be assertive. He was already practicing some assertive non-verbal strategies, by looking people in the eyes, standing up straight, smiling, and speaking clearly. He still needed to practice letting other's know what his needs were, while being respectful. He needed to do this by keeping his explanation simple, giving a reason, and to not blame. We practiced several scenarios of this.

We also discussed using humour, getting off the subject, and repeating himself if someone is being aggressive to him. He stated that he is most comfortable agreeing with the person or getting off the subject, because most fights are not worth getting into trouble for. He does not enjoy fighting, and therefore tries to resolve fights as quickly as possible.

The homework for Vince this week was to practice these assertive skills.

The tenth session took place at the school. We started with a questionnaire and discussed Vince's homework from last week. He said that he did not have any anxious moments in the last week so he did not have a chance to practice the skills. Therefore, he was to carry over this homework to the next week.

This session was a review of the previous sessions. Vince was still feeling very confident and looked for reassurance that he is not the only one seeing changes. He stated that school is going well for him. He was getting out more, and was looking

forward to the fall. When walking the hallways this week, he felt that there was no anxiety at all and wanted to keep walking until the students were in their classes.

The eleventh session was also a review, and completed at Vince's home. He was still feeling good about the gains he had made, did not felt the relaxation tape was needed at that time, and was using the positive thinking. As well, the social skills and assertiveness were not getting much practice because he was associating with his friends.

Vince's homework for the next four weeks was to remember all the skills that were taught and to use them as often as he could when he became anxious.

Four-week break-For these four weeks we met once a week to complete the questionnaires. During this break, no skills were introduced. This break was used to evaluate if Vince was using the skills without the aid of the therapist. He did meet for the first and fourth session, however he forgot about the second and third.

The twelfth session provided closure to the client and family. We discuss the gains of the client, complete the parental questionnaire as well as the client questionnaire. I also gathered feedback from the family of the practicum itself. The client had indeed made improvements, which is discussed in the next section.

Vince and his parents provided feedback of the process of the practicum. He did not feel that he would seek services again because he feels that he could handle any problem himself, or would seek help from family members or friends. Vince found that I was the most helpful when I took him to his school and we walked around in the crowds for the exposure, and to get up and face his fears. However, he did not have any suggestions as to how I was not helpful. He did feel that he CBT was helpful because it taught him to stand up for himself and how to be relaxed in every situation he comes

across. He found all the techniques helpful, however he felt that if he had to pick one that was the least helpful it was the social skills because he finds it difficult to reflect on his own body language and cues when nervous.

Vince felt that there had been drastic changes from the start of therapy until the end. He felt better about himself, felt happier, and wanted to do more things. When asked how close he was to achieving his goal, he said that he was 80%-90% there. We discussed that now he had the tools to cope with anxiety, he could continue practicing them and he will reach his goal.

His parents also thought that he had made some gains with his anxiety. They saw him going out more, and he had received his driver's license the day of our twelfth session, which they believed previously could have been an obstacle due to his anxiety. An area of continued growth for Vince, perceived by his parents, was to improve on his self-esteem. He often felt that he needed to be perfect, and would feel awful after something went wrong. We discussed how they could tell him to accept that not everyone is perfect and that it is OK to fail, but it is not OK to give up. Therefore, when something goes wrong, instead of dwelling on that, he could focus on how he could make it better.

<u>Overview-</u> I enjoyed working with Vince because he was eager to learn, and willing to face his fears without excuses. He was able to focus on how he could do things differently the next time, and was keen to hear positives, which his parents were able to provide him. The only difficulty we had in our practicum process was multiple missed appointments. As well, Vince's parents sometimes forgot to follow through with their

end of the practicum such as rewards. However, the clients' internal drive to be better made up for this.

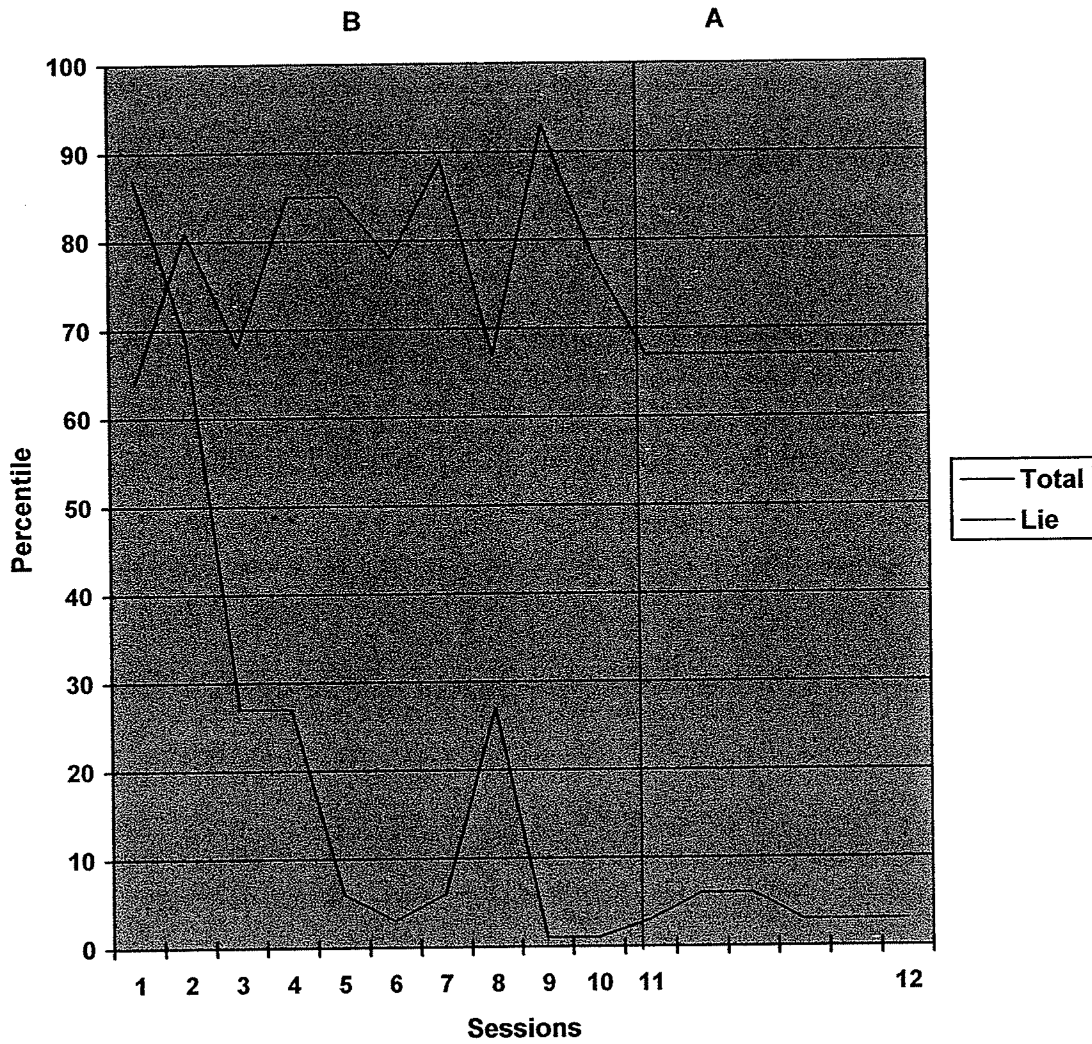
Case evaluation

The evaluation questionnaires supported the assessment and outcomes of the therapy. Figure 1 depicts Vince's Total anxiety score and Lie score from the RCMAS questionnaire throughout the therapy process. Figure 2 shows the three subscales: Physiological anxiety, Worry/ Oversensitivity, and Social Concerns/ Concentration. Lastly, Figure 3 has the parental report of their child's pre-post test results from the Revised Child Behavior Checklist.

Vince came to this program with a Total anxiety score in the 87% range (Figure 1). This high score, according to the manual, should have been given strong consideration because it was falling above two standard deviations from the mean. Further information and consultation was recommended for scores in this level (Reynolds, Bert and Richmond, 2000). This was not a concern at the beginning of the program, because I was aware there would be situations where clients, such as Vince, would have high anxiety coming into this program.

Throughout the intervention process, his scores did fluctuate, which is not uncommon. The fluctuation was in a decreasing motion. After session 3, Vince's total anxiety score was at the twenty-seven percentile. This score decreased further in session 6 to the third percentile, and ended at the third percentile before moving to the baseline phase. This suggests that Vince was feeling much better about himself and his symptoms throughout the treatment phase.

FIGURE 1



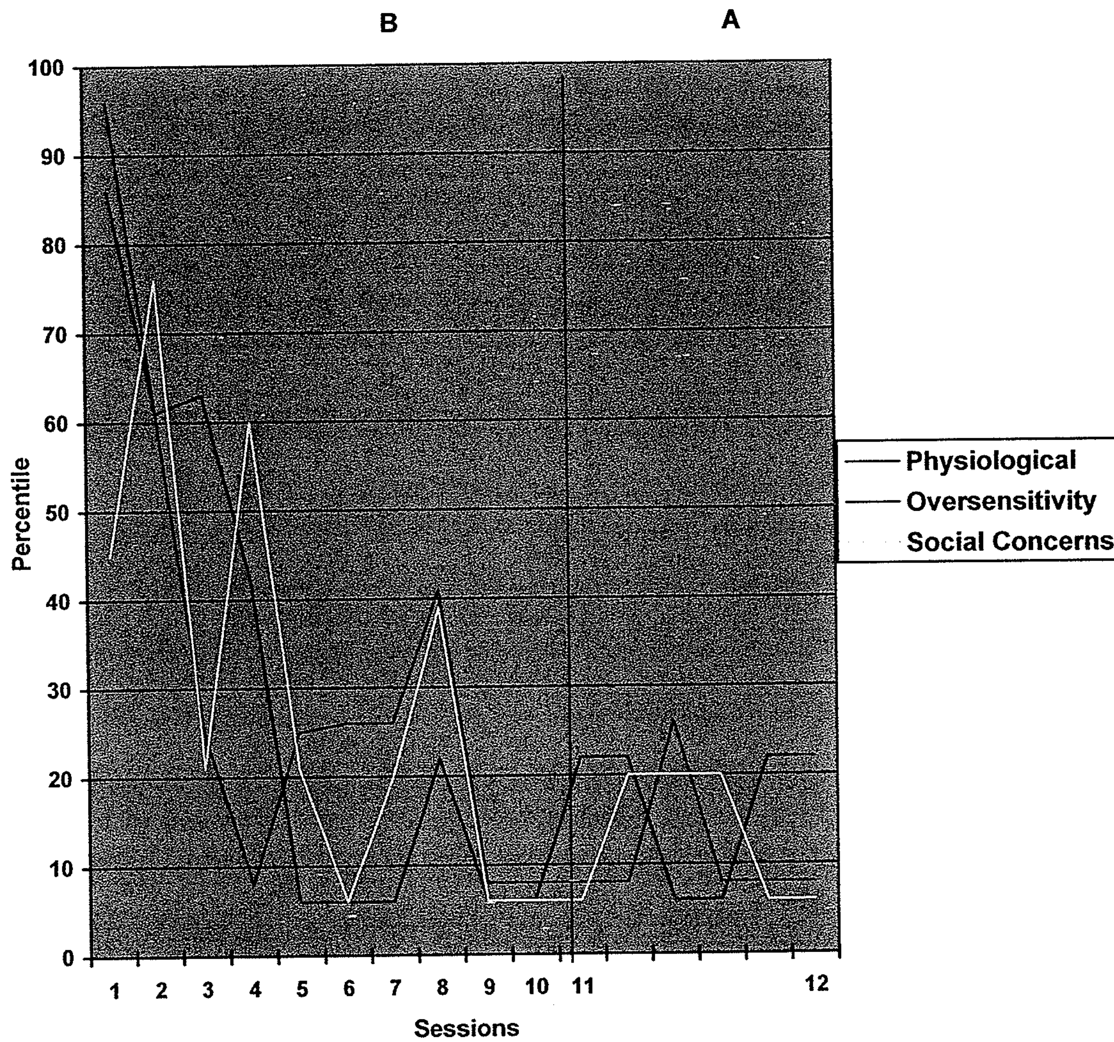
The baseline level of Total anxiety appeared to level off. The highest score during this phase was at the sixth percentile. This score did return to the third percentile in the baseline phase. This indicates that Vince was able to maintain his use of the skills taught without the assistance of a therapist. This was the hope of what would happen within the baseline phase.

The Lie scale (Figure 1), which provides an indication of the validity of an individual's ratings, however increased during the treatment phase. Vince came to the program with a score in the sixty-fourth percentile range. This score peaked during the ninth session to the ninety-third percentile, and ended at the sixty-seventh percentile before the baseline phase commenced. All of these scores are above the mean.

A high lie score may suggest that the child was "faking good" to be the ideal person for the researcher. Another interpretation of this lie score may be the child's inaccurate view of himself. After discussions of this score with Vince's parents, they stated their son does not lie, that he is very forthcoming of how he feels. Therefore, I am feeling that Vince wants to see himself as "perfect". The parents of Vince stated that this is probably true because he mentally beats himself up over mistakes he makes. They reinforce accepting the mistakes he had made and move on, or focus on how he could resolve the problem so it does not happen again. The lie scale throughout the maintaining phase stayed at rest in the sixty-seventh percentile.

The subscales (Figure 2) all moved in a similar pattern to one another throughout the treatment phase. They were all high when Vince came to the program. He scored in the eighty-sixth percentile on the Physiological Anxiety subscale, ninety-sixth percentile on the Worry/ Oversensitivity subscale, and forty-fifth percentile on the Social Concerns/

FIGURE 2



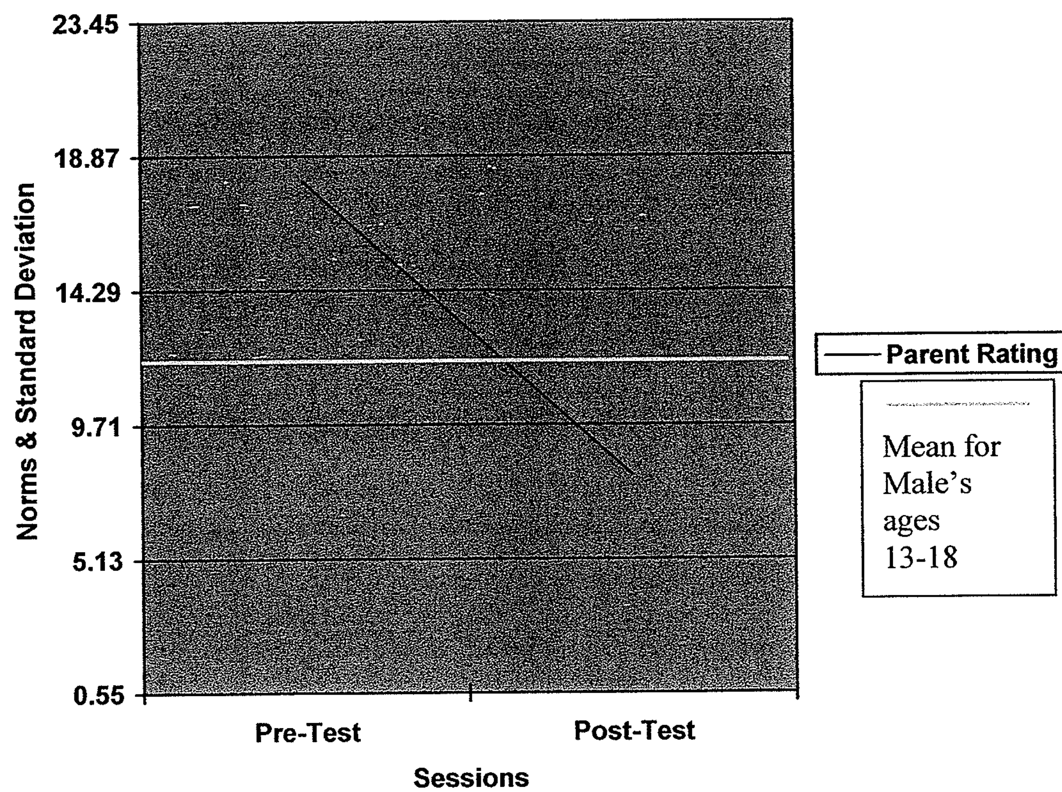
Concentration subscale. All subscale scores decreased with some fluctuation until the maintenance phase.

Prior to the baseline, Vince scored at the twenty-second percentile on the Physiological Anxiety subscale, eight percentile on the Worry/ Oversensitivity subscale, and sixth percentile on the Social Concerns/ Concentration subscale. These scores were significantly lower than pre-treatment. Vince was also able to maintain his subscale scores at a low level, with the Physiological Anxiety score peaking at the twenty-second percentile, the Worry/ Oversensitivity subscale score peaking at the twenty-sixth percentile, and the Social Concerns/ Concentration subscale score peaking at the twenty-percentile. These were all within an acceptable level of anxiety based upon the norms for this scale.

Vince's parents completed a questionnaire in the first session as well as during the last session, making this a pre-post measure. His parents rated him on the Revised Child Behavior Checklist, at a score of eighteen out of twenty-two when he came to this program (Figure 3). This checklist consisted of questions such as "Hypersensitive; feelings are easily hurt", and "Says nobody loves him or her". Vince's parents rated him at an eight out of twenty-two when he left.

On one of the questions in the post-test, Vince's parents rated him between a 0 (not a problem) and a 1(mild problem). Due to not being able to score between levels, I took the higher of the two scores. Parental views of this client's anxiety symptoms at the beginning of the program were significantly higher when compared to the norms for this measure, i.e. children who have been treated for anxiety, of the same age and gender, within an inpatient or outpatient setting. The average for this normative group was 9.71

Figure 3



with a SD of 4.58, which puts this client just below two standard deviations above the norm. However when compared to this group in his post-test, he scored between the norm and one standard deviation below. This suggests that this client had made significant improvements according to his parents.

"Debbie"

Debbie was a pre-teen girl referred to the practicum by her school social worker for concerns of school avoidance. Her paediatrician diagnosed her with school anxiety. Within the Lord Selkirk School Division, three social workers, two psychologists, as well as the local child and adolescent mental health worker, and three paediatricians have worked with this client. A psychologist at the Anxiety Clinic and a child psychologist in Winnipeg have also counselled Debbie. She was attending a specialized school for children with behavioral or academic difficulties.

The Assessment session took place at the Debbie's school with her and her mother. We started with a discussion of the parental information package, as well as an overview of what each session would look like. We also discussed the signs and symptoms of anxiety, as well as the strategies this family has used to reduce this client's anxiety. Prior to obtaining information, we completed the consent form (Appendix B & C) for both Debbie and her mother to participate in the program.

We completed an in-depth assessment of the anxiety. This student was experiencing anxiety at school and at any time of day. She stated that her anxiety occured a few times per day and would sometimes last all day. Her mother reported that her daughter would yell, swear, and throw things when her anxiety heightened.

Debbie's mother stated that Debbie did not have any congenital-genetic problems. She described her daughter as academically average, more mature socially for her age, and a leader because she is outgoing. Her teacher, however, stated that she is less mature than others, a follower, and often taken advantage of because of her need to be liked. Her teacher and principal stated they did not see the anxiety symptoms at school; however, they did see symptoms of Attention Deficit Hyperactivity Disorder.

Her physical complaints are headaches and stomach aches. However, her mother stated that sinus problems cause her headaches. Debbie's mom also alleged that her daughter often starts things and does not finish them. This included such activities as sports and academic assignments.

Debbie could see stressors coming up in the next year such as transitioning to the junior high, where she believed people would pick on her. She believed that the consequences of having anxiety are that family members were mad at her, that she would fight with people, and that things got broken. Debbie's mom stated her daughter had low self-esteem, and would often try to control her and her life. Moreover, she tried to take on a parental role in the family. Mom also stated her daughter cannot be by herself for an extended period.

Debbie was prescribed anti-anxiety medication by her paediatrician. However, neither her or her mom wished to pursue having her take the meds. When I asked Debbie what her most automatic thoughts were, she stated that she was afraid she was going to cry or that she was thinking she was going to start yelling when anxious.

The first session as stated in the case prior, started with the questionnaire and focused on cognitive restructuring. We discussed how events could lead Debbie to

thinking positively, which could form into positive behaviors, or how events could lead to thinking negatively which could form into negative behaviors.

Debbie stated that kids in her school talked about her behind her back, and gave her dirty looks, this lead to her not wanting to come back to school the next day. She stated that she would talk to her mom about these things, and her mom would feel sorry for her and allowed her to stay home. Debbie's thinking was focused on why she needed counselling when she did nothing wrong, and why other kids that she perceived as attacking did not need counselling.

The goal, therefore, of this session was on how she was misinterpreting things because of anxiety. We went through scenarios that she provided and discussed alternative explanations to her understanding of the situation. These were things such as people talking behind her back. She could hear girls talking and could hear her name in the conversation, but could not hear what it was regarding. We discussed that these girls could have said things about her that they liked, or that they wished they could get to know her.

When I spoke with Debbie's mother, I encouraged her to help her daughter see the other side of things. Her fear was that her daughter was depressed and would not be able do this, or would yell at her for trying to help.

Debbie's homework was to practice the positive thinking and to focus how things could be misinterpreted. Her mother's homework was to help her daughter with this line of thinking when she came home upset.

The second session started with the questionnaire and review of the homework assigned last week. Debbie stated that she did not think positively because she thought

that the assignment was "gay". We discussed how this homework could help with her goal to reduce anxiety and as a result said that she would try it again.

This session was a continuation of last week's cognitive restructuring. We focused on being detectives and looking for past evidence that supported the client's fears. Debbie was afraid of coming to school because she felt people made fun of her and talked about her. Therefore, the goal was to find if this has happened before, or if it could have been misinterpreted. She said it happened before, but we discussed what else could have happened, e.g., as the kids she stated were talking about her were also the same kids that came over to play. We discussed that kids sometimes kids are disrespectful, but by her example kids can also change they way they act towards someone. We discussed focusing on the positives, such as the friends that she did have, instead of the negatives.

We discussed her homework was to challenge her thinking with phrases such as "what else could be happening", or "Is this the end of the world if this person doesn't like me". I also spoke with her mother who was supportive in trying to encourage this type of thinking, especially in the morning when her daughter wanted to avoid school.

The third session started with the questionnaire and a review of the homework assignment. Debbie and her mother both said that she was sick that week and could not practice the skills.

This week's session focused on self-rewards and child management. As stated previously, the components that were encouraged to parents were to give attention, praise, and rewards to positive behavior and not give attention to the negative behavior. When I presented this to Debbie's mother, she said that she was already doing this.

However, from observing mother and daughter together, they confronted each other with everything they did wrong. It was encouraged that she tries to reflect in stressful times with her daughter if she is using these skills.

Debbie's mom was not interested in rewarding her daughter because she felt it was bribery, and her daughter should be good regardless. I explained to her that a bribe is something that you coerce the child into doing for your sake, and a reward is something given to the child when they have done something positive for themselves. This mom said that she felt she had no control over her daughter. This mom was presenting as stressed with trying to change her daughter therefore, we discussed how she could receive some relaxing days for herself before trying to help her daughter.

Debbie and I focused on self-rewards for accomplishing a small goal. At this time, she was coming and leaving school at times when she did not have to meet head-on other students. Her goal was to arrive on time in the morning, and leave at the same time as everyone else. Her reward for this would be something she could do for herself such as have a bubble bath, or watch her favourite TV show. This was Debbie's homework for the week.

The fourth session started with a questionnaire, and discussed the homework task from the previous week. Debbie was extremely apologetic, stating that she forgot to do the assignment. She stated that she would do the homework this week.

This session introduced relaxation therapy. We practiced the difference between tense muscles and relaxed muscles. Debbie was also having difficulty falling asleep so we discussed playing the relaxation tape before bed (Rapee et al, 2000). During this session, we listened to and practiced the strategies on the tape, which made her feel tired.

I informed the client's mom of the relaxation tape. She stated that they had tried the relaxation with the psychologist at the Anxiety clinic and it did not help. I stated that not everything I teach her would help, but that I would teach her everything so that she can find the skills that worked for her. I also explained that she may not have been ready for the relaxation at that time, and she still may not be ready for it. However, she will have it to rely on when she is ready to make changes.

Debbie's mom did not believe that we could expect someone who is twelve years of age to change. I explained that this is why parents are a key component in therapy as they can greatly help in the treatment process. I also focused on letting her know that I am teaching her daughter the skills and it is up to her to use them. This could mean that she could uses them now or in the future when she is older. We also discussed the possibility that her daughter does not want to change because of all the attention she is receiving from professionals and mom, because of her anxiety.

Debbie's homework for this week was to listen to the relaxation tape, especially before bedtime since she was having difficulty sleeping. It was also encouraged that she practiced the other session's homework.

The fifth session began with the questionnaire, and discussion of the relaxation tape provided last week. Debbie said that she had used the tape a few times and it helped the first few nights to relax, but that it did not help her sleep. We also discussed the use of the other session's skills, and she stated that she had not used the other coping styles. It was discussed that the tape in combination with the cognitive restructuring could be more helpful than the tape alone. It was suggested that she try this the next time.

This session was a review of the previous sessions. We reviewed cognitive restructuring, relaxation, and rewards. Debbie did not want to talk about the coping skills but stated that she was having difficulties getting along with her mother. Unfortunately, this practicum focuses specifically on anxiety, and did not have a lot of room for flexibility to discuss other problems. However, we did start the session with a discussion of her current situation and ended with a review of the previously taught skills.

The sixth session started with the questionnaire and review of the homework. Debbie once again forgot about the homework, and was focused on a disagreement that she had with her mother.

After a short discussion of her fight with her mom, Debbie was able to refocus and discuss exposure therapy. One of the major issues Debbie wanted to address was getting back to a "normal" school. Therefore, to do this her school stated that she needed to get back into a routine of going to school at "regular" times, needed to control her attitude, and needed to put more focus on completing schoolwork. Debbie wanted to focus on her attendance first. We made a chart with staying at school for lunch as the first step. She chose this because she was still uncomfortable with interacting with kids outside of her school. Secondly, she would try to start on time with walk into school instead of waiting for the bell to ring. The next step was leaving at the same time as other students, and the last step was to walk to and from school instead of her mother driving her. I discussed this with mom and she was excited that her child might stay at school for lunch so that she could find a full time job.

These above-mentioned steps were the homework assignment for Debbie, and her mother. It was not expected that she jumped up the steps quickly, but to try the first step and gradually move up at her own pace.

The seventh session was a review of techniques. Debbie's mother called the school to say that she was home sick. This, according to the school, is a frequent complaint that they were becoming suspicious of. Therefore, I made a surprise visit to the home. Debbie was home and appeared healthy. We discussed if her staying home was due to an illness, or if it was her anxiety acting up. She stated that she was tired and did not get up to go to school in time. Therefore, we decided to work on this week's session at her home. After completing the questionnaire, Debbie and I reviewed the homework, which she stated that she had stayed at school for lunch once this past week with a friend. Debbie was eager to go to school for the remainder of the day by the end of our session.

The homework assignment was for Debbie to continue using the coping skills, and to keep working her way up the exposure ladder. It was stressed that she needed to get to school everyday because absenteeism would not be accepted if she were to go back to her "normal" school.

The eighth session once again started with the questionnaire. Debbie did not complete the homework assignment and said she knew that she should have done it but that she really did not want to. I told her I appreciated her honesty, and if she practiced the skills later, it would help her then too.

Session eight focused on social skills. We discussed the three basic skills (Rapee et al., 2000) mentioned in the last case scenario: body language, voice quality, and

conversation skills. This client's mother stated that social skills are something her daughter needs the most. When she is amongst friends she had good social skills (with the exception of being a follower). However, if someone did something that she did not like or if she did not get her way, her social skills were weak. She would roll her eyes, have an "attitude", yell, say profanities, and always had to have the last word. If her mother tried to correct her, the comment was usually "I know, I know".

I called mom to let her know of this session. I encouraged her to help her daughter practice good social skills, and to model good social skills as well. Mom did state that she sometimes does things that she did not want her daughter to do such as use profanities. However, contradictory to this she thought this was acceptable because she was the adult in the relationship. It was encouraged that she showed her daughter, with her actions as well as her words, good social skills.

The ninth session focused on teaching assertiveness once the questionnaire was completed. Debbie often flipped between being passive by avoiding school when there was a problem, to aggressive when she fought with her mother at home. The school stated that she would go home happy; however, her mother would call the next day saying that there was a problem at school and that her daughter did not want to attend.

Debbie was unable implement good assertiveness skills when doing role-plays. Therefore, we discussed many scenarios that she may face in the future, so she would be prepared to act assertively.

The tenth session was a review of the previous sessions. We started with Debbie completing the questionnaire. She stated that she was feeling good this week because her birthday had just passed. She did not want to review the sessions, but did want to discuss

what she did on her birthday. When we were able to refocus on the anxiety, Debbie stated that she forgot to use the coping strategies.

When I spoke to her mom, she repeated her belief that it was unrealistic to expect someone of her daughter's age to change. I discussed with her the success of other children in the program that were her age or younger. However, I reiterated that Debbie might not be ready to make changes. Debbie still wanted to finish the program, even though she was not using the skills at this time.

The eleventh session was a review as well. In this session, Debbie did not want to meet with me, and wanted to get back into class. She did not want to talk about the previous sessions; she just kept asking if she could go back to class. Therefore, she completed the questionnaire, had a brief overview of the previous sessions, and then returned to class.

Four-week break- Debbie and I met once per week to complete the questionnaire. No therapy was provided at this time, but she was encouraged to continue using the skills.

The twelfth session provided closure to Debbie and her mom. We discussed the weekly sessions, completed the client questionnaire as well as the parental questionnaire. Debbie and her mom also provided feedback of the practicum itself.

When I asked about the practicum, and if Debbie or her mom would seek services again, they both said yes, because for Debbie felt it was good to tell someone how she felt. For her mom it would depend on the social worker. Debbie and her mom felt comfortable talking to me however; this was not the case with previous therapists. Debbie stated that she found me helpful due to my personality and found the program

helpful. The things that they did not find helpful were that mom did not see any changes in her daughter, and that her daughter preferred to talk about issues other than the anxiety.

Debbie did find the therapy helpful in some ways because she felt that her anxiety did reduce, although she did remain nervous about the transition to her new school. The technique that she found most helpful was the positive thinking because it gave her confidence. The technique that was the least helpful was the stepladder because she did not like it however; she could not provide a reason for why she did not like it.

When I asked Debbie if she felt she had made changes from the start of therapy until the end of therapy, she said that she was no longer scared of school. However, she and her mom did not feel that she achieved her goal with this therapy. When asked what needed to be done to get to her goal, mom stated that her daughter needed to build her self-esteem, stay away from the bad crowd, and join in interesting things that she can commit to.

<u>Overview-</u> I felt that this was the most difficult family to work with. I knew going into this commitment that it would be difficult due to the number of professionals who have tried to help. Neither Debbie nor her mother were at a point where they were able to make changes in their lives, or this therapist was unable to discuss anxiety techniques in a way that "hooked" them into trying the techniques.

<u>Case evaluation</u>

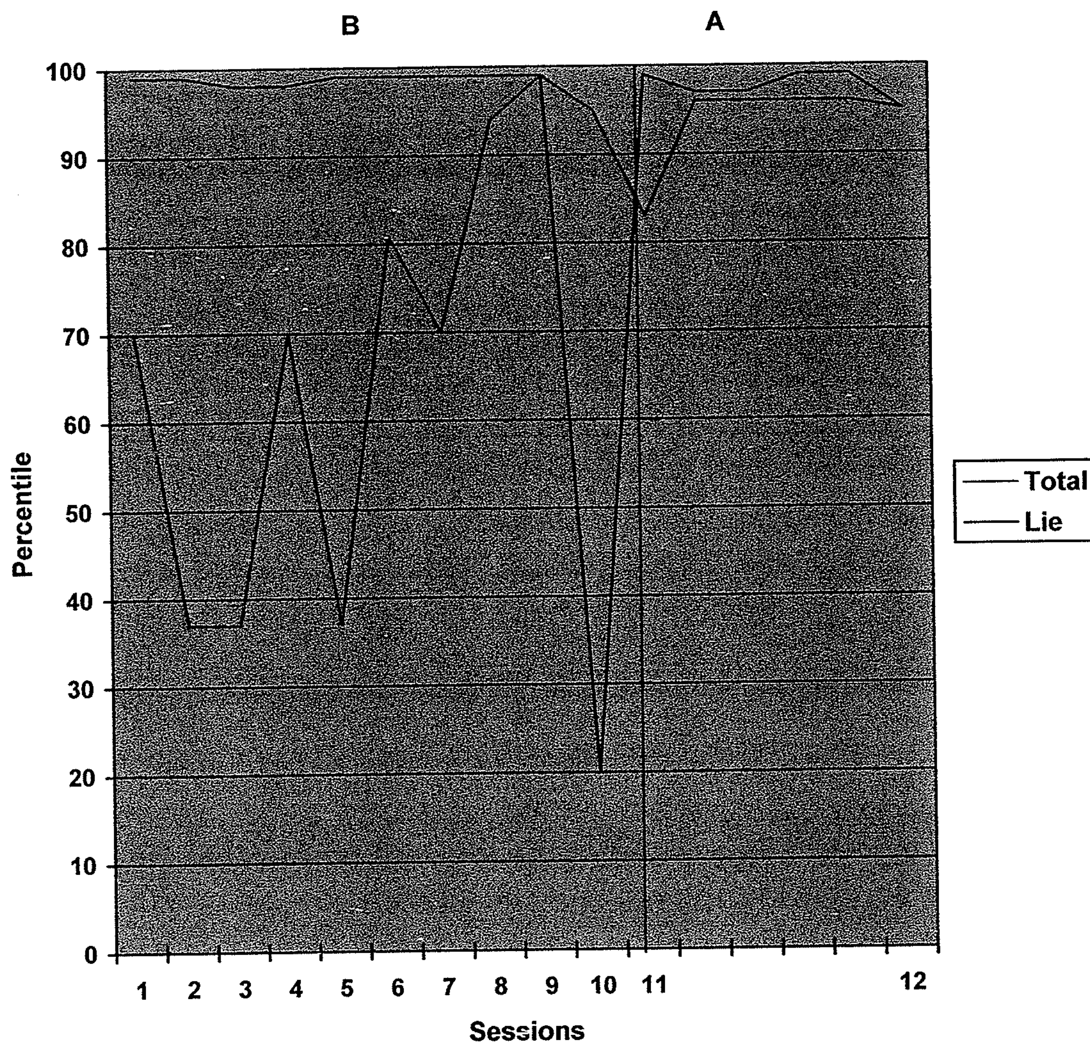
The evaluation questionnaires supported the assessment and outcomes of the therapy. Figure 4 depicts Debbie's Total anxiety score and Lie score from the RCMAS questionnaire throughout the therapy process. Figure 5 shows the three subscales:

Physiological Anxiety, Worry/ Oversensitivity, and Social Concerns/ Concentration. Lastly, in Figure 6 we have the parental report of Debbie's pre-post test results from the Revised Child Behavior Checklist.

Debbie entered the program with a Total anxiety score in the ninety-nine percentile. This score is extremely high and raised concerns. However, as the therapy process continued the score did not change a great deal. It lowered one percentile through the intervention phase with the exception of the tenth session, which dropped to the twentieth percentile and then rose back up to the ninety-ninth percentile the following session. The reason for the significant drop in anxiety that week was due to Debbie's birthday. The fact that she maintained a high percentile throughout the therapy program was a concern. She had also sustained a ninety-five to a ninety-nine percentile score throughout the maintaining phase. With high scores such as these, the child may be experiencing unusual stress in the home, school, or practice effects of continual therapy. Therefore, there should be discussions on the items of the questionnaire in which Debbie rated high.

A high Lie scale, as stated with the previous client, may be the child intentionally "faking good" to convince the examiner that she is an ideal person, or the child may have an inaccurate view of herself. Debbie entered the program with a Lie score within the seventieth percentile, which fluctuated and became higher throughout the treatment phase. This was not the goal of the therapy process. I am unsure if Debbie was not comfortable telling me the truth, however, in the debriefing session she stated that she thought that I was approachable and easy to talk to. This could point to her wanting me

FIGURE 4



to see her as the ideal person, and wanting to please me. The Lie score was stable in the baseline phase at the ninety-six percentile.

The subscales were similar to the Total Anxiety score. The Physiological Anxiety, Worry/ Oversensitivity, and Social Concerns/ Concentration subscale scores clustered together in the treatment phase as well as the baseline phase. The lowest score was at the ninety-two percentile on the Physiological Anxiety subscale, and the highest score was at the ninety-nine percentile on all subscale throughout the treatment. All subscale scores dropped significantly in the tenth session due to the client's birthday. The baseline reflected the treatment phase with subscale scores as high as the ninety-ninth percentile and as low as the ninety-third percentile. Therefore, Debbie had not made any significant gains in the treatment process.

The parental questionnaires were administered in a pre-test, post-test format. Debbie came to the program with her mother scoring her at a 13 on the Revised Child Behavior Checklist and ended the program with her mother continuing to score her at a 13. When compared to parent ratings of kids her age and gender in an inpatient or outpatient setting, this parent rated her daughter above the average range in anxiety symptoms. The average score for children of her age and sex on this scale is 6.16, with a standard deviation of 5.24, which places this child's score between one and two standard deviations above the mean for both pre-and post-test scores. This alone suggests that the client did not make any improvements in the eyes of her parent.

FIGURE 5

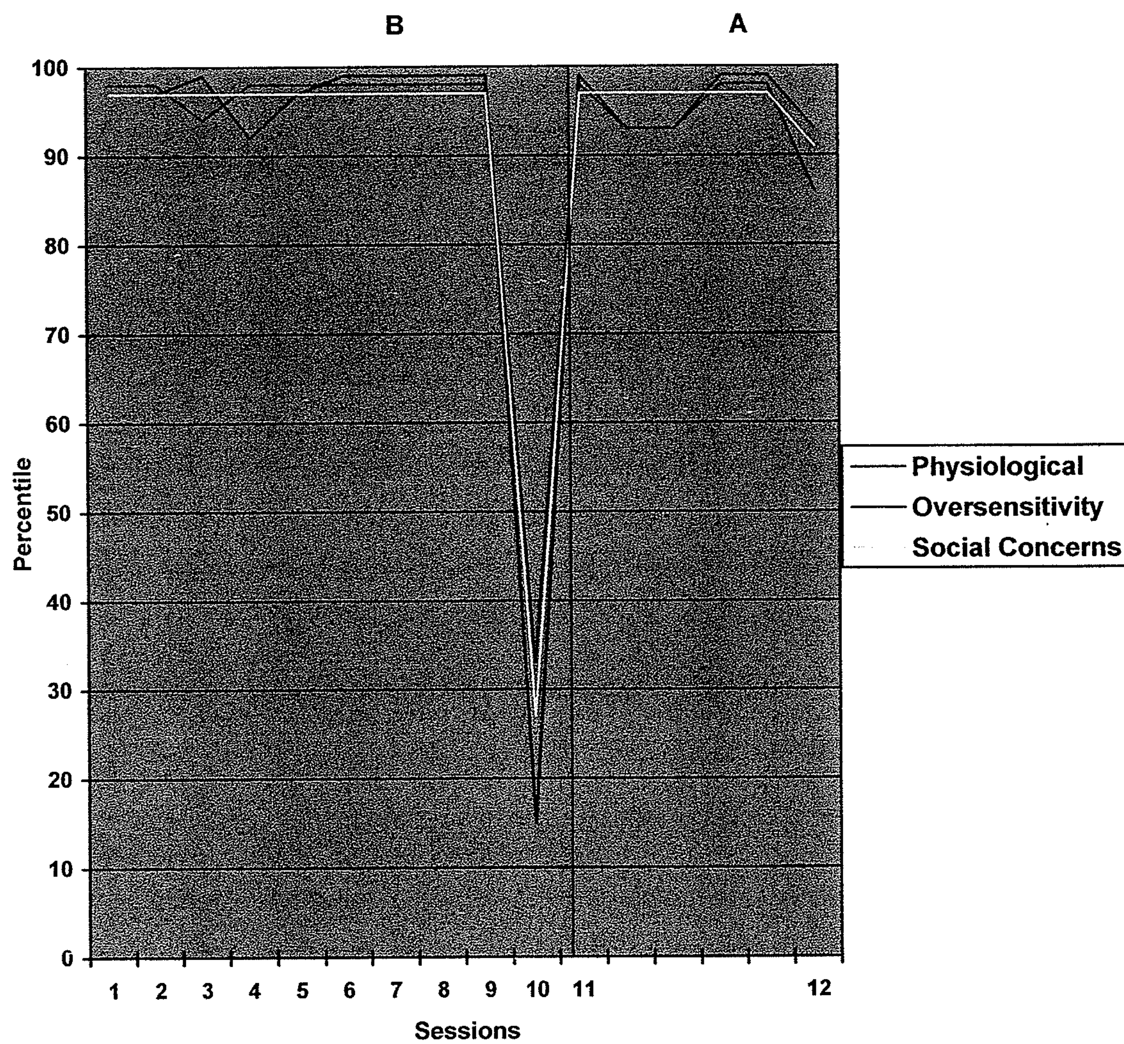
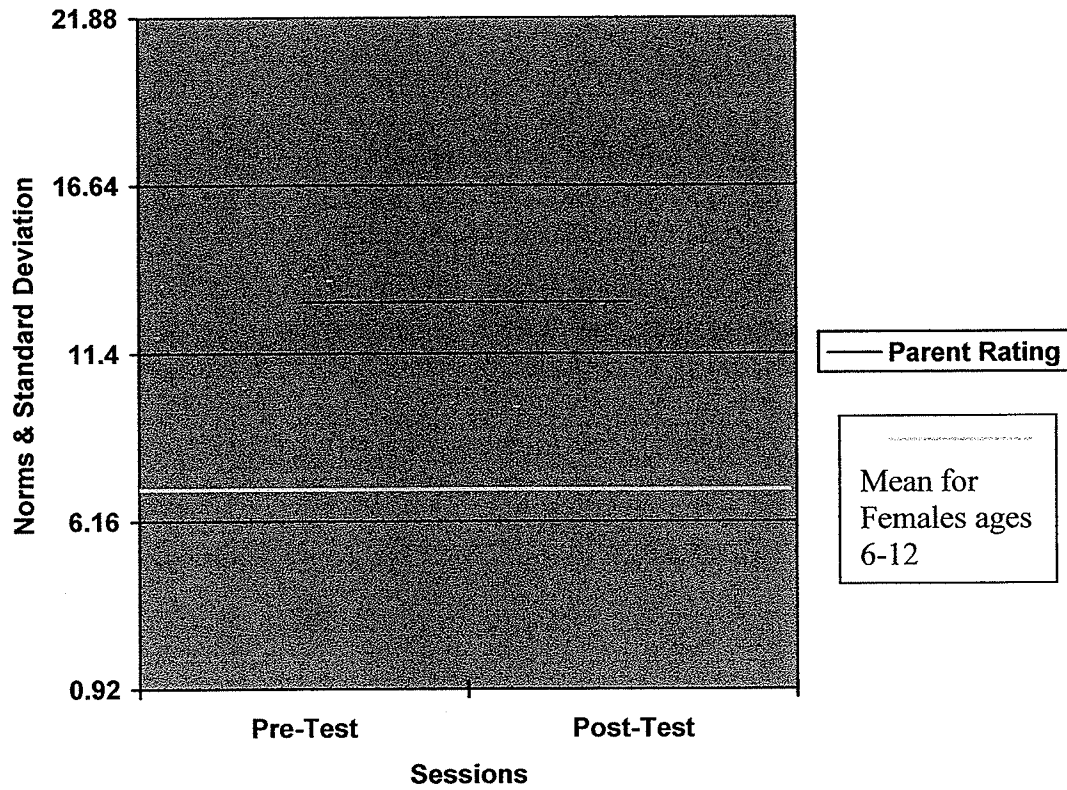


Figure 6



<u>"Don"</u>

Don was an adolescent boy referred to the practicum by his parents. His father, diagnosed with an anxiety disorder, feared that his sons' anxiety was interfering with his daily living.

<u>The Assessment Session</u> started with Don, his parents, and me reviewing the therapy sessions. We also discussed what anxiety symptoms look like and what Cognitive Behavioral Therapy was.

Don's father had been dealing with anxiety for many years and was quite knowledgeable about what his son was going through. His mother was also knowledgeable about how to help her son. We completed the consent forms(Appendix B & C) for the client and parents, and discussed the expectations of the parents throughout this process.

Don described his anxiety as heightening around strangers especially at school, although it has happened at any time or any place. He believed that he started to notice his anxiety in grade 7 when he transferred to a new school. Don described his anxiety as severe in intensity and lasting for approximately five minutes. His mother also stated when Don was born he had a low heart rate. This student was extremely smart and a perfectionist at everything he did. His anxiety was interfering with his life, to the point that he did not go out of the house. Even if the family went out for dinner, he would stay in. He also avoided doing things that he would take pleasure in, and will not join clubs that he knows he would enjoy.

His parents described him as not having a lot of self-confidence, and as being hard on himself. He also started medication for his anxiety at the beginning of this

practicum. He hoped it would take the edge off his anxiety. When asked what his most common automatic thoughts were when anxious he said that he thought he would embarrass himself.

<u>The first session</u> took place in Don's school, as eventually did all of our sessions. It started with completing the questionnaire and a discussion of his current thought process when anxious. He often thought of escaping and avoiding when he felt discomfort. When he was in situations with strangers, he would think they were all looking and thinking negatively of him. This would lead him to escape the situation, or become very quiet and shy. Often this would lead to a lonely day.

The goal of this session was to examine alternatives to his thought process such as thinking "others are not thinking of me", "there is no reason to think negatively", or "it is not the end of the world if some people don't like me". With these positive thoughts, Don stated that he would probably still feel anxious but be more confident in himself. He would therefore not avoid people as often.

The homework for this client was to practice thinking positively and evaluate how he felt before and after the thoughts changed. When this client was at home, his parents stated they would encourage him to use this thinking to get himself out of the house and join them in outings. His dad would reassure his son that the more he practiced facing his anxiety the better he would feel.

<u>The second session-</u> started with the questionnaire and a discussion of last week's homework. Don said that his predictions were true. He did feel better about himself when he thought positively however, he still felt a bit anxious. His parents also commented that it took a lot of work to get him to "come around" and practice these

skills. He was resistant to trying this skill when they encouraged it. However, when he was left alone he would change his thinking.

This week focused on looking at evidence to warrant Don's anxious feelings. He confirmed that he was most likely overestimating the probability that people were talking or thinking about him. He believed that the fear he had of other people was probably due to his own insecurities, because no one had ever teased or made fun of him. He understood that if other people were looking at him they might be thinking how smart he was, because he knew that he was.

His homework was to use the positive thinking as stated in session 1 to calm his nerves. He was to also challenge his negative thinking. Don's parents agreed they have not seen other kids bugging him, but believe their son's insecurities create the anxiety. They would again encourage his positive thinking for the next week.

The third session started with the questionnaire and a discussion of Don's successes with the positive thinking. He alleged that this exercise was getting easier to do and that he was feeling more confident when thinking this way. His parents reported that he was usually stuck in his thinking, and usually needed to come to a point himself when he realized that this was not helpful, and then he turned it around.

This week focused on self-rewards for accomplishing steps towards an identified goal. The goal was for Don to be comfortable using the stepladder technique and rewards. He came up with a list of things that he wanted to complete or accomplish. He wanted to focus on passing a test that was coming up, and he was worried about it like he usually was before tests. The night before was a restless one; however, he always did well on tests.

We prepared a stepladder of things he could do to get ready for this test. These were things such as find out what was on the test, read the relevant materiel from the text, and make notes based on the text. He would also ask his parents to make a pre-test for him, or have a friend quiz him. He also planed for a good night sleep by going to bed early, writing down his negative thoughts to get them out of his head, and have a good breakfast the day of the test. With this plan, he was to reward himself with each step he accomplished.

Don choose rewards such as buying himself his favourite chocolate bar, buying a magazine, watching his favourite TV show, and the satisfaction of doing well on the pre-test. Therefore, his homework was to work his way up the stepladder and reward himself with the above-mentioned rewards.

I contacted his parents in relation to how they could best manage their son's behavior. They were already doing the majority of the parenting steps such as reward the good behavior and ignoring the negative behavior. However, since Don's dad had been in his son's shoes he was more relaxed about letting his son avoid the anxiety, where as his mom will push him to face the anxiety. Both approaches were good because his dad shows him that he was supportive, and his mom shows him that he needed to push himself if he wants to get better. Nevertheless, they were encouraged to discuss this difference between themselves to come up with an approach for which they can both follow through.

<u>The forth session</u> focused on introducing relaxation therapy after the questionnaire and discussion of the homework task were completed. Don had not started the stepladder but said that he would when it got closer to test time. He did in later

discussions climb up the stepladder in the matter of one week. I praised him for his effort, and reminded him that not all of his goals would work that quickly. Therefore, he would not be disappointed in himself with later goals.

Don had not been introduced to relaxation therapy before this session. However, he did find reading to be relaxing. This was encouraged when anxious, but this would not work in settings such as school when he would be focusing on the teacher. I provided him with the cassette of the relaxation therapy (Rapee et al., 2000), and described what it asks him to do. We discussed the difference between being tense and relaxed. Often when he was anxious, he noticed his neck and shoulders becoming tense. We practiced tensing our neck muscles and relaxing them. We discussed the point of the tape was to have him feel the difference between tense and relaxed muscles.

His homework was to practice listening to the tape. Therefore, with practice he would be able to relax his muscles, and learn to do it within shorter periods. He could also use this tape to help him fall asleep.

The fifth session was a review of all the steps and how he needed to combine them together. Once the questionnaire was completed, we discussed the relaxation homework. Don did practice this tape a number of times and found it to be most helpful when trying to sleep. He listened to the tape so often that he felt it was becoming redundant. We discussed listening to soothing music if that was helpful. He stated that he believed his mom had some tapes like that he could try, or he could read before going to bed to get his mind off of the anxiety.

We discussed his positive thinking and challenging his own thoughts when he was avoiding. When he did face his fear of going out for dinner, for example, he could

visualize going to the restaurant, what he would order, who would be there, how he would order, and to not get someone else to order for him. Prior to going out, he could think positively, and think, "How bad is it really?" He would also focus on relaxing his muscles on the way to the restaurant, and breathe slowly and calmly. When talking to his parents they stated their son, who was very interested in hockey, had decided not to attend a summer camp, which he loved to go to. He was worried because he felt he would not be as good as he should. A week later, his parents informed me that he had changed his mind. He stated that he was afraid of not being as good as he knew he could be, and that other people would see him as a failure. With discussion of the positive thinking and this being something he enjoys, he stated that camp would be good for him to practice and possibly help him become better.

Don's homework was to practice these techniques for the next week. He was also to reflect on which techniques were helping the most, and which he was having the most difficulty.

The sixth session started with the questionnaire and discussion of the past coping strategies. Don said that he was still using the techniques, and was feeling better, however his actions had not changed much. This was perfect timing because in this session we were addressing the exposure therapy, which addressed his behaviors.

Don stated that he was afraid of new places and new people. Therefore, we focused on the both of these for the exposure. His stepladder slowly exposed him to new places, by first going to an arena he had not been to in a while, and walk around. He had fears of someone asking him what he was doing walking around, so we discussed that he could tell them that he lost his wallet and was looking for it. Next, he would go to an

arena he had not been to before and try to find the change rooms by himself. He would also expose himself to other new places once per week with the help of his parents driving him around.

In addition, he wanted to focus on trying to talk to new people at school. He would pick a person that he would like to get to know better and when he would walk by them, he would make eye contact. Once he was comfortable with this he would say "hi", and then would find something to initiate a conversation with such as "how did you find that test?" or, "what did that teacher assign for homework?"

Once the goal and the steps were identified, I explained that this was his homework. Don's parents were supportive in driving him around to new places, and were thrilled that he was pushing himself out of the house and facing his fears.

The seventh session focused on completing the questionnaire and the homework assignment. Don had picked a student in his class to talk to and they now talk almost daily. With each step, this client was to reward himself. This did not happen, but he felt that the satisfaction of facing his fears was enough of a reward.

This session was a review of the previous six sessions. Don stated his anxiety was reducing each week. He was talking to the student in his class now, and was feeling less anxious about it each time they conversed. He said that the positive thinking was easier to do now. He had the relaxation tape still, but had not used it in a while because he was sleeping better.

His parents state that he was still avoiding situations and stayed at home a lot, but they have seen him try and exposed himself to more than he used to. They believe that he may be overestimating his accomplishments with this therapy so far.

I encouraged Don and his parents to continue using the techniques discussed so far.

<u>The eighth session</u> started with completing the questionnaire and addressing the homework. I was unable to get a hold of the parents this week. However, Don reported that he was practicing the skills and his anxiety had not bothered him this past week.

This week I taught Don social skills. He used good social skills when anxious and when comfortable. He always used good facial expression. His voice quality was good in tone, pitch, rate, clarity, and tone. He also has good conversation skills, however does not always have self-confidence to use them. When role-playing conversations, he did fidget when he did not have an answer to my questions. He was not aware that he did this. The goal of this session was to make Don aware of skills that he was doing well, so to do more of them, and point out skills that need to be practiced appropriately such as volume.

We discussed possible conversation questions he could use with girls and boys. These could be such things as "have you seen any good movies lately?" "How did you find that test?" "What did you do this weekend?" Once he has a few conversations with someone he can play off the information he receives. This information could be a conversation starter for the next time. He was able to reflect how this could be done with the student he wanted to talk to in the exposure therapy session.

The homework assignment was to practice the conversation skills, and body language. It was hoped this would help him be confident in talking to people and not second-guess himself as to if he should have said this or that.

The ninth session began with the questionnaire and discussion of the homework assignment. Don could see that the conversation skills became easier as time went on. However, when talking to his parents, they stated that he was usually very good at his social skills, except he was also developing that teenager attitude at times. We discussed the difference between what is normal for someone his age, and what is anxiety induced.

This session focused on assertiveness training. Don describes himself as passive in nature when anxious. He felt that he hides, or avoids the anxiety when possible. We discussed how he could stand up for himself, needed to ask for what he wants while still being respectful of other people's feelings. Don did not present himself as disrespectful but did need confidence in telling people what he wanted. I taught him when he wanted to be assertive he needed to keep his message simple, give a reason for what he is asking for, and not blame others. When role-playing he did know how to ask for things, but he often did not have the courage to ask. Therefore, we discussed him visualizing asking the question he wanted to ask before he did it.

Don's homework was to practice the assertive skills and visualization. When I talked with his parents, they reported they saw him as aggressive rather than passive at home. They said that he often yells, and fights about wanting to avoid the anxiety. They believed he needed to work on talking about his choices rather than becoming defensive and yelling. They did say that after giving him a few days he would often come back and talk to them rationally and would often face his fears. I informed them to remind him to take time by himself to relax and then come back and finish the conversation. It may go better after he has time to reflect and see their point by himself.

The tenth session began with completing the questionnaire and reviewing of the homework assignment. Don, again, stated that his anxiety symptoms were not very visible.

This week's session was a review of the coping techniques. When quizzed, Don could remember most of the techniques taught. He was pushing himself to face his anxiety. Although facing his fears were not instantaneous, after a few days he could talk himself into it. Again, Don was encouraged to use the coping strategies as his homework assignment.

The eleventh session was also a review of techniques. This session was much like the last session, with more of a focus on Don pushing himself through his anxiety. He was seeing a difference from session 1 until now, between his willingness to go to new places and meeting new people.

His parents had not seen as much of a difference as he had reported. Therefore, we discussed what other things he could do to face his fears. He discussed wanting to go into flying lessons. This would be something that he would be interested in, would meet new people, and would get him out of the house. He would talk to his parents about signing up.

Four-week break- These next four weeks were focused on completing the questionnaire, and reminding Don to use the skills that were taught. No new techniques were introduced.

The twelfth session started with the completion of the questionnaires by Don and his parents. We followed up with a description of the improvements Don had made over the weeks, and ended with a discussion of the practicum process. Don had made

significant improvements through this therapy program, which will be described in the next section.

The family and I debriefed about the program, and my services. Both the parents and Don stated that they would return to see me if they needed services again. Don stated that I was good at explaining the therapy and was friendly. His parents stated they would use my services because of the positive results they have seen in their son, and because he had said to them, he trusts me. This being said, Don stated that he wished that he could have met twice per week because once per week was not often enough for him. Parents stated that they were satisfied, and had no complaints.

Don also stated that the CBT was helpful because he did not know how to deal with his anxiety before and it provided him with ways to conduct himself when worried. He found the relaxation and positive thinking used together were the most helpful of the techniques. His parents however, believed that the assertiveness training as well as the positive thinking and relaxation techniques were the most helpful for their son. We also discussed the techniques that were least helpful. Don stated that the assertiveness skills were the most difficult to grasp, his parents stated that their son needed to use the positive thinking to become more self-assured. They did state that his self-esteem had significantly increased in their eyes.

Don and his parents had seen changes in the anxiety from the start of therapy until completion. Don stated that he could now do things without getting panicky, sweating, or becoming easily embarrassed. His parents declared that they have the kid back that they used to know, they can have fun with him now, and he is not showing that he is scared. When asked if they had achieved their goal with this therapy they both stated

they had. Don said that he felt a lot better than he could have ever thought, and could still become stronger. His parents agreed that their son was on his way. They believe that he was 80% there. He showed them that he is driven, and was making good choices.

We ended this session with the client and his parents wanting follow-up sessions for their son. They stated that he enjoyed talking with me, and was feeling stronger after our sessions.

Overview

I learned the most from this client. He was driven to learn, and was constantly seeking knowledge. He was the client who was honest and provided me the good and the bad information about the therapy and the program. His parents were also the most involved parents of this practicum. I believe this was because his father had anxiety, had been through therapy himself, and had a supportive mother. They were willing to drive Don around, and displayed very positive parenting skills. This family also let me know when things were not going well and did not try to tell me what they thought I might want to hear. They supported the research of parent and child reports of improvement being at different levels. The parents did state that their son was making improvements, and he was feeling very positive, however his actions were not as significant. This was important because we were able to focus therapy on having the thoughts and feelings match the behaviors.

Case evaluation

The evaluation questionnaires supported the assessment and outcomes of the therapy. Figure 7 depicts Don's Total anxiety score and Lie score from the RCMAS questionnaire throughout the therapy process. Figure 8 shows the three subscales:

Physiological Anxiety, Worry/ Oversensitivity, and Social Concerns/ Concentration. Lastly, in Figure 9 we have the parental report of their child's pre-post test results from the Revised Child Behavior Checklist.

Don came to the program with a Total anxiety score in the ninety-seventh percentile. He was not leaving the home, interacting with peers, or doing the things that gave him pleasure. This Total score dropped significantly with some fluctuation in the ninth session, but was down to the forty-third percentile by the last intervention session. It continued to drop in the baseline phase to the twenty eighty percentile. It was hoped that in the baseline phase Don would maintain the level of anxiety they were at or continue to improve. He showed that he could use the techniques without the aid of the therapist. However, he has asked to continue sessions with the therapist to continue improving and for support.

Don's Lie score was high to begin with. It started at the ninetieth percentile and kept close to this level until the sixth session where it dropped drastically to the seventeenth percentile. This level was maintained throughout the rest of the treatment phase as well as the baseline phase. Both Don and his parents stated that they were comfortable talking to me and due to the client discussing with me the good as well as the bad, I felt that this score was in conjunction with how he was in the therapy sessions.

The subscales all decreased throughout the treatment phase as well as the baseline phase, with some fluctuation. Don improved with the Social Concerns/ Concentration, from the ninety-forth percentile to the seventeen percentile in the treatment phase and dropped in the maintaining phase but climbed again to the seventeenth percentile in the twelfth session. The Physiological signs of anxiety started at the seventy-seven

FIGURE 7

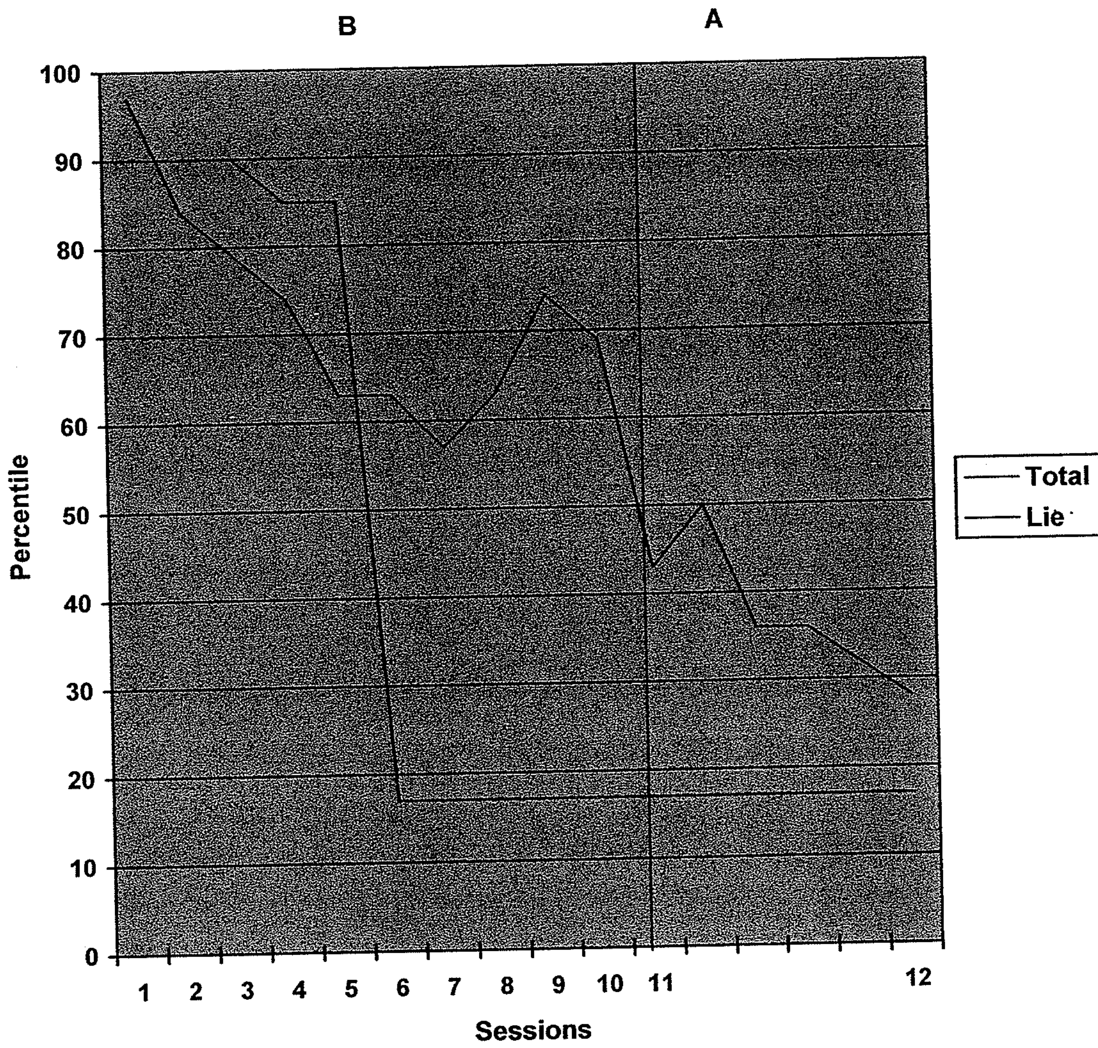


FIGURE 8

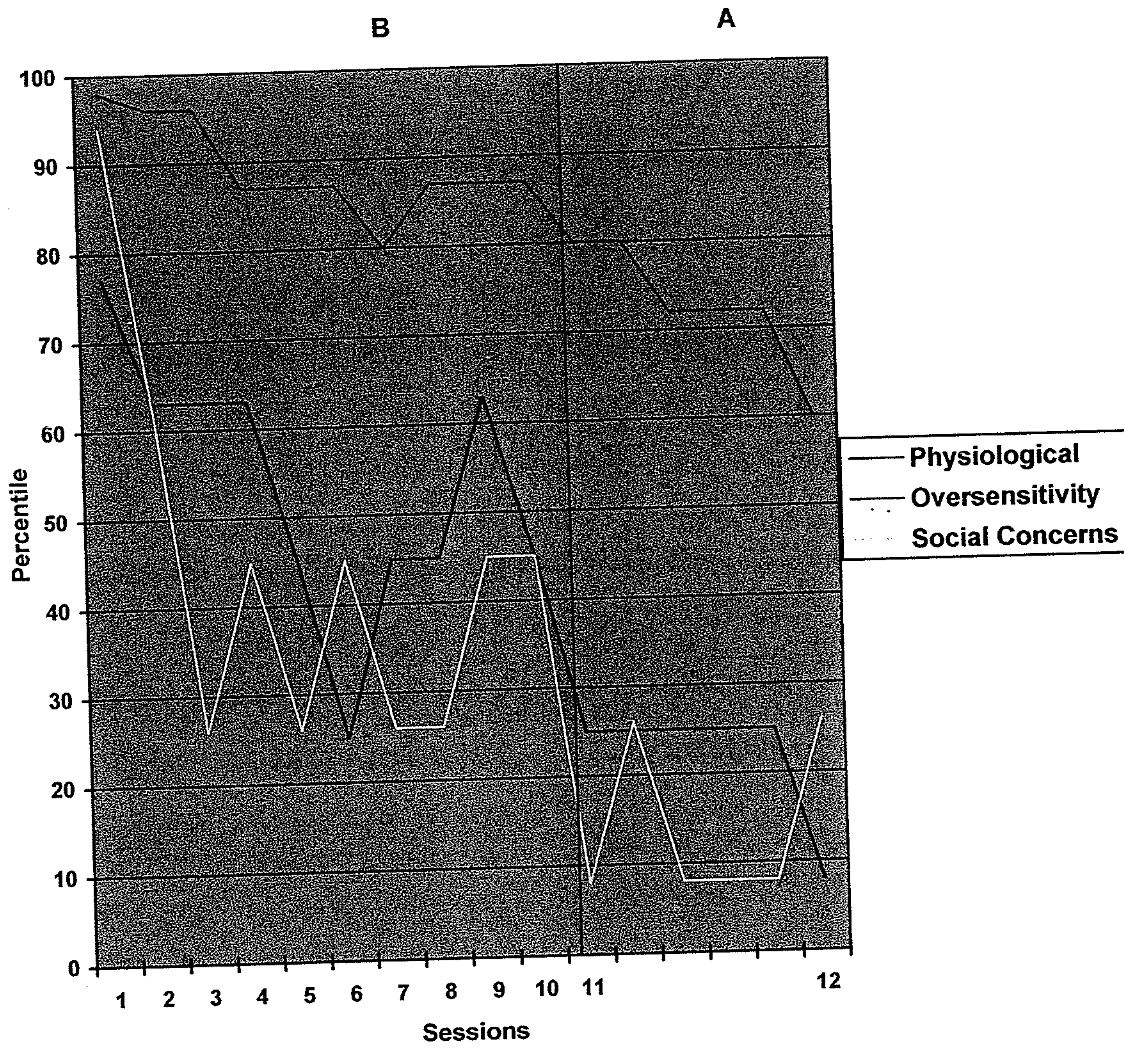
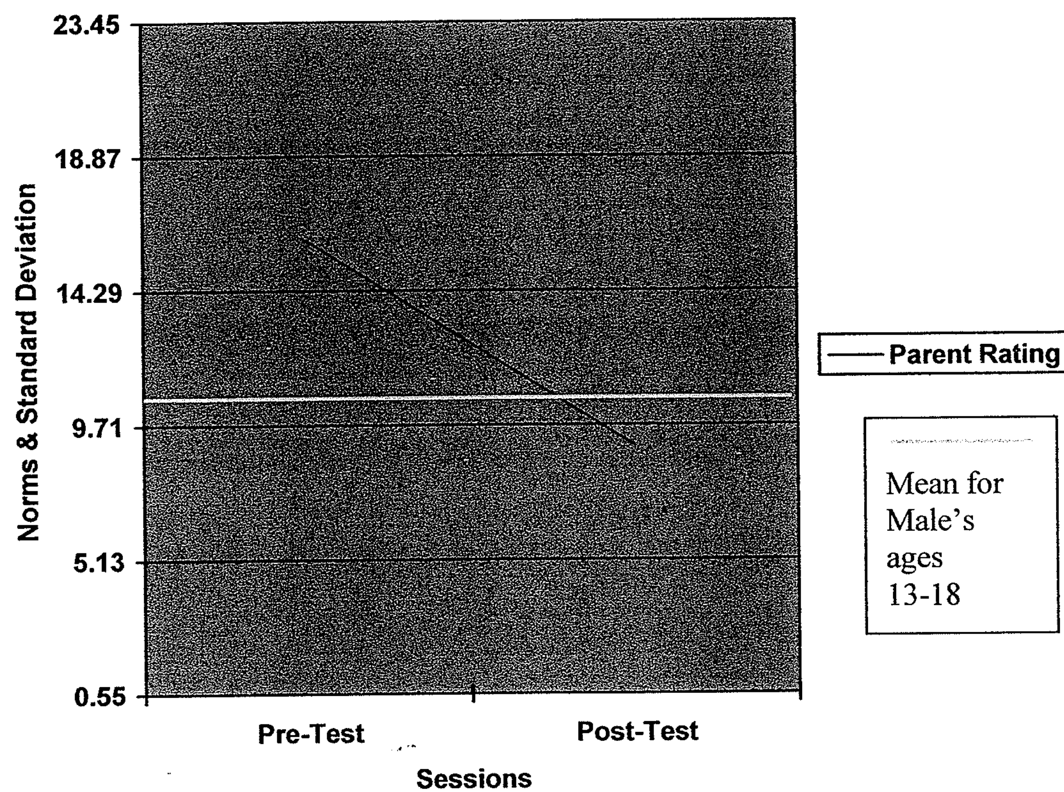


Figure 9



percentile and decreased to the twenty-fifth percentile with some variation through the treatment phase. The baseline phase continued at the twenty-fifth percentile and continued to drop to the eight percentile in the twelfth session. The Worry/ Oversensitivity was the subscale that dropped the least. This subscale was the highest score, at the ninety-eight percentile, when Don came to the program. It did decrease throughout the treatment phase with some variation until the eleventh session, where it was at the eightieth percentile. This continued to decrease in the baseline phase were we ended the sessions at the sixty percentile. This is still high, and it was recommended to the client and his parents that he continues to work on this by talking out his feelings.

Don was rated by his parents in the pre-test phase of the program at a sixteen. This score was compared to same age and gender kids who are in an inpatient and outpatient setting. The average score by parents for this group was 9.71, with a SD of 4.58, which places this client between the first and second standard deviation. However, when he completed the program he was rated by his parents at a nine, which is slightly below the average for an adolescent his age and sex. This indicated to me that he made significant gains through the therapy process. His parents backed up this impression when they verbalized the changes they had seen in their son over the past few months.

Other Clients

All of the clients participated in the twelve week CBT sessions as outlined in the above case studies. There were however some unique qualities to each of the students. All of the following client's figures of Total Anxiety/ Lie scores, Subscales and parental rating scores, can be viewed in Appendix G.

One of the clients had been diagnosed with a co-morbid condition as well as social anxiety. He resided at home and attended school infrequently. His family has a history of mental illness which complicated family involvement for this practicum. This client looked forward to our meetings, however became physically upset when we discussed topics that he felt he could not overcome. Often sessions needed to be cut short, or postponed due to this.

This client had made improvements from the start of the therapy until session twelve (Figure 10). There was a peak in two of the subscales during session eleven, but came back down to become more stable during the baseline phase (Figure 11). This client's parents also saw improvement from the start of the treatment phase until the last session. However, there was not a significant improvement in their eyes, there was improvement according to their rating scale (Figure 12).

A second client was younger in age and was anxious about becoming physically sick and feared germs. Due to the client's age, the approach to the therapy was age appropriate with cartoon figures, stories, and role-playing, as opposed to older sessions with self-directed questions and discussion. She displayed signs of hand washing, and needed constant reassurance that she would be OK. She had great support from her family, however they were becoming distraught with the constant need for reassurance.

This client had made improvements during the interventions stage, with fluctuations (Figure 13). Her subscales also fluctuated and elevated within the baseline phase (Figure 14). Her mother however, believed that she had improved through the sessions, however her scores on the Revised Child Behavior Checklist reflected that she had seen no improvement(Figure 15)

The third client was also afraid of becoming physically ill. However, this client was older in age and therefore better able to verbalize her understanding of the treatment sessions. She as well, had good parent support, as well as peer support. This client also discussed thoughts of suicide. We discussed that this could be a side effect of the medication, which her mother was looking into.

This client started this practicum with high anxiety scores and lie score (Figure 16), however her lie score remained high with her total score decreasing over time. There was fluctuation throughout the treatment phase, with all of her subscale scores decreasing in the baseline phase with some fluctuation (Figure 17). This client's mother also rated her, which reflected a slight increase in anxious behaviors from the start of the program until the end (Figure 18).

The forth client was diagnosed with school phobia and had a fear of dying. She resided in a single parent home. Her mother found it difficult to control her daughter's behavior due to being a single parent, and having her own illnesses. This client found her low socioeconomic status to be a difficult situation for her. She felt as though everyone else had things that she could not afford. She also discussed thoughts of suicide. She received great support from her mother during this time.

This client was the most stable in her scores. She improved slightly in her anxiety symptoms as well as her lie scores (Figure 19). However, one of her subscales (oversensitivity) increased throughout the treatment phase (Figure 20). This client and her mother did not meet for the twelfth session. Therefore it is unknown if this parent rated her daughter as improving over the twelve weeks (Figure 21).

The fifth client was asked to leave prematurely in the practicum due to drug use. It was unknown if the drugs were a coping mechanism for the anxiety or if the drugs were causing the anxiety. However, this was an exclusion criterion for the practicum that was not shared at the intake meeting. It was explained that the counselling for the anxiety would be able to continue once the drug use had ended. The client and her mother agreed to this.

This client participated until the fourth session. Her total anxiety score had all increased over these weeks as well as her lie score (Figure 22). Two of the three subscales also increased within these weeks (Figure 23). It was also unknown if this mother felt that her daughter had improved during these sessions, due to not completing the program (Figure 24).

The sixth, and final client, was diagnosed with anxiety and was diagnosed with Obsessive Compulsive Disorder however his and mother's major concern was his lack of social interaction. This client had a fear of other person's opinion of him. He often withdrew from social settings and appeared depressed. Multiple meetings were postponed, and follow through with assignments were lacking. However, this client near the end of our meetings began to display a more outgoing attitude, and was attempting to complete goals he had set for himself.

This Client came to the program with high scores all around. Throughout the treatment phase his total anxiety score remained stable and his lie score remained low but generally stable as well (Figure 15). It was not until the tenth session when his anxiety began to decrease, and continued to decrease in the baseline phase. This reflected the total anxiety scores as well, with the exception of one subscale increasing during the

baseline phase (Figure 26). This client's mother rated him as slightly improving from the start of the program until the completion (Figure 27).

Conclusion

Overall, I would conclude that Cognitive Behavioural Therapy was an effective form of treatment for anxious children and adolescents. Having adapted this therapy to Social Work it was helpful to involve the parents of the clients in supporting the improvements of the child. However, the major improvements came when the child themselves had the drive to become better.

Cognitive Behavioural Therapy was also effective in that it allowed for variation in the treatment approach depending on the child's age. Not all therapies will fit for every child therefore this therapy provided multiple cognitive, as well as behavioral approaches so the client can find the best fit for them.

The downfall of this structured practicum approach was that it did not allow for variation in topics to be discussed. It also did not allow for extra sessions on each technique that would be available in "regular" counselling sessions. I would definitely use Cognitive Behavioural therapy in my work setting, with the ability to work at the client's pace, and be able to incorporate it into solutions to other problems.

Chapter 6- Areas of Learning

This chapter describes the learning I have made from this practicum. I first give an overview of the knowledge and skills that were developed during the practicum. Secondly, I relate some of the research that was discussed in Chapter 3 to my practicum families. Ending this chapter, with a description of interesting findings I encountered through this practicum experience.

Knowledge and Skill Development as a Therapist

Prior to starting this practicum, I was working as a school social worker in the Lord Selkirk School Division. I had experience working with children and adolescents in a one on one setting as well as practicing family counseling. I had some knowledge of different coping strategies in the Cognitive Behavioral Therapy, such as social skills training and assertiveness training. I also had first hand knowledge in anxiety. I had experienced anxiety in my teenage years, and developed my own coping strategies to overcome the symptoms. By researching the topic for the Masters program, I learned that I was in fact using the relaxation and breathing strategies in the Cognitive Behavioral Therapy. I also developed knowledge of anxiety and CBT through articles and books for assignments that in the Masters program of Social Work.

I started the practicum by transferring my book knowledge and personal experience into practice. Through this, I had the opportunity to strengthen my skills and develop new ones. I also had the opportunity to become familiar with different resources and professionals in the Interlake area as well as Winnipeg that relate to anxiety. As a result, I am more confident in my abilities and have changed and grown in my skills as a therapist.

At the mid-point and end of the practicum experience, I as well as my onsite supervisor, Toni Cascegna, completed an Intern Evaluation form as described in Chapter 5. The purpose of this was to help me reflect on my skills as a student therapist. With my supervisor completing this evaluation form, it gave me the opportunity to evaluate strengths that I may not have considered myself having, as well as areas that I need to improve upon.

This form covered eight areas such as Basic Work Requirements, Ethical Awareness and Conduct, Knowledge and Learning, Response to Supervision, Interaction with Clients, Interaction with Coworkers, Work Products, and additional comments. The mid-point evaluation helped identify areas that I need to be more aware of while working as a therapist. This form was useful in identifying an overview of me as a working therapist however; it was not specific to my therapy approach for this practicum. My onsite supervisor did not sit in the therapy sessions therefore she could only rate me by listening to the audiotapes as well as discussions we had of my practicum experience. When evaluating my scores, I rated between scores of 4-5, or N/A if the topics did not apply to my practicum. Therefore, theses scores reflected that there were no areas that needed major attention for improvement.

The evaluation process was helpful for me to hear the areas I was excelling at in the eyes of my supervisor, and areas that we discussed in further detail. I would probably not use this evaluation form again because it was too general. This made it difficult for me, and my supervisor, to determine if I was developing the specific skills that relate to Cognitive Behavioral Therapy.

As discussed prior, my work history had been working with individuals and their families on a variety of issues. We generally worked together to develop a goal and planed to achieve the goal that was best suited for them. This practicum helped broaden my therapy strategies. I provided me with a structured therapy approach in which I am "a teacher" of coping strategies, and their homework was to practice these skills. In the end, they were the ones responsible for continuing to use the strategies best suited to their lifestyle, and personality. It was difficult to be structured. I am used to working at the client's pace, however I needed to keep introducing new ideas to keep the practicum moving. However, this experience did help me structure and organize the process of therapy.

These practicum experiences also helped me in identifying a problem, organizing a plan of action, and remain focused on the specified goal. Through my work as a school social worker, I have a tendency to focus our sessions according to issues of the client that week. This often leads to ongoing contact year after year, because new goals are constantly introduced. This practicum helped me develop a sense that I can set limits, and I do not have to solve every problem that comes through my door. I did feel a tendency in the practicum experience to want to help the client with other issues that were going on, such as family alcoholism, divorcing families, and lack of income. These issues were discussed to some degree in the practicum however if they were not the cause of the anxiety they were not focused on.

I started the practicum process being regimented in what I was going to discuss, how I was going to present it, and what I needed to learn from the family about their anxiety. This in itself is not bad however, as I started working with the clients and more

referrals came in, I found myself becoming more relaxed in my approach, and became a better listener to the client, and their parents.

I also had the opportunity to provide knowledge and skills to the clients in a number of ways that were age appropriate. For younger children we used more stories that were age related, as well as role-playing and use of cartoons. With the older children however, I structured the therapy approach as a teaching moment to discuss how they could use these skills and reflect on its helpfulness.

I have also developed knowledge in approaches to therapy based on this practicum. In my place of work, sessions are generally set up at times when parents can meet with me in person so we can discuss goals, plans, and follow-through. However, through this practicum I met parents in person for the assessment as well as the termination session, with weekly phone conversations in between. I did not feel that this approach was as helpful as face-to-face contact. However, due to this practicum was placement within the school division, this limited the hours of service available. I cannot say for sure that parents followed through with using the techniques that we spoke about on the phone however, I felt they did not because of discussions I had with the children and adolescents about the support they were not receiving at home. This feeling could also be due to my work with parents as a school social worker, we are developing a plan of action together. However, in the practicum I am introducing families to techniques that have helped other parents and encouraged them to use these skills.

My knowledge of using questionnaires and examining the client's improvement has broadened. I have used questionnaires in the past but not as an evaluation of improvement tool. This gave me another way as a therapist to determine the client's

improvement. This is a way that the client and I can tangibly observe what is and is not working.

Lastly, this experience has given me the opportunity to experience the research procedures through the University of Manitoba. I now have skills in the process of developing a proposal, presenting it to the ethics board for approval, then putting the plan into action.

Thus far, this chapter has briefly outlined some of the professional gains that I have made in my knowledge and skills through this practicum. However, the greatest knowledge has come from connecting the research to the families I have worked with. The following section discusses this in detail.

<u>My Practicum Experience at the Lord Selkirk School Division</u>

Throughout the course of my practicum at the Lord Selkirk School Division, from October 2003 to May 2004, I picked up nine client-families. Of these families, eight clients completed the full practicum experience. I have some interesting findings that were discovered through the practicum and lots of result that were conducive to the research described in Chapter 3. I will describe in detail these conclusions in the next section of this chapter.

One of the difficulties with meeting the client at their school was getting them out of class to attend an hour session. This was not due to the teachers or school personnel, but the clients themselves. Some found that a one hour per week time commitment was too difficult, for them to keep up with schoolwork. Therefore, throughout the practicum there needed to be some shifting of meetings from school time to lunches or after school.

Another factor that appeared to influence the commitment of the families was if the parents were working. It was often difficult to have lengthy discussions with the parents when they were working the same hours myself. To overcome this obstacle we made conversations over lunch hours or brakes.

Some of the sessions were canceled due to the child not feeling up to talking that week. As stated in Chapter 3, anxiety and depression are closely related. Therefore, the client may have felt down that week, not wanting to focus on positives, or would attend sessions and not participate in conversations. The sessions that were missed were re-scheduled for a later date. If there was a session where I felt that the client was not participating to their full ability, I would revisit the techniques the next week as a review.

Therapists can have a strong and positive influence on the clients that they are working with. In my experiences as a school social worker, I have developed a therapeutic style that may have had an impact in the success and challenges with my clients and their families.

One of these therapeutic styles was my ability to be friendly, outgoing and easily able to interact with the clients and their families. In the initial assessment, I met with the client and their parents. Here I gathered as much information about them and the anxiety as possible. I believe that my ability to listen and ask the right questions came out in these meetings.

A second factor that may have influenced my ability to work with these clients was my personal challenge in keeping the therapy focused. I did have sessions structured so that all of the clients received the same information however, I often found myself talking with the child about other issues. Sometimes the anxiety may not have been the

major issue of the week. I talked to the client about their other problems for a short time and discuss possible solutions, then tried to refocus them on to anxiety coping strategies. I believe that my skills of directing the conversation became stronger however; I believe there was still room for me to grow in this area.

One of my personal strengths was my enthusiasm, and constant encouragement with the clients and their parents. I had an ability to talk openly. With my ability to talk, I was able to provide a lot of knowledge about anxiety, and related topics. I usually fed off the client. If they were engaging in the conversation, I had them to provide me with more feedback, and do more role-plays. Where as if the client was not as talkative, I spoke more and give them opportunity to comment on what I was saying.

Prior to this practicum, I had knowledge about anxiety and therapeutic techniques from my own experiences. I was eager to hear all of the different experiences the clients had with their anxiety and their ways of coping. I was also excited to see all of the similarities between the clients. What I was not as prepared for was the challenges of keeping the client on topic, and incomplete homework tasks. There was also the challenge of the parents not seeing the growth in their child that they saw in themselves. However, from reviewing the literature, I am reassured that there will be differences in how the client perceives themselves, and how their parents see them.

It was also more difficult to work with clients who were told to participate in the program by their parents, as opposed to the clients who were seeking help themselves. Now that I am aware of these challenges, I could expect them in future clients and be able to be more flexible in my approach.

Unexpected Findings

There were many interesting findings discovered through this practicum. Some of these findings were conducive to the research stated in a previous chapter, and some were interesting in and of themselves.

The first interesting finding I discovered through this practicum was the way the types of anxiety disorders were clustered together by school. Of the clients who were diagnosed with anxiety, many different types of anxiety were displayed. In one of the schools, two girls displayed fear of germs/getting sick. A second school had two girls who were displaying panic attacks, and were not attending school. A third school had two boys who were both social phobic.

These findings could be because of the environment of the school. For example, the school where the boys were social phobic had a population of 1,400 students. This is extremely larger than the junior high schools from which they come. The two girls who did not attend school frequently came from a school that had a high prevalence of conflict among students.

Gender also played a factor in the findings of anxiety. All of the boys who had anxiety had difficulties to some degree interacting with peers. Whereas, some of the girls reported having difficulty with peers, but they had contact with friends and socialized with others in and out of school.

We ran into a roadblock with being able to practice the relaxation therapy to the same extent with males and females. With the girls, we would get relaxed and put our feet up on the desk in the office, shut off the lights and listen to the relaxation tape. This gave them the full effect, and allowed me to know how it made them feel right after.

However, in one session with a female client, the school principal interrupted by walking in. He could hear people in the room but the lights were off. He believed that a few of his teenage students were in there “making out”. After explaining what we were doing, we all had a good laugh however; I did not want to run the risk of having this happen with a male client. I was cautious after this session.

As for the clients age, research shows that anxiety symptoms could surface as young as 5 years old. The parents of my clients also stated that as young as three years of age they could tell that there was something different about their child and their inability to separate from their caregiver. However, since this practicum only accepted clients who were diagnosed with anxiety this limited the younger children displaying anxious symptoms to be part of the practicum. The younger students were not diagnosed, or are seen by their parents as something that they will grow out of.

Client’s ethnicity also played a role in the findings of this practicum. Two of my clients were of First Nations descent. One male client had lived on a reserve where there was a small population in the school, and had moved to one of the largest high schools in the province. However, he did not believe that his cultural background had any influence on his anxiety.

Research states that Caucasian people are more likely to engage in counselling and take medication for anxiety (Chavira et al., 2003). This was true to some extent for my small population. Of all the students that were referred to me only three were either Métis or First Nations, in a city with a large First Nations city population. One of these clients had tried medication, but discontinued using it because he felt that he could overcome the anxiety on his own. Another First Naitons client was willing to try

medication but was recommended by her doctor to discontinue substance use prior to using medication for anxiety. It was unknown if this client was self-medicating with drug use to ease the anxious symptoms, or if the drugs themselves were bringing on the symptoms. The other client was uncomfortable with taking medications.

Research also shows that the ethnic minority are more likely to terminate sessions (Kendall & Sugarman, 1997). The First Nations/Métis clients were of the ethnic majority in this town, but of the minority in the province. All of these clients missed many sessions or asked multiple times to reschedule. Of the clients, one was asked to leave the treatment program once the therapist discovered her addiction problem. This topic was one of the excluding factors for treatment in this program. I explained to her that once her addiction was dealt with we could re-visit a treatment program for her.

Research states that medication would be helpful to the clients in this program. However, I would not say, from this practicum, that the clients who used the medication did better in symptom reduction. Half of my clients, two girls and two boys were on medication for their anxiety, but it came with its down falls. A few of the clients complained of having increases in nightmares, and suicidal thoughts. These were side affects of the anti-anxiety medication. The medication affects levels of serotonin, a brain chemical linked to mood, emotions, and mental state, stimulates brain activity. One of the side effects of Fluoxetine Hydrochloride (Paxil) is unusual or vivid dreams (Readers Digest & Canadian Medical Association, 2002). The suicidal thoughts were also a side effect of anti-anxiety medications such as Sertraline Hydrochloride (Zoloft) due to interactions with other prescription and over the counter medications (Readers Digest & Canadian Medical Association, 2002) , especially medications for acne. The two

medications did not mix well, therefore increasing suicidal thoughts. These side affects, according to the client, were not bad enough to discontinue use because the positives outweighed the negatives.

The research states that single parent homes are more likely to terminate counselling (Kendall and Sugarman, 1997). This was not the case for my nine families. None of the clients terminated however, one was asked to leave.

Along the lines of socio-economic status (S.E.S), poorer long-term outcomes were associated with higher severity in anxiety, lower levels of support and more social difficulty. Of the nine families, four fit in the low S.E.S. category. Of these four families, three had high anxiety symptoms. All four had lower levels of improvement. Most of these families felt isolated from family and had few friends, and two of the four had social difficulties.

The research also states that parents had an impact on the success of their child's treatment (Mendlowitz et al., 1999). It states that the higher the parental involvement the better the clients did. This was true to some degree in my practicum. The parents who really wanted their child to improve were willing to go out of their way to help in exposure therapy. They were also more willing to change their parenting style to help. However, it was the child's desire to improve that made the most difference in the therapy. This finding is consistent with findings at the Winnipeg Anxiety Clinic, who felt that it was the client themselves, not parental impact that made the most impact on successful treatment.

The research states that when parents participated in the program, the children of the parents who were not diagnosed with anxiety would do better in treatment than

children of parents who did have anxiety (Cobham, Dadds & Spence, 1998). This is not so with this practicum due to four of the clients having parents with anxiety and two of them improving significantly, and two of them improving slightly. Of the four clients who did not have anxious parents, one improved significantly, two improved slightly, and one maintained her status.

Conclusion

This practicum has provided me with an opportunity to work with a single therapy approach (Cognitive Behavioral Therapy) instead of the bits and pieces approach I have used in may place of work. It also provided me with a specific group of children and adolescents who aided me in broadening my knowledge of anxiety disorders, and treatment. I learned more than I expected from this group of clients, and their families.

Another goal of this practicum was to develop assessment and clinical skills, as well as develop my skills in implementing a design for evaluation. I had completed assessments in the past with my place of work, but not specific to anxiety. This practicum helped me in identifying specific and related questions to ask about anxiety with my clients. It also provided me the opportunity to develop and implement a design for this practicum. Prior to this practicum, I did not have the time or chance to evaluate my work. However, I now have a greater understanding of the different types of designs, and data interpretations.

This section is a glimpse of the ways in which I have grown, and been challenged as a therapist through this practicum. It is my hope that I can apply my newly formed knowledge and skills to my place of work.

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Appendix A- Anxiety Disorder Classification

The following are descriptions of the anxiety disorders as classified in the DSM IV (1994):

A Panic Attack is a discrete period in which there is a sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensation, and fear of "going crazy" or losing control are present. (p.393)

Agoraphobia is anxiety about, or avoidance of, places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a Panic Attack or panic-like symptoms. (p. 393)

Panic Disorder without Agoraphobia is characterized by recurrent unexpected Panic Attacks about which there is persistent concern. (p. 393)

Panic Disorder with Agoraphobia is characterized by both recurrent unexpected Panic Attacks and Agoraphobia. (p.393)

Panic disorder displays several bodily symptoms such as sweating, trembling, shortness of breath, dizziness, and heart palpitations (Rapee, Wignall, Hudson and Schniering, 2000).

Agoraphobia without History of Panic Disorder is characterized by the presence of Agoraphobia and panic-like symptoms without a history of unexpected Panic Attacks. (p. 393)

> Specific Phobia is characterized by clinically significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behaviour. (p. 393)

The fears according to the DSM IV include animal type, natural environment type, blood-injection-injury type, situational type, or other type. These children will often throw tantrums, cry, freeze, or cling to the caregiver, as seen in social phobias (Rapee, Wignall, Hudson and Schniering, 2000).

> Social Phobia is characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behaviour. (p. 393).

Social situations can make the child experience nausea, stomachaches, blushing, sweating, trembling, heart palpitations, and dizziness. He or she often have few friends, are involved in few extracurricular activities, and will display poor social skills (Rapee, Wignall, Hudson and Schniering, 2000).

> Obsessive-Compulsive Disorder is characterized by obsessions (which cause marked anxiety or distress) and/or by compulsions (which serve to neutralize anxiety). (p.393)

Common compulsions are cleaning, checking, repeated rituals, ordering, and hoarding (Rapee, Wignall, Hudson and Schniering, 2000).

> Posttraumatic Stress Disorder is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma. (p.393)

Younger children will often complain of monsters, rescuing others, or threats to self and others. These children may re-enact killings with people or animals, create dangerous situations for toys such as car crashes (Rapee, Wignall, Hudson and Schniering, 2000).

Acute Stress Disorder- "is characterized by symptoms similar to those of Posttraumatic Stress Disorder that occur immediately in the aftermath of an extremely traumatic event," (DSM IV, 1994, p. 393).

> Generalized Anxiety Disorder is characterized by at least 6 months of persistent and excessive anxiety and worry. (p.393)

Children displaying this disorder seek excessive reassurance from others, and will avoid many situations. They will complain of stomachaches, headaches, and muscle aches. The behaviours that they will display are irritability, poor concentration, restlessness, tiring easily, difficulty sleeping (Rapee, Wignall, Hudson and Schniering, 2000).

> Anxiety Disorder Due to a General Medical Condition is characterized by prominent symptoms of anxiety that are judged to be a direct physiological consequence of a general medical condition. (p. 394)
>
> Substance-Induced Anxiety Disorder is characterized by prominent symptoms of anxiety that are phobic avoidance that do not meet criteria for any of the specific Anxiety Disorders defined in this section (or anxiety symptoms about which there is inadequate of contradictory information). (p.394)

> Separation Anxiety usually develops in childhood; therefore, it is covered in the Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence section of the DSM-IV. (p.110)

It is seen as immense fear when separated from a caregiver. The child will often feel that harm will come to them, such as being kidnapped, or lost, or feel harm will come to the ones they love. These children display behaviours such as crying, pleading, as well as throwing tantrums. When they are separated, they complain of stomachaches, headaches, nausea, and vomiting, (Rapee, Wignall, Hudson and Schniering, 2000).

Appendix B- Practicum Participation Consent Form (Participant)

Practicum Participation Consent Form

Cognitive-Behavioural Therapy for Children and Adolescents

Who have Anxiety Disorders

Amber Zetaruk

Dear Participant,

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The overall purpose of this practicum is for the Social Worker to use Cognitive Behavioral Therapy (CBT) with children/adolescents who suffer from anxiety disorder, and to use the skills and knowledge learned from the Masters of Social Work program at the University of Manitoba. This study involves voluntary children and adolescents who have been diagnosed with an anxiety disorder, and their families.

They will meet weekly for twelve weeks for approximately one hour with the Social Worker to learn coping skills using CBT. This experience will pose minimal risk. Some of the sessions and homework assignments may cause you to feel uncomfortable as we work towards helping you cope with anxiety. However, by working through these uncomfortable thoughts and feelings you will have an opportunity to learn coping techniques for dealing with problem anxiety. Such coping techniques have been useful for others who deal with problem anxiety.

If you do decide to participate, any information you provide will be written in a Social Work file that is locked in a filing cabinet at the Human Resources Centre. The only people who will have access to this information are other clinicians whom you consent to working with.

Sessions may be audio taped, videotaped, or observed to provide the Social Worker with feedback on her use of skills. Information collected verbally, written, or by questionnaires will also be written in the researcher's practicum paper. However, confidentiality will be protected using alias names such as (Family "A"). Information that is collected will also be shared by the researcher's advisors (Toni Cascegna, Psychologist at Lord Selkirk School Division; Dr. Harvy Frankel, Associate Dean of the University of Manitoba Social Work Dept.; and Ranjan Roy, professor at the University of Manitoba Social Work Dept). The findings or other study-related feedback will be made available to the subjects upon their request. Following the conclusion of the practicum, these forms of information will be erased once any relevant information is obtained from them. Data will be destroyed following approval of the final practicum report.

If I discover in the course of the study that child abuse is a factor, current laws require me to report this to the local legal authorities.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have any questions, now or in the future, you can contact Amber Zetaruk or Toni Cascegna, at the Human Resource Centre, #785-8224. The mailing address is Human Resource Centre, 211 Main Street, Selkirk, MB, or call the Social Worker's advisor, Dr, Harvy Frankel at the University of Manitoba #474-8378.

This research has been approved by the Joint-Faculty REB. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human

Ethics Secretariat at 474-7122, or e-mail margaret_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Thank you for considering this request.

__________________________ __________________

Signature of Client Date

__________________________ __________________

Signature of Guardian Date

__________________________ __________________

Signature of Researcher Date

Appendix C- Practicum Participation Consent Form (Parent)

Practicum Participation Consent Form

Cognitive-Behavioural Therapy for Children and Adolescents

Who have Anxiety Disorders

Amber Zetaruk

Dear Parents,

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The overall purpose of this practicum is for the Social Worker to use Cognitive Behavioral Therapy (CBT) with children/adolescents who suffer from anxiety disorder, and to use the skills and knowledge learned from the Masters of Social Work program at the University of Manitoba. This study involves voluntary children and adolescents who have been diagnosed with an anxiety disorder, and their families.

You will meet with me for the initial meeting as well as the final session. During these times you will be asked to fill out a questionnaire which will be used to compare data from your child's questionnaires. This experience will pose minimal risk.

If you do decide to participate, any information you provide will be written in a Social Work file that is locked in a filing cabinet at the Human Resources Centre. The only people who will have access to this information are other clinicians whom you consent to working with. Information collected verbally, written, or by questionnaires will also be written in the researcher's practicum paper. However, confidentiality will be protected using alias names such as (Family "A"). Information that is collected will also be shared by the researcher's advisors

(Toni Cascegna, Psychologist at Lord Selkirk School Division; Dr. Harvy Frankel, Associate Dean of the University of Manitoba Social Work Dept.; and Ranjan Roy, professor at the University of Manitoba Social Work Dept). The findings or other study-related feedback will be made available to the subjects upon their request. Following the conclusion of the practicum, these forms of information will be erased once any relevant information is obtained from them. Data will be destroyed following approval of the final practicum report.

If I discover in the course of the study that child abuse is a factor, current laws require me to report this to the local legal authorities.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

If you have any questions, now or in the future, you can contact Amber Zetaruk or Toni Cascegna, at the Human Resource Centre, #785-8224. The mailing address is Human Resource Centre, 211 Main Street, Selkirk, MB, or call the Social Worker's advisor, Dr. Harvy Frankel at the University of Manitoba #474-8378.

This research has been approved by the Joint-Faculty REB. If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122, or e-mail margaret_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Thank you for considering this request.

_________________________ ________________

Signature of Guardian Date

_________________________ ________________

Signature of Researcher Date

Appendix D- "What I Think and Feel" (RCMAS) Scale

Item		
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 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 is 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	Yes	No

Appendix E- Revised Child Behavior Checklist

Please indicate which of the following are problems, as far as this child is concerned. If an item does **not** constitute a problem or if you have had no opportunity to observe or have no knowledge about the item, circle the zero. If an item constitutes a **mild** problem, circle the one; if an item constitutes a **severe** problem, circle the two. Please compete every item.

1. Self-conscious; easily embarrassed	0	1	2
2. Feels inferior	0	1	2
3. Shy, bashful	0	1	2
4. Lacks self-confidence	0	1	2
5. Hypersensitive; feelings are easily hurt	0	1	2
6. Generally fearful; anxious	0	1	2
7. Depressed; always sad	0	1	2
8. Says nobody loves him or her	0	1	2
9. Difficulty in making choices; can't make up mind	0	1	2
10. Afraid to try new things for fear of failure	0	1	2
11. Feels he or she can't succced	0	1	2

Appendix F- Ethics Approval Certificate

APPROVAL CERTIFICATE

03 November 2003

TO:
Amber Zetaruk

Principal Investigator

FROM: **K. Duncan, Interim Chair**
Joint-Faculty Research Ethics Board (JFREB)

Re: **Protocol #J2003:149**
"Cognitive Behavioral Therapy with Children and Adolescents who have Anxiety Disorders"

Please be advised that your above-referenced protocol has received human ethics approval by the **Joint-Faculty Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note that, if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix G- Figures 10-27

FIGURE 10

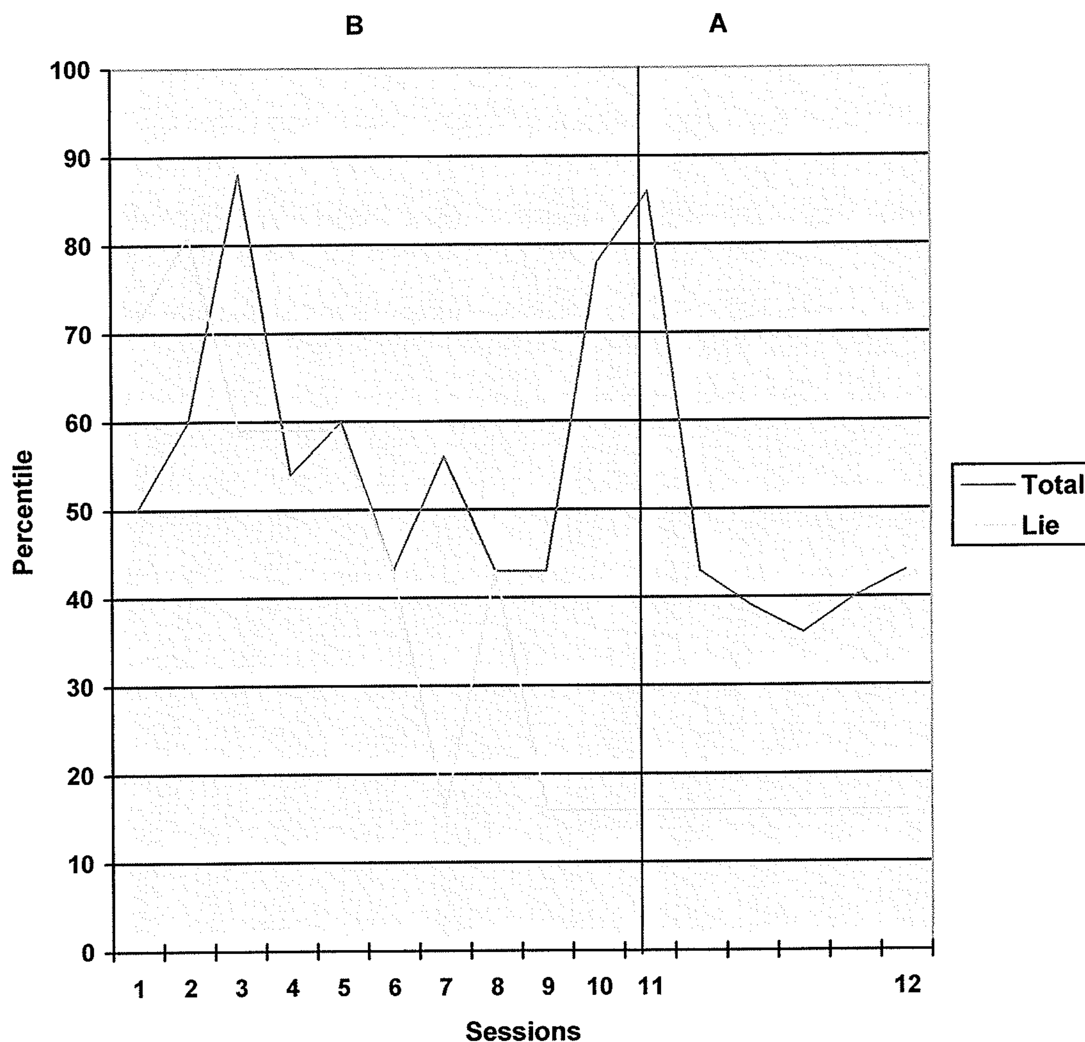
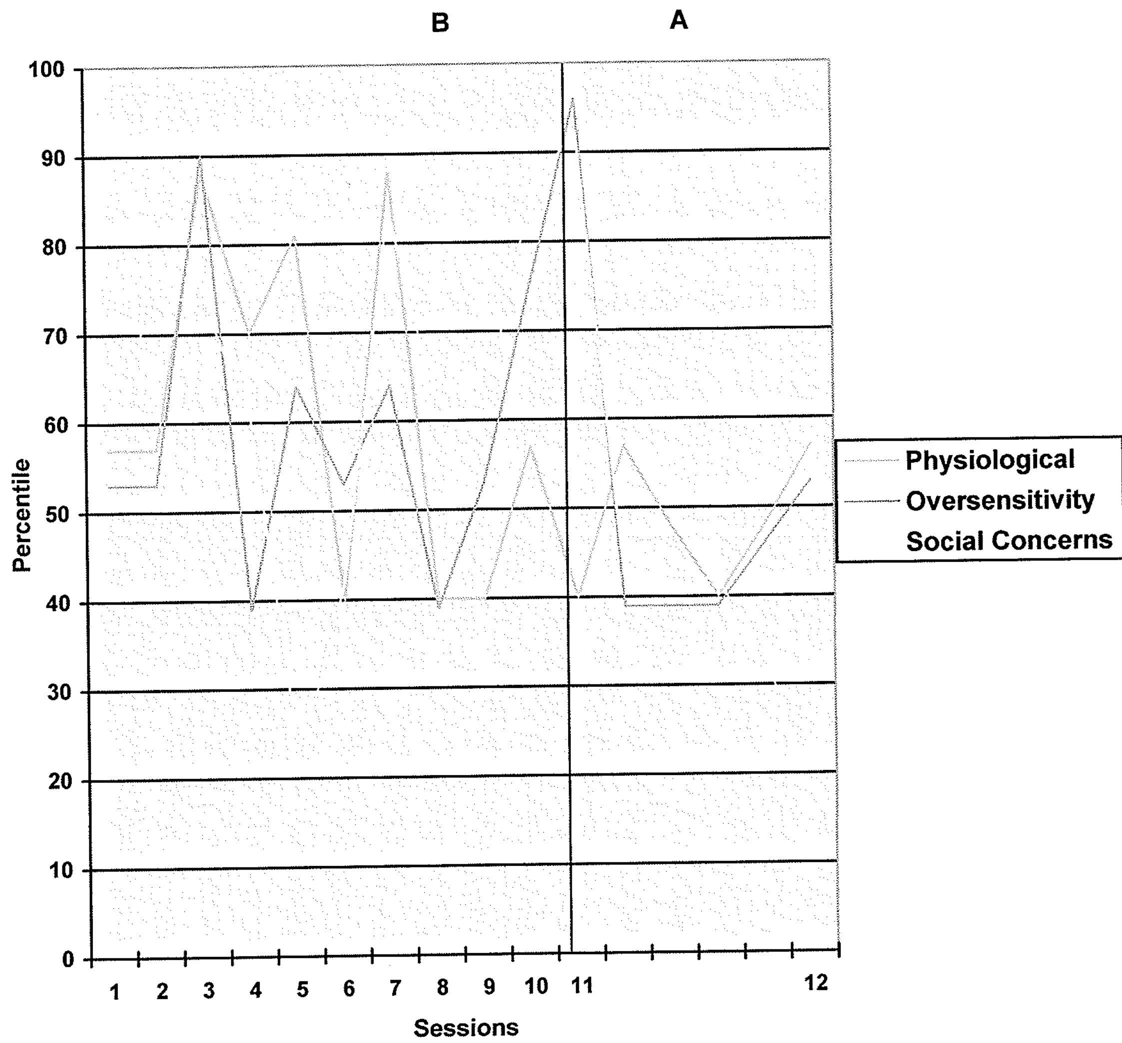


FIGURE 11



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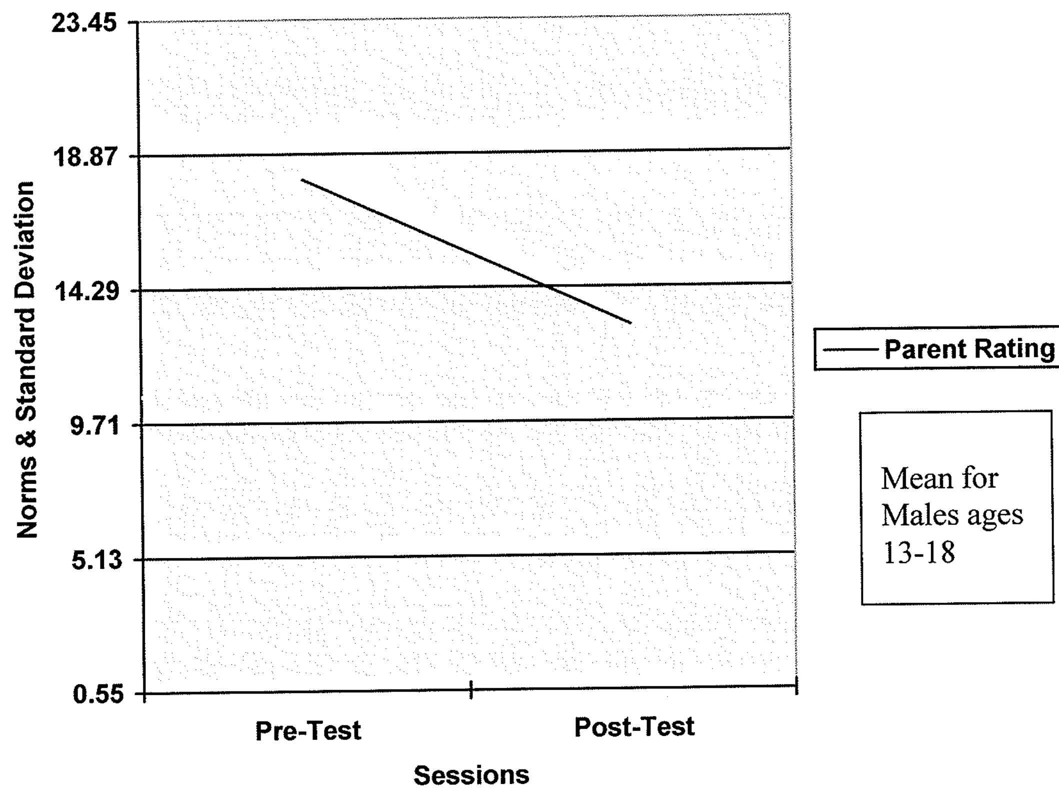

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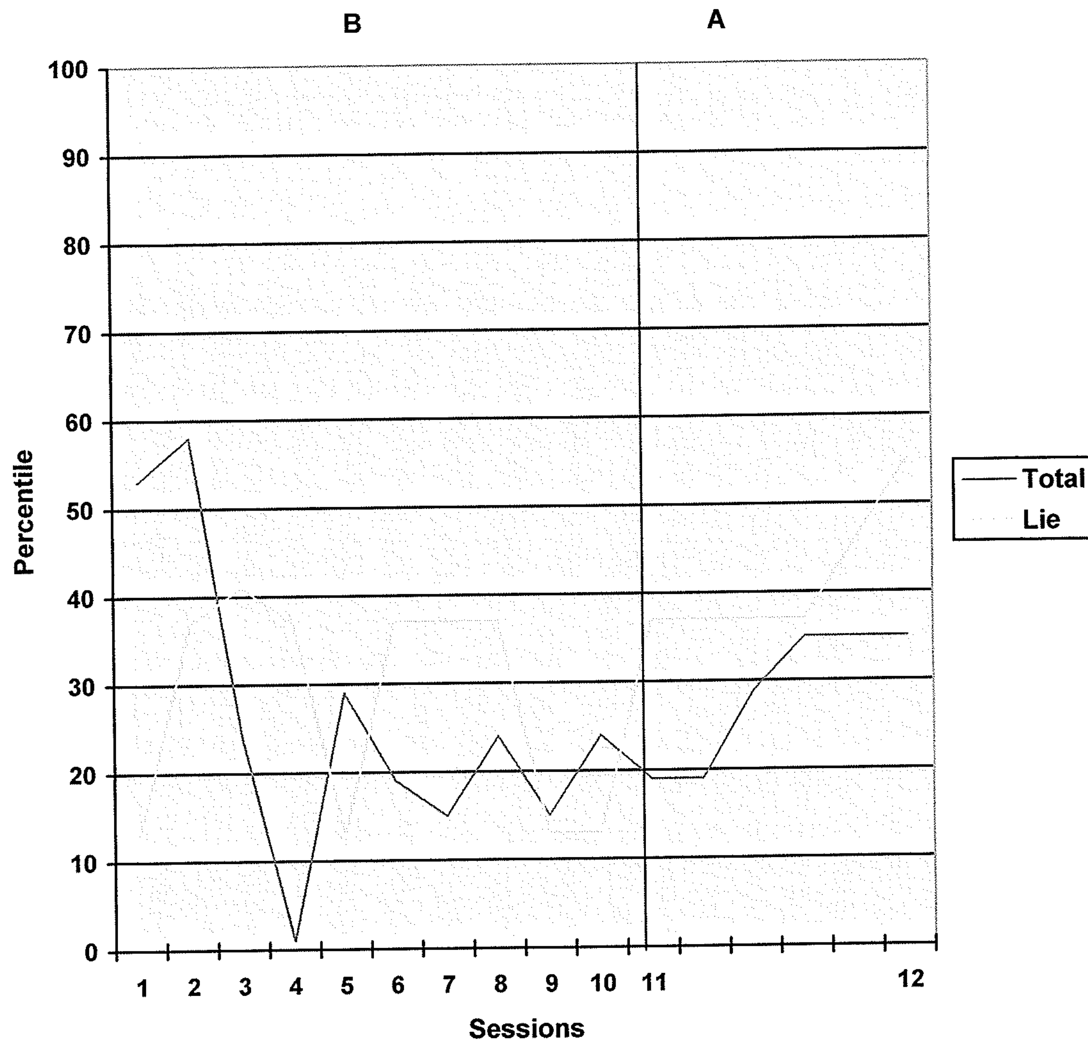

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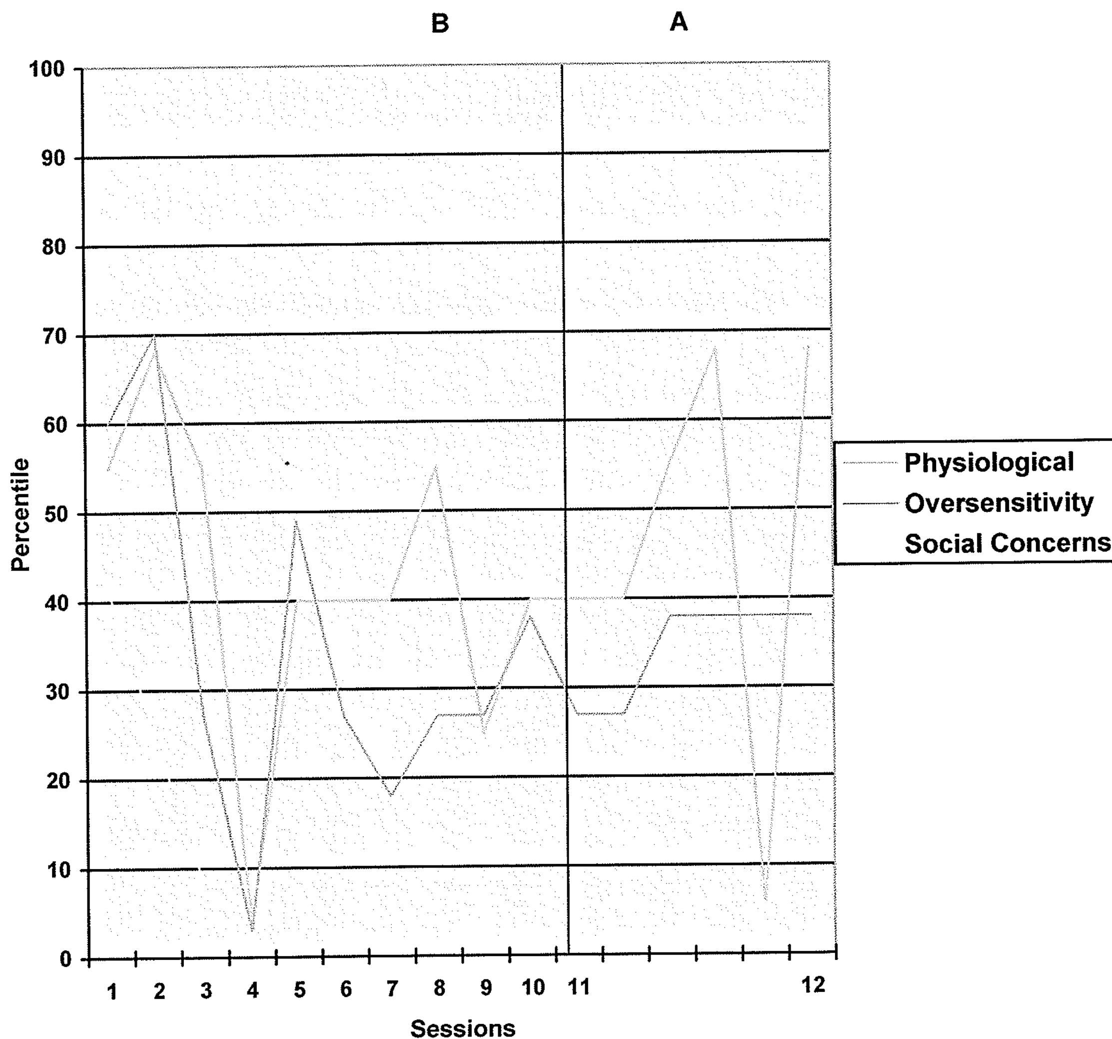

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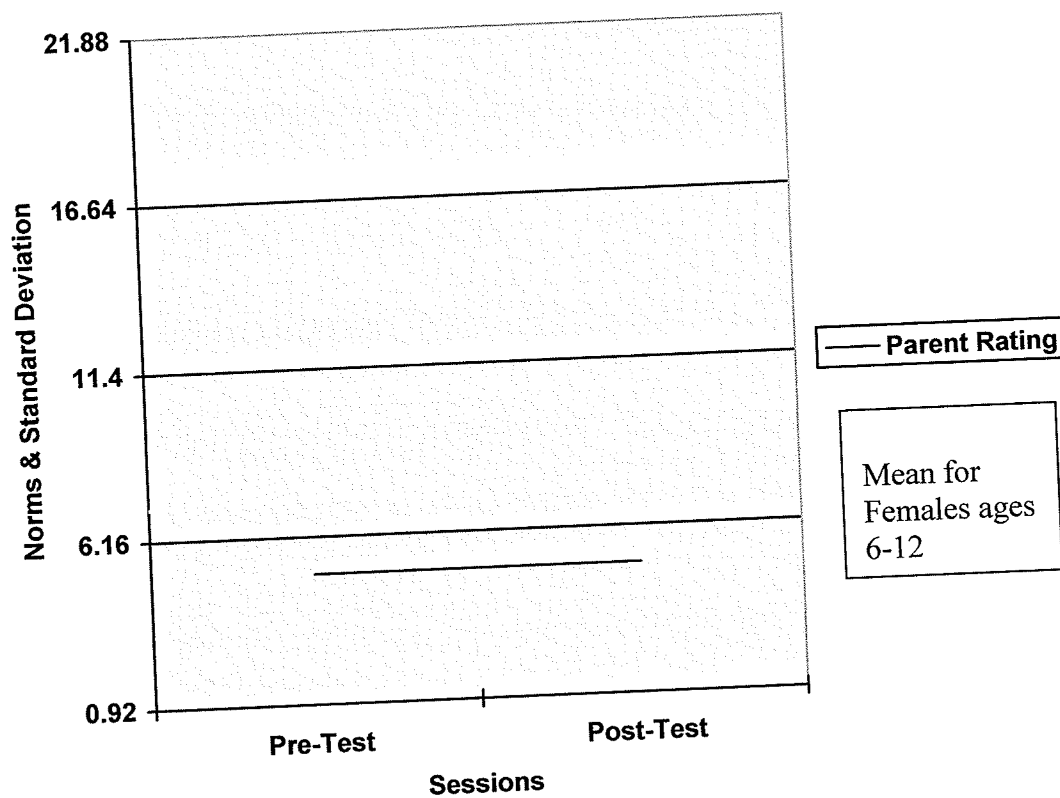

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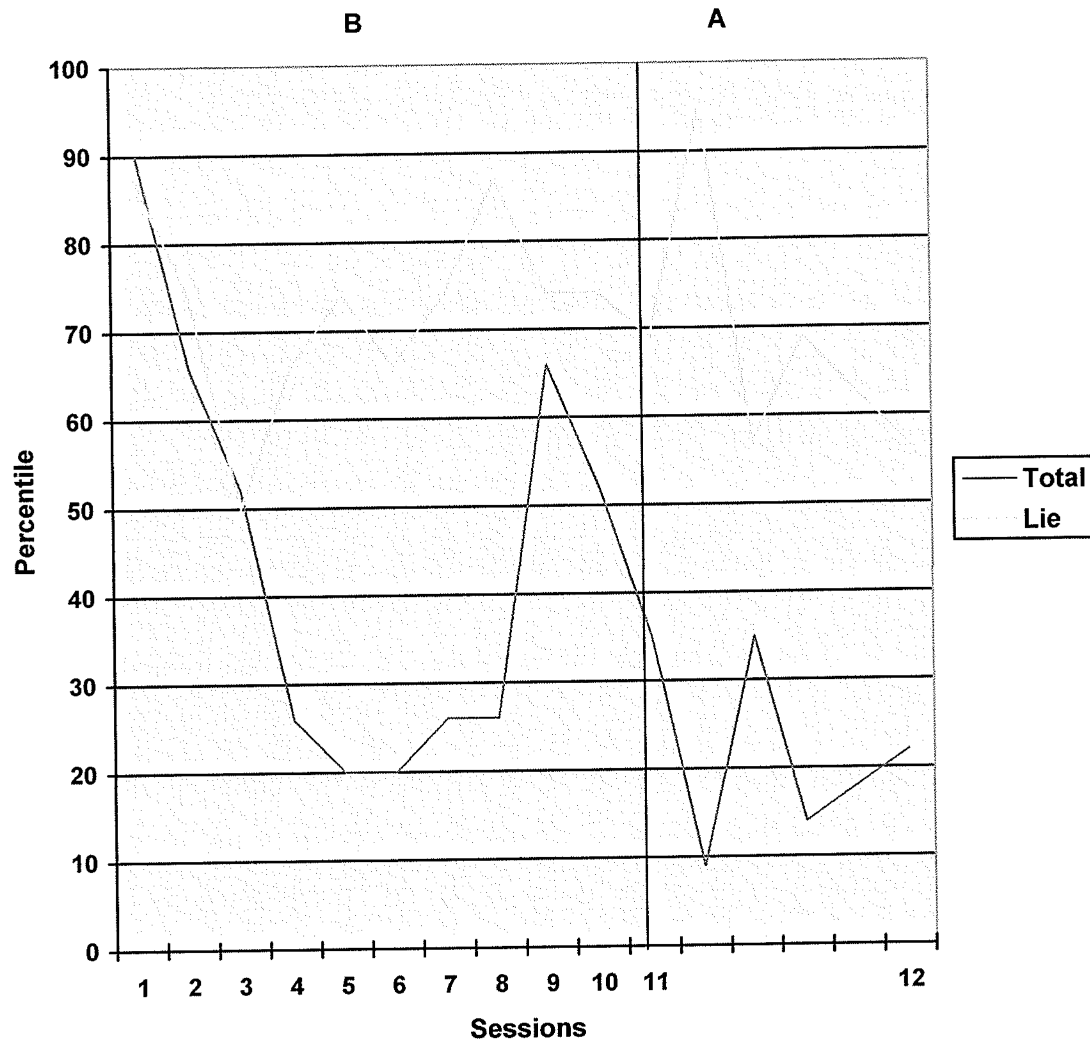

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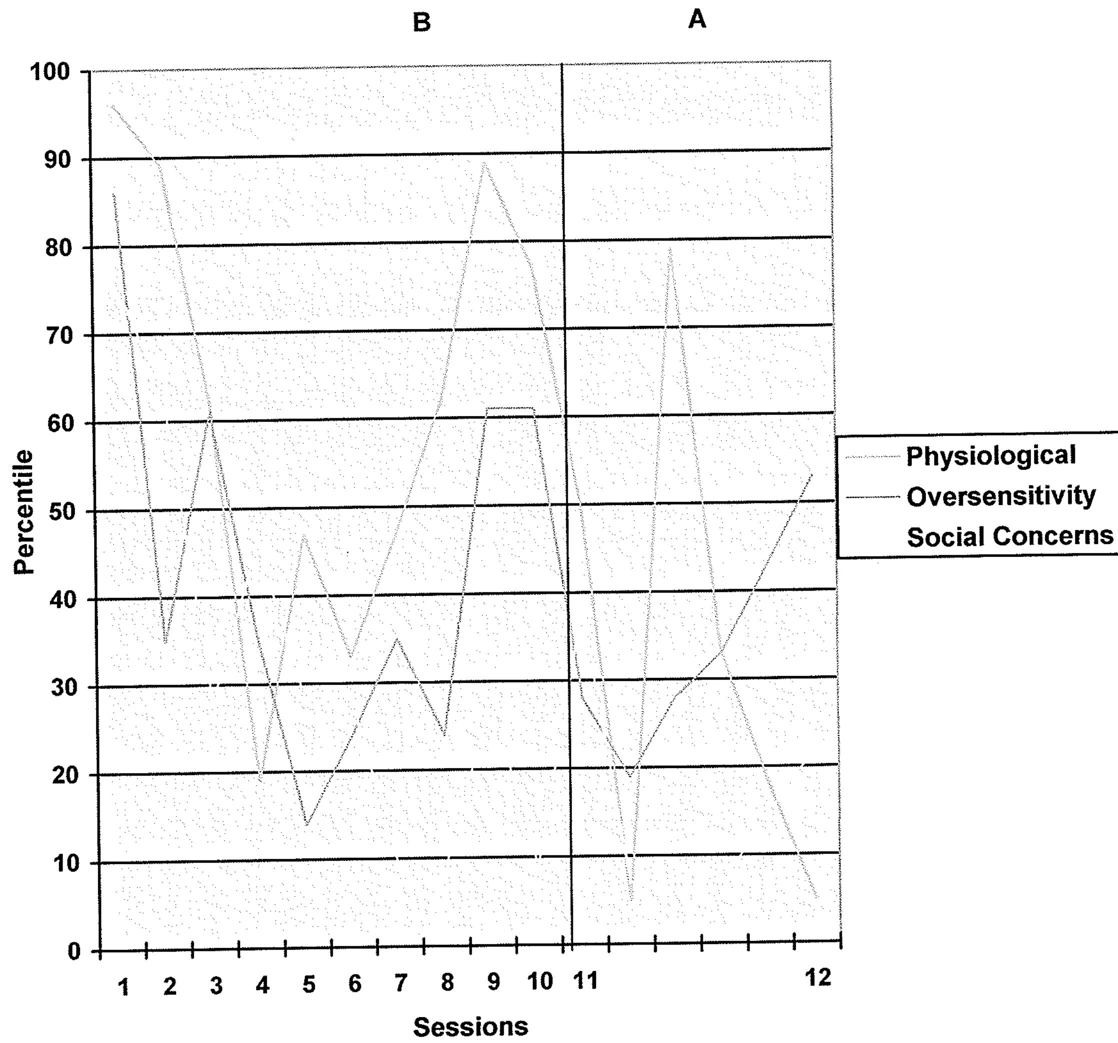

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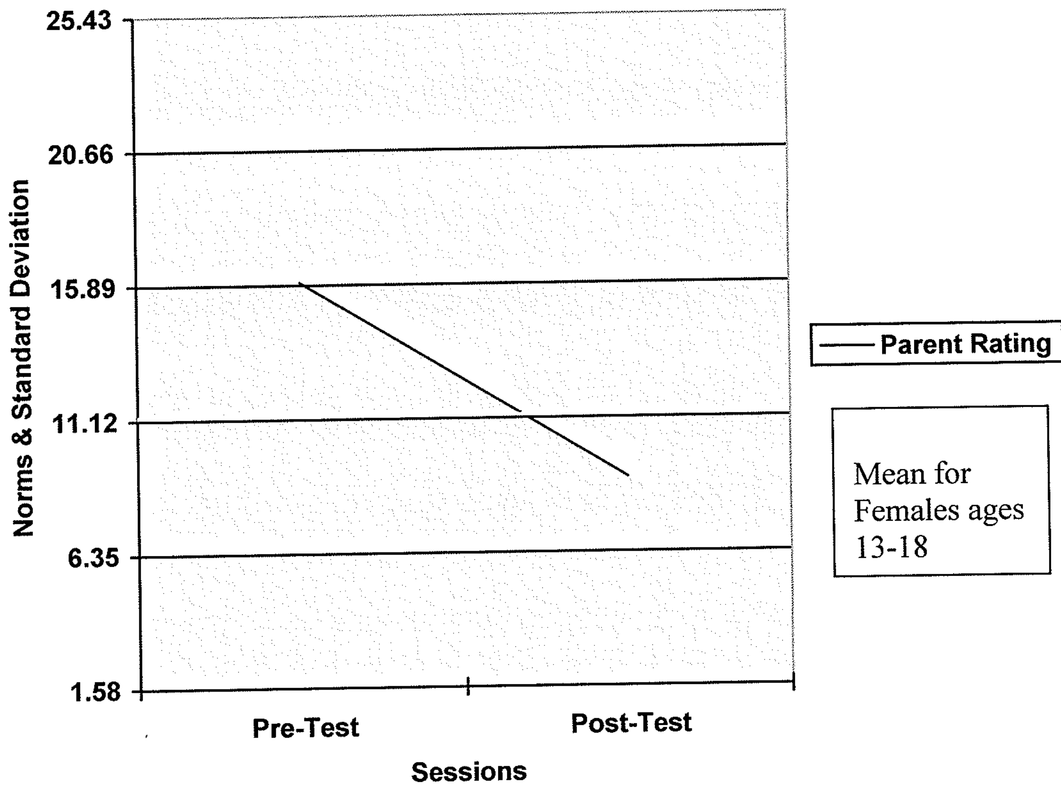

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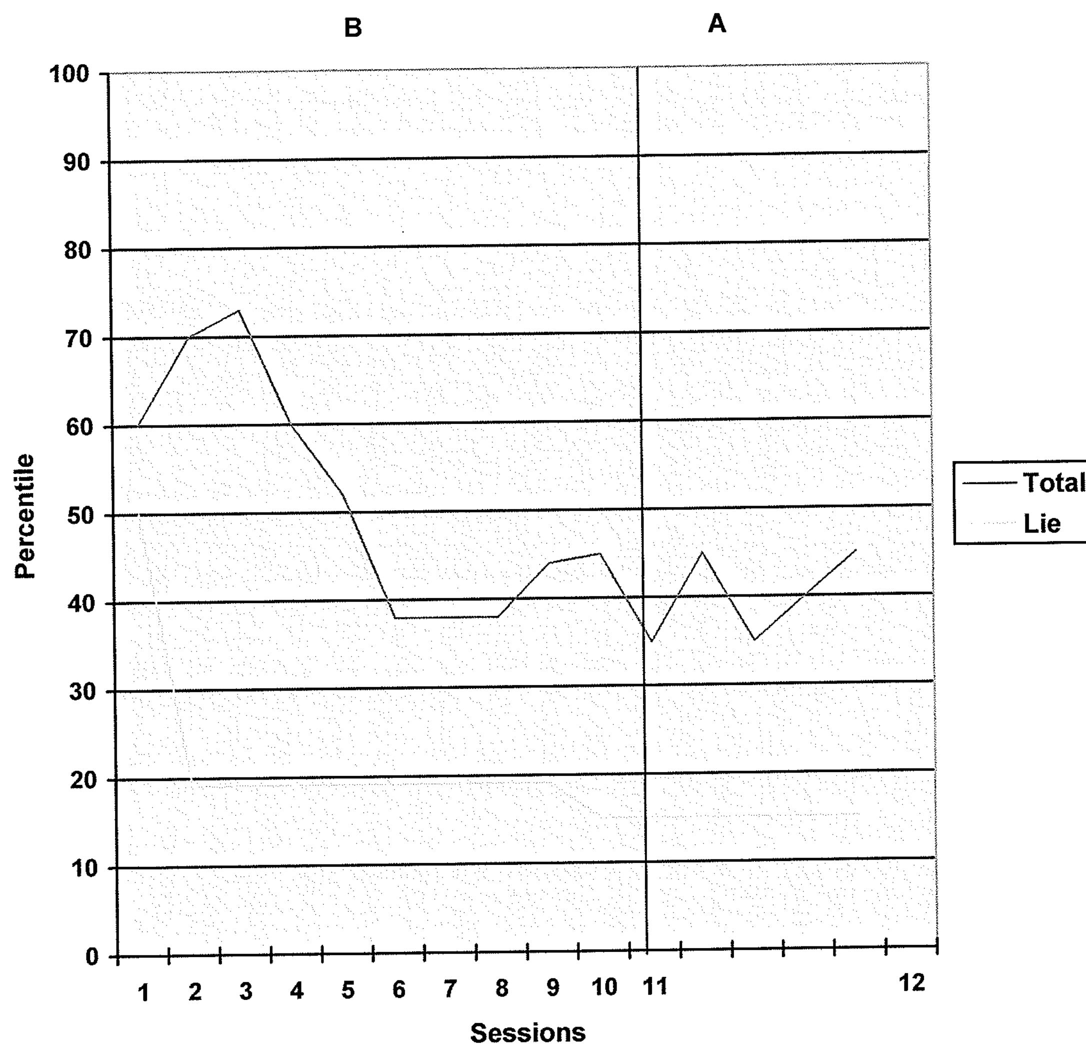

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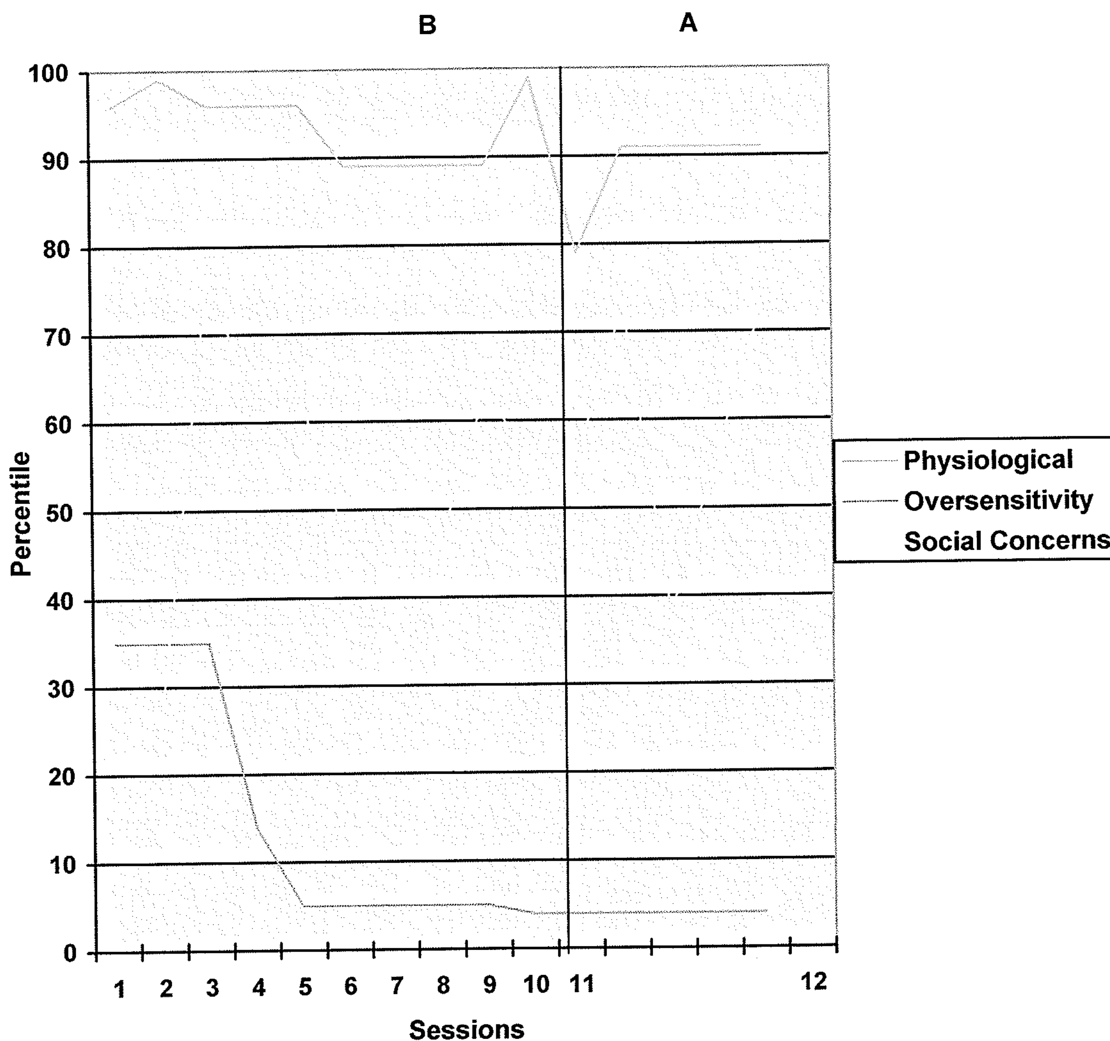

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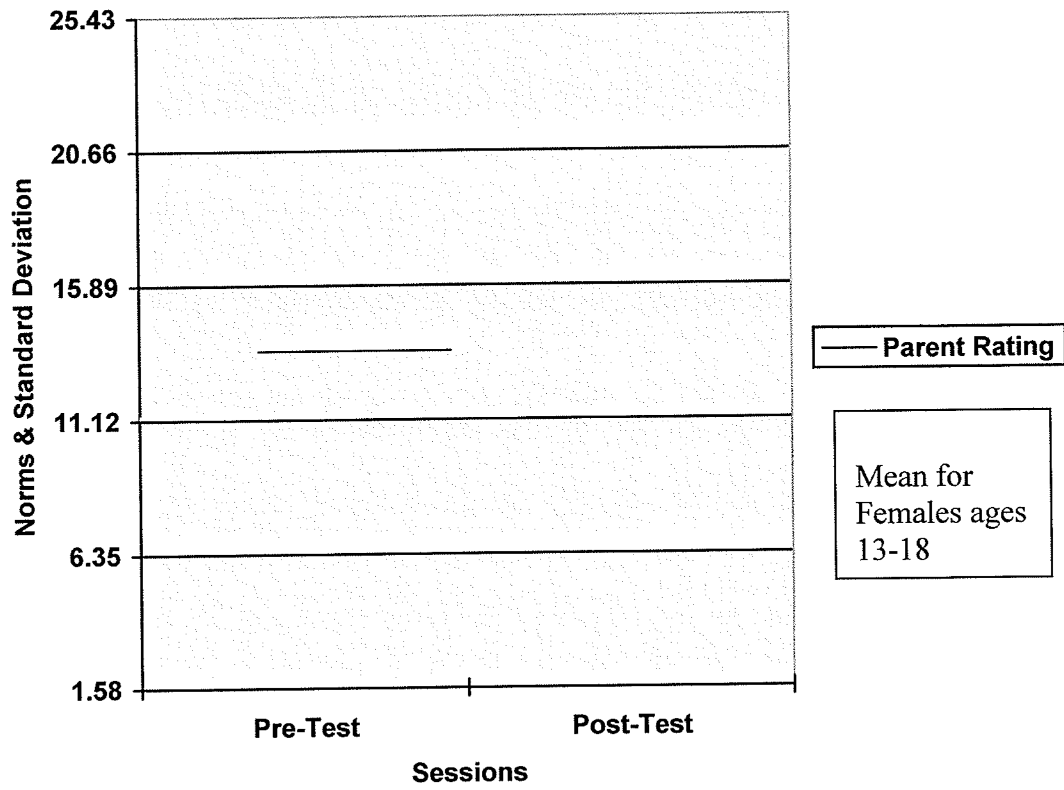

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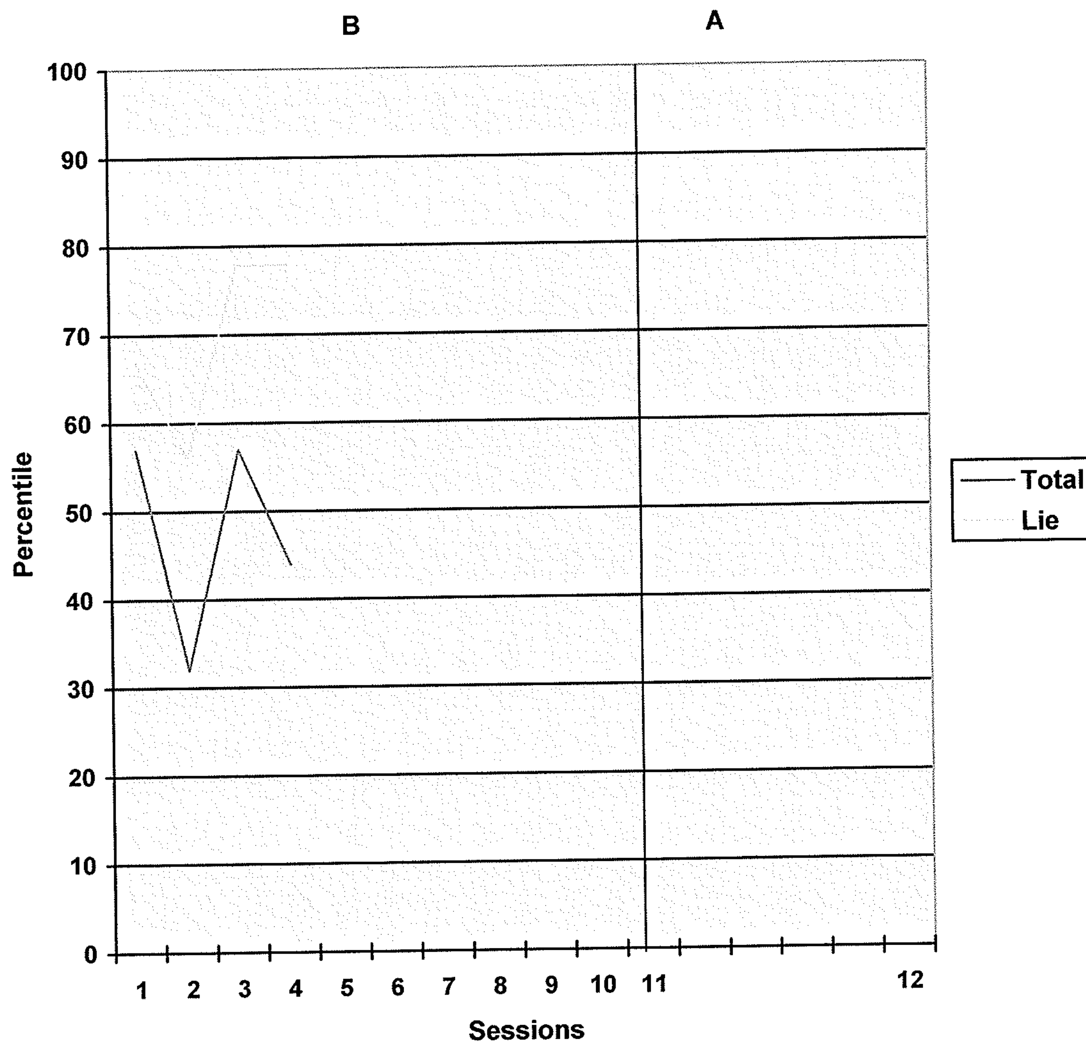

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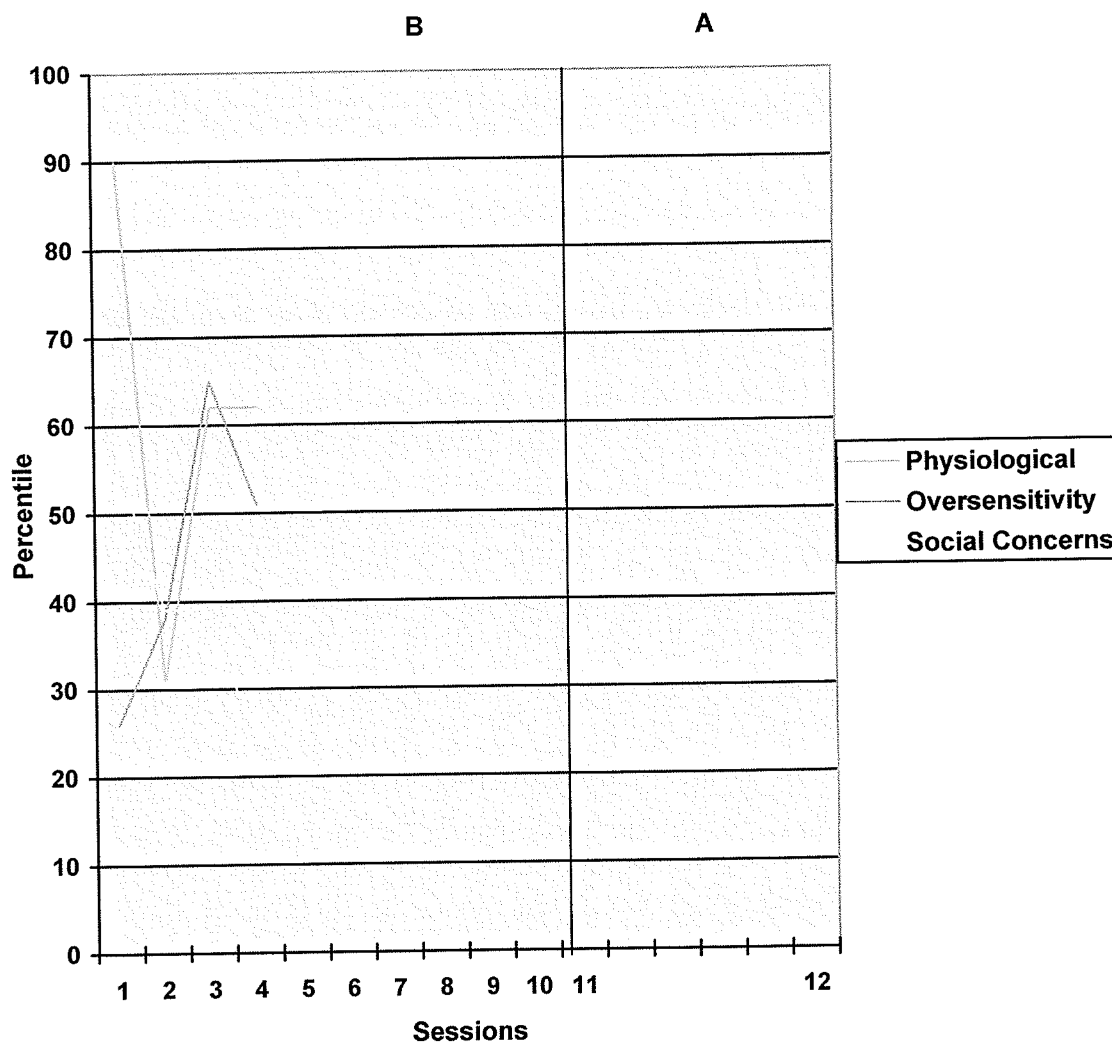

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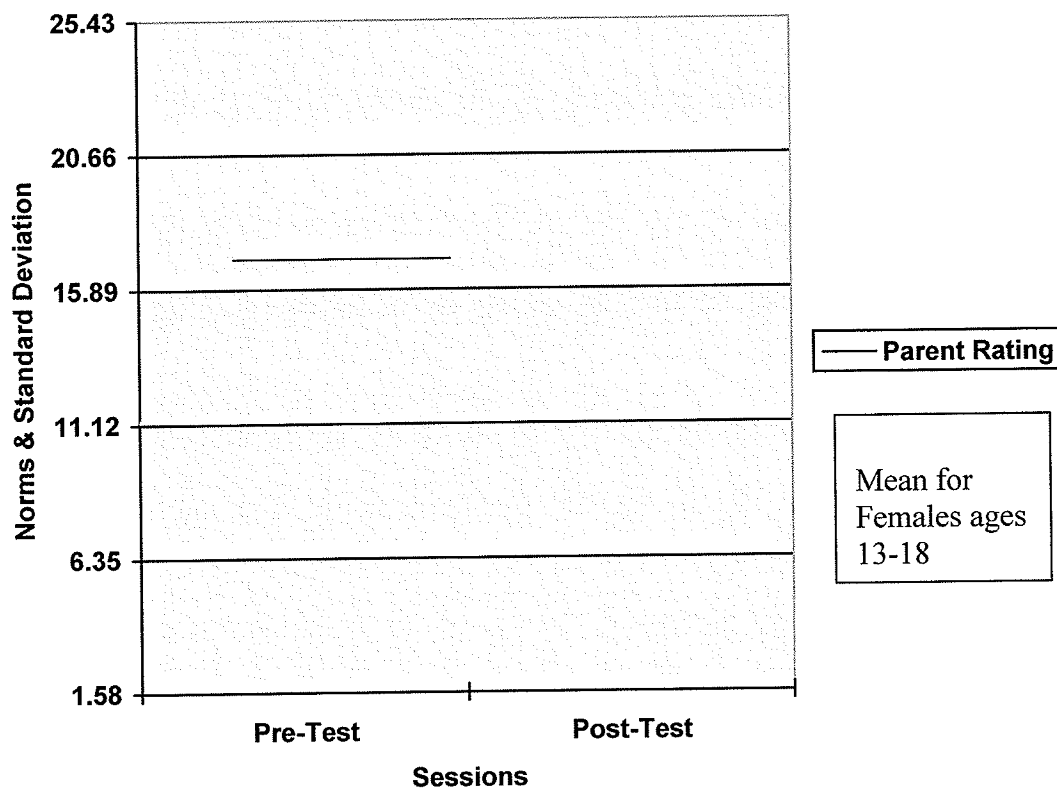

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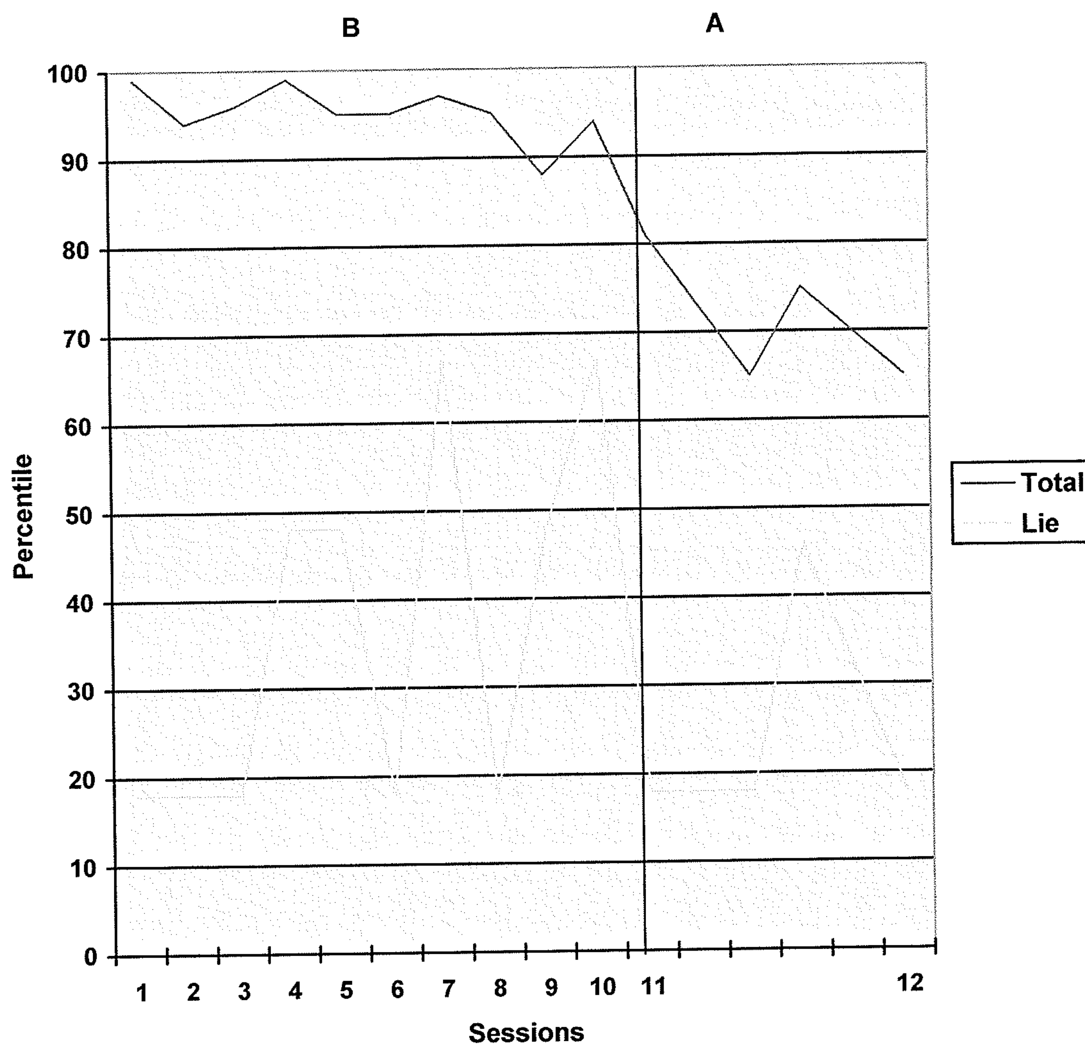

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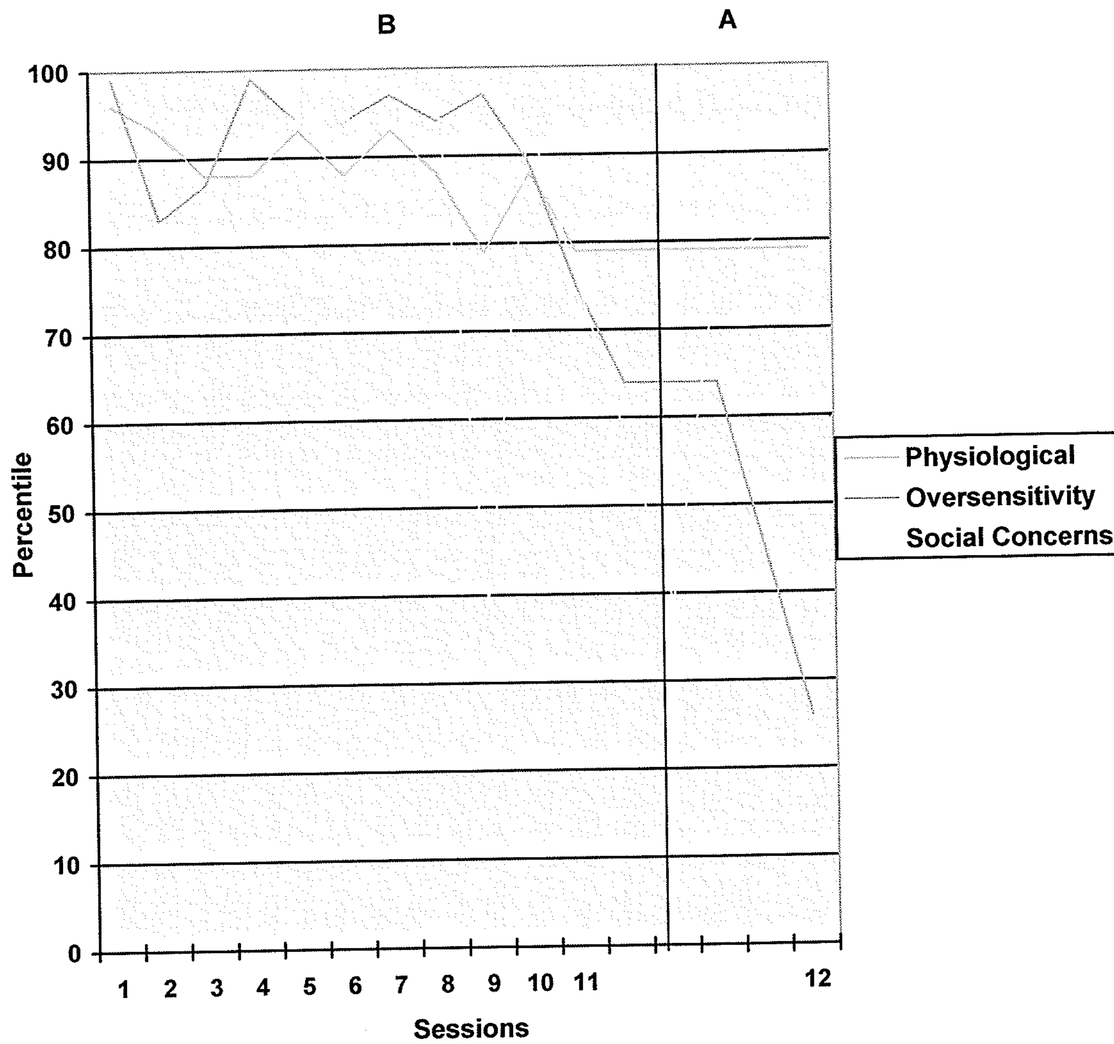

Figure 27