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Kids Able to Fight Stress Everyday (KAFSE): A Stress-Management Program for Children with Medical Diagnoses

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KIDS ABLE TO FIGHT STRESS EVERYDAY (KAFSE): A STRESS-MANAGEMENT PROGRAM FOR CHILDREN WITH MEDICAL DIAGNOses

PROFESSIONAL DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE SCHOOL OF PROFESSIONAL PSYCHOLOGY

WRIGHT STATE UNIVERSITY

BY

AIMEE N. TOWNSEND, M.A.

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PSYCHOLOGY

Dayton, Ohio September, 2012

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I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY AIMEE N. TOWNSEND, M.A. ENTITLED KIDS ABLE TO FIGHT STRESS EVERYDAY (KAFSE): A STRESS-MANAGEMENT PROGRAM FOR CHILDREN WITH MEDICAL DIAGNOSES BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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ABSTRACT

It is estimated that 10-30% of children in the United States are currently diagnosed with a chronic illness. Due to recent medical advances and increased knowledge of disease maintenance, many of these children will live into adulthood. In addition to physical symptoms of chronic illness, recent attention has been drawn to the psychological effects of chronic illness on children and adolescents. Illustrating this fact, researchers have recently called for increased research on children with chronic illness and disease. One psychological symptom that may be considered is that of stress and its effects on this special population. As a result of their illness and associated implications in outside areas (e.g., social, educational), children with chronic illness are at risk for experiencing increased levels of stress.

Despite the above, there is currently no published programming developed specifically to address stress management in children with medical diagnoses. To address this gap, the Kids Able to Fight Stress Everyday (KAFSE) program is proposed. This is an eight-week program utilizing cognitive-behavioral techniques in a group setting, including psychoeducation, feeling identification, and coping skills, including relaxation techniques. Distinguishable from existing programs is the KAFSE program’s inclusion of caregivers providing stress-based education to aid in parent support and collaboration with their youth. Another distinguishable feature is that the KAFSE program addresses a specific problem (i.e., stress) in a population that is often overlooked (i.e., children with medical diagnoses). Recommended behavioral and emotional outcome measurement, both qualitative and quantitative in nature, is highlighted to assess for curriculum efficacy.
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I want to acknowledge the support, guidance, and encouragement provided to me by family, friends, and academic advisors throughout this process. I would not be where I am today without your love and support.
DEDICATION

This document is dedicated to my parents and partner, Mark, from whom I have learned, grown, and become the passionate woman I am today. I love you and thank you for your presence in my life.
Chapter One

A growing number of children are diagnosed with chronic medical conditions each year. Due to continued advances in research and medicine, these children are more often managed in outpatient medical settings compared to past mandates for inpatient (i.e., hospital) care. As a result, they are interacting among their peers in developmentally-appropriate settings, including school and community. The following document argues that although these children are being managed via outpatient medical care, they continued to show increased psychological distress compared to the general population. Current literature illustrates that this distress, particularly the presence of stress, is rarely identified and treated in children of the general population, and particularly not within the pediatric medical population. As a result, professional organizations have called for continued research and development in the area of psychological intervention within the child medical population. Despite the above, there is a current dearth of research and development of specific programming to address the construct of stress within this particular population.

Aim and Purpose

To address the above need for specific programming, the following program is proposed. The Kids Able to Fight Stress Everyday (KAFSE) curriculum was developed as an 8-week group intervention program, conceptually-driven within the cognitive-behavioral therapy (CBT) framework. This curriculum targets children aged 8-11 years old with a chronic medical diagnosis. Throughout the eight weeks psychoeducation and
stress management skills will be taught, modeled, and practiced. It is believed that the KAFSE program will begin to address a significant gap in the current pediatric psychology literature. Specifically, the curriculum is designed as both a population-specific (i.e., children with medical diagnoses) as well as topic-specific (i.e., stress management) group intervention. In addition, a distinguishable feature of the KAFSE program is its inclusion of caregivers in an attempt to increase generalizability outside of the intervention. Following an extensive literature review to support the theoretical-backing of the KAFSE program and the outlined curriculum, a proposed outcome measurement protocol is highlighted. This measurement is necessary to test the program’s efficacy as well as support empirical validation.
Chapter Two

Literature Review

Stress has been conceptualized as a primary universal experience amongst the human race. Although a large amount of research exists regarding the effects of stress and appropriate management techniques for adults, there is a dearth of research on how stress applies to children. Romano (1992) cited the importance of educating young children on stress and stressors so that they are equipped to develop the skills to cope with the inevitable stressors of everyday life. He also argued that children and adolescents’ experiences of common stress is often compounded by developmental changes and potential environmental conditions (e.g., instability in home life, poverty). It may be argued that in addition to those factors cited by Romano (1992), children with medical diagnoses run the risk of increased vulnerability to stress due to their medical conditions. In fact, Lemanek (1994) reported that “psychological research involving children and adolescents with chronic illness has been ranked by pediatric psychologists as a priority area for future investigations” (p. 143). Although this statement was made in 1994, there continues to be a dearth of studies examining the impact of stress on children with medical diagnoses.

McCraty, Atkinson, Tomasino, Goelitz, and Mayrovitz (1999) supported the notion of increased research of stress and its management for children and adolescents, reporting that children who do not have the ability to appropriately manage chronic stress and negative emotions can experience a sense of hopelessness. This hopelessness and
depression can ultimately lead to an increase in impulsive, destructive, and socially inappropriate behaviors (Kashani, Suarez, Allan, & Reid, 1997).

The concept of stress and its management, as applied to children, will be explored throughout this document. Specifically, a stress management program for children with medical diagnoses will be developed. Throughout this section, a comprehensive literature review of the following will be highlighted: (a) current theories of stress, (b) exploration of stress as it applies to children and adolescents, (c) the impact of medical diagnosis on children and adolescents, (d) various coping styles related to stress, (e) and psychological intervention, specifically Cognitive-Behavioral Group Therapy (CBGT) with children and adolescents.

**Stress: Current Theories**

Despite its universal nature, there appears to be an overall lack of consensus on how to define the construct of stress. The one commonality amongst definitions is that, as humans, stress appears to have both short and long term effects on our minds and bodies. One of the earliest contributors to the stress literature is that of Cannon (1963) who introduced the concept of the fight-or-flight response. It was reported that when an organism perceives a threat, various body systems quickly become aroused and motivated, mobilizing the organism to either attack the threat or flee.

A few decades later, Selye (1956) conceptualized stress unilaterally, focusing upon the body’s physical response to the stressful event and/or experience. This conceptualization stated that regardless of whether the stress was positive (i.e., “eustress”) or negative (i.e., “distress”), the body responded to it in physiologically similar ways. As a result, he proposed the General Adaptation Syndrome, citing that
individuals, when confronted with a stressor, mobilize themselves for action. The action following this mobilization was proposed to be nonspecific to the stressor in that the individual will respond with the same physiological pattern of reactions, despite the nature of the stressor. Selye reported that over time, with repeated or prolonged exposure to stress, detrimental effects occurred on the system. Although Selye’s model has been praised for the introduction of both positive and negative stress to our understanding, it has been criticized due to its unilateral focus on solely physiological factors (i.e., excluding the role of psychological factors). Another criticism is that Selye presents stress responses as uniform across stressful situations encountered when they may not be. Addressing this criticism, Lazarus and Folkman (1984) defined stress in terms of an interaction between individuals and their environments. Specifically, when individuals confront a new or changing environment, they engage in a process of primary appraisal where the meaning of the event is sought (i.e., positive, neutral, or negative consequences). As primary appraisal is occurring, individuals begin to examine their ability to cope and whether these resources will be sufficient to meet the harm, threat, or challenge of the event (i.e., secondary appraisal).

Formal definitions and conceptualizations of stress continue to attempt to integrate these factors, moving away from a uni- or bi-lateral definition and including the consideration of individuals’ assessment and sense of self-efficacy in coping. For example, Baum (1990) defined stress as “a negative emotional experience accompanied by a predictable biochemical, physiological, cognitive, and behavioral stages that are directed either toward altering the stressful event or accommodating to its effects.” That is, within Baum’s conceptualization, the stressor is experienced, the body responds to it
in a variety of ways, and finally the stressful event is accommodated or altered. It is when the stress is not accommodated or altered that it presents a problem and barrier to adaptive functioning in the individual.

Taylor (2006), using the definition proposed by Baum (1990), suggests that not only must we, as humans, understand what stressors and resulting stress are, but also understand the role of coping on how individuals experience stress. Specifically, when a person’s resources are more than adequate to deal with the stressor, the individual may feel little stress. Individuals who feel little self-efficacy in their ability to cope will experience high amounts of stress. Thus, the perception of stress, in Taylor’s definition (2006) results from individuals’ process of appraising events, assessing potential responses, and then of responding to those events. The proposed stress management program, KAFSE, will be built upon the principles proposed by Taylor. In particular, the role of assessment and individual responses will be targeted within the program by teaching children more adaptive and effective stress management techniques and thus boosting their sense of self-efficacy.

**Stress as Applied to Children and Adolescents**

It is argued that there are currently three barriers to the identification of stress in children: (a) generalized myth that children do not experience stress, (b) stress in children presents differently than what is generally observed in the adult population, therefore complicating identification, and (c) children lack the knowledge and vocabulary to express their experiences of stress and its effects. The proposed KAFSE program will address these barriers by educating both children and their caregivers to the concept of
stress, its presence, and its impact, while facilitating the learning and development of healthier and more adaptive coping skills.

Regardless of definition or conceptualization, recent literature has begun to support the notion that stress affects children and adolescents, not solely adults. Psychological research no longer considers children and adolescents to be exempt from stress’ hazardous effects (McCraty et al., 1999).

The stressful emotions experienced by children and adolescents each day can influence a plethora of complex and interacting physiological reactions (McCraty et al., 1999). These reactions affect many organ systems within the body. For example, emotional stress can stimulate the sympathetic nervous system and alter heart rhythm patterns, ultimately altering the activity pattern in the afferent neurological information transmitted from the heart to the brain. Matthews, Gump, Block, and Allen (1997) also found that children with significant sources of ongoing stress in their lives exhibited increased physiological activation in response to acute laboratory stressors. Negative affect was also found to be linked to increased resting blood pressure levels in adolescents (Ewart & Kolodner, 1994). Similarly, Matthews et al. (1997) found that children and adolescents who had chronic or ongoing stressors present in their lives exhibited higher diastolic blood pressure responses to acute laboratory stress tasks when compared to individuals with less background stress in their lives. The above data supports the notion that ongoing stress and improper management not only affects a child or adolescent’s health status in the present, but also may have cumulative and long-term effects. In examining the present affects of stress, research has also supported the notion that the presence of stress in children and adolescents has been found to impair cognitive
processes involved in learning (McCraty et al., 1999) as well as appropriate social
interactions with others.

Parents may lack the ability to identify the presence of stress and its impact on
their children. Lite (2005) suggests that many parents are conditioned to think that the
child is attention-seeking, being difficult, on the verge of being sick, or tired, rather than
recognize the child’s behaviors as a result of stress. The Pennsylvania State Children’s
Hospital/Pediatric Trauma Program lists the following as common feelings of the
“stressed child”: agitation, overactive, confused, afraid, angry, sad, anxious, and
withdrawn. Lite (2005) argued that we educate our children on such common ailments
such as head or stomachaches, educating them what they are and how to cure them, yet
do not make it a priority to introduce the concept of stress and its accompanying effects
on the well-being of our children.

Special Population: Children with Medical Diagnoses

An estimated 10-30% of children in the United States are affected with chronic
medical illness (Newacheck & Taylor, 1992). Rolland (1987) defined chronic medical
illness as resulting from both congenital and/or acquired conditions, varying in terms of
onset, course, incapacitation, treatment demands, and prognosis. Congenital disorders
are those which are present at birth and diagnosed either immediately or shortly after
birth, are variable in their course, often require preventative intervention, and may be life
shortening. Acquired conditions are diagnosed after birth such as pediatric headache or
recurrent abdominal pain. Both types may have prescribed treatments for the minimizing
of pain and discomfort. Last, Stam, van Nieuwenhuizen, and Grootenhuis (2007) report a
slightly different definition of chronic illness, demarcating a minimum threshold of
duration and life impact: “chronic illness refers to illnesses that require at least six months of continuous medical care, permanent lifestyle changes and continuous behavioral adaptation to the unpredictable course of the illness” (p. 101). In addition, current rehabilitation psychology has expanded upon the above-listed definitions, instead of categorizing illnesses into two distinct categories (i.e., acquired versus congenital). Illnesses are conceptualized as falling along a continuum from chronic health conditions to disability.

Thompson, Zeman, Fanurik, and Sirotkin-Roses (1992) estimated that in children with chronic illness, the risk of significant psychological or social problems during childhood was 1.3 to 3 times greater than the risk for healthy children. In addition to the illustrated effects of stress on all children, it may be argued that children with medical conditions hold increased risk. That is, coping with the ongoing demands of chronic medical conditions may exacerbate the negative impacts of stress. These children often deal with persistent symptoms as well as frequent medical intervention, which is not only time-consuming, but also may be physically and emotionally taxing. These medical demands may also serve as a detractor from age-appropriate social interactions with peers. They may view themselves as “different”, perceiving a level of social isolation or rejection from their peers. In addition, these children may be treated differently by caregivers (e.g., over protection, hypervigilence), likely impacting the child’s emotional and behavioral functioning. Particular to this document, both child and caregiver stress has also been noted to significantly impact adherence to medical regimens (i.e., medical adherence decreases as stress increases).
Research suggests that children with chronic medical diagnoses are at risk for a number of problems including physical, academic, and psychosocial functioning (Wallander, Thompson, & Alriksson-Schmidt, 2003). These problems appear to be dependent upon such factors as disease characteristics, social resistance, and personal adjustment. Supporting the notion that this population may be at increased risk compared to the general population, Last et al. (2007) reported that these children face several problems including frequent hospitalizations, undergoing painful medical procedures, taking medicine, absenteeism from school, and restriction of activities due to the medical regimen. It was also argued that children with chronic disease show more submissive behavior and tend to be more socially withdrawn than their peers. It is argued that the above demands add to the stress levels experienced by children with medical diagnoses that may increase their levels when compared to age-related peers.

In examining the impact of medical conditions on psychological functioning, Stewart and Esposito (2007) reported that social and emotional complications can result from being at risk for disease, diagnosis and prognosis of an illness, the illness’ impact on social and academic functioning, the impact of treatment on functioning, medication regimens that may result in psychological symptoms, and lifestyle changes. Specifically, the authors broke these problems in functioning down into four distinct categories: (a) cognitive, (b) emotional, (c) social, and (d) behavioral. Cognitive factors included medication side effects and prescribed treatment regimens that may interfere with the child’s mental capacities and functioning. It was also reported that such abilities as memory, concentration, attention, problem-solving, and inhibition may be negatively impacted by physiological functioning. Feelings of helplessness and a lack of control
over one’s circumstances were discussed as emotional effects of medical illness. The social category included social difficulties such as a perception of other children feeling uncomfortable around those children who display physiological differences or difficulties as well as noted social isolation. Finally, the behavioral domain included acting out, withdrawal and isolation, clingingness, developmental regression, and sleep or appetite disturbance. The authors reported that the medical condition, combined with natural developmental abilities of children, may result in lower tolerance for frustration and stress, increased sensitivity to stressful situations or to perceived social rejection, and difficulty in managing and expressing the plethora of emotions that accompany specific situations.

When examining the direct effects of stress on children with medical diagnoses, a number of disruptions in functioning have been documented, as described in Table 1.

Table 1

Summary of commonly observed symptoms of stress in children with chronic health problems

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Emotional</th>
<th>Social</th>
<th>Behavioral</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Statements about self and others</td>
<td>Crying or looking sad</td>
<td>Social withdrawal from others</td>
<td>Whining</td>
<td>Frequent headaches, stomachaches, nausea</td>
</tr>
<tr>
<td>Daydreams or has difficulty concentrating</td>
<td>Increase in depressive symptoms</td>
<td>Decrease in age-appropriate social skills</td>
<td>Hurting self or others</td>
<td>Grinding teeth</td>
</tr>
<tr>
<td>Drop in grades</td>
<td>Increase in anxiety</td>
<td>Activity limitations</td>
<td>Clinging to adults</td>
<td>Low grade fevers</td>
</tr>
<tr>
<td>Decrease in problem-solving abilities</td>
<td>Irritability</td>
<td></td>
<td>Frequent tantrums</td>
<td>Sick more than often</td>
</tr>
<tr>
<td>School absences</td>
<td>Decreased self-esteem</td>
<td>Nervous behavior (e.g., biting nails, pulling hair)</td>
<td></td>
<td>Fatigue</td>
</tr>
<tr>
<td>Treatment side effects</td>
<td></td>
<td>Self-destructive behavior (e.g., eating disorders)</td>
<td></td>
<td>Change in eating habits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abuse of</td>
<td></td>
<td>Elevated lipids</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Elevated blood pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Decreased immunity</td>
</tr>
</tbody>
</table>
As noted, these symptoms are varied in nature and highly dependent upon the individual characteristics of child or adolescent effected. Therefore it is beneficial for both treatment providers and caregivers to be cognizant of common symptoms while understanding the individuality of the child so that intervention can commence early prior to the development of further problems. It may be hypothesized that although symptoms persist in each of the categories, behavioral and health symptoms may be those most readily noted in the child and indicative of stressed children. In comparison, cognitive or social effects may be more common in adults, therefore contributing to the barrier of identification of stress in children as discussed above. It is argued that this varied symptom presentation provides further support for a stress intervention program for this population.

As children with medical diagnoses have been found to be susceptible to the development of anxiety, depressive symptoms, feelings of guilt, anger, hopelessness, and frustration (Stewart & Esposito, 2007), the need for effective treatment within this population appears evident. Research has shown that this treatment will not only improve the child’s psychological skills (e.g., self-efficacy, effective emotional coping, problem-solving skills) and adjustment, but also has decreased experienced anxiety related to medical treatment as well as increased adherence to unpleasant treatment regimens. Wallander and Varni (1998), supporting the above, reported that enhanced
coping and the facilitation of social support would improve adaptation and increase the quality of life for both ill children and their families.

**Stress and Coping**

Given the KAFSE program’s emphasis on the development of adaptive coping to stress, it is important to first explore the concept of coping and how it develops. Taylor (2006) described coping as the process of managing demands that are appraised as taxing or that exceed the resources of the person, consisting of efforts to manage the demands and conflicts among the individual. Several factors have been identified as influencing one’s ability to cope, including personality, personal coping style, as well as external resources.

In regards to personality, those individuals whom exhibit a pervasive negative mood marked by anxiety, depression, and hostility are more likely predisposed to experience stressful events as especially stressful, ultimately increasing their psychological distress. Burns and Seligman (1989) introduced the pessimistic explanatory style, reporting that this style may relate to illness. That is, those individuals who explain negative events in terms of internal, stable, and global qualities of themselves may have reduced immune system capability and a negatively impacted sense of self-efficacy in coping with life stress. Contrarily, others’ personality styles have been noted as enhancing one’s ability to cope with stress effectively. For example, optimism, sense of control over stressful events, high self-esteem, and ego strength (i.e., dependability, trust, and lack of impulsivity) appear to show positive effects on one’s ability to effectively cope with life stress.
One’s general propensity to deal with stressful events in a particular way (i.e., coping style) has also been examined as contributing to one’s overall experience of stress. For example, avoidant versus confrontative coping styles have been examined, both having cited advantages and disadvantages. Factors such as the duration of the stressor whether long-term or short-term must also be considered. Similarly, problem-focused versus emotion-focused coping has been explored. Important to note is that the later-mentioned coping mechanisms are not exclusive. That is, they often compliment one another by working together when an individual is confronted with a stressful situation. Additionally, problem-focused versus emotion-focused coping styles are not automatically seen as good or bad, in this case it’s all relative to the problem at hand.

Finally, the role of external resources has been investigated. Taylor (2006) reported that coping is not only influenced by individual factors (e.g., personality traits, coping mechanisms), but also by external resources such as time, education, friends, and presence of positive life events. It has been noted that individuals with greater resources typically cope more effectively with stressful events. A specific external resource noted is that of social support in the forms of tangible support, informational support, emotional support, and invisible support. Of note, is that it is not necessarily the presence of social support, but instead the perception of social support by the individual that is beneficial. The buffering hypothesis states that the health and mental health benefits of social support are primarily evident during periods of high stress, either altering the effects of stress or enabling the individual to cope with the stress more effectively.

It is believed that the KAFSE program curriculum is consistent with current research’s understanding of stress and coping. As stated above, the program was
developed using the current conceptualization of stress that considers the presence of the stressor as well as the individual’s appraisal (i.e., cognitions) and use of coping strategies. Because the proposed program will be delivered within the group modality, it is hypothesized that the benefits of social support will be apparent and will also be facilitated via group activities and sharing of each other’s experiences with medical conditions, consistent with Yalom’s universality concept (Yalom and Leszcz, 2005).

The Use of Cognitive Behavioral Group Therapy (CBGT) with Children and Adolescents

Cognitive Behavioral Group Therapy (CBGT) has been researched as an effective treatment approach for children and adolescents with a number of presenting problems. Friedberg et al. (2003) argued that a cognitive-behavioral approach that emphasizes the development of coping skills, presenting them in an understandable way, and inviting children to apply their skills in an emotionally meaningful manner allows clinicians to help children modify their emotional distress.

Friedberg et al. (2003) developed the Preventing Anxiety and Depression in Youth (PANDY) group intervention program targeting children who were experiencing mild to moderate symptoms of depression and anxiety. A CBT framework was used in the program’s development addressing the connection of the child’s thoughts, feelings, and behaviors in regards to their current symptom presentation. Such child-friendly modifications as therapeutic group exercises, activities, board games, and video vignettes were made to enhance the engagement and overall experience of the youth. It was argued that the group format allowed the children to recognize they are not alone in their experiencing of distress, that others have similar problems, as well as provided ample
opportunity for social skills training and testing out fears of negative evaluation in vivo. Symptoms were assessed prior to beginning the intervention, after completion of the group, and then again at a follow-up appointment. Overall, a decrease in symptoms was found at post-intervention when compared to pre-intervention. Although a slight increase was noted at follow-up (when compared to post-intervention levels), this level was still lower than when assessed pre-intervention, arguing that the PANDY program was successful in decreasing participants’ symptoms of anxiety and depression.

Also supporting the use of CBGT with children, Stewart, Christner, and Freeman (2007) cited a number of benefits to utilizing this particular approach and modality. For example, a primary benefit of this modality is the ability to reach a large number of participants at one time. Another cited benefit was the ability for clinicians to begin seeing clients quicker so that increases in difficulties could be prevented that often arise during a long wait period between referrals. The group format also allows clinicians to directly observe participants’ emotional and behavioral reactions with others, offering valuable information regarding the members’ interpersonal skills. It has been argued that groups provide an increased emphasis on psychoeducation, which supports the notion of skills acquisition. Curle, Bradford, Thompson, and Cawthron (2005) in their report of users’ satisfaction of a group therapy with chronically ill or disabled youth reported that the most frequently cited and important benefit of the group, identified by both parents and children, was the reduction of feelings of isolation.

Stone (2007) cited three main factors that contribute to the success of group treatment with children and adolescents: (a) the clients that compose the group, (b) the therapists responsible for conducting the group, and (c) the setting in which the group
occurs. Client factors such as age, gender, education level, developmental level, culture, presenting problems, and levels of cooperation and motivation were some of those listed as needing to be considered. Therapists’ factors considered valuable to effective group facilitation, included skill level, personal attributes, and approach to the role assumed. Stone (2007) reported that group success initially rests upon the role of the therapist due to the fact that modeling plays such a pivotal role in working with this population. Finally, it was noted that the setting must support the role of group treatment by both commitment to treatment goals as well as the group process as a whole.

**Selection of group members.** Piper and Perrault (1989) supported the inclusion of an individual interview prior to the child or adolescent’s inclusion in the group. It was noted that this interview aids the clinician in determining the individual’s appropriateness for participation in the group, as well as an opportunity to assess for individual goals, strengths, and weaknesses that may potentially impact the whole group. Stone (2007) supported the notion of an individual interview, citing that this interview also provides an opportunity to establish limits and expectations with the individual, discussing the group’s intended process, rules, and procedures. Rules should be few in number, but explained as essential for group success. Because members are encouraged to engage in group activities and processes, they begin to feel as though they are active participants in their own treatment.

Gans (1996) discussed group composition, encouraging leaders to be flexible in their conceptualization of group members when working with children and adolescents. That is, children and adolescents vary in many levels (e.g., verbal skills, group experience, anxiety) and therefore just because they are quiet or reserved it must not be
concluded that they lack insight or are not motivated. The author encouraged leaders to use support and careful facilitation or encouragement of responses when working with this population to encourage active participation, while cautioning that some persons will require more time and encouragement than others.

Establishing goals and agenda-setting within the group. The determination of specific goals has been outlined as a requirement for effective and efficient treatment (Stone, 2007). It is noted that not only do specific goals allow for quantitative tracking of progress, but also provides a measure for both clients and group leaders to measure and discuss the efficacy of the group. Clear, measurable goals allow for specific determination of progress gained or not achieved. That is, leaders and participants will be gratified when they can see progress and note movement (Stone, 2007). When movement is not noted, this must be addressed between group members and leaders, processing and problem-solving the lack of movement. The above author suggested initially identifying attendance as a specific and necessary goal. This goal, although simple, is used to illustrate the importance of consistency and commitment to group members. Goals that follow should be established collaboratively between the group leader and its participants. Stone (2007) warned not to underestimate the capacity for children and adolescents to contribute to this task. Leaders are also encouraged to engage the children and adolescents to participate in the tracking and implementing of goals to increase level of self-efficacy within the group setting and to teach self-monitoring. Although goals for the group as a whole are important, it is also beneficial to establish individual goals for the participants, encouraging them to develop a sense of ownership.
This is consistent with cognitive therapy in that it is the goal of therapy to lead the client to become their own teacher and healer (Beck, 1995).

Similarly, agenda-setting has been identified as a useful tool to support the maintaining of focus, relevance and most efficiently utilizing the limited group time for all members. Group leaders are encouraged to be both flexible as well as consistent in their agenda-setting. That is, coming into the group setting with a specific agenda to target is necessary for effective time utilization, however a level of flexibility to process and address individual group dynamics is essential. Similar to goal-setting, leaders are encouraged to include group members in agenda-setting to an extent possible. Stewart et al. (2007) cited the following as common elements of agenda-setting: checking in since last session, reviewing between session work, discussing specific issues planned for the session, obtaining feedback from other members, setting new between session work, and adjourning.

**Typical group processes and stages.** Lewis and Beck (1983) identified several stages of group development that may be applied and/or considered when examining CBGT with children and adolescents. In the initial stage (i.e., first few sessions), members are often looking to the group leaders for direction and affirmation, making this an important time for leaders to clarify and implement rules and goals of the group. This is also the stage where trust and openness need to be established, as well as such barriers as defensiveness and resistance worked through. Lewis and Beck (1983) reported that at this stage leaders must move the group’s focus from the leaders to establishing a collective, cohesive group membership.
Following the initial stage, members will be noted as engaging in more exploration, initiating new behaviors and change. Especially in working with children and adolescents, leaders must be cognizant of the fact that members will vary in how much exploration they engage in, encouraging leaders to greet these reservations with support and interest. It is hoped that this support and interest will encourage them to move past the tentativeness to new levels of awareness and self-improvement. At the termination stage, leaders must affirm the growth and process of the group. Similarly, offering strategies for the future is important. This latter suggestion has been noted as an opportunity to continue growth and support members so that they do not feel abandoned.

**Specific strategies and interventions.** Stone (2007) listed the employment of specific strategies as the essence of an effective group. Many CBT strategies that have been proven efficacious in working with individuals are also supported within the group modality, with slight variations needed. CBGT with children and adolescents, similar to individual work, emphasizes the individual’s core beliefs. These core beliefs are the rules for living, formed early in life, combined with the child’s upbringing (Stone, 2007). These beliefs dominate and guide one’s behaviors. In regards to change, it has been noted that when children and adolescents have learned a style of behaving that is self-serving, but perhaps not truly effective, they do not think about changing. The author argues that CBT offers very specific skills that can be easily learned by children and adolescents, highlighting first what automatic thoughts are initiated and then how those thoughts create and maintain a specific behavior. CBGT sessions will involve exercises and activities that support the modification of automatic thoughts, underlying assumptions, and core beliefs. In specific, core beliefs will be targeted given their
pervasive and rigid nature. It is hoped that with an increased understanding of these beliefs and associated modification, more adaptive behaviors and coping skills will be learned and implemented.

In a group setting, the goal is to make the environment an in-vivo laboratory where children and adolescents are encouraged to examine the relationships between their thoughts in response to stressors and the impact these thoughts (i.e., core beliefs) have on their behavior. Group is a forum by which members can use real life experiences to connect their actions with positive and negative outcomes, by acting them out with age-related peers. This setting is confrontational, in that members will be challenged to confront difficult topics, yet supportive in that members will successively guided through exercises that will build on skills. It helps children and adolescents to understand themselves better while initiating change.

Brandler and Roman (1999) reported that leaders must first introduce CBT concepts and strategies to the group, illustrating how this approach can be used to understand their current functioning as well as facilitate problem-solving skills and consequential thinking. Group leaders are also encouraged to support group members in the breaking down of large problems into separate, manageable tasks and to then engage in consequential thinking. The authors argued that within the group setting, members must be supported to apply these new skills as well as practice their behavior change in a setting that is safe and supportive. Another element to CBGT is the focus on behaviors. This is often broken down into two areas: skills deficits and skills application difficulty. Leaders are challenged to assess these difficulties as they apply to the individual group
members, tailoring activities and exercises as appropriate. That is, as tasks are broken down, chances of success and self-efficacy are built.

Stone (2007) reported that collaboratively developing a systematic approach to problem-solving and skill-building is the essence of CBGT. These authors also supported the use of homework (e.g., bibliotherapy, audiotapes, videotapes) to reinforce and generalize new learning to real life and to illustrate the relevance of group treatment. Homework has been labeled as the crux of CBT, providing an opportunity for in-vivo practice of learned behaviors and strategies, as well as increasing group cohesion and commitment amongst members. Especially in working with children and adolescents, Mennuti, Freeman, and Christner (2005) advised leaders to develop useful, but clear and simple tasks to be used as homework. The use of developmentally appropriate language such as "experiments" or “between session practice” has also been noted as beneficial. Stewart et al. (2007) outlined specific interventions that may be used in CBGT with youth. Leaders must first assess the specific needs of the group, including whether a focus on behavioral or cognitive would most benefit its members. Those strategies that are behavioral in nature include systematic desensitization, exposure, relaxation techniques, social skills training, social problem solving, activity scheduling, and communication skills. Useful CBT techniques, applicable to the group modality, that are more cognitive in nature were listed as the following: self-monitoring, self-instructional training, dysfunctional thought records, problem-solving skills training, and socratic dialogue. As stated above, it is the leaders responsibility to determine appropriate techniques that are applicable to their specific CBGT group.
Psychological Intervention in Medical Settings

As the above-mentioned problems (e.g., behavioral, emotional) have been identified as impacting youth, a greater need has arisen in addressing these concerns in the medical population. One such movement has been the inclusion of mental health treatment in the primary care medical setting. In fact, it has been predicted that the field of psychology’s contribution to the prevention, assessment, treatment, and management of chronic and acute illnesses will dramatically increase as the field of psychology progresses in the coming years (Stewart & Esposito, 2007). When conceptualizing the psychological treatment of medical patients in the medical setting, it is important to note that medical settings may include primary care physician offices, healthcare clinics, medical hospitals, rehabilitation facilities, as well as school-based healthcare centers (Stewart & Esposito, 2007).

Literature has illustrated that as our healthcare system evolves, the demand for “one stop shopping” continues to increase. Physical proximity has been cited as an advantage to including mental health services within the medical setting. Not only does this proximity reduce the stigma of an outside referral, but parents have also been noted to show an increased willingness to seek intervention from a pediatrician-referred provider, especially when located within a familiar clinic. Proximity has also been cited as decreasing one of the primary barriers to accessing health care within low income or minority families. Another cited strength of this integration is the availability of formal and informal consultation between the primary care providers and the mental health specialist (Stewart & Esposito, 2007).

Although a number of effective interventions have been identified, Bauman,
Drotar, Leventhal, Perrin, & Pless (1997) explored a number of barriers and complications that have been recorded in providing psychological treatment for this population (i.e., children with chronic medical diagnoses). Barriers cited include difficulties recruiting sufficient numbers of children with medical illness, lack of articulation of the theory underlying interventions and an inadequately described program, and problems coordinating multidisciplinary teams to inform and conduct interventions. It was argued by the authors that such barriers provide further support for the integration of such services into points of contact for the population, including community health centers. That is, accessibility to both patients as well as multidisciplinary teams (i.e., various treatment providers) is significantly higher in these settings.

Last et al. (2007) reported behavioral and cognitive-behavioral techniques as the most commonly used intervention approaches for typical problems experienced by chronically ill children and adolescents, addressing such areas as disease management, management of procedural distress, and psychosocial adjustment problems. It was reported that such techniques have been used with a variety of pediatric populations.

Stewart and Esposito (2007) concluded that CBGT is well-suited for inclusion in the medical setting based upon a number of factors, including its solution-focused, time-limited, educational, and skill-building components. The authors reported that it is beneficial of therapy of this modality in the primary care setting to address not only the presenting problem (e.g., medical diagnosis, behavioral functioning) but also include a level of parent education. Groups should also explore belief systems of group members related to topics, how people develop illness and their response to treatment, and insight
into one’s own health. Stewart and Esposito (2007) reported that groups in the medical setting may be considered less threatening or taboo because they appear to relate to the physical health issues that are regularly addressed in this setting. That is, physical health issues traditionally carry less stigma than those of mental health.

Harbeck-Weber and McKee (1995) cited the following factors often seen in children with medical diagnoses, supporting the notion of group treatment for this population: social adjustment, peer relationships, and adaptation to the disease. All of these factors may be addressed in the group setting. It was also reported that groups provide participants the opportunity to engage in modeling, problem-solving, helping others, and relating with peers with similar conditions.

Although not specific to the medical setting, Kaslow and Thompson (1998) reported that integrated CBT approaches that include such components as self-control therapy, social skills/social competence training, cognitive restructuring, and relaxation problem-solving have reduced depressive symptoms in elementary school children. It should be noted that typically these skills were delivered via the group therapy modality. Given depressive symptoms is a highly observed product of stress, it is argued that the research by Kaslow and Thompson supports the notion of developing a program to address such symptoms in children of a specialized population (i.e., with medical diagnoses).

From a CBT framework, “illness, health, wellness, and consequences of each are stimuli that activate the belief systems within individuals” (Stewart & Esposito, 2007, pg. 190). The authors reported that youth facing illness or a potential health crisis may experience doubts about their competence to handle the condition or treatment, fears
about progression and outcome, worries and guilt for the effects on loved ones, beliefs about their inability to control the situation or aspects of it, fears about the abilities of others to help or care for them, for example. All of the above may be argued to impact the overall stress experienced by children and adolescents with chronic medical illness.

In a review of group interventions for pediatric chronic conditions, Plante, Lobato, and Engel (2001) examined which strategies have been proven efficacious in accordance to the Chambless/Society for Pediatric Psychology criteria. Within this review, nine studies targeting coping skills such as social problem solving, stress management, and behavior change were examined. Due to the nature of this document, and the applicability of such groups with the KAFSE program that is being developed, this review is being highlighted. As cited in the Plante et al. (2001) article, individuals with diabetes showed decreased levels of perceived stress, improvements in knowledge, adherence, social skills, metabolic control, and quality of life when compared to psychoeducation or medical treatment alone. It was also reported that group-based education programs combined with relaxation training and coping with asthma have been demonstrated as more effective in improving both behavioral functioning and physical symptoms when compared to no treatment or relaxation-only conditions. Therefore, coping skills groups have been found to meet the Chambless/Society for Pediatric Psychology criteria of a well-established treatment program.

Overall, CBGT within the medical setting will aim to provide clients with an enhanced emotional coping, problem-solving, cognitive awareness, and interpersonal skills. These skills will allow them to make better behavioral and social choices, contributing to healthier lifestyles and better qualities of life (Stewart & Esposito, 2007).
In specific, the authors highlight the following goal as applicable within the medical setting to improve overall health status and well-being: (a) emotional identification, expression, and coping skills, (b) stress management skills, (c) cognitive awareness and control, (d) acceptance, (e) behavioral change, (f) problem-solving skills, (g) interpersonal skills, and (h) self-advocacy and assertiveness skills.
Chapter Three

Proposed Program: KAFSE

The KAFSE program is an eight-week CBGT program for youth with medical diagnoses. The non-categorical approach will include children with a variety of medical diagnoses (e.g., obesity, asthma, diabetes mellitus), rather than targeting one specific diagnosis. Plante et al. (2001) supported the notion of a non-categorical approach to group composition, stating that it has yet to be demonstrated that forming homogeneous groups is necessary for effectiveness of group treatment with children with medical conditions. Kibby, Tye, and Mulhern (1998) also supported the non-categorical approach when working with children with medical diagnoses, instead striving to focus on the similarities in experiences of children with varied medical conditions rather than distinct differences in conditions.

Program Curriculum

Consistent with the above-presented information, the KAFSE program is based on the concept that children with medical diagnoses experience a heightened level of psychological distress and maladaptive coping compared to their healthy peers. Of specific interest is the hypothesized increased level of stress in this population. As a result, the KAFSE program was developed to address these psychological problems, including stress management, within the medical setting to support and improve the functioning of children and adolescents diagnosed with chronic illness. The program is conceptually-driven, based on a CBT framework, including therapeutic games, activities,
and concrete goals, modified to address the child and adolescent population. Table 2 outlines the program curriculum week-by-week. Please refer to Appendix A for the expanded weekly agenda.

Table 2

*KAFSE program weekly curriculum*

<table>
<thead>
<tr>
<th>Week</th>
<th>Theme</th>
<th>Specific interventions/activities</th>
</tr>
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| 1    | Caregiver Overview & Education | • Pre-data collection  
• Discussion regarding stress in children and the impact of medical diagnosis  
• KAFSE Overview  
• Psychoeducation regarding stress in children, impact of medical diagnosis, and role of KAFSE |
| 2    | Introduction to KAFSE         | • Pre-data collection  
• What is KAFSE? (general overview and program expectations)  
• Identification and discussion about experienced worries  
• Introduction of group members and leader  
• Establishment of group rules  
• Homework: Decorating of personal Worry and Coping jars |
| 3    | The Cognitive Behavioral Model | • Group check-in  
• Sharing of personal jars  
• What is the Cognitive-Behavioral model?  
• Activity: Baseball Diamond exercise to illustrate connection between thoughts, feelings, physical sensations, and behaviors  
• Homework: Event-feeling tracking sheet |
| 4    | What is Stress?               | • Group check-in  
• Psychoeducation on stress, including potential impact of physical health  
• Introduction to coping  
• Activity: Use of Stress Thermometer, |
<table>
<thead>
<tr>
<th>Session</th>
<th>Topic</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 5 | Coping Skills (Caregivers Participate) | - Group check-in  
- Review homework assignment  
- Discuss cognitions and feelings associated with stress  
- What can I do about stress? – discussion of the role of diet, exercise, and coping strategies  
- Activity: Group brainstorming on coping strategies, Kimochi dolls to illustrate cognitions and brainstorm coping skills  
- Homework: How do my family members cope with stress?, Sharing of worries |
| 6 | Relaxation Training (Caregivers Participate) | - Group check-in  
- Review of homework assignment  
- Review of last week’s discussed stress management techniques – focus on relaxation  
- Experiential exercise: Whole body relaxation script  
- Psychoeducation on how to do belly breaths  
- Experiential activity: Bubble breaths  
- Homework: Take home script and practice whole body relaxation two evenings during the week |
| 7 | Generalizability/Relapse Prevention | - Group check-in  
- Processing of homework assignment – How was it? Difficult? Questions?  
- Review and integration of learned information and relaxation techniques – focus on using this information in real-life situations  
- Activity: “This is my life…”  
- Homework: Creation of list of personal “coping cards” |
| 8 | Graduation/Celebration | - Group check-in  
- Review of homework – place cards in |
As noted, the first week of the program will be used to encourage the involvement of caregivers in the intervention program. Caregivers will also be included during weeks five and six (i.e., coping skills and relaxation training). This inclusion is to support the generalizability of learned techniques to the home setting and family system. In accordance with the conceptually-driven development, the KAFSE curriculum has been designed to begin with psychoeducation, moving into skill development and implementation, and finally relapse prevention.

During the first child session, children will receive a program booklet, which includes all activity sheets for the program. This, combined with the caregiver component, is a way to increase the generalization of KAFSE concepts to post-intervention settings as it is a tangible reminder of learned information. Each week will begin with a “check-in” that will encourage group conjugality as well as integrate past week’s experiences. This “check-in” will be based around the participants’ identified worries from the Worry jars (i.e., Any changes? Comments?), providing a connecting thread between all sessions. All members of the group will have the opportunity to speak of their identified worries, adding or subtracting worries to their jar as they may present.
Conceptually, this is a visual reminder that these worries (i.e., stressors) can be either temporary or long-standing. It is also a way to introduce and model the concept of distress tolerance.

Participants are also making personal Coping jars that will be filled with personal coping strategies and positive self-talk throughout the program, but particularly during the last session. The Coping Jar will be connected to the Worry Jar in that they support both the establishment of self-efficacy as well as support relapse prevention.

Consistent with the CBT model, each session will conclude with a homework assignment to be reviewed at the beginning of the next session. To encourage caregiver involvement, they will be included in the assignment and discussion of each week’s homework assignments at the end of the session.

The KAFSE program was developed to build upon previous weeks’ experiences. Week six of the program was designed to integrate all learned material to that point, providing an opportunity for review of past knowledge and learning coping strategies through a problem-solving framework. Participants are continually encouraged to draw upon one another’s thoughts and experiences to support their growth and development throughout the KAFSE program.

In light of previous research, the KAFSE program was designed to build upon past programs in the following ways: inclusion of a caregiver component, using a topic-specific approach, and use of a population-specific approach. Existing studies may address one of these three factors, but not all. It is the goal of the KAFSE program to investigate the efficacy of a stress management program (topic-specific) on children with medical diagnoses (population-specific), a group and topic that has not been explored
within the literature. Program outcomes will be measured pre- and post-intervention, with the following hypotheses made:

- **H1:** Both depression and anxiety symptoms (measured separately) will decrease at post-intervention when compared to pre-intervention assessment.
- **H2:** At post-intervention, children’s CATIS scores will have decreased, compared to pre-intervention assessment.
- **H3:** Caregivers’ reports on the PSC will decrease at post-intervention assessment.
- **H4:** At post-intervention, depression and anxiety symptoms will be positively correlated with CATIS scores. That is, as CATIS scores decrease, so will CDI and RCMAS-2 scores, per child report.
Chapter Four

Proposed Program Implementation and Outcome Measurement

As outlined above, the KAFSE program has been developed as a conceptually-driven group therapy program to address stress management in children with chronic medical diagnoses. In order to ascertain empirical validation, this program needs to be implemented as well as have outcomes measured. The following section will outline recommended program implementation as well as qualitative and quantitative procedures for outcome measurement.

Participants

Children aged 8-11 years old will be targeted due to this age group’s developmental level and similar ability to process and abstract information. That is, consistent with the recommendations outlined by Hill and Coulson-Brown (2007), children under the age of 11 years of age need to have psychological qualities and dynamics reduced to very concrete behavioral terms and not delivered in abstract ways. Using a developmental model, this age group is also at a stage where they are able and likely willing to learn and grow emotionally and behaviorally. A group size of ten children will be targeted due to the nature of the group and its goals. That is, the group must be able to be maintained by the group facilitator but also large enough to provide for ample social comparison, problem-solving, and reduced feelings of isolation.

Exclusionary criteria for the program should include developmental delays,
significant behavioral dyscontrol (e.g., sole behavior disorder diagnosis) as well as MR/DD functioning. This exclusion is made in order to ensure that all participants are at a similar cognitive level to process and understand presented material as well as to actively participate in group activities. Although treatment has been found efficacious for this population, it is outside the scope of this particular program. For referrals that do not meet inclusionary criteria, other referral information will be made available (i.e., within-clinic psychology department, community agencies). During intake interviews with the group facilitator, caregivers and potential participants will be asked about all of the above, including intensity of reported behaviors.

**Outcome Measures**

As highlighted above, as a conceptually-driven program, KAFSE must be implemented and then measured for outcome effectiveness in order to gain empirical support. It is believed that both qualitative and quantitative measurement is essential to gain comprehensive feedback and outcome measurement.

To obtain qualitative feedback, it is recommended that the program curriculum and associated materials be shared with clinical psychologists whom are experts in the area of child psychopathology and intervention. Specifically, feedback regarding conceptual framework, proposed implementation, and quantitative outcome measurement would be beneficial. Qualitative measurement will also be obtained during the pre-, post-, and follow-up data collection. Caregivers will be asked about their satisfaction with the program, what coping skills are being used to manage their stress, and how the caregivers would rate their level of stress related to the child’s illness (using a Likert scale).
In addition to the above, quantitative measurement of child symptom presentation is recommended. The following outcome measurement protocol and associated measures are proposed:

**Demographic Questionnaire.** A demographic questionnaire, developed for this curriculum, consists of basic information including: age; gender; medical diagnosis, including date diagnosed, current symptoms, current treatment regimen; grade in school; and current or past psychological treatment. Please refer to Appendix B for a copy of this questionnaire.

**Child Attitude Toward Illness Scale (CATIS).** The CATIS (Austin & Huberty, 1993) is a 13 item self-report questionnaire designed to provide an assessment of how favorably or unfavorably children feel about having a chronic physical condition. Items such as “How good or bad do you feel it is you have ____”, “How often do you feel that your _____ keeps you from doing things you want to do”, and “How often do you feel just as good as other kids your age even though you have ____” are answered using a Likert-type scale individualized to each item. The coefficient alpha for total scale reliability was found to be .80. This scale should be used to measure how participants’ views of their illness is altered after completion of the KAFSE program, compared to prior to the program. Please refer to Appendix C for a copy of this measure.

**Pediatric Symptom Checklist (PSC).** The PSC (Jellinek, Murphy, Little, Pagano, Comer, & Kellener, 1999) is a 35 item questionnaire completed by caregivers, designed to be used by pediatricians and other health professionals to recognize and treat psychosocial problems in children. The PSC assesses for cognitive, emotional, and behavioral problems in children. It has been referenced as an “essential office tool” for
primary care settings and is increasingly used for outcome studies as a pre- and post-
intervention measure. Please refer to Appendix D for a copy of this measure.

**Children’s Depression Inventory (CDI).** The CDI (Kovacs, 1992) is a 27 item
self-report questionnaire designed to assess depression in children and adolescents along
the following five scales: negative mood, interpersonal difficulties, negative self-esteem,
ineffectiveness, and anhedonia. Because depression is often noted in child experiencing
high levels of stress, the CDI should be used to measure depressive symptoms both pre-
and post- KAFSE program. Internal consistency coefficients range from .71 to .89. The
Total Scale should be utilized as part of the KAFSE outcome measures. Please refer to
Appendix E for a copy of this measure.

**Revised Manifest Anxiety Scale – Second Edition (RCMAS-2).** The RCMAS-
2 (Reynolds & Richmond, 2008) is a 49 item self-report measure designed the measure
the level and nature of anxiety experienced by children along the following scales:
physiological anxiety, worry, social anxiety, defensiveness, and the inconsistent
responding index. All items are answered ‘yes’ or ‘no’. This scale should be used to
measure participants’ symptoms of anxiety in many domains both pre- and post-KAFSE
program. Please refer to Appendix F for a copy of this measure.

**Proposed Recruitment Procedure**

As the proposed program will target children with medical diagnoses and be
implemented in a medical setting, interface with medical providers is essential for
recruitment efforts. Medical providers (e.g., doctors, nurses) at selected facilities should
be presented with information regarding the KAFSE program by the group facilitator.
This presentation will include such information as aim of the program, targeted
population, program goals, and enrollment protocol. Informational flyers should also be
created and provided to medical providers to be handed out to appropriate clients.
Providers will then identify patients whom they believe would benefit from the KAFSE
program (i.e., diagnosed with a chronic medical illness and perceived to be experiencing
a level of related stress).

Following the identification of an appropriate patient by their medical care
provider, the caregiver should be provided with the contact information to further discuss enrollment. An initial interview will be scheduled between the child, caregiver, and
program leader to obtain basic demographic information including medical illness
information and client needs, as well as to introduce the KAFSE program, outlining its
goals and procedures. If inclusionary criteria is met, and child agrees to attend group and
comply with requirements, the child will then be enrolled in the KAFSE program and
informed consent and child assent completed. As noted above, for those children who do
not meet inclusionary criteria, information will be provided and recommendations made
regarding follow-up services, either from the in-house psychologist or within the
community.

Caregivers will be asked to complete pre-intervention measures (i.e.,
Demographic Questionnaire, PSC) at the first group session (i.e., parent education
session). The child participants will fill out their pre-intervention measures (i.e., CATIS,
CDI, RCMAS) at the second group session (first child-inclusive session). Once the
group is established the above-provided curriculum will be followed. Please refer to
Appendix A for a detailed weekly program schedule.
Post-intervention data should be obtained the week following completion of the program. Caregivers will be asked to establish an appointment time with the primary researcher to complete post-intervention measures (i.e., CATIS, PSC, CDI, RCMAS-2). At this time, caregivers and children will then be asked to complete a KAFSE feedback sheet, including both positive and negative feedback. This feedback sheet will provide qualitative data that can be examined regarding program satisfaction, efficacy, and room for improvement. As stated above, current coping strategies utilized as well as parenting stress will also be included on this feedback sheet. Current literature also demonstrates the benefit of collecting follow-up data after completion of the intervention program to determine generalizability and sustainability of symptom reduction (Friedberg et al., 2003). As a result, caregivers of KAFSE participants should be contacted six months after program completion to obtain the second set of post-intervention data. At this time, qualitative data regarding symptom presentation as well as information regarding how often their KAFSE workbook is now utilized.
Chapter Five

Discussion

The KAFSE program addresses a current gap in the literature by both acknowledging and addressing the presence and impact of stress in children and adolescents. The program takes this acknowledgment one step further by considering the role of medical diagnoses in its presence and impact. Although past literature has noted the impact of medical diagnoses on children (e.g., social adjustment problems, higher school absenteeism, increased rates of depressive and anxious symptomatology), there is a current dearth of research on appropriate intervention approaches for this population. The KAFSE program attempts to add to the current literature by proposing a group intervention approach, based on CBT framework, to teach stress management and problem-solving skills to children while also acknowledging and integrating their medical diagnosis into programming and their personal identities. Another important addition to the KAFSE program, in comparison to other interventions, is the importance of caregiver involvement. It is believed that this involvement facilitates not only the generalizability of the program but also increases intervention efficacy at the systems level.

Utilizing a CBT framework, the KAFSE program was developed to be implemented in a primary care facility. It is believed that providing psychological intervention in the medical setting allows for increased accessibility to patients as well as reduces stigma related to psychological intervention by integrating the connection between physical and mental health. Using the current literature regarding child and
health psychology, the curriculum has been developed to establish a group intervention where skills are taught, practiced, and encouraged to be implemented outside of the group sessions. It is believed that group intervention not only allows for the sharing of experiences and a sense of normality amongst participants, but also increases the opportunity for learning and varied perspective-taking. Participants are able to listen and integrate others’ experiences and efforts into their own, increasing program efficacy. It is hypothesized that children’s depressive and anxious symptomatology will decrease at post-intervention data collection (i.e., after completion of the KAFSE program).

**Scope of the Intervention Curriculum and Future Directions**

As discussed above, the KAFSE program was designed using a non-categorical approach to participant inclusion. That is, it was proposed that participants with various medical diagnoses (e.g., diabetes, obesity, asthma) be included in the group intervention. A limitation to this approach is that in exploring the impact of medical diagnoses, indepth exploration of medical diagnoses cannot occur. That is, children may share their experiences, however they may not feel understood if no other child in the group is living with this illness. Future research may wish to consider the use of a categorical approach in curriculum implementation. If a categorical approach was used, it is believed that more specific integration of medical impact could be incorporated.

In congruence with collecting outcome data to determine program impact on symptom presentation, comparison with a control group is also suggested. With these comparisons, more definitive efficacy conclusions may be drawn and revisions to program curriculum made. These revisions may address such things as the weekly
program agenda, data collection measures, or the length of the program, dependent upon efficacy findings.

Implementation with various age groups may also be explored in future implementation and outcome measurement. The current program targets children aged 8-11 years, however once efficacy is established with this developmental group, it would be advantageous to implement the curriculum with various age groups (with appropriate developmental modifications) to target and aid in symptom presence.

Finally, once KAFSE is empirically supported, the use of a multi-disciplinary team is recommended to expand intervention focus. As current developed, the scope of KAFSE targets the psychological impact, including experienced stress, related to medical diagnosis. In future development and/or expansion of the curriculum, a biopsychosocial framework would be beneficial, including psychoeducation from a trained medical provider on specific disease processes and physiological effects. The conceptual groundwork of KAFSE supports the notion that physiological effects impact psychological functioning and experiences, therefore the knowledge and expertise of a health care provider would only enhance the KAFSE curriculum and program implementation.

**Conclusion**

The KAFSE curriculum was developed to address the need for stress-management and problem-solving skills in children with medical diagnoses. As highlighted throughout this document, literature has supported the notion that stress is experienced by children however is not adequately recognized and treated. It is hypothesized by this writer that stress in children with medical diagnoses is likely elevated compared to the
general population due to such things as high rates of absenteeism, social difficulties, as well as altered family dynamics.

It is argued that stress in children will not be dissipating anytime in the near future and therefore the field of psychology must aggressively intervene to benefit our children and adolescents. Past research has called upon the importance of such intervention, yet there is a dearth of continued research or program development in the area. As a consequence, the following curriculum was proposed with the following goals in mind: (a) to reduce stress symptomatology in children (e.g., attitudes towards illness, depression, anxiety) through the learning of empirically-supported management techniques and (b) to provide psychoeducation to both caregivers and children regarding the stress process and presence, aiding in the generalizability of the program curriculum to everyday functioning. As outcome measurement is imperative to the determination of curriculum efficacy, a pre- and post-intervention measurement protocol was outlined.
APPENDIX A

Expanded Weekly Program Agenda

Week One: Caregiver Overview & Education

1. Caregivers to complete Pediatric Symptom Checklist (PSC) and Demographic Questionnaire

2. KAFSE overview
   - Discussion of weekly agenda
   - Why was your child chosen to participate?
   - Program expectations (attendance, timeliness, importance of parental involvement)

3. Psychoeducation regarding stress in children
   - What is stress?
   - How is stress demonstrated in children? How is it different from how we, as adults, experience stress?
   - What is the impact of a medical diagnosis? How might this impact the presence of stress in children?
   - What are the long-term effects of chronic stress?

4. Questions?

Week Two: Introduction to KAFSE

1. Children to complete pre-intervention measures: CATIS, CDI, RCMAS-2

2. What is KAFSE?
• Overview of program, including what to expect
• Pass out program booklets (includes all activities/worksheets that will be used)

3. Introduce discussion about worries
• What are worries?
• What are some worries that we experience?

4. Introduction of group members
• Pretzel activity – pass around bag of pretzels; children have to tell one thing about themselves for every pretzel they grabbed
• Share one worry that was identified

5. Program expectations
• Children sign contracts

6. Make rules together (participants and group leader)
• Write out on poster board to be hung up at each weekly session

7. Caregivers return
• Explanation of homework: Making of Worry Jar and Coping Jar (pass out jars)

Week Three: CBT Model

1. Check-in on worries

2. Sharing of jars

3. Leader provides overview of CBT model (Use baseball diamond handout in book)
   • How can this be applied to each of us?
   • Questions? Confusion?

4. Experiential activity: Baseball Diamond
- Bases on floor for body sensations, thoughts, feelings, behavior – participants move around them identifying

5. Caregivers return
- Explanation of homework: Event-feeling tracking sheet

**Week Four: What is Stress?**

1. Check in on worries

2. Education regarding stress
   - What is stress?
   - Do I feel stress?
   - Impact of physical health?
   - Positive and negative events
   - Use of stress thermometer

3. Experiential activity: Life events worksheet to discuss stress – both positive and negative

4. Introduction to the idea of coping – adaptive versus maladaptive

5. Experiential activity: Trashcan activity of “throwing away” negative thoughts/feelings

6. Caregivers return
- Explanation of homework: Where do I feel stress? (Body coloring sheet)

**Week Five: Coping Skills (Caregivers participate)**

1. Check-in on worries

2. Review of homework assignment from last week

3. Review last week’s discussion on stress
4. Discuss some cognitions and feelings associated with stress

5. Introduce coping
   - Using worksheet, talk through the importance of diet, exercise, challenging thoughts, etc.
   - Have participants brainstorm on other coping skills

6. Experiential activity: Kimochi dolls – use to discuss cognitions, feelings, and brainstorm coping strategies

7. Explanation of homework: Family worksheet, Sharing of worries

**Week Six: Relaxation Training (Caregivers participate)**

1. Check-in on worries

2. Review homework – What did people find? Use as base for discussion.

3. Education on relaxation training

4. Experiential activities (Process each afterwards)
   - Whole-body relaxation script
   - Bubble breaths activity

5. Explanation of homework: do whole-body relaxation two times this week

**Week Seven: Generalizability/Relapse Prevention**

1. Check-in on worries

2. Review of the homework assignment
   - How was it? Difficult? Any questions?

3. Focus upon generalization of learned techniques to outside KAFSE sessions. When can techniques be used? Importance of choosing what works for your individually.

4. Experiential activity: “This is my life”
5. Caregivers return
   • Explanation of homework: Complete personal coping cards

Week Eight: Graduation (Caregivers participate)

1. Check-in on worries

2. Review of homework – put cards in personal coping jar
   • Discuss connection between coping jar and relaxation jar (ex: some stressors go away whereas some stay, some stressors change, importance of coping skills to handle worries)

3. Discuss use of positive self-talk as a coping strategy

4. Participant activity: “What I like about you…”
   • Distribute in jars

5. Debriefing with caregivers and participants
   • Encourage participant involvement

6. Distribute individual awards and certificates

7. Schedule follow-up meetings with caregivers and participants
APPENDIX B

Demographic Questionnaire

ID _________________________      Date ______________

Child’s Birthdate _____________
Child’s Gender _____ M _____ F
Child’s Ethnicity ____________

Medical History

Child’s Diagnosis ________________________________
Date of Diagnosis ________________

Please describe your child’s current prescribed treatment. How often is the child seen by his/her medical provider? Please describe any treatment programs (e.g., medication, regular surgeries) that your child is prescribed related to his/her medical diagnosis:

Does your child follow his/her prescribed treatment? _____ Y _____ N

School History

Is your child home schooled? _____ Y _____ N
Child’s current grade level ______
Has your child ever repeated a grade? ____ Y ____ N

What are you child’s current grades?

Estimated number of school days missed so far this year: ______ of ______ days

Other comments:

Please provide any other comments not covered in the above that you feel are relevant to your child. For example, problems at school, at home, impact of medical illness, etc.
APPENDIX C

Children’s Attitudes Towards Illness Scale

1. How good or bad do you feel it is that you have ________?
   Very good  A little good  Not sure  A little bad  Very bad

2. How fair is it that you have ________?
   Very fair  A little fair  Not sure  Unfair  Very unfair

3. How happy or sad is it for you to have ____________?
   Very sad  A little sad  Not sure  A little happy  Very happy

4. How good or bad do you feel it is to have ___________?
   Very good  A little good  Not sure  A little bad  Very bad

5. How often do you feel like your ___________ is your fault?
   Never  Not often  Sometimes  Often  Very often

6. How often do you feel that your ________ keeps you from doing things you like?
   Very often  Often  Sometimes  Not often  Never

7. How often do you feel that you will always be sick?
   Never  Not often  Sometimes  Often  Very often

8. How often do you feel that your ________ keeps you from starting new things?
   Very often  Often  Sometimes  Not often  Never

9. How often do you feel different from others because of your ___________?
   Never  Not often  Sometimes  Often  Very often

10. How often do you feel bad because you have ____________?
    Very often  Often  Sometimes  Not often  Never

11. How often do you feel bad about being sick?
    Never  Not often  Sometimes  Often  Very often

12. How often do you feel happy even though you have _____________?
    Never  Not often  Sometimes  Often  Very often

13. How often do you feel just as good as other kids your age even though you have ________?
    Very often  Often  Sometimes  Not often  Never
APPENDIX D

Pediatric Symptom Checklist

### BRIGHT FUTURES TOOL FOR PROFESSIONALS

**Pediatric Symptom Checklist (PSC)**

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complains of aches and pains</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Spends more time alone</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>3. Tires easily, has little energy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>4. Fidgety, unable to sit still</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>5. Has trouble with teacher</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>6. Less interested in school</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>7. Acts as if driven by a motor</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>8. Daydreams too much</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>9. Distracted easily</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>10. Is afraid of new situations</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>11. Feels sad, unhappy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>12. Is irritable, angry</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>13. Feels hopeless</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>14. Has trouble concentrating</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>15. Less interested in friends</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>16. Fights with other children</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>17. Absent from school</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>18. School grades dropping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>19. Is down on him or herself</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>20. Visits the doctor with doctor finding nothing wrong</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>21. Has trouble sleeping</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>22. Worries a lot</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>23. Wants to be with you more than before</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>24. Feels he or she is bad</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>25. Takes unnecessary risks</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>26. Gets hurt frequently</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>27. Seems to be having less fun</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>28. Acts younger than children his or her age</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>29. Does not listen to rules</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>30. Does not show feelings</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>31. Does not understand other people’s feelings</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>32. Teases others</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>33. Blames others for his or her troubles</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>34. Takes things that do not belong to him or her</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>35. Refuses to share</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Total score

---

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?

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APPENDIX E

Children’s Depression Inventory

Name: __________________________ Age: _______ Birthdate: __________
Grade in school: ____________ Sex: _______ Today’s date: __________

CDI

Maria Kovacs, Ph.D.

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this X next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you best.

Example:

☐ I read books all the time.
☐ I read books once in a while.
☐ I never read books.

When you are told to do so, tear off this top page. Then, pick the sentences that describe you best on the first page. After you finish the first page, turn to the back. Then, answer the items on that page.

Remember, pick out the sentences that describe you best in the PAST TWO WEEKS.


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<table>
<thead>
<tr>
<th>Item 1</th>
<th>Item 8</th>
</tr>
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<tbody>
<tr>
<td>I am sad once in a while.</td>
<td>All bad things are my fault.</td>
</tr>
<tr>
<td>I am sad many times.</td>
<td>Many bad things are my fault.</td>
</tr>
<tr>
<td>I am sad all the time.</td>
<td>Bad things are not usually my fault.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 2</th>
<th>Item 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing will ever work out for me.</td>
<td>I do not think about killing myself.</td>
</tr>
<tr>
<td>I am not sure if things will work out for me.</td>
<td>I think about killing myself but I would not do it.</td>
</tr>
<tr>
<td>Things will work out for me O.K.</td>
<td>I want to kill myself.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 3</th>
<th>Item 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do most things O.K.</td>
<td>I feel like crying every day.</td>
</tr>
<tr>
<td>I do many things wrong.</td>
<td>I feel like crying many days.</td>
</tr>
<tr>
<td>I do everything wrong.</td>
<td>I feel like crying once in a while.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 4</th>
<th>Item 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have fun in many things.</td>
<td>Things bother me all the time.</td>
</tr>
<tr>
<td>I have fun in some things.</td>
<td>Things bother me many times.</td>
</tr>
<tr>
<td>Nothing is fun at all.</td>
<td>Things bother me once in a while.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 5</th>
<th>Item 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am bad all the time.</td>
<td>I like being with people.</td>
</tr>
<tr>
<td>I am bad many times.</td>
<td>I do not like being with people many times.</td>
</tr>
<tr>
<td>I am bad once in a while.</td>
<td>I do not want to be with people at all.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 6</th>
<th>Item 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think about bad things happening to me once in a while.</td>
<td>I cannot make up my mind about things.</td>
</tr>
<tr>
<td>I worry that bad things will happen to me.</td>
<td>It is hard to make up my mind about things.</td>
</tr>
<tr>
<td>I am sure that terrible things will happen to me.</td>
<td>I make up my mind about things easily.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item 7</th>
<th>Item 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hate myself.</td>
<td>I look O.K.</td>
</tr>
<tr>
<td>I do not like myself.</td>
<td>There are some bad things about my looks.</td>
</tr>
<tr>
<td>I like myself.</td>
<td>I look ugly.</td>
</tr>
</tbody>
</table>

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Remember to fill out the other side.
CDI

Remember, describe how you have been in the past two weeks....

Item 15
☐ I have to push myself all the time to do my schoolwork.
☐ I have to push myself many times to do my schoolwork.
☐ Doing schoolwork is not a big problem.

Item 16
☐ I have trouble sleeping every night.
☐ I have trouble sleeping many nights.
☐ I sleep pretty well.

Item 17
☐ I am tired once in a while.
☐ I am tired many days.
☐ I am tired all the time.

Item 18
☐ Most days I do not feel like eating.
☐ Many days I do not feel like eating.
☐ I eat pretty well.

Item 19
☐ I do not worry about aches and pains.
☐ I worry about aches and pains many times.
☐ I worry about aches and pains all the time.

Item 20
☐ I do not feel alone.
☐ I feel alone many times.
☐ I feel alone all the time.

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Remember to fill out the other side

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

Item 22
☐ I have plenty of friends.
☐ I have some friends but I wish I had more.
☐ I do not have any friends.

Item 23
☐ My schoolwork is alright.
☐ My schoolwork is not as good as before.
☐ I do very badly in subjects I used to be good in.

Item 24
☐ I can never be as good as other kids.
☐ I can be as good as other kids if I want to.
☐ I am just as good as other kids.

Item 25
☐ Nobody really loves me.
☐ I am not sure if anybody loves me.
☐ I am sure that somebody loves me.

Item 26
☐ I usually do what I am told.
☐ I do not do what I am told most times.
☐ I never do what I am told.

Item 27
☐ I get along with people.
☐ I get into fights many times.
☐ I get into fights all the time.

MHS
APPENDIX F

Revised Children’s Manifest Anxiety Scale

“WHAT I THINK AND FEEL”
(RCMAS)

Cecil R. Reynolds, Ph.D. and Bert O. Richmond, Ed.D.

Name: ________________________ Today’s Date: ____________
Age: ____________  Sex (circle one):  Girl Boy  Grade: ____________
School: ________________________  Teacher’s Name (Optional): ________________________

**DIRECTIONS**

Here are some sentences that tell how some people think and feel about
themselves. Read each sentence carefully. Circle the word “Yes” if you think
it is true about you. Circle the word “No” if you think it is not true about you.
Answer every question even if some are hard to decide. Do not circle both
“Yes” and “No” for the same sentence.

There are no right or wrong answers. Only you can tell us how you think
and feel about yourself. Remember, after you read each sentence, ask
yourself “Is it true about me?” If it is, circle “Yes.” If it is not, circle “No.”

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<thead>
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<th></th>
<th>Raw Score</th>
<th>Percentile</th>
<th>T-Score or Scaled Score</th>
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W-19MA

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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 G

KAFSE: Kids Able to Fight Stress Everyday

Program Booklet for Kids

Name __________________________
Welcome to the KAFSE program! ☺ This program is for kids to come together each week to talk, learn, and have some fun! Throughout the next 7 weeks we will learn about stress – what it is, how we feel it, and how our health can affect it. After we’ve learned all about stress, we are going to learn some things that we can do to manage it – you may have heard adults call these things “coping strategies.” Each week will include some learning, an activity, and even an activity to take home to do with your family!

Get ready to have some fun and meet some great people ... and remember: if you have any questions, you can always ask your group leader!

My Group Leader’s Name is: __________________
**Week #1**

Introduction to KAFSE

**GOAL:** To understand what the program is all about and how it can help you

- Identify and talk about some of our worries
- Learn what the KAFSE program is
- Get to know each other
- Sign agreements
- Make our list of group rules

**Take-home Activity:** Decorate your Worry and Coping Jars!**
My group members names are:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________
9. ________________________________
10. ________________________________
Now let’s figure out what our rules are!…

1. Listen to each other

2. Do not interrupt each other

3.

4.

5.

6.
Other things I don’t want to forget…

[

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Week #2

Learning About My Thoughts, Feelings, and Behaviors

GOAL: To understand the connection between the way my body feels, my thoughts, my feelings, and my behaviors

- To define and identify body sensations, thoughts, feelings, and behaviors
- Use real-life examples to apply these connections to real-life
- Play the Baseball Diamond game to illustrate the connection (Friedberg et al, 2003)

**Take-home Activity: Event-Feeling Tracking Sheet**
How my body feels

What I’m feeling

What I’m thinking

How I act
Other things I don’t want to forget…
# Emotions

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## Event-Feeling Tracking Sheet

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<th>What happened?</th>
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Week #3

Now let’s learn about stress!

GOAL: To learn about stress and how I may feel it
• Explore: What is stress? Do I feel stress?
• Talk about positive versus negative events
• Learn about health and how it might impact the stress I feel
• What are some things that people do to deal with stress?

**Take-home Activity: Body Coloring Sheet**
What are some events that may lead to stress?

Having blood taken
Starting at a new school
Being bullied
Getting a bad grade
Moving into a new house
My parents fighting
Divorce of my parents
Going to the hospital
Having a lot of doctor’s appointments
Missing a lot of school days
Getting a new brother or sister
The first day of school

Now work with someone else in the group to come up with other things...
What might stress look like...
Other things I don’t want to forget…
Week #4

Lets learn how to start becoming a warrior of our stress!

GOAL: Learn things we can do to make us feel better when we have stress

• Review how we may feel and think when we feel stress
• Learn some things that we can do when feeling stress

**Take-home Activity: Family Worksheet**
What are some things that people do to feel better at times of stress?...

- Make sure to eat healthy foods
- Get a good night’s sleep each night
- Challenge my thoughts
- Look at the problem with different “glasses”
- Get some exercise everyday
- Try a different solution
Other things I don’t want to forget…
Family Worksheet

Pick one member of your family to sit down and talk with – ask these questions:

1. *What do you worry about?*

   (Then go through YOUR Worry Jar together with them, talking about the things that make you worry!)

2. *How do you know when you feel stressed?*

3. *How do you make yourself feel better?*
Week #5

What else can I do to be a stress warrior?

GOAL: Learn about relaxation and what I can do to feel relaxed

• Teach and practice whole body Progressive Muscle Relaxation
• Teach and practice “Bubble Breaths”

**Take-home Activity: Practice whole-body relaxation 2x this week!**
Relaxation Exercise

Hands and Arms

Pretend you have a whole lemon in your left hand. Now squeeze it hard. Try to squeeze all the juice out. Feel the tightness in your hand and arm as you squeeze. Now drop the lemon. Notice how your muscles feel when they are relaxed. Take another lemon and squeeze. Try to squeeze this one harder than you did the first one. That’s right. Real hard. Now drop the lemon and relax. See how much better your hand and arm feel when they are relaxed. Once again, take a lemon in your left hand and squeeze all the juice out. Don’t leave a single drop. Squeeze hard. Good. Now relax and let the lemon fall from your hand. (Repeat the process for the right hand and arm)

Arms and Shoulders

Pretend you are a furry, lazy cat. You want to stretch. Stretch your arms out in front of you. Raise them high over your head. Way back. Feel the pull in your shoulders. Stretch higher. Now just let your arms drop back to your side. Okay, kitten, let’s stretch again. Stretch your arms out in front of you. Raise them over your head. Pull them back, way back. Pull hard. Now let them drop quickly. Good. Notice how your shoulders feel more relaxed. This time let’s have a great big stretch. Try to touch the ceiling. Stretch your arms way in front of you. Raise them way up high over your head. Push them way, way back. Notice the tension and pull in your arms and shoulders. Hold tight. Now. Great. Let them drop very quickly and feel how good it is to be relaxed. It feels good and warm and lazy.

Jaw

You have a giant jawbreaker bubble gum in your mouth. It’s very hard to chew. Bite down hard on it. Hard! Let your neck muscles help you. Now relax. Just let your jaw hang loose. Notice how good it feels just to let your jaw drop. Okay, let’s tackle that jawbreaker again now. Bite down. Hard! Try to squeeze it out between your teeth. That’s good. You’re really tearing that gum up. Now relax again. Just let your jaw drop off your face. It feels good just to let go and not have to fight that bubble gum. Okay, one more time. We’re really going to tear it up this time. Bite down. Hard as you can. Harder. Oh, you’re really working hard. Good. Now relax. Try to relax your whole body. You’ve beaten that bubble gum. Let yourself go as loose as you can.
Face and Nose

Here comes a pesky old fly. He has landed on your nose. Try to get him off without using your hands. That’s right, wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch up your nose real hard. Good. You’ve chased him away. Now you can relax your nose. Oops, here he comes back again. Right back in the middle of your nose. Wrinkle up your nose again. Shoo him off. Wrinkle it up hard. Hold it just as tight as you can. Okay, he flew away. You can relax your face. Notice that when you scrunch up your nose your cheeks and your mouth and your forehead and your eyes all help you, and they get tight too. So when you relax your nose, your whole body relaxes too, and that feels good. Uh-oh. This time that old fly has come back, but he is on your forehead. Make lots of wrinkles. Try to catch him between all those wrinkles. Hold it tight now. Okay, you can let go. He’s gone for good. Now you can just relax. Let your face go smooth, no wrinkles anywhere. Your face feels nice and smooth and relaxed.

Stomach

Hey! Here comes a cute baby elephant. But he’s not watching where he is going. He doesn’t see you lying in the grass, and he’s about to step on your stomach. Don’t move. You don’t have time to get out of the way. Just get ready for him. Make your stomach very hard. Tighten up your stomach muscles real tight. Hold it. It looks like he is going the other way. You can relax now. Let your stomach go soft. Let it be as relaxed as you can. That feels so much better. Oops, he’s coming this way again. Get ready. Tighten up your stomach. Real hard. If he steps on you when your stomach is hard, it won’t hurt. Make your stomach into a rock. Okay, he’s moving away again. You can relax now. Kind of settle down, get comfortable, and relax. Notice the difference between a tight stomach and a relaxed one. That’s how we want to feel – nice and loose and relaxed. You won’t believe this, but this time he’s coming your way and there is no turning around! He is headed straight for you. Tighten up. Tighten hard. Here he comes. This is really it! You’ve got to hold on tight. He’s stepping on you. He’s stepped over you. Now he’s gone for good. You can relax completely. You’re safe. Everything is okay, and you can feel nice and relaxed.

This time imagine that you want to squeeze through a narrow fence and the boards have splinters on them. You’ll have to make yourself very skinny if you’re going to make it through. Suck your stomach in.
Try to squeeze it up against your backbone. Try to be as skinny as you can. Ok, now just relax and feel your stomach being warm and loose. Okay, let’s try to get through that fence now. Squeeze up your stomach. Make it touch your backbone. Get it real small and tight. Hold tight, now. You’ve got to squeeze through. Alright, you got through that narrow little fence with no splinters! You can relax now. Settle back and let your stomach come back out where it belongs. You can feel good now. You’ve done fine.

**Legs and Feet**

Now pretend that you are standing barefoot in a big, fat mud puddle. Squish your toes down deep into the mud. Try to get your feet down to the bottom of the mud puddle. You’ll probably need your legs to help you push. Push down, spread your toes apart, feel the mud squish up between your toes. Now step out of the mud puddle. Relax your feet. Let your toes go loose and feel how nice that feels to be relaxed. Okay, back into the mud puddle. Squish your toes down. Let your leg muscles help push your feet down. Push your feet! Hard! Try to squeeze that puddle dry. Okay. Come back out now. Relax your feet, relax your legs, and relax your toes. It feels so good to be relaxed. No tenseness anywhere. You feel kind of warm and tingly.

**Conclusion**

Stay as relaxed as you can. Let your whole body go limp and feel all your muscles relaxed. As you go through the day, remember how good it feels to be relaxed. Sometimes you have to make yourself tighter before you can be relaxed, just as we did in these exercises. Practice these exercises at home to get more and more relaxed. A good time to practice is at night, after you have gone to bed and the lights are out and you won’t be disturbed. Then, when you are a really good relaxer, you can relax anywhere! Just remember the elephant, or the jaw breaker, or the mud puddle, and you can do your exercises and no one will know. Today is a good day, and you are ready to feel relaxed. You’ve worked hard and it feels good to work hard. Good job – you’re a super relaxer!

Other things I don’t want to forget…


**Week #6**

How do I keep doing what I’ve learned?

**GOAL: Learn how to use KAFSE in real-life**
- Review stress management techniques
- Talk about the importance of picking what works for YOU
- Practice, practice, practice using these things in real-life with the “This is my Life” activity

**Take-home Activity: Fill out personal coping cards**
Other things I don’t want to forget…
**What coping skills work for YOU??...**

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Week #7

Graduation Celebration!!

GOAL: Review of Program

- *Talk about real-life use of coping*
- *Summarizing with participants and caregivers*
- “*What I like about you*” activity – *talk about positive self-talk as a coping strategy*
- *Schedule follow-up meetings with caregivers*

You’ve done it! Congratulations on completing the KAFSE program! 😊 I hope that you had fun and learned a lot that will help you – maybe you can even teach some of it to your friends! Keep using those personal stress management techniques!!
Other things I don’t want to forget…
APPENDIX H

KAFSE: Kids Able to Fight Stress Everyday

Program Booklet for Group Facilitators
Dear facilitator,

Welcome to the KAFSE program! This booklet will outline the curriculum week-by-week, providing instruction on how to conduct each session. The program is conceptually-grounded in a CBT framework and therefore has a specific curriculum and agenda for each session. That being said, the program is also built to allow a level of flexibility in order to meet the needs of the participants – please feel free to allow for deepened discussions or opportunities for learning while following each week’s agenda.

In order to provide empirical support, outcome measurement is also built into the program. This protocol will also be outlined within this booklet.

Ready, set, go...!!
**KAFSE Weekly Schedule**

**Orientation:** Caregiver Overview and Education (Caregivers)

**Week #2:** Introduction to KAFSE (Kids)

**Week #3:** Learning about my Thoughts, Feelings, & Behaviors (Kids)

**Week #4:** Now let’s learn about stress! (Kids)

**Week #5:** Let’s learn how to start becoming a warrior of our stress! (Kids & Caregivers)

**Week #6:** What else can I do to be a stress warrior? (Kids & Caregivers)

**Week #7:** How do I keep doing what I’ve learned? (Kids)

**Week #8:** Graduation Celebration! (Kids & Caregivers)
1. Caregivers to complete pre-intervention measures
   - Pediatric Symptom Checklist (PSC)
   - Demographic Questionnaire

2. KAFSE Overview
   - Described as an 8-week program (1 hour each week with only children and then 15-30 minutes that includes caregivers) – Caregivers brought in at the end of each session to discuss that session’s activities as well as review homework assignment. Week #5 and week #6: Caregivers are expected to participate in the entire hour.
   - Provide a brief overview as to what will be covered with their children throughout the program:
     o Education on stress
     o Identification of thoughts, body sensations, and feelings associated with stress
     o Development of coping and relaxation skills
     o Learning how to take the skills they have learned and apply them to “real life”
   - Each session will include an activity for the kids to engage in.
   - Each week their child will be assigned a “take-home task” that they are to complete and bring back the next week – stress caregiver involvement in completing these tasks!

3. Why was your child chosen to participate?
   - Recruitment from pediatric primary care settings to address stress management in children with medical diagnoses
4. Program Expectations
   • Weekly attendance – consistent attendance extremely important as the program was designed to build upon the previous week’s knowledge, attitudes, and skills
   • Please be on time!
   • Importance of caregiver involvement! – research shows the significant role of caregivers in the sustainability and generalizability of learned concepts in children

5. Pass out Caregiver booklets
   • Explain that children will get their own booklet at next week’s session
   • Highlight importance of the children bringing their booklet to each session

6. Provide psychoeducation on stress in children
   • Stress is feeling overwhelmed, anxious, or any sort of negative emotion related to current stressors
   • Education regarding the presence of both positive and negative events that may lead to stress
   • How is stress different in children?
     o Children often don’t have the words to describe
     o Children often don’t recognize that stress is what they are experiencing
     o Children may display symptoms of stress in many different ways than adults do (use handout in Caregiver Booklet)
   • Impact of medical diagnosis?
     o Brainstorm with caregivers. Ex: medical procedures, medication regimens, school absenteeism, bullying from peers
   • What are the long-term effects of stress?
     o Physiological
     o Academic
     o Social
**Common Symptoms of Stress in Children**

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<th>Cognitive</th>
<th>Emotional</th>
<th>Social</th>
<th>Behavioral</th>
<th>Health</th>
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<td>• Negative Statements about self and others</td>
<td>• Crying or looking sad</td>
<td>• Social withdrawal from others</td>
<td>• Whining</td>
<td>• Frequent headaches, stomachaches, nausea</td>
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<td>• Daydreams or has difficulty concentrating</td>
<td>• Increase in depressive symptoms</td>
<td>• Decrease in age-appropriate social skills</td>
<td>• Hurting self or others</td>
<td>• Grinding teeth</td>
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<td>• Drop in grades</td>
<td>• Increase in anxiety</td>
<td>• Nervous behavior (e.g., biting nails, pulling hair)</td>
<td>• Clinging to adults</td>
<td>• Low grade fevers</td>
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<tr>
<td>• Decrease in problem-solving abilities</td>
<td>• Irritability</td>
<td>• Self-destructive behavior (e.g., eating disorders)</td>
<td>• Frequent tantrums</td>
<td>• Sick more than often</td>
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<td>• School absences</td>
<td>• Decreased self-esteem</td>
<td>• Abuse of alcohol or other substances</td>
<td>• Fatigue</td>
<td>• Change in eating habits</td>
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<td>• Treatment effects</td>
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<td>• Trouble sleeping</td>
<td>• Elevated lipids</td>
<td>• Elevated blood pressure</td>
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<td>• Nervous tic or stuttering</td>
<td>• Decreased immunity</td>
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<td>• Avoids homework</td>
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**Note:** Not all children will experience all of the above symptoms. These symptoms are noted as possible symptoms that may be seen in some children.

**PROVIDERS:** Also spend time talking about any positive/adaptive outcomes of stress (e.g., resiliency)
1. Children to complete pre-intervention measures (may want to have those that are able come approximately 30 minutes early or consider have a co-facilitator/psychometrician for Week #2 to help with pre-intervention measures)
   - Children’s Attitudes Toward Illness Scale (CATIS)
   - Children’s Depression Inventory (CDI)
   - Revised Children’s Manifest Anxiety Scale (RCMAS-2)

2. What is KAFSE?
   - 8-week program meeting every ______ for 1 hour
   - Each week: lesson, activity/game, take-home task
   - Caregivers will participate in some of the activities
   - Will learn about stress, how our body’s may feel when we feel stressed, and what we can do to feel better
   - Why were you chosen to participate in KAFSE? Because KAFSE is a program for kids with medical diagnoses – you will spend time with other kids like you talking about experiences and having fun!

3. Pass out Child Booklets
   - Explain to kids that the booklets contain everything that they will need for the program
   - Remind them of the importance of bringing their booklet with them each week

4. Discussion about worries
   - What is a worry?
   - What are some worries that we might have?

5. Introduction of group members
   - Pretzel Activity: Pass around a bag of pretzels with each child grabbing some – they then have to tell one
thing about themselves for each pretzel that they grabbed (must include one worry)
• Kids to write down other group member’s names in their booklets

6. Program Expectations
• Regular attendance, On time, Follow rules
• Kids to sign contracts

7. Develop program rules
• Discuss the importance of rules – why do they think rules may be important?
• Brainstorm together (facilitator and kids) to develop group rules – kids to write down in their booklets

8. Caregivers return
• Briefly review this week’s lesson/activity
• Pass out two jars to each participant
• Explanation of take-home task: Identify one jar as their personal Worry Jar and one as their Coping Jar – kids can decorate them any way they like
• Remind them to bring the jars and their booklets back next week!
Week #2
Learning about my Thoughts, Feelings, and Behaviors

1. Group check-in on worries
   - Any changed? Any new? Any go away?

2. Review of take-home task
   - Allow each kid to share their Worry and Coping jars
   - Pass around index cards – allow a few minutes for children to identify personal worries to place in their jars (**Note: Jars are to remain with the facilitator each week)

3. Introduction to CBT model (use Baseball Diamond handout)
   - Discuss the presence of body sensations, thoughts, feelings, and actions in all of us – provide and brainstorm examples
   - Introduce the idea of all these things being connected

4. Activity: Baseball Diamond game
   - Bases set up on the ground – identified as body sensations, thoughts, feelings, actions
   - Facilitator acts like announcer – provide common situations (e.g., being bullied, getting a good grade on a test, first day at a new school, etc.) and have one of the children move around the bases with the other kids brainstorming on what each base could be

5. Caregivers return
   - Briefly review this week’s lesson/activity
   - Point out feelings handout in child and caregiver booklets – encourage each family to put one on their refrigerator and to use these words in the family
• Explanation of take-home task: Event-feeling Tracking Sheet – each day child is to write down an event that happened to them as well as how they were feeling (use feeling sheet!)
• Remind them to bring their booklets back next week!
How my body feels
What I'm thinking
What I'm feeling
How I act
How my body feels
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1. Group check-in on worries
   - Any change? Any new? Any go away?
   - If applicable, encourage kids to make changes in their personal Worry Jar

2. Review of take-home task
   - Any questions? Thoughts about the task?
   - Highlight the presence of feelings with everything that we do/experience

3. Education regarding stress
   - What is stress? (Ask kids before providing answer)
   - How might you feel stress?
   - Do you feel stress?
   - How might our physical health impact stress? (e.g., medical treatments, medication regimen, many doctors appointments, missing school, bullying from peers) – have kids participate in discussion and identify if they have experienced any of these things as well as that they verbally understand the information

4. Positive versus negative life events and stress
   - Using worksheet in the booklet, introduce the idea of positive and negative events – both can lead to experiencing stress!
   - Have kids circle ones that they have experienced in last 3 months
   - Kids to brainstorm with a partner other events to write in their booklets – share with the group

5. Look at sheet in child booklet that shows different pictures of stress
• Discuss how it may feel/be experienced many different ways

6. Introduce stress thermometer to discuss variety of intensity

7. Briefly introduce coping
   • Some “good”, some “not so good” (e.g., hitting something, breaking something, yelling at someone) – will be discussed next week

8. Activity: “Throwing away negative experiences”
   • Set up trashcan in the middle of the room
   • Provide pieces of paper to kids – encourage them to write negative thoughts and feelings that they want to “throw away” on these sheets – crumple up the paper and throw into the trashcan

9. Caregivers return
   • Briefly review this week’s lesson/activity
   • Explanation of take-home task: Where do I feel stress? (Body coloring sheet) – kids to color in and identify parts of the body where they feel stress
   • Remind them to bring their booklets back next week!
What are some events that may lead to stress?

Having blood taken
Starting at a new school
Being bullied
Getting a bad grade
Moving into a new house
My parents fighting
Divorce of my parents
Going to the hospital
Having a lot of doctor’s appointments
Missing a lot of school days
Getting a new brother or sister
The first day of school

Now work with someone else in the group to come up with other things...
What might stress look like?…
**Week #4**

Let’s learn how to start becoming a warrior of our stress!

**Note: Caregivers participate in the entire session**

1. Group check-in on worries
   - Any changes? Any new? Any go away?
   - If applicable, encourage kids to update their Worry Jar

2. Review of take-home task
   - Ask kids to share some of their identified body sensations
   - Any questions?

3. Briefly review last week’s discussion on stress
   - Any lingering questions?

4. Discuss some cognitions and feelings that may be associated with stress (e.g., “I can’t do this”, “No one likes me”, “This will hurt”, “I won’t be able to stand it”, anger, fear)

5. Introduce coping
   - What is coping? Something that helps us feel better at times of stress.
   - Use worksheet to talk through the importance of various coping skills (e.g., diet, exercise, challenging thoughts)
   - Have kids brainstorm with peers and caregivers other possible coping skills to write on their worksheet – share with group (e.g., counting through pain, taking “control” of the pain by acknowledging)
5. **Activity:** Kimochi Dolls
   - Provide a medical situation (e.g., scary doctor’s appointment) – use dolls to illustrate thoughts and feelings experienced – have kids and caregivers brainstorm and identify coping skills

6. **Explanation of take-home task:** Family worksheet – have children interview one family member to complete the questions
   - Have children discuss identified worries with caregivers and listen to caregivers worries
   - Remind them to bring back their booklets next week!
What are some things that people do to feel better at times of stress?…

- Make sure to eat healthy foods
- Get a good night’s sleep each night
- Challenge my thoughts
- Look at the problem with different “glasses”
- Get some exercise everyday
- Try a different solution
Family Worksheet

Pick one member of your family to sit down and talk with – ask these questions:

4. *What do you worry about?*

(Then go through YOUR Worry Jar together with them, talking about the things that make you worry!)

5. *How do you know when you feel stressed?*

*How do you make yourself feel better?*
**Week #5**

*What else can I do to be a stress warrior?*

**Note: Caregivers participate for the entire session**

1. Group check-in on worries
   - Any changes? Any new? Any go away?
   - If applicable, encourage kids to update their Worry Jar

2. Review of take-home task
   - What did people find? – use as basis for discussion and review of coping skills

3. Discuss relaxation training
   - What is it?
   - Why is it important to be able to relax?

4. *Activity: Whole-body relaxation*
   - Children and caregivers get into comfortable position and lights are dimmed – facilitator to read the script
   - Process experience

5. *Activity: Bubble Breaths*
   - Discuss deep breathing as a coping skill
   - Walk kids and caregivers through diaphramatic breathing
   - Pass out bubbles to each kid/caregiver pair and have them practice
   - Process experience

6. Explanation of *take-home task: Practice whole-body relaxation at home 2x this week*
   - Remind them to bring their booklets back next week!
Relaxation Exercise

Hands and Arms

Pretend you have a whole lemon in your left hand. Now squeeze it hard. Try to squeeze all the juice out. Feel the tightness in your hand and arm as you squeeze. Now drop the lemon. Notice how your muscles feel when they are relaxed. Take another lemon and squeeze. Try to squeeze this one harder than you did the first one. That’s right. Real hard. Now drop the lemon and relax. See how much better your hand and arm feel when they are relaxed. Once again, take a lemon in your left hand and squeeze all the juice out. Don’t leave a single drop. Squeeze hard. Good. Now relax and let the lemon fall from your hand. (Repeat the process for the right hand and arm)

Arms and Shoulders

Pretend you are a furry, lazy cat. You want to stretch. Stretch your arms out in front of you. Raise them high over your head. Way back. Feel the pull in your shoulders. Stretch higher. Now just let your arms drop back to your side. Okay, kitten, let’s stretch again. Stretch your arms out in front of you. Raise them over your head. Pull them back, way back. Pull hard. Now let them drop quickly. Good. Notice how your shoulders feel more relaxed. This time let’s have a great big stretch. Try to touch the ceiling. Stretch your arms way in front of you. Raise them way up high over your head. Push them way, way back. Notice the tension and pull in your arms and shoulders. Hold tight, now. Great. Let them drop very quickly and feel how good it is to be relaxed. It feels good and warm and lazy.

Jaw

You have a giant jawbreaker bubble gum in your mouth. It’s very hard to chew. Bite down hard on it. Hard! Let your neck muscles help you. Now relax. Just let your jaw hang loose. Notice how good it feels just to let your jaw drop. Okay, let’s tackle that jawbreaker again now. Bite down. Hard! Try to squeeze it out between your teeth. That’s good. You’re really tearing that gum up. Now relax again. Just let your jaw drop off your face. It feels good just to let go and not have to fight that bubble gum. Okay, one more time. We’re really going to tear it up this time. Bite down. Hard as you can. Harder. Oh, you’re really working hard. Good. Now relax. Try to relax your whole body. You’ve beaten that bubble gum. Let yourself go as loose as you can.
Face and Nose

Here comes a pesky old fly. He has landed on your nose. Try to get him off without using your hands. That's right, wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch up your nose real hard. Good. You've chased him away. Now you can relax your nose. Oops, here he comes back again. Right back in the middle of your nose. Wrinkle up your nose again. Shoo him off. Wrinkle it up hard. Hold it just as tight as you can. Okay, he flew away. You can relax your face. Notice that when you scrunch up your nose your cheeks and your mouth and your forehead and your eyes all help you, and they get tight too. So when you relax your nose, your whole body relaxes too, and that feels good. Uh-oh. This time that old fly has come back, but he is on your forehead. Make lots of wrinkles. Try to catch him between all those wrinkles. Hold it tight now. Okay, you can let go. He's gone for good. Now you can just relax. Let your face go smooth, no wrinkles anywhere. Your face feels nice and smooth and relaxed.

Stomach

Hey! Here comes a cute baby elephant. But he's not watching where he is going. He doesn't see you lying in the grass, and he's about to step on your stomach. Don't move. You don't have time to get out of the way. Just get ready for him. Make your stomach very hard. Tighten up your stomach muscles real tight. Hold it. It looks like he is going the other way. You can relax now. Let your stomach go soft. Let it be as relaxed as you can. That feels so much better. Oops, he's coming this way again. Get ready. Tighten up your stomach. Real hard. If he steps on you when your stomach is hard, it won't hurt. Make your stomach into a rock. Okay, he's moving away again. You can relax now. Kind of settle down, get comfortable, and relax. Notice the difference between a tight stomach and a relaxed one. That's how we want to feel - nice and loose and relaxed. You won't believe this, but this time he's coming you way and there is no turning around! He is headed straight for you. Tighten up. Tighten hard. Here he comes. This is really it! You've got to hold on tight. He's stepping on you. He's stepped over you. Now he's gone for good. You can relax completely. You're safe. Everything is okay, and you can feel nice and relaxed.

This time imagine that you want to squeeze through a narrow fence and the boards have splinters on them. You'll have to make yourself very skinny if you're going to make it through. Suck your stomach in.
Try to squeeze it up against your backbone. Try to be as skinny as you can. Ok, now just relax and feel your stomach being warm and loose. Okay, let’s try to get through that fence now. Squeeze up your stomach. Make it touch your backbone. Get it real small and tight. Hold tight, now. You’ve got to squeeze through. Alright, you got through that narrow little fence with no splinters! You can relax now. Settle back and let your stomach come back out where it belongs. You can feel good now. You’ve done fine.

**Legs and Feet**

Now pretend that you are standing barefoot in a big, fat mud puddle. Squish your toes down deep into the mud. Try to get your feet down to the bottom of the mud puddle. You’ll probably need your legs to help you push. Push down, spread your toes apart, feel the mud squish up between your toes. Now step out of the mud puddle. Relax your feet. Let your toes go loose and feel how nice that feels to be relaxed. Okay, back into the mud puddle. Squish your toes down. Let your leg muscles help push your feet down. Push your feet! Hard! Try to squeeze that puddle dry. Okay. Come back out now. Relax your feet, relax your legs, and relax your toes. It feels so good to be relaxed. No tenseness anywhere. You feel kind of warm and tingly.

**Conclusion**

Stay as relaxed as you can. Let your whole body go limp and feel all your muscles relaxed. As you go through the day, remember how good it feels to be relaxed. Sometimes you have to make yourself tighter before you can be relaxed, just as we did in these exercises. Practice these exercises at home to get more and more relaxed. A good time to practice is at night, after you have gone to bed and the lights are out and you won’t be disturbed. Then, when you are a really good relaxer, you can relax anywhere! Just remember the elephant, or the jaw breaker, or the mud puddle, and you can do your exercises and no one will know. Today is a good day, and you are ready to feel relaxed. You’ve worked hard and it feels good to work hard. Good job – you’re a super relaxer!

Week #6
How do I keep doing what I’ve learned?

1. Group check-in on worries
   - Anything changed? Any new? Any no longer worries?
   - If applicable, encourage kids to update their Worry Jar

2. Review of take-home task
   - How was it?
   - How did you feel afterwards? During?
   - What did you like or not like?
   - Questions?

3. Discussion to identify all coping skills reviewed over the last weeks
   - Which ones do people like best? Not like?
   - When do we feel that certain skills can be used?
   - Facilitator to discuss the importance of picking the right skills for YOU – no skill will work perfectly for everyone!

4. Activity: “This is my life…”
   - Each kid gets an index card to write one real-life situation on – do not put their names on it
   - After all cards are collected, the facilitator randomly picks them to read out loud – kids can identify coping skills that could be used and why they may work

5. Caregivers return
   - Briefly review this week’s lesson/activity
   - Explanation of the take-home task: Complete personal coping cards – Using the blank cards in their booklets, kids are to write coping skills that they feel might work for them
   - Remind them to bring their booklets back next week!
What coping skills work for YOU???

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**Note:** Caregivers participate in the entire session

1. Group check-in on worries
   • Any changes? Any new? Any go away?
   • If applicable, encourage kids to update their Worry Jar

2. Discuss Worry Jars
   • Some worries stay the same, some worries go away, some change
   • Metaphor: Worries are like clouds in the sky..some are big, dark, and stormy...some are small, light, and fluffy...but they are not ALWAYS bad...

3. Review of take-home task
   • Put cards in personal Coping Jar

4. Discuss Coping Jars
   • Connect to Worry Jar – highlight importance of having personal coping skills to “attack” worries/stressors

5. Discuss the use of positive-self talk as a coping skill

6. Activity: “What I like about you”
   • Pass out one index card for each participant to each child
   • Encouraged to write “what I like about ____” on each card (one for each group member)
   • Distribute cards into individual Coping Jars

6. Program debriefing
   • Review material learned
   • Any lingering questions?
   • Thank kids and caregivers for involvement
   • Encourage them to continue using their learned skills
7. Distribute individual certificates

8. Schedule follow-up meetings with caregivers to obtain post-intervention outcome measures (child and caregiver must attend)
APPENDIX I

KAFSE: Kids Able to Fight Stress Everyday

Program Booklet for Caregivers
First, I would like to welcome you as a very important part of the KAFSE team! Over the next 8 weeks, I will be working hard to provide your child and family with both information and new skills to combat stress. This booklet has been designed to provide you, as caregivers, an overview to each week’s activities so that you may work with your child throughout the program.

Please look through the booklet each week, prior to the KAFSE session, and begin talking to your child about upcoming concepts. You will also find information on each week’s “take-home tasks.” It is my hope that you will work with your child each week to complete these tasks together.

Thank you for allowing me to work with your child! I look forward to the next 8 weeks. Please contact me with any questions or concerns. Now let’s begin to have fun!!
<table>
<thead>
<tr>
<th>KAFSE Program Schedule</th>
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<tbody>
<tr>
<td><strong>Orientation:</strong></td>
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<td><strong>Week #2:</strong></td>
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<td><strong>Week #3:</strong></td>
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<td><strong>Week #8:</strong></td>
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Orientation
Caregiver Information Session

Agenda:
- Complete pre-session surveys
- Discuss KAFSE program and caregiver expectations
- Review of stress in children

What can I do to help my child prepare for next week?
- Talk to them about KAFSE program, answering any questions they may have about today’s session
- Introduce the concept of stress
# Common Stress Symptoms in Children

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Emotional</th>
<th>Social</th>
<th>Behavioral</th>
<th>Health</th>
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<tr>
<td>• Negative Statements about self and others</td>
<td>• Crying or looking sad</td>
<td>• Social withdrawal from others</td>
<td>• Whining</td>
<td>• Frequent headaches, stomachaches, nausea</td>
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<td>• Daydreams or has difficulty concentrating</td>
<td>• Increase in depressive symptoms</td>
<td>• Decrease in age-appropriate social skills</td>
<td>• Hurting self or others</td>
<td>• Grinding teeth</td>
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<tr>
<td>• Drop in grades</td>
<td>• Increase in anxiety</td>
<td>• Nervous behavior (e.g., biting nails, pulling hair)</td>
<td>• Clinging to adults</td>
<td>• Low grade fevers</td>
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<td>• Decrease in problem-solving abilities</td>
<td>• Irritability</td>
<td>• Self-destructive behavior (e.g., eating disorders)</td>
<td>• Frequent tantrums</td>
<td>• Sick more than often</td>
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<td>• School absences</td>
<td>• Decreased self-esteem</td>
<td>• Abuse of alcohol or other substances</td>
<td>• Nervous tic or stuttering</td>
<td>• Fatigue</td>
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<td>• Treatment effects</td>
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<td>• Trouble sleeping</td>
<td>• Avoids homework</td>
<td>• Change in eating habits</td>
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**Note:** Not all children will experience all of the above symptoms. These symptoms are noted as possible symptoms that may be seen in some children.
Week #1
Introduction to KAFSE

Agenda:
• Identify and talk about worries
• Introduce KAFSE program and answer any questions
• Introduction of group members
• Create program/group rules

Take-Home Task: Decorate Worry Jar and Coping Jar
• Kids are able to personalize each jar to bring back to next week’s session. These jars will be used throughout the program to highlight and personalize various concepts.

What can I do to help my child prepare for next week?
• Check-in to determine reactions to first KAFSE session
• Help them complete the decorating of their two jars – remember to bring them back to group next week!
Week #2
Learning about my Thoughts, Feelings, and Behaviors

Agenda:

• Each child will share their jar and one worry that is inside it
• Provide an overview of the CBT model using baseball handout in Child Booklet. Information on the connection between body sensations, thoughts, feelings, and actions will be provided and discussed. Kids will then play an activity where situations are “thrown out” and they move between bases to identify the connections.

Take-Home Task: Event-Feeling Tracking Sheet

• For each day of the week, your child is to identify an event that occurred as well as the feeling they were experiencing. A feelings sheet is also included in their book – encourage your child to look at the sheet and choose!

What can I do to help my child prepare for next week?

• Review baseball diamond activity and concepts. Throughout the week, help the child identify body sensations, thoughts, and feelings that they may experience during certain times.
• Post the feelings sheet on your refrigerator and use it to stimulate conversation about different feelings and when family members are/might be feeling them.
<table>
<thead>
<tr>
<th>Emotions</th>
<th>Curious</th>
<th>Lovestruck</th>
<th>Mischievous</th>
<th>Miserable</th>
<th>Pained</th>
<th>Proud</th>
<th>Puzzled</th>
<th>Relieved</th>
<th>Sad</th>
<th>Satisfied</th>
<th>Sorry</th>
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What might stress look like?...
Week #3
Now let’s learn about stress!

Agenda:
- Review Event-Feeling tracking sheet (take-home task from last week)
- Provide information on stress. What is it? Do I feel it? How might stress be impacted by physical health?
- Introduce positive and negative events that may result in stress (Worksheet in Child Booklet)
- Use stress thermometer to introduce variety of stress reactions (Worksheets in Child Booklet)
- Activity: “throwing away” negative experiences
- Brief introduction to coping with stress

Take-Home Task: Body Coloring Sheet
- Children are asked to identify where in their body they feel stress. Using whatever colors, medium, etc. they are to color these parts of their body on the worksheet in the Child Booklet.

What can I do to help prepare my child for next week?
- Discuss with your child the information they learned about stress. This is likely the first time they have heard about this concept – therefore, it would be helpful to hear about your understanding and experiences! Review, clarify, and share!
- Use the stress thermometer throughout the week to help your child identify the intensity of his/her feelings.
- Begin to brainstorm with your child on the things that can be done to “combat” stress
Week #4

Let’s learn how to start becoming a warrior of our stress!

Agenda:
- Share body drawings (take-home task from last week)
- Review and answer any questions about last week’s discussion on stress
- Discussion about possible cognitions and feelings about stress.
- Using the worksheet in the Child Booklet, talk about possible coping skills. Have children and caregivers brainstorm about other coping skills using the worksheet.
- Activity: Kimochi dolls to demonstrate the above – have children and caregivers brainstorm on coping skills for each role play

Take-Home Task: Family Worksheet
- Encourage your child to interview a family member (maybe you!) using the worksheet in their booklet. Use this as a basis for discussion.
- Have your child share their identified worries from their Worry Jar. Discuss what some of your worries are too – same? Different?

What can I do to help my child prepare for next week?
- Review this week’s session. How do you both feel that it went? What was your favorite part? What do you feel applies to your family?
- Continue dialogue about worries and possible coping skills that could be used.
Week #5
What else can I do to be a stress warrior?

Agenda:
- Sharing of Family Worksheet (take-home task from last week)
- Education on relaxation training
- Activities with discussion afterwards:
  - Whole-body relaxation script
  - Bubble breaths

Take-Home Task: Practice the whole-body relaxation script two times this week
- After you have completed the activity, discuss with your child what it felt like!

What can I do to help my child prepare for next week?
- Continue to encourage your child to identify feelings and experiences related to stress – talk about them!
- Remember the importance of role modeling for your child the use of positive coping skills.
- Discuss with your child the various coping skills that have been taught in KAFSE – which ones are their favorite? Which ones do they find difficult?
Relaxation Exercise

Hands and Arms

Pretend you have a whole lemon in your left hand. Now squeeze it hard. Try to squeeze all the juice out. Feel the tightness in your hand and arm as you squeeze. Now drop the lemon. Notice how your muscles feel when they are relaxed. Take another lemon and squeeze. Try to squeeze this one harder than you did the first one. That’s right. Real hard. Now drop the lemon and relax. See how much better your hand and arm feel when they are relaxed. Once again, take a lemon in your left hand and squeeze all the juice out. Don’t leave a single drop. Squeeze hard. Good. Now relax and let the lemon fall from your hand. (Repeat the process for the right hand and arm)

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Try to squeeze it up against your backbone. Try to be as skinny as you can. Ok, now just relax and feel your stomach being warm and loose. Okay, let’s try to get through that fence now. Squeeze up your stomach. Make it touch your backbone. Get it real small and tight. Hold tight, now. You’ve got to squeeze through. Alright, you got through that narrow little fence with no splinters! You can relax now. Settle back and let your stomach come back out where it belongs. You can feel good now. You’ve done fine.

**Legs and Feet**

Now pretend that you are standing barefoot in a big, fat mud puddle. Squish your toes down deep into the mud. Try to get your feet down to the bottom of the mud puddle. You’ll probably need your legs to help you push. Push down, spread your toes apart, feel the mud squish up between your toes. Now step out of the mud puddle. Relax your feet. Let your toes go loose and feel how nice that feels to be relaxed. Okay, back into the mud puddle. Squish your toes down. Let your leg muscles help push your feet down. Push your feet! Hard! Try to squeeze that puddle dry. Okay. Come back out now. Relax your feet, relax your legs, and relax your toes. It feels so good to be relaxed. No tenseness anywhere. You feel kind of warm and tingly.

**Conclusion**

Stay as relaxed as you can. Let your whole body go limp and feel all your muscles relaxed. As you go through the day, remember how good it feels to be relaxed. Sometimes you have to make yourself tighter before you can be relaxed, just as we did in these exercises. Practice these exercises at home to get more and more relaxed. A good time to practice is at night, after you have gone to bed and the lights are out and you won’t be disturbed. Then, when you are a really good relaxer, you can relax anywhere! Just remember the elephant, or the jaw breaker, or the mud puddle, and you can do your exercises and no one will know. Today is a good day, and you are ready to feel relaxed. You’ve worked hard and it feels good to work hard. Good job – you’re a super relaxer!

Week #6
How do I keep doing what I’ve learned?

Agenda:
- Discuss the practicing of whole-body relaxation (take-home task from last week) – How was it? How did you feel during and after?
- Review coping skills that have been learned in KAFSE – thoughts about each?
- Discussion about the importance of identifying which skills work for YOU.
- “This is my life” activity to highlight the importance of finding skills that work for us individually (i.e., not everyone uses the same coping skills).

Take-Home Task: Complete personal coping cards
- Using the blank cards in the Child Booklet, help your child to pick the coping skills that they feel would work for them and write one on each card. As they pick their skills, talk to them about when this skill may be used, if they have used it before, etc.
- Remember to bring these cards back to next week’s session!

What can I do to help prepare my child for next week?
- Remind them that next week is the last KAFSE session. Is there anything they want to talk about next week? Any lingering questions?
Week #7
Graduation Celebration!

**Agenda:**
- Review of coping cards that were completed at home – put cards in their personal Coping Jar
- Discussion the connection between the Coping Jar and Worry Jar
- Discuss the use of positive self-talk as a coping skill
- Activity: “What I like about you” – distribute into each child’s Coping Jar
- Debriefing with caregivers and participants
- Distribute individual awards and certificates
- Schedule follow-up meetings

*Congratulations, caregivers! You have supported your child through the completion of the KAFSE program! I encourage you to not stop here – please continue using the worksheets to inspire conversation in your homes regarding emotions, stress, and coping. You now have great information and must remember that YOU play an important role in how much of the KAFSE skills get used after the program is over! Best wishes!! ☺*
References


American Academy of Child and Adolescent Psychiatry, 36(11), 1625-1631.


Lite, L. (March 2005). Helping children conquer stress: Your daughter “knows about terrorist attacks and school shootings. She talks about it more than you are comfortable with…Is she becoming the nervous type or is this simply a symptom of stress?” USA Today (Society for the Advancement of Education).


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