

Running Head: CLINICAL EFT FOR POSITIVE COPING IN EARLY CHILDHOOD

Master of Arts (Research) Confirmation Document and upgrade to PhD

Raising Resilience; An Adapted Clinical Emotional Freedom Technique Program for Positive Coping in Early Childhood.

Primary Supervisor: Dr Peta Stapleton

Secondary Supervisor: Dr Aileen Pidgeon

Student Researcher: Laura L. Love

SN: 13202873

Word Count: 9, 395

Author Note

Laura Louise Love, Department of Psychology, Faculty of Society and Design, Bond University. This confirmation document was submitted in partial fulfilment of the course requirements for the Master of Arts (Research). Correspondence concerning this paper should be addressed to Laura Louise Love, e-mail: laura.love@student.bond.edu.a

Impact of Anxiety Disorders in Australia

The impact of anxiety – lifespan

Considering the high prevalence of anxiety disorders diagnosed prior to adulthood, this would suggest anxiety first emerges in childhood (Rapee, Schniering & Hudson, 2009). Costly pharmacological and psychological programs are a primary source of treatment for anxiety, these also tend to be lengthy in course (Wang et al., 2007). Anxiety and conduct disorders feature amongst the top five most prevalent disorders that have the greatest impact on children as well as adolescents in Australia (Sunderland et al., 2015). There are calls for programs to teach productive coping need to be directed at a younger cohort. Anxiety disorders are the most prevalent mental health issue in Australia and are the most commonly occurring mental health condition in children. Estimates suggest anxiety disorders impact upon approximately 15% of the population (Kendall, Furr & Podell, 2010; Pirkis, et al., 2009; Wilde, 2008). In the United States of America (USA), Generalized Anxiety Disorder (GAD) and Social Anxiety Disorder (SAD), are the leading types of mental health diagnoses in youth (Merikangas et al., 2009). Studies in the USA suggest that the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by the American Psychological Association states the cluster of anxiety disorders are also the most frequently occurring mental health issue in adults (APA, 2013; Merikangas et al., 2009). While course and onset can vary, numerous population-wide studies have found that anxiety disorders in adults almost always originated in childhood (Rapee, Schniering & Hudson, 2009). Additionally, children with anxiety have a significantly increased risk of developing other co-morbid disorders such as depression later on in life (Costello et al., 2003; Rapee, Schniering & Hudson, 2009). This suggests that anxiety originating in childhood can have a long lasting impact on a person's wellbeing and potentially throughout the lifespan, if appropriate treatment

is not sought. Thus early detection of anxiety disorders and early intervention could have far reaching longitudinal consequences on the mental health of this populous.

The Diagnostic Picture of GAD 300.02 (F41.1)

GAD is classified in DSM-5 as a distress disorder (American Psychological Association, 2013). Anxiety itself is defined as the “anticipation of future threat” (American Psychological Association, 2013). The cluster of anxiety disorders collectively “share features of excessive fear and anxiety and related behavioural disturbances” beyond what may be considered developmentally appropriate or typical (American Psychological Association, 2013). Anxiety disorders are reported to primarily originate in early childhood, be long lasting and twice as often in females when compared to males (American Psychological Association, 2013). GAD is broadly defined as a condition characterized by excessive worry, nervousness or apprehension, which “the individual finds difficult to control” across many aspects of life (American Psychological Association, 2013). Inherent in the diagnosis is that these fears or worries decrease quality of life and functioning.

There are numerous physiological symptoms associated with GAD, while tension is a core aspect numerous other “somatic symptoms” are mentioned in the DSM-5 such as but not limited to feeling “shaky”, experiencing “aches” and even things like “irritable bowel syndrome” (American Psychological Association, 2013). It is stipulated that full recovery from GAD is rare. Furthermore, there is a well established longitudinal co-morbidity between GAD and depression, particularly in childhood as well as adolescent populations (Cummings, Caporino & Kendall, 2014). The literature also suggests there is a strong co-occurrence of children that present with both GAD and a diagnosis of an ASD (Tsai, 2014).

Early predictors of Anxiety Disorders in at risk Children

Current theory on the manifestation of anxiety disorders indicates there may be many early markers to suggest an anxious temperament and that those children may present with clinically disordered anxiety at some stage. From as early as 3 months of age children that are reported by parents as; harder to settle, get to sleep, crying and waving their limbs more than developmentally appropriate are likely to become anxious children (Hudson & Rapee, 2004). The literature on twin studies also shows some support for a genetic loading (Hudson & Rapee, 2004). The DSM-5 also states that one-third of the risk of a GAD diagnosis may be predicated by genetic factors (American Psychological Association, 2013). Despite this the environmental, familial processes and parental influences cannot be underestimated as there is a strong link between anxious parents, with high emotionality as well a neurotic avoidant personality styles and anxious children (Hudson & Rapee, 2004). Thus there tends to be a relationship between parents with diagnosed GAD and their children then developing GAD also (Hudson et al., 2014).

Thesis Overview

It is innately part of the human condition that we all tend to experience challenges in our lives at some point. Indeed, historically the field of psychology itself has developed in part as a result of the need to discover, explore and implement effective strategies to cope with the stressors that life inevitably presents (James, 1890). The ability to positively adapt to changes in the environment and cope with stress, tends to be a protective quality against the development of a myriad of clinical mental health diagnoses later in life (Darwin, 1959; Masten, 2007). Considering that almost 14% of children as well as adolescents in Australia have had a mental health episode (such as depression or anxiety to a clinical level) assessed as severe in the last 12

months alone, warrants a more proactive approach to better facilitate the wellbeing of future generations (Sunderland et al., 2015). Furthermore, predictions suggest that by the year 2030, internalising mental health issues will be amongst the most severe problems in the world, in terms of a global disease burden (Mathers & Loncar, 2006). Internalising mental health disorders are broadly referred to as conditions such as anxiety or depression, and are often concerned with a person's thoughts, attitudes, beliefs or values (Mathers & Loncar, 2006). This suggests that strategies to shape brighter futures for children and thus adults of the future is an important issue both here in Australia and internationally.

Much of the literature on coping theory is primarily focused on how adult and adolescent populations cope with stress (Carver & Connor-Smith, 2010). However, a growing body of research on the impact of early learning and child development suggests that a more proactive, hands-on approach is needed (Chalmers, Frydenberg & Deans, 2011; Perry, 2009). There is controversy in current literature however, developmental psychologists purport that the national Australian movement towards resilience promotion pitched towards school aged children may not be as efficacious as efforts directed at a pre-school co-hort (despite this being pedagogical practice) (Centre on the Developing Child at Harvard University, 2015; Chalmers, Frydenberg & Deans, 2011). The personal and social capabilities of the national Australian curriculum for primary school aged children advocates the importance of social as well as emotional learning. However, research on pre-school aged children and programs focused on teaching resilience to this group is surprisingly scant (Perry, 2009). A growing area of study indicates that social and emotional learning needs to start early in the life cycle, with some researchers suggesting it be given as much if not more of a priority as the teaching of academic skills (Sugai & Horner, 2006). Considering that some kind of emotion regulation repertoire starts to develop in children

as early as age two, the pre-school years are an important time for educators to facilitate some helpful and productive coping capabilities (Berk, 2006).

Given one of the first major transitions in life, that of commencing mainstream schooling, can be an anxiety provoking experience for many children it is important that pre-school children learn some skills to effectively cope with changes before this transition (Gutteling, de Weerth & Buitelaar, 2005; Wilde, 2008). By pre-school age (approximately five years) it is reported that children have potentially learnt some un-helpful coping mechanisms such as those based on either the maladaptive expression of anger (confrontive coping) or anxiety (avoidant coping), which can have far reaching consequences on their outcomes and development (Chalmers, Frydenberg & Deans, 2011). For programs directed at this group to be effective there is still likely to be some ‘unlearning’ of some maladaptive coping styles that children have modelled from adults. However, it would be expected that there would be more unhelpful patterns to correct or ‘unlearn’ as children get older and thus strategies may be less effective (Chalmers, Frydenberg & Deans, 2011). A recent meta-analytic review of the literature, stated that adaptive problem focused coping was found to positively correlate with overall physical and mental health outcomes in non-clinical adult populations (Penley, Tomaka and Wiebe, 2002). Thus the innovative interventions proposed in this targeted at having a long term impact on building resilience and decreasing anxiety could have the potential to carve out more adaptive, productive as well as “psychologically well” futures for young children. The aim of the proposed studies is to teach pre-school aged children effective strategies for emotional regulation and positive coping through an holistic, multisensory intervention. By strengthening these adaptive skills as they start to emerge in early childhood, this research bridges quite a substantial gap in the resilience literature.

Proposed M Arts (Research)/PhD Chapter Outlines

The first chapter will provide a broad theoretical overview of Anxiety Disorders as they relate to those originating in early childhood, particularly a diagnosis of GAD. This will contain information relevant to the aetiology particularly onset and presentation. This will also discuss literature in relation to the prevalence, the nature of maladaptive thinking practices, economic burden, course, biopsychosocial factors, comorbidities, mortality as well as the longitudinal impact of GAD in Australia. The impact of childhood anxiety, particularly GAD on the psychological, environmental, behavioural, social and educational functioning of children will also be discussed in terms of a lifetime trajectory. Current programs targeted at anxiety reduction in childhood will also be evaluated in terms of long term efficacy.

Chapter two will discuss the theoretical models which underlie the research in relation to the way in which anxiety and resilience are linked. Building upon this, current theory regarding resilience and positive coping in early childhood as well as throughout the lifecycle will be discussed. Current programs used in Australia targeted at building student resilience in early childhood and their efficacy will be evaluated (in terms of the longitudinal impact on resilience).

Chapter three will detail the literature on the nature of learning and development at a pre-school age group, particularly focusing on the age group of five year olds. Early pedagogy in education relevant to emotion regulation (particularly the role of somatosensory approaches), building executive functioning and fostering resilience will also be explored in depth.

Chapter four will address the current gold standard treatments for anxiety and resilience promotion at present in Australia, as well as the relevance of these approaches for an early childhood co-hort. Here CBT and clinical EFT will be discussed in detail, as will the historical backgrounds as well as efficacy in long term impact on mental diagnoses.

Chapter five will discuss the role of clinical EFT on anxiety and resilience. The remaining chapters will focus on the rationale for the development of a new multi-sensory approach to anxiety reduction and resilience promotion in early childhood. Findings from prior research will be integrated into the interventions proposed and any shortcomings of the intervention planned will be reported as future directions.

The studies proposed

The present study will be divided into four related studies. The first aims to collect survey data from parents, community members and psychologists regarding treatment options for anxious children in the first 5 years. This will enable more to be learnt about treatment stigmas, preferences and beliefs specifically in relation to clinical Emotional Freedom Techniques (EFT) and Cognitive Behavioural Therapy (CBT) as strategies to foster resilience and decrease childhood anxiety.

Study two, will present a series of randomly allocated scenarios along with open ended questions to early learning educators and Psychologists. This qualitative study will gather information regarding beliefs about coping in early childhood, in addition to beliefs regarding developing resilience in early childhood, in two groups of professionals who regularly interact with these children.

Study three, will conduct a convenience sample, of semi-structured focus groups with children in early childhood and childhood. Group one will be conducted by the researcher, directed at five year olds. Group two will again be facilitated by the student researcher and

investigate children around eight years of age. Both groups will involve non-clinical populations of children and it is envisioned that these will span approximately one hour maximum in length. The purpose of these focus groups is to gather information regarding each samples' knowledge, thoughts and beliefs regarding coping with stress. Differences in responses from each age group may enable a developmental comparison between groups and more to be known regarding children's beliefs about coping at these ages. The collaborative and semi-structured process of this environment may also enable a collection of age appropriate phrases or words to be integrated into the scripts for the treatment intervention. It is expected that parents will sit outside close by during this process.

Study four, is an anxiety reduction and resilience building treatment program for young Australians in early childhood who are potentially at risk of developing GAD. The groups will compare a traditional CBT based program with that of a new clinical EFT program developed in this research. This treatment aims to target a slightly younger cohort than previous programs, thereby bridging the gap in the literature. The groups will consist of children aged five years and work in conjunction with their parents during this time. The study will be comprised of two groups of children assessed as "at risk" of GAD. All children will engage in a six week resilience training group program which involves an adapted version of clinical EFT, or a current gold standard treatment based on CBT, the 'Little Cool Kids' program. The CBT intervention will not be conducted by the researcher, but by another psychologist in Tasmania, with participants being given the pre and post test measures as a point of comparison, to the clinical EFT treatment group. The clinical EFT treatment intervention will be delivered by the student researcher. Lastly, all participants in both treatment groups will be contacted again six months post

intervention, to complete a post-test measures. This is to assess if there has been a longer term impact of the treatment. Based on previous research with adults, it is anticipated that the clinical EFT program developed will decrease the symptoms of internalising issues in anxious children and be as effective as the CBT intervention.

The Relationship Between Anxiety and Resilience

Current theory on resilience defines it as social, emotional and behavioural functioning involving ‘the ability to bounce back from adverse circumstances’ and positively adapt in the face of such challenges where one would normally expect diminished functioning (Kilka, & Herrenkohl, 2013; Lowenthal, 2001; Newman & Blackburn, 2002). An international study of resilience conducted in over 11 countries found a universal capacity for resilience in children and in the process the researchers developed the ‘Child and Youth Resilience Measure’ (CYRM) (Ungar & Liebenberg, 2009). The study suggests that even across many cultural settings, resilient children are better equipped to handle adversity (or even traumatic events) and cope more effectively with change (Ungar & Liebenberg, 2009). The status of mental health amongst children has been a driving force behind enquiry into resilience in pedagogy settings (Berk, 2006). There is controversy in the literature however; disputing that resilience is a teachable quality. Resilience theory concentrates on protective factors advantageous to children developing this quality. This is often associated with respective stability in family circumstances, inherent personality traits and environmental conditions during upbringing, which could make it difficult for some to easily acquire (Afifi, & Macmilan, 2011).

The study into the field of resilience, particularly the strategies that can be taught to

prevent or remedy the impact of maltreatment or poor coping is a rapidly growing area of research (McAllister & McKinnon, 2009). Research amongst children and adolescents in Norway suggests there may be an inverse relationship between depression, anxiety, stress and obsessive–compulsive symptoms with high levels of resilience (Hjemdal et al., 2011). Future directions from current research into cultivating childhood resilience, suggest that by attending to and improving the child’s underlying psychological symptoms (which act as a barrier to their resilience) this may have a positive impact on their overall resilience (Hjemdal et al., 2011). Research also suggests that resilience interventions that target gender related issues or diagnoses (e.g. Generalised Anxiety Disorder (GAD)) may be more effective than general programs (Westen & Morrison, 2001).

Current Early Childhood Programs CBT

Anxiety Reduction and Resilience Promotion

At present there are very few group therapy programs which target improving the resilience of anxious children while also simultaneously reducing their anxiety (Watson et al., 2014).

Embedding evidence-based treatment programs in pedagogy settings is reported to be a method by which to have a lasting impact on children with GAD, especially in making treatment more accessible to those that might not otherwise access it (Fox et al., 2014). At present the gold standard treatments for reducing the severity of GAD in childhood are programs centered on CBT methods only. The most efficacious CBT programs are focused on interventions that address both the anxiety of the children as well as the parents’ (Kendall & Hedtke, 2006; Rapee, Schniering & Hudson, 2009). Anxiety reduction programs aim to reduce parent overprotection and the ways in which parents may model anxious coping for their children (Kendall, Furr &

Podell, 2010; Rapee, Schniering & Hudson, 2009). These programs typically involve elements of cognitive restructuring, exposure, social skills interventions, psycho-education and some relaxation procedures to bring about changes in maladaptive thought patterns (Kendall, Furr & Podell, 2010). However, in Australia these programs focused on teaching emotion regulation skills, resilience and anxiety reduction strategies typically commence after a child reaches school age. Given what is known about the highly influential nature of the early years of a child's life on their later development, it is surprising that emotion regulation programs are not being taught as an essential part of early childhood pedagogy (Kurstjens & Wolke, 2001).

A 12 week CBT based 'Resilience Builder Program' was examined for children aged seven and above years for 22 children with a GAD diagnosis and yielded significant results (Watson et al., 2014). Sessions focused on proactive resilience skills, social skills, reading social situations, positive thinking and managing stress. Behavioural and social skills assessments were completed, pre as well as post intervention. Particular areas of success included decreases in problem behavior and improvements in family functioning, positive emotions as well as resilience (Watson et al., 2014). A recent pilot study in Australia of the BOUNCE BACK! Resilience Program teaches positive coping skills to school aged children, primarily those 11-12 years of age (McGrath, 2000; Nobel & McGrath, 2008). The program is comprised of five essential cognitively based elements; coping skills, supportive social skills, values, anti-bullying and thinking for success (McGrath, 2000). It is designed to be conducted in a holistic manner by teachers and in a school context. It also aims to build to social and emotional capacity of teachers to better support student resilience as well as coping. Results of the efficacy of this program are not yet known, however self report measures from the pilot study indicate that it is a user friendly program with high levels of teacher satisfaction (McGrath, 2000). The problem the

proposed research is trying to solve, is to target a program specifically for younger children, so that strategies for anxiety reduction and resilience promotion can have a long term impact on their coping.

The ‘Cool Little Kids’ Anxiety Prevention Program developed by the Macquarie University Centre of Emotional Health, is a version of the CBT skills based ‘Cool Kids’ Program (typically consisting of 12 sessions) adapted for those of pre-school age. The original program for older children is used extensively throughout Australia and is currently considered the most effective treatment for childhood anxiety in combination with medication, with some results indicating it is 60% effective although little is known about long term effects (Beatson et al., 2014). The researchers in this study use the Strengths and Difficulties Questionnaire (SDQ) to screen for symptoms of anxiety and inhibition (Beatson et al., 2014).

Cool Little Kids as the version for younger children, is reported as an efficacious way to prevent anxiety disorders developing in preschool children and is a total of six brief group sessions that develop bravery and aim to decrease parental overprotection (Bayer et al., 2011; Beatson et al., 2014). This program is currently being trialed at present for longitudinal efficacy, so the outcome of this program is not yet known. Another, The Aussie Optimism: Program-Positive Thinking Skills (AOP-PTS) is a preventative program targeted at children between nine-10 years of age (Johnstone et al., 2014). While this program is not particularly targeted at children with GAD, it is designed for children who present with anxiety and depression. While benefits were reported immediately after the intervention, no significant longitudinal effects were noted, as captured by a follow up after a few years (Johnstone et al., 2014). This may suggest

that purely cognitive behavioural programs may lack having a lasting change on the presentation of internalising disorders.

FRIENDS for Life (the title of which is a helpful acronym) is a 10 week program is another CBT based program designed to prevent anxiety disorders in childhood and is also delivered in school based curriculum time (Barrett et al., 2006; Barrett & Pahl, 2006). Awareness of physiological symptoms, stress management, strategies to develop emotional resilience and explicit teaching are core components of this program. Meta-analyses of the program have shown some improvements in participants with a low-risk of anxiety post-test however, long term gains are not sustained (Maggin & Johnson, 2014). Fun FRIENDS is a play based adapted version of the program designed for children aged 4-7 years and their families (Barrett et al., 2006). Research shows the FRIENDS programs effective in assisting children showing signs of anxiety disorders, as after the program 80% of children are reported to no longer show these symptoms (Barrett et al., 2006).

Conceptual Model Underlying Treatment

Coping Models in Early Childhood

Coping can be defined as helping one to manage and process various external stimuli occurring by using our internal skills (Andersson & Willebrand, 2003). Stress appraisal is reported to be an essential aspect of the coping process. This appraisal involves a primary component, to determine if the event is something we feel is relevant to be concerned about and secondary appraisal, which involves one's ability to act or respond effectively (Andersson & Willebrand, 2003; Kerig, Grych & Fincham, 2001). There are a variety of approaches to coping that research suggests are more productive than others. A problem focused coping repertoire

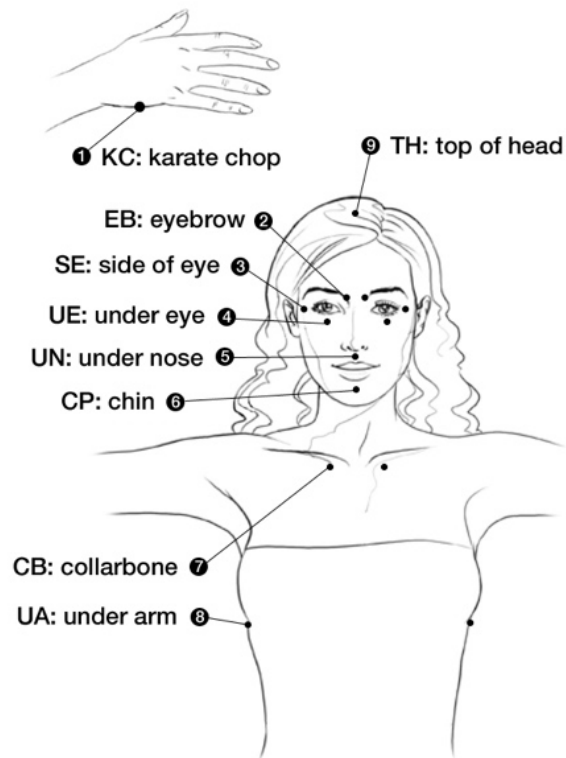
starts to present in children as early as four years of age. Problem focused coping enables active cognitive re-structuring of an issue and constructively working towards possible solutions to a challenge (whether this is internally or externally) (Skinner et al., 2003). A problem focused approach is linked to better long term outcomes in the domains of adjustment, resilience and it is regarded as one of the most effective as well as adaptive ways to cope (Compas et al., 1992; Van Slyck, Stern, & Zak-Place, 1996). When a caregiver, particularly the mother models the problem-focused ways to cope with stress for children, this is reported to assist children in being more likely to adopt this approach also. Emotion focused coping, is largely considered an unhelpful and maladaptive coping style centered on taking one's attention away from the stressful feelings using a variety of methods (i.e. avoidance) (Folkman & Moskowitz, 2004). This strategy can often be acquired later on in childhood and while some emotion focused approaches to coping can be positive such as re-appraising a situation or seeking social support, these only tend to be helpful in situations where alternatives are not possible (Ben-Zur, 2009).

There is some criticism in the resilience and coping literature, which suggests that resilience is simply another term for the constructs of adjustment or coping. However resilience is reported to be a quality resonant with optimal functioning, flourishing and thriving, and resilience is the result of continually utilizing effective strategies for positive coping in order to adjust in the midst of challenging situations (Leach, Green & Grant, 2011). The Positivity Institute in Australia also suggests that skills for enhancing resilience need to be explicitly taught and modelled in order for children to meaningfully acquire as well as apply this skill set (irrespective of family and environmental circumstances) (Leach, Green & Grant, 2011; Oades, Robinson & Green, 2011).

A New Wave of Treatment - Clinical EFT in Early Childhood for Anxiety

Clinical EFT is a problem focused coping strategy that can be taught, as research suggests it is possible to think clearer about a problem after engaging in the Clinical EFT process. Several theories form the foundation of clinical EFT as it is known today (Pulos & Denker, 1999). Thought Field Therapy (TFT) is a novel therapy from which clinical EFT was derived. TFT suggests that by lightly tapping on acupressure points on the upper body using two fingers while focusing the mind on a problem at hand, will bring about positive changes in emotional states (Pignotti, 2007). Essential aspects of Clinical EFT include exposure, cognitive shift, acupressure and mindfulness (e.g. staying in the present moment) (Church & Marohn, 2013). The somatic process of tapping on acupressure points or even applying pressure through needles to clear energy blockages or qi has a strong basis in the field of Traditional Chinese Medicine and in particular, the practice of acupuncture (Waite & Holder, 2003). In adult populations the acupressure points and process typically utilized in Clinical EFT include firmly tapping approximately five to seven times on nine distinct areas of the body (see Figure one below) while cognitively verbalizing a problem or emotion (Flint, 2001).

Figure 1. Clinical EFT points in adult populations



Subjective Units of Distress (SUDS) are used in clinical EFT as a method by which to gauge the intensity of an issue, problem or sensation a client is experiencing, as well as a means by which to ascertain changes in intensity throughout the process. A set up statement declaring and acknowledging the emotional problem (or associated physical sensations) several times, while simultaneously tapping on the outer part of the hand (known as the ‘karate chop’ point) is typically how the process of Clinical EFT begins (Flint, Lammers & Mitnick, 2006). A specific set up statement would then be followed by a declaration of self-acceptance, for instance ‘even though I feel this deep fear about the future in the pit of my stomach, I accept myself and this problem’. Then a client would then proceed to move through various rounds of tapping in a sequence on the remainder of the points while extracting short reminder phrases from the set up statement or other emotions that emerge as the tapping process progresses e.g. “deep fear”. As the rounds of tapping progress, the client typically experiences a change in emotion and

cognitive perception towards the issue and is thus able to build in positive affirmations in the last few rounds of the tapping process. In addition to the acupressure tapping component, the clinical EFT process also involves cognitive elements, aspects of classical conditioning, distress tolerance, systematic desensitization, response prevention and exposure (Stapleton, Sheldon, Porter & Whitty, 2011). The exposure and response prevention literature reports significant long term results in the treatment of hypochondria's, obsessive-compulsive disorder and anxiety disorders with these techniques (Whittal, Thordarson & McLean, 2005; Visser & Bouman, 2001). These techniques involve exposure to anxiety provoking stimuli (actual, represented or imagined) and the process of responding/behaving differently to the previous compulsive conduct the stimuli may have previously triggered. Clinical EFT is comprised of many exposure and response prevention elements. The process of clinical EFT involves not only acupressure tapping, but also acknowledging feelings and thoughts, while working towards greater self-acceptance.

Research on clinical EFT has grown rapidly in recent years as it is considered a practical treatment method. It has been found to be an effective, easy to apply strategy for stress reduction, alleviating emotional pain and reducing the symptoms of Post Traumatic Stress Disorder (PTSD) (Flint, Lammers & Mitnick, 2006). A randomized control trial on veterans with PTSD reported significant reductions in psychological distress and PTSD symptom levels after six sessions of clinical EFT (compared to standard treatment) (Church et al., 2013). A one month follow up showed that treatment benefits remained, furthermore 90% of the clinical EFT treatment group no longer met symptom criteria for PTSD, which far surpassed the 4% reported through the standard treatment group (Church et al., 2013). In addition to this, other studies on traumatized adult populations examined two randomized controlled trials and six outcome

studies have found clinical EFT to quickly and effectively reduce fear responses as well as traumatizing memories (Feinstein, 2010). The populations examined were not only veterans with PTSD but also included disaster survivors and those suffering other kinds of trauma (Feinstein, 2010). These efficacious, lasting results show that clinical EFT as an effective treatment for PTSD.

Recent clinical research found a significant reduction in psychological distress in those who participated in an eight week trial focused on weight issues. Significant reductions in psychological distress, in addition to food cravings and depression were reported (Stapleton et al., 2011). A pilot study of 22 students in America focused on the treatment of specific phobias (i.e. fear of flying) via random assignment to either a Clinical EFT group or a diaphragmatic breathing group. The clinical EFT group was comprised of five tapping sessions spanning two minutes each in duration, and results yielded significant reductions in phobia related anxiety as well as improvements in ability to approach feared stimuli, however the breathing group along did not report significant results (as per psychometric measures) (Salas, Brooks & Rowe, 2011). This study also showed that treatment effects from the clinical EFT sessions remained through the course of the intervention and comparison.

Clinical EFT has also been compared to a control group for the treatment of public speaking anxiety with the Clinical EFT treatment yielding significant improvements in self-reported anxiety as measured by the State-Trait Anxiety Inventory (STAI) (Jones & Andrews, 2001). Despite the study involving treatment sessions only spanning 45 minutes in duration, the Psychologist's administering the treatment tracked progress throughout the session and noted

that the participants anxiety (as per subjective units of discomfort and behavioural observations) significantly reduced after just 15 minutes into the treatment (Jones & Andrews, 2001).

Mechanism of Change

EFT is encompassed within a broad group of therapies within the field of energy psychology. As previously mentioned clinical EFT incorporates principles from a few modalities (including acupuncture), which enable negative emotions in the body to be released via energy or meridian fields (Feinstein, 2008). This is able to occur through the process of tapping on the acupuncture (or meridian) points while focusing one's internal resources on a specific negative emotion, sensation, memory or thought while gradually moving towards deeper levels of self-acceptance and compassion through the rounds of tapping (Church, 2013). A few neurological, cognitive, physiological and psychological elements are attributed to the fast acting emotional shifts that can be experienced through the clinical EFT process. While the exact mechanism is not known, on a neurological level clinical EFT theory and research has shown that the techniques act on specific neurotransmitters (particularly dopamine and serotonin), particularly changing connections and neural pathways related to the specific issue at hand (Feinstein, 2008). The clinical EFT process is further theorized as acting on the area of the brain concerned with stress, particularly eliciting a calming response in the amygdala and hypothalamus (Feinstein, 2008). Studies have shown that clinical EFT can also have an impact on reducing cortisol levels in the body and normalizing brain waves, which further validate the effectiveness of these techniques as a stress reducing strategy (Church, 2013). When clinical EFT has been applied particularly for the treatment of clinical emotional disorders such as anxiety, it has been found to decrease arousal in the limbic system; various aspects of the exposure component to the process

have been attributed to these results (Church, Yount & Brooks, 2012). Further research to explore these actions in greater depth found that it was not only the exposure elements that resulted in stress reduction for participants but that the essential components of physically tapping on acupressure points and verbalizing the self-affirming statements also led to greater benefit (Fox, 2008).

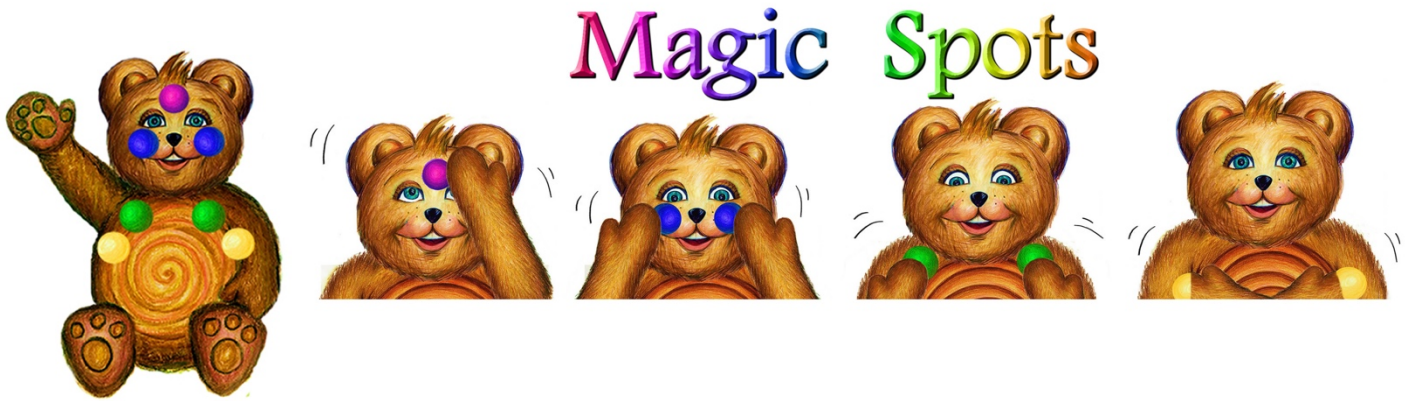
EFT and Youth

Research suggests that clinical EFT may be an effective tool for children and adolescents to improve their mental health (Church, Pina & Brooks, 2012). A cohort of sixteen male adolescents in the juvenile justice system experiencing PTSD underwent one session of Clinical EFT and were compared to a wait list who received no treatment, to see if this had an impact after 30 days (Church, Pina & Brooks, 2012). While the wait list showed no improvement the clinical EFT group improved significantly, and were reported to be ‘non-clinical’ one month later because of the intervention (Church, Pina & Brooks, 2012). Comparisons have been drawn between Progressive Muscle Relaxation (PMR) and clinical EFT, in terms of its anxiety reducing benefits (Sezgin, Ozcan & Church, 2009). A recent study on 312 high school students randomly assigned them to either a PMR or clinical EFT group to compare the impact on decreasing test taking anxiety after a single treatment (in addition to following up the techniques at home) (Sezgin, Ozcan & Church, 2009). The Test Anxiety Inventory (TAI) showed significantly reduced test anxiety from the clinical EFT group, when compared to PMR showing that clinical EFT is more efficacious. At present there is no research on clinical EFT on children.

Application of clinical EFT for an early childhood population, involves somatic simulation of four main acupressure points located between the eyes, under the eyes, on the chest

and under the arm (see Figure two below developed by the student researcher) (Church & Marohn, 2013). This is a simplified version of the nine points recommended for adults.

Figure 2. Four adapted points for child populations



Less points are more age appropriate for a pre-school cohort to retain, they lack complexity and easier to be applied. The sensory components of clinical EFT may be advantageous when used with a pre-school aged population, given their cognitive capacity and stage of development. Eclectic packages of hypnotherapy and acupuncture, involving a blend of relaxation, sensory as well as cognitive aspects have been reported to be well adopted by children, especially in the chronic pain literature (Zeltzer et al., 2002). Despite this there appears to be no research on clinical EFT treatment with children across any issue. Teaching children effective methods to manage their own pain or emotions may be a worthwhile skill, which would be highly beneficial if integrated into early pedagogical learning (Zeltzer et al., 2002). Given the positive outcomes reported from clinical EFT in treating a range of adult mental health disorders, it may be an effective strategy when applied with those in early childhood (Lane, 2009; Stapleton, Sheldon & Whitty, 2011). The emotion regulation literature suggests that strategies pitched at an early childhood demographic need to include reflective time in addition to being patterned, repetitive and sensory to assist one's capacity for self-regulation at this stage of

development (Perry, 2009). Studies investigating clinical EFT for GAD in adults found, the stimulation of acupuncture points normalized brainwaves and this normalized brain activity had a longitudinal effect 12 months later (Andrade & Feinstein, 2004). This comparison between a clinical EFT treatment and alternatively one including CBT with medication, showed the treatment time was significantly shorter with clinical EFT (e.g. 3 sessions compared to 15 sessions) (Andrade & Feinstein, 2004). While significant reductions in anxiety symptoms were reported across the board, the improvement in the clinical EFT group, surpassed that of the mainstream treatment with some participants even having complete remission of anxiety symptoms (Andrade & Feinstein, 2004).

Pre-school Children

The pre-school period in a child's life around the age of five years, is an early time in the lifecycle, it is also a time of self-interest and learning about the self in order to acquire basic skills (Kohlberg, 1971). At this time aggressions, anxieties and frustrations can also emerge (Kohlberg, 1971). At approximately five years of age, a typically developing child reaches a number of milestones and self-help skills. There are two major schools of thought regarding child development. Erikson (1940), a developmental Psychologist and landmark theorist originally defined the emotional crises experienced at this stage of psychosocial development as concerned with that of initiative versus guilt, pertaining to the child feeling good about purpose, exploring and creating. Erikson suggests that it is at this stage in the lifecycle (four-five years of age) that guilt feelings start to emerge, however these feelings cause much confusion due to their illogical nature, as the experience of guilt does not always have a rational basis. Neurologically and cognitively Piaget's more recent theory instead conceptualized this as the second stage of

pre-operational development. Here symbolic thinking, self-expression, intuition, conversational skills and deeper issues on a belief level develop (Piaget, 1952). Great advances in receptive as well as expressive language, enjoyment of rhyming and alliterations also occur during this time, making it possible for children to repeat 6-10 syllable words by five years of age (Piaget, 1952). According to neurodevelopmental researchers, the brain develops from the base upwards in a sequence and it is important for young children to be taught in a method which matches their developmental needs (Perry, 2009). The brainstem is well developed at birth and the early years of life have a profound impact on this region. This lower, most primitive part of the brain acts on the Autonomic Nervous System (ANS), thus it can be less malleable and harder to change as time goes on. When exposed to extreme neglect in the early stages of life this can damage a child's developing brain, with some research indicating brain size may be smaller than a typically developing child and the cortex develop abnormally (Perry, 2009). For children who have experienced conditions where they have been subject to traumatic circumstances or lived in conditions of chronic stress this can decrease their distress tolerance and lead their systems to be in a state of hyperarousal (Perry, 2009). For children who have experienced trauma or significant emotional events, somatosensory regulation (essential aspects of which are patterned, rhythmic and repetitive activities) is recommended as a bottom up way to regulate and process emotions (Perry, 2009). The proposed clinical EFT treatment is a somatosensory approach which fits with this ideal, and can assist an individual to elicit a calming response in the brain. The zone of proximal development suggests that optimal learning occurs between the intersection between assimilation and accommodation, a homeostatic balance between hypo and hyper arousal (Chaiklin, 2003; Vygotsky, 1978). Furthermore, there is a consensus in the literature that executive functioning can be trained (Ochsner, Bunge, Gross & Gabrieli, 2002). Executive

functioning is also a major predictor of a child's capacity to self-regulate (Perry, 2009).

Therefore, skills and strategy teaching is essential for children to increase their stress threshold for and the proposed clinical EFT treatment is aiming to answer this coping (Greene et al., 2002).

In terms of human functioning in work, education or even social settings, there is an optimal range for our internal processes to be at that supports productive functioning (Cole, Martin & Dennis, 2004). Thus the ability to regulate our emotions or have a strategy to process them is an essential skill to master in order to effectively function to one's true potential.

Current and Proposed Studies

Study One - *Beliefs about Treatment Options for Children with Anxiety Disorders*

The design of this study is a three by two between group comparison involving an online survey (via survey monkey). This study commenced in August 2015 and is accessed online. The surveys are presented to parents, community members and Psychologists in order to determine their beliefs about treatment for anxious children. All participants in study one will be adults aged between 18-60 years of age. Gender distribution will be reported in results. Participants are presented (by a random stimulus control) one of two vignettes conceptualizing the treatment of GAD in childhood in terms of either a Clinical EFT approach or a CBT modality. An unveiling of the name and simple definition of each treatment approach shortly follows after the participant determines their level of agreement with the approach in the vignette. The goal for the amount of participants in each subgroup is $n = 100$ participants. To achieve a medium effect, Tabachnick and Fidell suggest the required sample size is $50 + 8(k)$ (where k is predictors). If there are three predictors (e.g. self-efficacy, self-compassion and gratitude) this would need a sample of 74 for instance. For robust power in study one a sample size of at least $N = 200$ will enable this.

In terms of other inclusion criteria;

- Parents must be the parental guardian for at least one child
- Community Members must not be the parental guardian for any children
- Psychologists must be currently registered or provisionally registered as a Psychologist and practicing in Australia. This group are also be asked if they are a parent.

All participants will complete a demographic questionnaire. Each group will be administered a selection of psychometric inventories regarding beliefs about psychological treatment. The parent and community group will be administered the Belief in Efficacy of Psychotherapy (BEP) scale (Volpe, 2014). The BEP scale was developed to measure outcome expectations for therapy exclusively. The BEP scale includes 15 items to measure the belief system of a non-clinical population regarding potential beneficial outcomes of psychotherapy. Items are scored on a 5-point Likert scale (1=strongly disagree, 2=disagree, 3=neutral/don't know, 4=agree, 5=strongly agree).

The Psychologist group are presented with the Therapist Beliefs Scale (TBS) which asks them about beliefs they hold regarding their own practice as it relates to children (McLean, Wade & Encel, 2003). They are also presented with the Therapist Beliefs about Exposure Scale, which provides some insight into the Psychologists beliefs regarding the effectiveness and safety of using exposure with children (Deacon et al., 2013). All of the measures are re-worded to specifically refer to child clients.

The data will enable some base information to be known about the beliefs from the various groups regarding the two treatment options for anxiety in children. The questions will enable further information to be known about participant beliefs about children's psychological

therapy and how these may impact on their preferences for children's treatment. There are three groups with two sets of conditions in study one. It is anticipated an ANOVA will be conducted as the method of statistically analyzing the data, this will enable comparisons of the groups.

Hypotheses

1) It is anticipated that the parent and community group will yield similar results, with a high degree of openness to treatment options (as a lack of bias is expected) due to a potential lack of exposure to either treatment modality prior. A slight preference for EFT may exist, for parents who have more children in early childhood age range because of its novelty and accessibility to children. However, it is expected parent and community groups will accept both treatments equally.

2) It is anticipated that the Psychologist group will have a preference for the CBT condition, this is also anticipated once the name of the treatment is given. It is projected that the revealing of the clinical EFT treatment name will influence their acceptance of this modality and decrease it. This is due to clinical EFT not being included in Psychologists current training in Australia and also due to lack of familiarity or exposure to this treatment modality.

3) It is also expected that Psychologists who score higher in flexibility, intuition and belief in exposure in their practice will be more accepting of clinical EFT.

4) It is projected that Psychologists who live in rural locations or practice rurally, will be more accepting of CBT and less accepting of clinical EFT, due to lack of familiarity or exposure to this modality.

Study Two - *Beliefs about Coping and Resilience in Early Childhood*

This is designed to give the research a qualitative aspect, it is an exploration of resilience in early childhood administered to Psychologists and Early Learning Educators. A series of open ended questions will enable more to be learnt about the beliefs of early childhood educators and Psychologists about resilient children.

The intention of this online survey (via survey monkey) is to present these groups with random stimulus control assignment to a vignette and present a series of open ended questions. An example of an open ended question presented is '*what do you think about Susan's coping response?*' and '*what do you expect to hear about Susan's functioning at the end of Primary School?*'.

The purpose of this study is to ascertain what Psychologists and Early Learning Educators know about pre-school children's capacity to be resilient and cope with life challenges. It will also be able to provide information on these groups beliefs regarding the efficaciousness of teaching resilience and positive coping during pre-school years. An Nvivo thematic analysis will be performed to analyze the common themes in the responses. Certain themes are expected i.e. Psychologists will be in support of teaching resilience improving strategies to this age group, however Early Learning Educators may will be in support of this due to concrete responding, due to a lack of understanding of psychological interventions, questioning the relevance or believing this is the parent's responsibility.

Study Three - Focus Groups on Resilience and Coping with Children

Small groups of approximately 10 children aged five years (pre-operational stage) and 10 children aged eight years (concrete operational stage) will participate in study 3. This study is designed to elicit the language from children to be used in later development of tapping/EFT

scripts in the program in study four. This will be conducted by the student researcher and enable her to examine what a group of typical children know about ‘coping’ and ‘stress’ at a young age. The language and terms used by these groups may also be incorporated in the later interventions in study four. Children will be accessed through child and family centers (and advertised through local media) in Tasmania and parents will be close by (outside) during these focus groups.

Study Four –*The Intervention CBT vs Clinical EFT vs control group and 6 month follow up*

Little is known about the efficacy of clinical EFT as an effective early intervention treatment strategy for assisting children with anxiety and resilience.

Design.

These children will engage in a six week resilience training group program which involves an adapted version of clinical EFT for children. All participants in both the treatment and control groups will also be contacted six months post intervention, to complete follow-up measures.

The present study aims to assess the efficacy of a clinical EFT program with five year olds presenting with anxiety symptoms for anxiety reduction and resiliency building, and will be compared to the Cool Little Kids CBT program (due to the ease of availability and access to this in Tasmania). A control group of children who meet inclusion criteria will receive no treatment at all, but will be offered a thank you gift at the end of the research period. The sample of children aged five years will be recruited from early childhood centers across Tasmania and through advertising in local media. This will be a pre-test post-test control group design with six month follow up. A demographic questionnaire will be administered to the parents of child participants completing the research, along with the Adverse Childhood Experiences (ACE)

inventory. The ACE will provide information on any potentially abusive circumstances the child has endured. A child growing up experiencing some of the following conditions in the household are considered adverse; recurrent physical abuse, sexual abuse, living with an alcohol or drug abuser, having a household member incarcerated, mother treated violently and a family member who is mentally ill etc. This will be completed by a parent or guardian of the participating child.

Screening tools

Children must be five years of age during the time of the study and not medicated for their primary diagnosis. Children require a high score on the Pre-school Anxiety Scale indicating they may be at risk of developing GAD (as they are starting to display symptoms) to participate in the main treatment group in the study. The control group will involve typically developing children.

The researcher will screen children with the following tools in person prior to inclusion in the study (for those deemed not eligible for participation in the research, their parents will be given a list of local Psychologists in the area);

- Griffiths Mental Development Scales – Extended Revised 0-8 years (GMDS-ER) – a developmental assessment to ascertain any significant developmental delays. The GMDS-ER, assesses the child’s ability levels in various areas of development (subscales include; locomotor, personal-social, language, eye and hand co-ordination, performance and practical-reasoning).

The informal identification of emerging skills and motivators for learning establishes appropriate starting points for teaching. The developmental age levels provided for the various subtests are regarded as a measure of the child’s development at the point in time that they are assessed and what can be obtained within a formal assessment context. A developmental quotient, which

utilizes information from each subtest is also provided and this may be different to the child's biological age. While the developmental quotient and levels may well change over time, it nevertheless provides a picture of a current level of development and a baseline of skills from which to measure future progress.

- Childhood Autism Rating Scale – Second Edition-Standard Version (CARS2-ST) – this assessment would be completed by researcher prior to assessment through observations of the student at a pre-school facility (also completed by parents). This will mean children that present with likelihood of ASD are not included in the research. The CARS2-ST is a behavioural rating scale that measures behavioural problems specific to an Autism Spectrum Disorder (ASD). The CARS2-ST distinguishes children into three severity groups: “minimal symptoms”, “mild-moderate symptoms”, and “severe symptoms”.

Executive functioning involves the ability to suppress one's own emotional state or frustration because there is a desirable future pull one is heading towards (Luria, 1996). Some children have a weakness in the area of executive functioning, these children may be those that present with developmental delays and those who have a diagnosis of an Autism Spectrum Disorder (ASD) (Perry, 2009). The rationale for excluding children with an ASD in the therapeutic sessions and group interventions (proposed later) is that a desire to be part of a group does not appear to be strong in these children. Inherent in the diagnosis of ASD is a significant impairment or difficulties, in socialisation, communication and interaction (American Psychological Association, 2013). Furthermore children with this diagnosis also have a tendency to lack theory of mind as well as literally interpret words which would pose difficulties and potentially confound the results (American Psychological Association, 2013). In future the clinical EFT program proposed could be modified or altered to be used particularly with children

with an ASD diagnosis, however the method of delivery would need to be specialised for this group. Therefore, it is anticipated that children with an ASD, significant developmental delay or four or more on the ACE may confound the research, as such they will be screened prior to the proposed intervention in study four and excluded from the project.

Once the participants are deemed as eligible for inclusion, they will be randomly allocated to the clinical EFT group or control group and, the following measures will be administered:

Pre and Post Test measures include;

- Devereux Early Childhood Assessment Program (DECA) – resilience measure for all groups.

“The DECA is a standardized, norm-referenced, behaviour rating scale that assesses childhood difficulties. The DECA evaluates within-child protective factors (age 2-5) with a 37-item rating scale” (Lien & Carlson, 2009). The parent or guardian who has daily contact with the child, responds on a rating scale (never, rarely, occasionally, frequently, very frequently) how often a behaviour has been observed in the past 4 weeks. This tool takes approximately 15 to 20 minutes to complete. Two different scores are produced: behavioural concerns and total protective factors (comprised of initiative, self-control, and attachment subscales) (Lien & Carlson, 2009).

- Pre-school Anxiety Scale – for anxiety group. The Pre-school Anxiety Scale is a 34 item inventory that is completed by the child’s parents (designed for children between the ages of 2-6 years) in order to show if a child is showing early symptoms of anxiety (Edwards et al., 2010). It is freely available online for use, with permissions given by the authors. The items are answered on a 4 point Likert scale from 0 ‘not true at all’ to 4 ‘very often true’ in relation to questions about the child’s anxiety. The questions are based on a 5 factor model of anxiety symptoms

related to the domains of social phobia, separation anxiety, generalized anxiety, obsessive-compulsive disorder and fears of physical injury as they correlate with the DSM-IV (Spence et al., 2001).

The student researcher will be accessing an existing CBT treatment group as a comparison treatment (Little Cool Kids program), therefore assignment to treatment groups will not be randomized. These participants will complete the same pre, post and follow up measures.

This study is a mixed (between-within subjects) 3 x 3 analysis of variance (a MANOVA is likely to be conducted) to determine whether the different interventions (EFT vs CBT vs control) had an effect on the dependent variables (e.g., Generalised Anxiety and Resilience) combined, over time (pre-intervention vs immediately post-intervention vs 6-month follow-up). Less than 30 participants are expected for each group. It is anticipated there will be approximately $n = 25-30$ children per group (clinical EFT, CBT and control group). The total number of participants engaged in all groups of the study is anticipated to be a maximum of $N = 90$. A series of analyses of variance (ANOVAs) are also likely to be conducted to examine the effects of time and group, to further explore study aims in relation to comparing the effectiveness of groups over time.

Hypotheses

1) The CBT group is expected to result in a reduction in anxiety and better resilience scores in the Cool Little Kids program, and the clinical EFT treatment is expected to result in the same benefits given its efficacy in adult populations

2) While clinical EFT and CBT are expected to make equal gains (in reducing anxiety and improving resilience), the clinical EFT group may show lasting results over the long term (during a six month follow up), due to research with adult populations showing sustained effects up to one year.

Future Directions and Implications

The purpose of the project is ultimately to determine if clinical EFT is equal to a gold standard treatment, at decreasing anxiety in preschool aged children at risk of developing an anxiety disorder while also having a lasting, significant impact on resilience. While CBT is the current gold standard treatment for anxiety, there are still 20-40% children that do not respond to this type of treatment and clinical EFT may be a way to cater for these children. The objective of the project in its entirety is to develop a protocol for a 'Tapping 4 Kids' clinical EFT program that can be used in early learning centers Australia wide and thus make a meaningful difference to the lives of pre-school children suffering from anxiety through this developmentally targeted early intervention strategy.

Reference

- Afifi, T., & Macmillan, H. (2011). Resilience following child maltreatment: A review of protective factors. *Canadian Journal of Psychiatry, 56* (5), 266 -272.
- Akiyoshi, J. (1999). Neuropharmacological and genetic study of panic disorder. *Nihon shinkei seishin yakurigaku zasshi = Japanese Journal of Psychopharmacology, 19*(3), 93-99.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (Fifth ed.). Arlington, VA: American Psychiatric Publishing. pp. 189–224. ISBN 978-0-89042-555-8.
- Andersson, G., & Willebrand, M. (2003). What is coping? A critical review of the construct and its application in audiology. *International Journal of Audiology, 42* (1), 97-103.
doi:10.3109/14992020309074630
- Andrade, J., & Feinstein, D. (2004). Energy psychology: Theory, indications, evidence. *Energy Psychology Interactive: Rapid Interventions for Lasting Change, 1*, 199-214.
- Barrett, P. M., Farrell, L. J., Ollendick, T. H., & Dadds, M. (2006). Long-term outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: An evaluation of the FIRENDS program. *Journal of Clinical Child and Adolescent Psychology, 35*, 403-411. doi:10.1207/s15374424jccp3503_5
- Barrett, P. M., & Pahl, K. M. (2006). School-Based Intervention: Examining a Universal Approach to Anxiety Management. *Australian Journal of Guidance and Counselling, 16*(01), 55-75. doi:10.1375/ajgc.16.1.55
- Bayer, J. K., Rapee, R. M., Hiscock, H., Ukoumunne, O. C., Mihalopoulos, C., Clifford, S., & Wake, M. (2011). The Cool Little Kids randomised controlled trial: Population-level early prevention for anxiety disorders. *BMC public health, 11*(1), 11. doi:10.1186/1471-

2458-11-11

- Beatson, R. M., Bayer, J. K., Perry, A., Mathers, M., Hiscock, H., Wake, M., & Rapee, R. M. (2014). Community Screening for Preschool Child Inhibition to Offer the 'Cool Little Kids' Anxiety Prevention Programme. *Infant and Child Development, 23*(6), 650-661. doi: 10.1002/icd.1863
- Behar, L. B. (1977). The preschool behavior questionnaire. *Journal of Abnormal Child Psychology, 5*(3), 265-275.
- Ben-Zur, H. (2009). Coping styles and affect. *International Journal of Stress Management, 16*(2), 87. doi:10.1037/a0015731
- Berk, L. E. (2006). *Child development* (7th ed.). Boston: Pearson/Allyn and Bacon.
- Carver, C. S., & Connor-Smith, J. (2010). Personality and coping. *Annual Review of Psychology, 61*, 679–704. doi:10.1146/annurev.psych.093008.100352
- Chalmers, K., Frydenberg, E., Deans, J. (2011). An Exploration into the Coping Strategies of Preschoolers: Implications for Professional Practice. *Children Australia, 36*, 3, 120-127. Retrieved from: http://elc.unimelb.edu.au/pdf/research_2011_1.pdf.
- Chaiklin, S. (2003). The zone of proximal development in Vygotsky's analysis of learning and instruction. *Vygotsky's educational theory in cultural context, 1*, 39-64.
- Church, D., Hawk, C., Brooks, A. J., Toukolehto, O., Wren, M., Dinter, I., & Stein, P. (2013). Psychological trauma symptom improvement in veterans using emotional freedom techniques: A randomized controlled trial. *The Journal of nervous and mental disease, 201*(2), 153-160.
- Church, D., & Marohn, S. (Eds.). (2013). *Clinical EFT Handbook: A Definitive Resource for Practitioners, Scholars, Clinicians & Researchers*. Hay House. pp. 1–235.

- Church, D., Piña, O., Reategui, C., & Brooks, A. (2012). Single-session reduction of the intensity of traumatic memories in abused adolescents after EFT: A randomized controlled pilot study. *Traumatology, 18*(3), 73. doi:10.1177/1534765611426788
- Cole, P. M., Martin, S. E., & Dennis, T. A. (2004). Emotion regulation as a scientific construct: Methodological challenges and directions for child development research. *Child development, 317-333*.
- Compas, B. E., Worsham, N. L., & Ey, S. (1992). *Conceptual and developmental issues in children's coping with stress*. New York, NY: Guilford Press, pp 413
- Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of general psychiatry, 60*(8), 837-844.
- Cummings, C. M., Caporino, N. E., & Kendall, P. C. (2014). Comorbidity of anxiety and depression in children and adolescents: 20 years after. *Psychological bulletin, 140*(3), 816. doi:10.1037/a0034733
- Center on the Developing Child at Harvard University. (2015). *Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13*. Retrieved from www.developingchild.harvard.edu
- Darwin, C. R. (1859). *On the origin of species by means of natural selection, or the preservation of favoured races in the struggle for life* [1st ed.]. London: John Murray.
- Deacon, B. J., et al. (2013). Assessing therapist reservations about exposure therapy for anxiety disorders: The Therapist Beliefs about Exposure Scale. *Journal of Anxiety Disorders*.
- Development through Conflict Resolution Education, braining, and Practice An Innovative Approach for Counseling Psychologists. *The Counseling Psychologist, 24*(3), 433-461.

- Dinges, D. F., Whitehouse, W. G., Orne, E. C., Bloom, P. B., Carlin, M. M., Bauer, N. K., & Orne, M. T. (1997). Self-hypnosis training as an adjunctive treatment in the management of pain associated with sickle cell disease. *International Journal of Clinical and Experimental Hypnosis*, 45(4), 417-432. doi:10.1080/00207149708416141
- Edwards, S. L., Rapee, R. M., Kennedy, S. J., & Spence, S. H. (2010). The assessment of anxiety symptoms in preschool-aged children: the revised Preschool Anxiety Scale. *Journal of Clinical Child & Adolescent Psychology*, 39(3), 400-409.
- Erikson, E. H. (1940). Studies in the interpretation of play: clinical observation of play disruption in young children. *Genetic Psychology Monographs*.
- Ernst, E., & White, A. R. (1998). Acupuncture for back pain: a meta-analysis of randomized controlled trials. *Archives of internal medicine*, 158(20), 2235-2241. doi:10.1001/archinte.158.20.2235.
- Ernst, E., Pittler, M. H., Wider, B., & Boddy, K. (2007). Acupuncture: its evidence-base is changing. *The American journal of Chinese medicine*, 35(01), 21-25. doi: 10.1142/S0192415X07004588
- Fanurik, D., Zeltzer, L. K., Roberts, M. C., & Blount, R. L. (1993). The relationship between children's coping styles and psychological interventions for cold pressor pain. *Pain*, 53(2), 213-222. doi:10.1016/0304-3959(93)90083-2
- Feinstein, D. (2010). Rapid treatment of PTSD: Why psychological exposure with acupoint tapping may be effective. *Psychotherapy: Theory, Research, Practice, Training*, 47(3), 385.
- Flint, G. A. (2001). Emotional freedom: Techniques for dealing with emotional and physical distress (Rev. ed.). Vernon, British Columbia: NeoSolTerric Enterprises.

- Flint, G. A., Lammers, W., & Mitnick, D. G. (2006). Emotional Freedom Techniques: A safe treatment intervention for many trauma based issues. *Journal of aggression, maltreatment & trauma*, *12*(1-2), 125-150. doi:10.1300/J146v12n01_07
- Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annu. Rev. Psychol.*, *55*, 745-774.
- Fox, J. K., Herzig, K., Colognori, D., Stewart, C. E., & Warner, C. M. (2014). School-based treatment for anxiety in children and adolescents: new developments in transportability and dissemination. In *Handbook of school mental health* (pp. 355-368). Springer US.
- Goodman, J., & McGrath, P. (1991). The epidemiology of pain in children and adolescents: a review. *Pain*, *46*(3), 247–264. doi:10.1016/0304-3959(91)90108-A
- Greene, R. W., Biederman, J., Zerwas, S., Monuteaux, M. C., Goring, J. C., & Faraone, S. V. (2002). Psychiatric comorbidity, family dysfunction, and social impairment in referred youth with oppositional defiant disorder. *American Journal of Psychiatry*, *159* (7), 1214-1224.
- Grych, J. H., & Fincham, F. D. (2001). *Interparental conflict and child development: Theory, research, and applications*. New York: Cambridge University Press.
- Gutteling, B. M., de Weerth, C., & Buitelaar, J. K. (2005). Prenatal stress and children's cortisol reaction to the first day of school. *Psychoneuroendocrinology*, *30*(6), 541-549. doi:http://dx.doi.org/10.1016/j.psyneuen.2005.01.002
- Hjemdal, O., Vogel, P. A., Solem, S., Hagen, K., & Stiles, T. C. (2011). The relationship between resilience and levels of anxiety, depression, and obsessive–compulsive

- symptoms in adolescents. *Clinical psychology & psychotherapy*, 18(4), 314-321.
- Hudson, J. L., Newall, C., Rapee, R. M., Lyneham, H. J., Schniering, C. C., Wuthrich, V. M., & Gar, N. S. (2014). The impact of brief parental anxiety management on child anxiety treatment outcomes: a controlled trial. *Journal of Clinical Child & Adolescent Psychology*, 43(3), 370-380.
- James, W. (1890). *The principles of psychology*. New York: H. Holt and Company.
- Johnstone, J., Rooney, R. M., Hassan, S., & Kane, R. T. (2014). Prevention of depression and anxiety symptoms in adolescents: 42 and 54 months follow-up of the Aussie Optimism Program-Positive Thinking Skills. *Frontiers in psychology*, 5.
- Jones, S., & Andrews, H. (2001). *The efficacy of emotional freedom technique in reducing public speaking anxiety: An exploratory study*. Western Australian College of Counselling Psychologists.
- Kendall, P., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual*. Workbook Pub..
- Kendall, P., Furr, J., & Podell, J. (2010). Child-focused Treatment of Anxiety. In J. R. Weisz & A.E Kazdin (Eds.), *Evidence-based Psychotherapies for Children and Adolescents* (2nd ed., pp. 45-60). New York, NY: Guilford Press.
- Kerig, P., Grych, J., & Fincham, F. (2001). *Interparental conflict and child development: Theory, research, and applications*. New York, NY: Cambridge University Press, pp. 213-245.

Klika, J., & Herrenkohl, T. (2013). A Review of Developmental Research on Resilience in Maltreated Children. *Trauma Violence Abuse, 14* (3) 222–234.

doi:10.1177/1524838013487808

Kohlberg, L. (1971). *From is to ought: How to commit the naturalistic fallacy and get away with it in the study of moral development*. publisher not identified.

Kurstjens, S., & Wolke, D. (2001). Effects of maternal depression on cognitive development of children over the first 7 years of life. *Journal of Child Psychology and Psychiatry, 42* (5), 623-636.

Lane, J. R. (2009). The Neurochemistry of Counter Conditioning. *Energy Psychology, 1*(1), 1-14.

Leach, C. J., Green, L. S., & Grant, A. M. (2011). Flourishing Youth Provision: The potential role of positive psychology and coaching in enhancing youth services. *International Journal of Evidence Based Coaching and Mentoring, 9*(1), 44-58.

LeBaron, S., & Zeltzer, L. K. (1996). *Children in pain: evaluation and treatment*. New York: W.W. Norton & Co., Inc.

Lien, M. T., & Carlson, J. S. (2009). Psychometric properties of the Devereux early childhood assessment in a head start sample. *Journal of Psychoeducational Assessment, 27*(5), 386-396.

López, J. F., Akil, H., & Watson, S. J. (1999). Neural circuits mediating stress. *Biological psychiatry, 46*(11), 1461-1471.

Luria, D. (1996). Why markets tolerate mediocre manufacturing. *Challenge, 11*-16.

Maggin, D. M., & Johnson, A. H. (2014). A meta-analytic evaluation of the FRIENDS program

- for preventing anxiety in student populations. *Education and Treatment of Children*, 37(2), 277-306.
- Merikangas, K. R., Nakamura, E. F., & Kessler, R. C. (2009). Epidemiology of mental disorders in children and adolescents. *Dialogues in clinical neuroscience*, 11(1), 7.
- Masten, A. S. (2007). Resilience in developing systems: Progress and promise as the fourth wave rises. *Development and Psychopathology*, 19(3), 921–930.
doi:10.1017/S0954579407000442
- Mathers, C. D., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *Plos med*, 3(11), 442.
- McAllister, M., & McKinnon, J. (2009). The importance of teaching and learning resilience in the health disciplines: a critical review of the literature. *Nurse education today*, 29(4), 371-379.
- McCarty, M. F. (2000). High-dose pyridoxine as an ‘anti-stress’ strategy. *Medical Hypotheses*, 54(5), 803-807.
- McGrath, H. (2000). The BOUNCE BACK! Resiliency Program: A Pilot Study.
- McLean, S., Wade, T.D. & Encel, J. (2003). The Contribution of Therapist Beliefs to Psychological Distress in Therapists: An investigation of Vicarious Traumatization, burnout and symptoms of avoidance and intrusion. *Behavioural and Cognitive Psychotherapy*, 31, 417-428.
- Melchart, D., Linde, K., Fischer, P., White, A., Allais, G., Vickers, A., & Berman, B. (1999). Acupuncture for recurrent headaches: a systematic review of randomized controlled trials. *Cephalalgia*, 19(9), 779-786. doi 10.1046/j.1468-2982.1999.1909779.x

Newman, T., & Blackburn, S. (2002). Transitions in the Lives of Children and Young People: Resilience Factors. *Interchange* 78. <http://files.eric.ed.gov/fulltext/ED472541.pdf>

Ninan, P. T. (1999). The functional anatomy, neurochemistry, and pharmacology of anxiety. *Journal of Clinical Psychiatry*, 60 (22), 12-17.

Noble, T., & McGrath, H. (2008). The positive educational practices framework: A tool for facilitating the work of educational psychologists in promoting pupil wellbeing. *Educational and Child Psychology*, 25(2), 119-134.

Oades, L. G., Robinson, P., & Green, S. (2011). Creating flourishing students, staff and schools. *Positive education*, 16.

Ochsner, K. N., Bunge, S. A., Gross, J. J., & Gabrieli, J. D. (2002). Rethinking feelings: an fMRI study of the cognitive regulation of emotion. *Journal of cognitive neuroscience*, 14(8), 1215-1229. doi:10.1162/089892902760807212

Penley, J. A., Tomaka, J., & Wiebe, J. S. (2002). The association of coping to physical and psychological health outcomes: a meta-analytic review. *Journal of Behavioral Medicine*, 25 (6), 551-603. doi:10.1023/A:1020641400589

Pirkis, J., Dare, A., Blood, R. W., Rankin, B., Williamson, M., Burgess, P., & Jolley, D. (2009). Changes in media reporting of suicide in Australia between 2000/01 and 2006/07. *Crisis*, 30(1), 25-33.

Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: clinical applications of the neurosequential model of therapeutics, *Journal of Loss and Trauma: International Perspectives*, 14 (4). doi:10.1080/15325020903004350

Piaget, J. (1952). *The origins of intelligence in children* (Vol. 8, No. 5, p. 18). New York:

International Universities Press.

Pignotti, M. (2007). Thought Field Therapy A Former Insider's Experience. *Research on Social Work Practice, 17*(3), 392-407. doi: 10.1177/1049731506292530

Pintov, S., Lahat, E., Alstein, M., Vogel, Z., & Barg, J. (1997). Acupuncture and the opioid system: implications in management of migraine. *Pediatric neurology, 17*(2), 129-133. doi:10.1016/S0887-8994(97)00086-6

Pulos, V., & Denker, P. (1999). One Step Forward, One Step Back: Children's Health Coverage after CHIP and Welfare Reform.

Rapee, R. M., Schniering, C. A., & Hudson, J. L. (2009). Anxiety disorders during childhood and adolescence: Origins and treatment. *Annual review of clinical psychology, 5*, 311-341.

Salas, M. M., Brooks, A. J., & Rowe, J. E. (2011). The immediate effect of a brief energy psychology intervention (Emotional Freedom Techniques) on specific phobias: A pilot study. *Explore: The Journal of Science and Healing, 7*(3), 155-161.

Sezgin, N., Ozcan, B., & Church, D. (2009). The Effect of Two Psychophysiological Techniques (Progressive Muscular Relaxation and Emotional Freedom Techniques) on Test Anxiety in High School Students: A Randomized Blind Controlled Study. *International Journal of Healing and Caring, 9*.

Shi, M., Liu, L., Wang, Z. Y., & Wang, L. (2015). The Mediating Role of Resilience in the Relationship between Big Five Personality and Anxiety among Chinese Medical Students: A Cross-Sectional Study. *PloS one, 10*(3).

Skinner, E. A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: a review and critique of category systems for classifying ways of coping.

Psychological bulletin, 129(2), 216.

Spence, S. H., Rapee, R., McDonald, C., & Ingram, M. (2001). The structure of anxiety symptoms among preschoolers. *Behaviour Research and Therapy*, 39(11), 1293-1316.

Stapleton, P., & Brunetti, M. (2013). The effects of somatisation, depression, and anxiety on eating habits among university students. *The International Journal of Healing and Caring*, 13(3), 1-16.

Stapleton, P., S. Devine, H. Chatwin, B. Porter and T. Sheldon, 2014. A feasibility study: emotional freedom techniques for depression in Australian adults. *Curr. Res. Psychol.*, 5: 19-33.

Stapleton, P. B., Sheldon, T., Porter, B., & Whitty, J. (2011). A randomised clinical trial of a meridian-based intervention for food cravings with six-month follow-up. *Behaviour Change*, 28, 1-16. Retrieved from http://epublications.bond.edu.au/hss_pubs/631/

Sugai, G., & Horner, R. R. (2006). A Promising Approach for Expanding and Sustaining School-Wide Positive Behavior Support, *School Psychology Review*, 35 (2), 245–259.

Sunderland, M., Anderson, T. M., Sachdev, P. S., Titov, N., & Andrews, G. (2015). Lifetime and current prevalence of common DSM-IV mental disorders, their demographic correlates, and association with service utilisation and disability in older Australian adults. *Australian and New Zealand journal of psychiatry*, 49(2), 145-155.

Tabachnick & Fidell (2013). *Using multivariate statistics* (6th Ed.). Boston: Pearson

Tsai, L. Y. (2014). Prevalence of Comorbid Psychiatric Disorders in Children and Adolescents with Autism Spectrum Disorder. *Journal of Experimental & Clinical Medicine*, 6(6),

179-186.

- Ungar, M., & Liebenberg, L. (2009). Cross-cultural consultation leading to the development of a valid measure of youth resilience: The International Resilience Project. *Studia Psychologica, 51*(2-3), 259-268.
- Van Slyck, M., Stem, M., & Zak-Place, J. (1996). Promoting Optimal Adolescent Development through Conflict Resolution Education, braining, and Practice An Innovative Approach for Counseling Psychologists. *The Counseling Psychologist, 24*(3), 433-461.
- Visser, S., & Bouman, T. K. (2001). The treatment of hypochondriasis: exposure plus response prevention vs cognitive therapy. *Behaviour Research and Therapy, 39*(4), 423-442.
- Volpe, E.G., (2014). Belief in the Efficacy of Psychotherapy (BEP): Psychometric Scale Development and Examination of Theoretical Correlates. PhD diss., University of Tennessee.
- Vygotsky, L. (1978). Interaction between learning and development. *Readings on the development of children, 23*(3), 34-41.
- Waite, W. L., & Holder, M. D. (2003). Assessment of the emotional freedom technique. *Sci Rev Ment Health Pract, 2*(1), 1-10.
- Wang, S. M., Punjala, M., Weiss, D., Anderson, K., & Kain, Z. N. (2007). Acupuncture as an adjunct for sedation during lithotripsy. *The Journal of Alternative and Complementary Medicine, 13*(2), 241-246.

- Watson, C. C., Rich, B. A., Sanchez, L., O'Brien, K., & Alvord, M. K. (2014, June). Preliminary Study of Resilience-based Group therapy for improving the functioning of anxious children. In *Child & Youth Care Forum* (Vol. 43, No. 3, pp. 269-286). Springer US.
- Wells, S., et al. (2003). Evaluation of a meridian-based intervention, Emotional Freedom Techniques (EFT), for reducing specific phobias of small animals. *Journal of Clinical Psychology*, 59 (9), 943-966.
- Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: an empirical examination of the status of empirically supported therapies. *Journal of consulting and clinical psychology*, 69(6), 875.
- Wilde, J. (2008). Rational-emotive behavioral interventions for children with anxiety problems. *Journal of Evidence-Based Psychotherapies*, 8(1), 133.
- Whittal, M. L., Thordarson, D. S., & McLean, P. D. (2005). Treatment of obsessive-compulsive disorder: Cognitive behavior therapy vs. exposure and response prevention. *Behaviour Research and Therapy*, 43(12), 1559-1576.
- Zeltzer, L. K., Tsao, J. C., Stelling, C., Powers, M., Levy, S., & Waterhouse, M. (2002). A phase I study on the feasibility and acceptability of an acupuncture/hypnosis intervention for chronic pediatric pain. *Journal of pain and symptom management*, 24(4), 437-446.
doi:10.1016/S0885-3924(02)00506-7

Appendix

Vignettes and definitions of treatment as per Study One

CBT Group

Generalised Anxiety Disorder (GAD) is a psychological disorder which can develop in early childhood, it occurs on an intellectual level and subconscious level. GAD also tends to have some common physiological symptoms (i.e. digestive system upset) and has an impact on a child's behaviour. These children experience difficulty processing and regulating their emotions. Children with GAD think and act in ways which often cause distress to them, hindering their adaptive functioning as well as their ability to engage fully in life. They often ruminate or worry excessively about aspects of life, even if the subject of worries is not at their current developmental level. They often find their thoughts difficult to control and can engage in unhelpful harm avoidance type behaviours, as a result of these excessive fears. One treatment for young sufferers of GAD is 'talk therapy' to assist them to recognise and change the unhelpful thoughts, which cause them distress and learn what feelings are and mean. This can help them cope and behave in more helpful ways. Through one-to-one talk therapy they can learn cognitive strategies to control their anxiety and learn how to engage or behave in anxiety-inducing situations more adaptively.

Cognitive Behaviour Therapy (CBT) is a type of psychological therapy focused on assisting clients to change unhelpful ways of thinking feeling or behaving.

EFT Group

Generalised Anxiety Disorder (GAD) is a psychological disorder which can develop in

early childhood, it occurs on an intellectual level and subconscious level. GAD also tends to have some common physiological symptoms (i.e. digestive system upset) and has an impact on a child's behaviour. These children experience difficulty processing and regulating their emotions. Children with GAD think and act in ways which often cause distress to them, hindering their adaptive functioning as well as their ability to engage fully in life. They often ruminate or worry excessively about aspects of life, even if the subject of worries is at their current developmental level. They often find their thoughts difficult to control and can engage in unhelpful harm avoidance type behaviours, as a result of these excessive fears. One treatment for young sufferers of GAD is for them to learn to process their emotions using a distress tolerance and somatic strategy. Through acknowledging the physiological symptoms of their anxiety they can learn the underlying causes as well as sensory and cognitive strategies to process associated feeling of discomfort. They can also learn how to release the emotional patterns that induced anxiety previously and more readily function to their potential.

Clinical Emotional Freedom Techniques (EFT) are a form of therapy which assists clients to process their emotions through 'tapping' on pressure points whilst talking about various thoughts or beliefs causing them distress. This enables both physical sensations and emotional symptoms to ease.

Proposed Advertisements for Study Four

ANXIETY GROUP

Is your child preschool age?

Do they stress and worry – more than other kids?

Laura Love is running a six week program to help pre-schoolers to learn a strategy to manage these distressing feelings.

Each child will get a free book + plush bear as part of the program.

If your child has a significant developmental delay, Autism Spectrum Disorder or are currently medicated for anxiety they unfortunately cannot participate in this study.

Study Two Vignettes and Open Ended Questions

Susan (this will also be randomly presented as Samuel to control for gender impacts)

Susan is a 5 year old girl in pre-school who resides in Tasmania. Susan lives with her mother, father and is an only child. When Susan was 3 her family home was burnt to the ground during the Victorian bush fires. This was a huge tragedy for the community. Her family along with many other families in the area lost their homes. Luckily Susan and her parents were able to get out of the house in time, and were not injured.

Susan has made many friends in pre-school since moving to Tasmania last year. She shared her story of the bush fires with her class during show and tell. She shared how she came to live in Tasmania for a 'fresh start' because the loss of her home was very sad. She sometimes cries about her home saying she 'misses it' but her teachers help her to work through these feelings. Her parents are marathon runners and the family is always active. Susan enjoys hoola hooping, art, craft and gardening. As she prepares for primary school next year, she feels excited to make even more friends in the community and go to 'big school'.

Samuel (this will also be randomly presented as Susan to control for gender impacts)

Samuel is a 5 year old boy in pre-school who resides in Tasmania. Samuel lives with her mother, father and is an only child. When Samuel was 3 his family home was burnt to the ground during the Victorian bush fires. This was a huge tragedy for the community. His family along with many other families in the area lost their homes. Luckily Samuel and his parents were able to get out of the house in time.

Samuel has not made many friends in pre-school since moving to Tasmania last year. His parents are having a hard time making a 'fresh start', they have started smoking and drinking in order to cope. He has had difficulty making friends, is reserved and can often be found playing on his own in the sandpit. He has an aversion to other children and often fails to finish activities saying that he 'can't do it' well enough. He likes to watch TV and play video games. He is worried about starting primary school next year, as he has 'just gotten used to' the kids in pre-school.

- 1) Do you think about _____'s coping response?
- 2) Do you think _____ displays resilient coping? Why?
- 3) How do you think _____ learnt how to cope?
- 4) How well do you think _____ bounced back from the loss of the family's home?
- 5) What factors do you think supported _____ to cope?
- 6) What factors do you think have hindered _____ to cope?
- 7) What do you expect to hear about how _____ 's functioning at the end of Primary School?

Study Three – Draft Script for Focus Groups with Children

“Today I would like to learn about you – the things you like and what you do when some not very nice things happen.

Let’s start – can some of you tell me what is your favourite thing in the world to do that makes you feel good?

We are also going to talk about what we could do to feel better when something sad or bad happens.

What would be the worst thing in the world you think could ever happen to you?

Does anyone know what coping means? Can you tell me what you think it means?

Coping means how we help ourselves to handle something in our lives, how we would get through it without hurting ourselves too much on our insides or on our outsides....

How would you cope with your ‘worst thing’?

How would Mummy and Daddy cope with the worst thing?

It might be sad at the start but how do you think you would keep yourself bouncing back from bad things over time?

Do you know what stress or worry is? Can you tell me what you think it might be?

Stress is something that happens in our minds and in our bodies when there is too much going on. Maybe we have had to work really hard to get an activity done in time. Maybe we had a really big day at pre-school and lots of things to get ready. Have you ever felt stressed before? What things make you feel stress? What happens in your body if you feel stressed?

Does anyone know what relaxed means? Or even the word calm? Can you tell me what you think they mean?

What things make you feel calm?

What things do you do to relax when you feel stressed?

What things do mummy and daddy do to relax or feel calm when they feel stressed?

Are Mummy and Daddy stressed most of the time or calm?

How do you know Mummy and Daddy are Calm?"