Using role reversal in the treatment of learners with performance anxiety in the school environment

C Crous

Using role reversal in the treatment of learners with performance anxiety in the school environment

by

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submitted in accordance with the requirements for

the degree of

Masters of Education with specialisation in Guidance and Counselling

at the

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Study leader: Professor H.E. Roets

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DECLARATION

ETHICAL CLEARANCE CERTIFICATE

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DECLARATION

Student number: **44931549**

I declare that “Using role reversal in the treatment of learners with performance anxiety in the school environment” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

_____ _____

SIGNATURE DATE

(Mrs Charleen Crous)

UNISA college of education

Research Ethics Clearance Certificate

This is to certify that the application for ethical clearance submitted by

Mrs C Crous (44931549)
for a M Ed study entitled

Using role reversal in the treatment of learners with performance anxiety in the school environment

has met the ethical requirements as specified by the University of South Africa College of Education Research Ethics Committee. This certificate is valid for two years from the date of issue.

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2 October 2012

Reference number: 2012 SEPT/ 44931549/CSLR

SUMMARY

In this study the technique of role reversal for the treatment of performance anxiety, experienced by learners in the school environment, was investigated. Performance anxiety sometimes presents as part of a larger pattern of social phobia and negatively impacts on an individual's tasks performance due to the fear of negative evaluation.

My qualitative study involved a collective, instrumental case study. Role reversal was implemented as part of a group-therapeutic intervention which continued for approximately three months, and involved participants acting as peer tutors. Data analysis focused on the participant's personal experiences of the technique as well as therapeutic gains and the usefulness of the technique from a school-based counsellor's perspective.

The research findings revealed that although the helping role held certain challenges for the participants, it seemed to generally impact positively on their social and academic confidence and functioning. Additionally their levels of performance anxiety appeared to decrease.

KEY WORDS AND PHRASES:

role reversal; performance anxiety; social phobia; learner; school environment; peer tutoring; qualitative research; school-based group counselling; causes of performance anxiety; effects of performance anxiety

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CHAPTER 1
ORIENTATION TO THE RESEARCH

1.1 AWARENESS OF THE PROBLEM

Working in a remedial setting where many children suffer from debilitating levels of performance anxiety, it has come to my attention that teachers often do not know what else to do to help these learners, other than to refer them for psychotherapy or anxiety medication. Although the need to take such steps are often indicated, I realized that there is still a gap as to what more these teachers can do on a daily basis within the school environment to support learners in overcoming their performance-related fears.

Pondering about this took me back to when I was a high school student who suffered from performance anxiety and how I eventually overcame it, thanks to a teacher who unknowingly helped me to do so. My first fear was for public speaking, my second for Mathematics. Both of these fears had developed in response to little experiences of failure and shame throughout my school career, and had grown in intensity as a result of the only coping strategy that I knew: avoidance. With public speaking tasks, this was easy – I would simply choose the zero mark over doing the speech. In the case of Mathematics, however, avoidance was just not practically possible, and tests, examinations and oral reports on homework were tolerated with great effort and anxiety. Like many school-aged sufferers of performance anxiety, I kept my 'problem' to myself for fear of standing out as a failure even more.

Luckily, and 'quite by chance', life provided me with certain opportunities that enabled me to overcome my fears, by changing the ways in which I thought about myself and my capabilities. The first opportunity to do so came in my Grade 12 year. By this time, my anxiety towards Mathematics had increased to such an extent that my mind went 'blank' when I wrote tests. This caused me to nearly fail on what used to be known as 'higher grade Mathematics' and I subsequently had to move to the 'standard grade' Math class.

My new Math teacher (the one to whom I owe my overcoming the anxiety) assumed that, as a former higher grade learner, I would know more than the other learners in his class. He further assumed that I would be able to assist individual classmates in grasping certain Mathematical concepts or procedures. His positive perception of me, as well as my peers' subsequent confidence in me to help them, started to change the way in which I viewed myself and my abilities. Before long, I enjoyed showing my peers 'how it's done' and my self-perceived role seemed to reverse from being 'the one who cannot' to 'the one who can'. Through this growth in my self-confidence, I eventually conquered my fear for Mathematics and achieved an A-symbol for the record exam that year (standard grade, but still a significant improvement!). A similar experience occurred during my first year at University when I conquered my fear of public speaking. Circumstances led me to become the one whom my peers depended on for giving oral feedback on group assignments in class, which gradually reversed my role from 'scared and incapable' to 'confident and capable'. My growing confidence and willingness to speak up in groups later enabled me to give presentations in class and speeches at social gatherings.

These experiences lead me to my research question, as I now wonder whether what had helped me grow in confidence, might be able to help other sufferers of performance anxiety as well. Could the reversal of their self-perceived roles from 'the one who cannot' to 'the one who can' also aid them in overcoming their fears? Furthermore, how would they personally experience the helping role? I hope to answer these questions by conducting a scientific research project.

1.2 ANALYSIS OF THE PROBLEM

1.2.1 Investigation of the problem

Performance anxiety is scientifically known as a form of specific social phobia – a sub-category of social phobia (Wehrenberg & Prinz, 2007:190). Social Phobia is the most common anxiety disorder with an estimated lifetime prevalence of 13% (Fresco, Erwin, Heimber, Turk & Kessler, in Hoffart, Abrahamsen, Bonsaksen, Borge, Ramstad & Markowitz, 2007:7). It is additionally reported by Barlow and Durand (2002:139) that social phobia is the most prevalent psychological disorder and that, alarmingly, the number of young people suffering from this disorder appears to be increasing (Magee *et al.* in Barlow & Durand, 2002:139). Such reports call for further investigation of not only the problem also of effective intervention strategies. Hoffart *et al*. (2007:7) agree that effective treatment methods are strongly needed, as social phobia is a "*prevalent, severe, impairing, and chronic disorder*". However, due to various reasons, such as children's inability to express their emotions adequately or teachers' unfamiliarity with the disorder, it is often not recognized (and therefore not attended to) within the school setting (Wicks-Nelson & Israel, 2003:128; Wehrenberg & Prinz, 2007:230; Gosch & Flannery-Schroeder, 2006:65).

Muris, Mayer, den Adel, Roos and van Wamelen (2008) note anxiety disorders' considerable co-morbidity with other psychiatric problems, in particular depression. According to Costello *et al.* (in Muris *et al.*:2008) depression is eight times more likely in youths with anxiety disorders than in youths without anxiety disorders. Thus, learners with social phobia have the risk of developing further psychological difficulties.

Various researchers advocate the value of school-based programs for the treatment of social phobia, as the school environment has many available resources (e.g. teachers, peers, real-life exposure) which can aid in such programs (Klein, 2010; Menutti, Freeman & Christner, 2006:65; Gosch & Flannery-Schroeder, 2006:77). However, most school-based treatment approaches that were reported on in the literature are employable only by school-based psychologists or counsellors, with little mention of how teachers can become involved. Teachers have the unique opportunity of spending up to six hours per day with their learners, observing their behaviour in real-life situations. It is for this reason that I would like to find a way in which teachers can become more involved in the treatment of learners with social phobia, manifested as performance anxiety, in the school environment.

In investigating the problem, I will focus on three main issues: The nature of performance anxiety, its causes (aetiology) and possible treatment methods.

1.2.2 The nature of performance anxiety

Anxiety in general is defined as "*a negative mood state, characterized by bodily symptoms of physical tension and apprehension about the future*" (American Psychiatric Association in Barlow & Durand, 2002:113). The term 'performance anxiety' is, in some contexts, also referred to as 'stage fright'. It is generally known as the anxiety, fear or persistent phobia which may be aroused in an individual in response to an activity that involves self-presentation, such as public speaking for example (Wikipedia, 2013). While many people experience such 'stage fright' without any wider problems, it may in some cases exist as part of a larger pattern of social phobia. Social phobia is one of many different types of anxiety disorders.

Anxiety disorder consists of nine main sub-categories with which children may be diagnosed according to the fourth, text revised version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), namely Separation Anxiety Disorder (SAD); Panic Disorder (PD); Agoraphobia; Generalised Anxiety Disorder (GAD); Social Phobia / Social Anxiety Disorder, Specific Phobia; Obsessive Compulsive Disorder (OCD); Post-traumatic Stress Disorder (PTSD) and Acute Stress Disorder (Southam-Gerow & Chorpita, 2007:348).

Social phobia is identified by a marked and persistent fear of social or performance situations due to the fear of embarrassment or humiliation (American Psychiatric Association in Schneier, 1999:274). This disorder has two basic subtypes as described in the Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association, in Wehrenberg & Prinz, 2007:190), namely 'generalized social phobia' and 'specific social phobia'.

Individuals who are extremely shy in almost all situations meet the criteria for the subtype generalized social phobia (also known as social anxiety disorder) (Barlow & Durand, 2002:139). In the case of specific social phobia however, the experience of anxiety is limited to situations in which the performance of a specific task is going to be observed or evaluated – also known as "*performance anxiety*" (Wehrenberg & Prinz, 2007:190). These individuals usually have no difficulty with social interaction but they become anxious the moment they need to do something in front of people (Barlow & Durand, 2002:138). The anxiety causes them to battle with the execution of a task which they would normally be able to do when not being watched by others. An example of this would be a learner who can read well and even enjoys reading when he is by himself but battles to accurately perform this skill when expected to read out loud in front of his teacher or peers in the classroom. Other examples of performance anxiety within the school environment are a fear of public speaking or writing tests, in which both cases one's performance would be observed or evaluated by others.

Wehrenberg and Prinz (2007:191-194) outline three clusters of symptoms that are related to both generalized- and specific social phobia (performance anxiety):

a) Physiological indicators (intense physiological arousal that is unpleasant and/or visible to others, such as rapid heart rate, sweating, flushing, gastrointestinal disturbance like nausea or diarrhoea, and tremors of muscles and voice).

b) Cognitive indicators (cognitive fear of being observed when looking frightened or embarrassed, such as being certain that others are observing and rejecting them, expecting to be humiliated or expecting to be embarrassed because others will see their shaking hands, wobbly knees, quivering voice or red face).
c) Behavioural indicators (avoidance of anything that triggers the arousal).

1.2.3 Aetiology

The aetiology of social phobia is multi-factorial and may develop in various ways. According to Barlow and Durand (2002:140) there are three possible pathways to developing social phobia:

a) An inherited generalized biological vulnerability to develop anxiety and/or a biological tendency to be very socially inhibited.
b) This vulnerability would be increased by a generalized psychological vulnerability, reflected in a sense that events (particularly stressful events), are potentially uncontrollable.
c) A real social trauma, where anxiety would then be conditioned in the same or similar social situations.

1.2.4 Other relevant factors

Relevant to this research project in terms of the causes (and effects) of performance anxiety, are the following key concepts:

1.2.4.1 External negative feedback

According to Wehrenberg and Prinz (2007:198) shame can be like trauma when experiencing one small social humiliation after the other in performance or social tasks. Humiliations like these can be 'small things' like an insensitive remark from a teacher in front of one's peers after forgetting the words to a speech, or being laughed at by others for tripping in the hallway. According to the reflected appraisal theory, self-perceptions are formed from internalizing others' feedback in the form of attitudes and communications (Gergen in Narcie & Norwhich, 2004). One can thus, according to this theory, expect that a child will internalize feelings of incompetence or insignificance if such negative messages are conveyed to him or her by significant others, such as parents, teachers and peers.

1.2.4.2 Internal negative feedback

The feedback one gets during the performance of a task does not always come from others, but many times from one's own thoughts or intra-psychic dialogue. The intra-psychic dialogue is "*the way in which people think about themselves"* (Venter, 2008:19). Evidence shows that anxious youth engage in negative thinking when confronted with a (potentially) dangerous stimulus or situation (Muris, 2007:153). Examples of such negative beliefs, which are often irrational (false), would be thoughts like "*People will always notice my embarrassment and respond negatively"* or "*The worst possible outcome will always occur*".

1.2.4.3 Cognitive functioning

Anxiety tends to negatively impact on cognitive capacities relating specifically to concentration and the working memory, which increases an individual's likelihood of making 'careless' errors when carrying out complex mental operations.

Working memory is "*the ability to actively maintain information in conscious awareness, perform some operation or manipulation with it, and produce a result*" (Wechsler, 2003:8). Sarason (in Whitaker *et al.*, 2007) explains that worry is believed to absorb some of the processing capacity of working memory. Zeidner (in Whitaker *et al*, 2007) add to this the fact that, as worry increases, more effort and spare processing capacity are devoted to the solution of the anxiety problem at the expense of solving the real problem (such as the question or problem in a test). According to Greene (2002:20) stress can cause attention problems which take one's focus away from immediate performance, to other times or places. Pargman (2006:112) defines attention, in this particular context, as concentration upon stimuli that are relevant to the particular problem, issue, task, or challenge at hand. Concentration problems have, for example, been found to occur in students who suffer from test-anxiety (Swanson & Howell in Whitaker *et al.*, 2007).

1.2.4.4 Behavioural functioning

Children may execute behaviours such as crying, freezing, shrinking from the feared situation or performing a tantrum in response to their experience of anxiety (Grohol, 2011). The negative thinking which anxious youth engage in when confronted with a potentially dangerous situation promotes avoidant coping strategies (Prins in Muris, 2007:153) and in the long run maintains fear and anxiety (Muris, 2007:153). Such avoidant behaviour may extend beyond specific tasks such as public speaking, and lead to the avoidance of social situations in general, to the degree that it limits or disrupts the individual's life (Smith & Jaffe-Gill, 2012). Such severe social avoidance can lead to substantial impairments in social and/or vocational functioning (Hofman, Meuret, Smits, Simon, Pollack, Eisenmenger, Shiekh & Otto, 2006).

1.2.5 Treatment

According to the literature, mainly three types of approaches can be followed for the treatment of social phobia (and thus also specifically performance anxiety), namely individual therapy, group therapy and medication.

1.2.5.1 Individual therapy

Individual therapy for children with anxiety disorders often takes on a cognitive-behavioural form and is aimed at addressing the cognitive, physiological and behavioural symptoms of the disorder (Wehrenberg & Prinz, 2007:203). Very similar CBT (cognitive-behavioural therapy) is rational-emotive therapy (REBT), where the individual's belief-system is explored, evaluated and adapted. Another form of psychotherapy which may be employed

for the treatment of anxiety disorders is narrative therapy. This approach allows for the use of therapeutic metaphors which have the purpose of externalizing the problem and giving form to the abstract concept of anxiety (Goodyear-Brown, 2011:132).

Different therapeutic modalities may be integrated in the treatment of anxiety disorders. Paris Goodyear-Brown developed the Worry Wars Protocol for example, which utilizes a variety of therapeutic intervention models namely psycho-education, cognitive restructuring, systematic desensitization, gradual exposure, therapeutic storytelling and play therapy (Goodyear-Brown, 2011:129-133).

1.2.5.3 Group therapy

The same principles of individual cognitive-behavioural- or rational emotive therapy for social phobia can also be employed within small groups. With the incorporation of role play, members rehearse their socially phobic situations in front of each other, whilst the therapist conducts cognitive therapy aimed at uncovering and changing their automatic or unconscious perceptions of danger. Group therapy holds the advantage of exposure to others, which can support the development of children's social skills (Diguseppe in Vernon, 2007:121). This indicates that group therapy can be of value to children who suffer from a social type of anxiety disorder such as performance anxiety.

1.2.5.3 Medication

Medication addressing the physiology of social phobia can be administered in order to support the effectiveness of psychotherapy (Wehrenberg & Prinz, 2007:235). However, relapse is common after treatment stops, and for that reason it is not recommended that social phobia be treated with medication alone. It is rather suggested that medication be used in combination with therapeutic intervention (Wehrenberg & Prinz, 2007:235).

1.2.5.4 School-based interventions for social phobia

According to Smallwood, Christner & Brill (2007:89), when considering the vast numbers of children and adolescents who attend school on a daily basis, *"it is clear that schools are an ideal access point for provision of a broad range of services for the school-age population".* Within the school environment, school psychologists or counsellors have many resources available to them for planning and providing therapy to learners suffering from social phobia in the form of performance anxiety. Examples of such resources include access to teachers as well as to true-to-life performance activities which can aid skill-transfer from the therapy room to the natural environment. All of this makes the school environment an optimal setting for intervention. Research suggests that school-based interventions for anxiety disorders are feasible and show promise of good treatment effects (Menutti, *et al.* 2006:65).

Various techniques have proved to be successfully employable within the school setting, most of them being cognitive-behavioural in nature. Examples of such techniques include cognitive behavioural group therapy with the incorporation of 'Kendall's Coping Cat anxiety program' (Gosch & Flannery-Schroeder, 2006:68-69) or the 'FRIENDS for Life program', which is an evidence-based, cognitive-behavioural anxiety program for children and youth

(Barrett in Barret & Pahl, 2006:55-75). The 'Coping Koala program' (Barret, in Smallwood *et al.,* 2007:99) is another cognitive-behavioural program that have been employed in group format for the treatment of childhood anxiety disorders. However, these techniques, although proved to be effective, are to be employed by psychologists or school counsellors only, leaving little left to do for the teachers. In fact, very few school-based treatment programs for employment by teachers could be identified in the literature.

One example of a school-based anxiety treatment program which involves teachers is the R.E.L.A.X program, developed by psychologist Roger J. Klein (Klein, 2010). His program mainly focuses on teaching children various relaxation techniques as well as problem solving skills. Another way in which teachers can become more involved in the treatment or even prevention of performance anxiety or social phobia in the school setting is explained by Gosch and Flannery-Schroeder (2006:77), who advocate the value of teaching children coping skills for emotional health. Lastly, and especially relevant to the proposed technique of role reversal, is a concept known as cross-age peer tutoring which involves older students helping younger students learn new skills or concepts. A pilot study using cross-age peer tutoring as a method of intervention for anxious adolescents revealed a decrease in the anxiety experienced by the adolescents who acted as peer tutors (Campbell, 2008).

1.2.6 Breaking the negative cycle

After considering the experiential and behavioural factors associated with anxiety, I came to the conclusion that a negative cycle appears to exist. In this cycle, anxiety is not only caused by certain factors, but also seems to reinforce the occurrence of such factors.

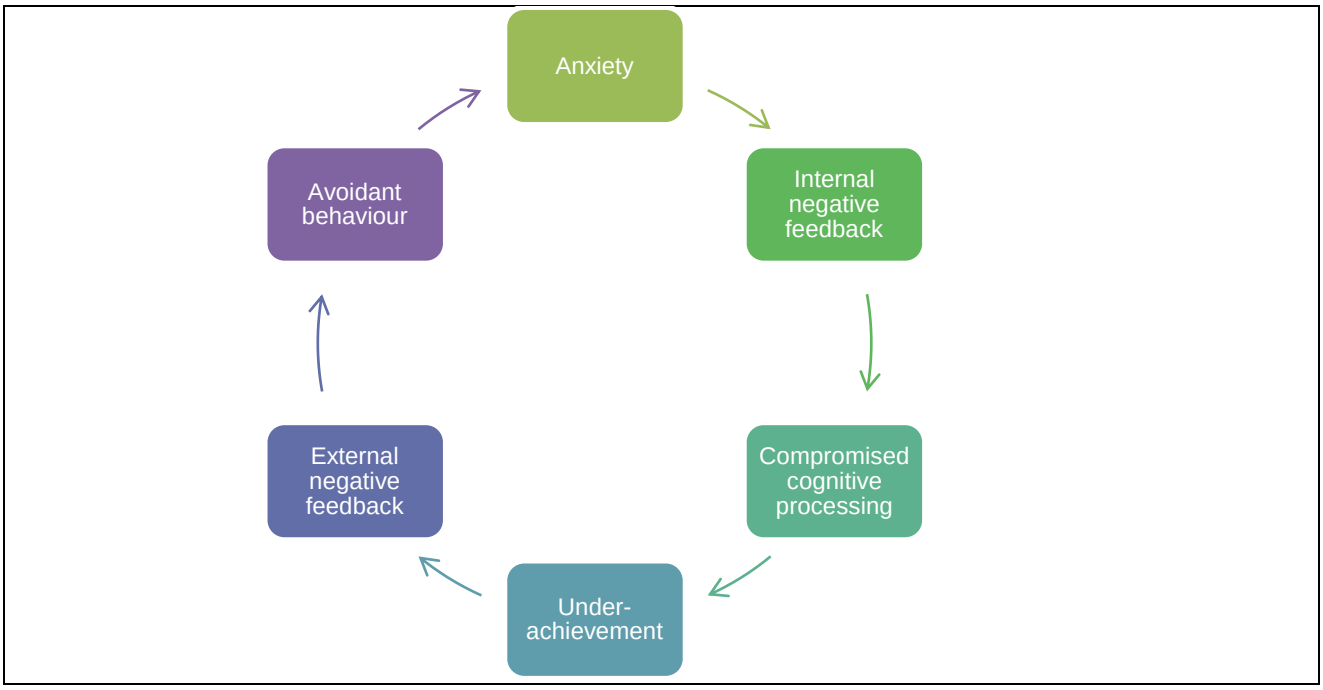


Figure 1.1 The negative cycle of performance anxiety

The continuous reinforcement of performance anxiety as depicted in Figure 1.1 calls for a need to identify a point at which such a negative cycle might be broken and possibly steered into a different, more positive direction.

With role reversal, the idea is to put the learner with performance anxiety in a situation where he takes on the role of the 'helper'. Finding himself in a situation where he gets repeated messages from others as being "the one who can" rather than "the one who cannot", he might start accepting this new ('reversed') role or identity of competency, leading to confidence and the willingness to approach, rather than avoid, the feared task. In reaction to repeated instances of positive feedback from others, the learner might slowly start adapting his self-talk from negative to more positive. Furthermore, increased confidence and subsequent lessened anxiety in the execution of tasks such as reading or mathematics might support the child's ability to concentrate and apply his working memory capacities more sufficiently.

An example of this would be having the learner who has developed a fear of mathematics serve as a peer-helper for children of a younger age. In such a situation the younger learners would turn to this learner for help and guidance, sending out messages of "We think that you are good at this and that you can help us''. One might let the anxious learner start with fairly 'easy' tasks related to the feared stimulus, and as his confidence grows, expose him to more challenging tasks such as eventually helping learners from his own grade. Since he is not the one 'battling' or being evaluated while he provides help, the pressure is taken off, enabling him to focus more on the actual task at hand and less on his fear of negative evaluation. In this way, providing the anxious learner with an opportunity to perceive himself as 'the helper, the one who can', might change the once negative cycle of performance anxiety into a more positive cycle of confidence.

The purpose of this research project is to find out whether role reversal might be helpful in boosting a learner's confidence and lessening his performance anxiety. I further hope to gain more insight into how children personally experience the helping role, and how it makes them view themselves.

1.2.7 Statement of the problem

Can role reversal contribute to the treatment of performance anxiety experienced by learners in the school environment?

1.3 AIMS OF THE RESEARCH

1.3.1 General aim

The aim of this study is to explore the effects and usefulness of a proposed technique named role reversal for the treatment of performance anxiety experienced by children in school environment.

1.3.2 Specific aims

More particular aims of this study involve the following:

- Embarking on a comprehensive literature review in order to establish what knowledge is available regarding the nature and treatment of performance anxiety experienced by children in the school environment.
- Exploring and discovering, through an empirical investigation, the experiences of children who suffer from performance anxiety when their role becomes that of a helper to other learners in the school environment.
- Learning more about the usefulness and application of role reversal in the school environment.
- Ideally making a positive contribution to the various techniques typically employed in psychology when supporting children who suffer from performance anxiety within the school environment.

1.4 RESEARCH METHOD

1.4.1 The literature review

A comprehensive literature study will forego the empirical investigation in order to establish what knowledge is available regarding the nature and treatment of performance anxiety experienced by children within the school environment. Special attention will be given to the exploration of existing school-based treatment programs. This literature study will be conducted by consulting various academic books, scientific articles, theses and dissertations which are to be obtained in academic libraries (such as the UNISA library) and also via different search engines available on the internet.

1.4.2 The empirical investigation

After having equipped myself with relevant knowledge as obtained through the literature review, I will start my empirical investigation which will allow me to practically explore the phenomenon and treatment of performance anxiety experienced by learners in the school environment.

According to Leedy and Omrod (2005:133), qualitative research approaches focus on studying phenomena that occur in natural settings (in other words the "*real world*"), in all their complexity. Qualitative researchers recognize that different individuals may hold different perspectives, and they aim to reveal these multiple perspectives. According to Peshkin (in Leedy & Omrod, 2005:134-135) a qualitative approach can be useful when the researcher wishes to describe, interpret, verify or evaluate phenomena. More specifically, such an approach can enable the researcher to evaluate or judge the effectiveness of particular policies, practices or innovations. In this particular study, the aim is to evaluate a particular method for the treatment of performance anxiety within a real-life school setting. The more specific aim is to discover the personal meanings (perspectives) or experiences that individual children ascribe to their exposure to the particular treatment approach within their school environment. A qualitative research approach is expected to be most helpful in gathering rich, meaningful data in this study.

The qualitative design will take the form of collective instrumental case studies. Johnson and Christensen (2004:376) define case study research as "*research that provides a detailed account and analysis of one or more cases*". According to Fouché (2002:267) the

instrumental case study is used to elaborate on a theory or to gain a better understanding of a social issue. The case study serves the purpose of facilitating the researcher's gaining of knowledge about the issue under investigation. More than one case study will be used, since with the use of a single case study, one cannot be sure that the findings can be generalized to other situations (Leedy & Omrod, 2005:135). Johnson and Christensen (2004:378) provide further advantages to studying more than one case. Firstly, the cases can be compared to one another for differences and similarities. Secondly, a theory can be tested more effectively by observing the results of multiple cases.

With this particular research project, children's experiences of a proposed treatment approach for performance anxiety will be under investigation. The goal will be to achieve the depth of data and analysis normally associated with a single instrumental case study, while still obtaining results that may be generalized to other situations as well. The investigation of more than one case would be expected to achieve the latter. In order to come as close as possible to reaching both outcomes, it is ultimately decided that the technique of a collective case study, studied instrumentally, will serve best to gain optimal results from this qualitative research project.

1.4.2.1 Respondent identification

Possible respondents will be identified by means of purposive, non-probability sampling. In order to confirm that possible respondents do not appear to suffer from an anxiety disorder other than that of performance anxiety (as a form of social phobia), the SCAS, or Spence Children's Anxiety Questionnaire (Spence, 2012), will be employed. The SCAS is a DSM-based questionnaire for youth, which discriminates between youths with and without anxiety disorders, and within youths suffering from different types of anxiety disorders (Muris, 2007:196).

1.4.2.2 Data collection and analysis

Case study methodologists advocate the use of multiple methods and sources to collect data (Johnson & Christensen, 2004:379). The specific data collection methods that will apply to this study include secondary data, questionnaires, interviews (semi-structured and unstructured) and observation.

The interpretation of the results will be done objectively and will not be contaminated by researcher expectations. Objectivity will be ensured by the fact that any changes in the participants' symptoms will not be determined exclusively by myself as researcher, but especially through the reports received from the learners themselves, their teachers, parents and, where applicable, other school-based therapists. All interviews will be recorded, and all questionnaires will be kept together with a data trail to serve as proof of the data collected.

The data will be categorized and interpreted in terms of common themes. Each case will first be examined in its totality where after the separate cases will be compared in a cross-case analysis for similarities and differences (Johnson & Christensen, 2004:379).

Eventual synthesis into an overall portrait of the cases will be aimed for. Creswell's data analysis spiral will be followed as a guide to achieve this (Leedy & Omrod, 2005:150).

1.4.2.3 Ethical considerations

Johnson and Christensen (2004:101-112) provide guidelines to assist the wellbeing of the participants, which will be adhered to in the planning of this research project.

- Informed consent and assent

Informed consent (from adults) and assent (from minors) refer to the respondents' agreement to participate in the study after having been informed of its purpose, procedure, risks, benefits, alternative procedures and limits of confidentiality (Johnson & Christensen, 2004:102). With this study, the respondents will be included as participants only after their parents and themselves have consented to it. See Addendums 2 and 3 for the consent and assent forms that will be used, which clearly outline what will be discussed with the children and their parents prior to letting them decide whether to consent to, or decline, participating in the study.

- Freedom to withdraw

AERA (The American Educational Research Association) in Johnson and Christensen (2004:110) states that "*participants have the right to withdraw from a study at any time, unless otherwise constrained by their official capacity or roles*". It will be made clear to the respondents (as well as their parents) that refusing to participate, or withdrawing from the study, will not have any adverse effects on them.

- Protecting participants from mental and physical harm

Johnson and Christensen (2004:111) view this principle as the most important principle to be adhered to by researchers. Upholding this principle will be strived for by carefully considering all aspects of the study, particularly aspects relating to the therapy sessions and the manner in which role reversal activities will be conducted. The creation and monitoring of such activities will be based on my observations of each participant's functioning in terms of individual temperament, emotional state, peer-helping skills etcetera. Participation in activities will never be compulsory and thus participants will have the freedom to choose to refrain from participating in any activity that might make them feel uncomfortable.

In order to avoid 'labelling' from taking place, other learners in the school will not be made aware of the fact that the participants' performance anxiety are being addressed during role reversal activities. Teaching staff and school-based therapists will be urged not to make public the child's diagnosis or involvement in the study. During role reversal activities in homework class or normal class time, the message portrayed to the rest of the peer group will be that the teacher believes in the respondent's ability to be of assistance to fellow learners. Nothing is to be said about the respondents' anxiety or their participation in the study. The participant will thus be portrayed by his or her teacher as a helper (which would implicate competency) and not as anxious (which could implicate struggling).

- Confidentiality

Participants will be given the opportunity to make up their own names (pseudonyms) to be used by the researcher in the dissertation. The school where the research will be conducted will not be named in the research report.

Audio recordings of group therapy sessions will be saved on a password-protected computer, where after it will be deleted from the recording device. Back-up recordings will be saved on an external storage device which will be locked away. All completed questionnaires and field notes will be locked away and will only be available for viewing by myself and my study leader.

With regard to the confidentiality of information shared with me by participants and their parents, the code of conduct for psychologists (Department of Health, 2006:25) will be adhered to. Prior to the onset of therapy, respondents and their parents will be made aware of the fact that all information shared by the child as participant will be kept confidential, unless harm to any person is suspected or anticipated, in which case the participant's parents will be informed. Such disclosure however will only be made with the child's prior knowledge. As set out in the various consent forms (Addendums 2 and 3), confidentiality issues will be explained in full to all participants and their parents. Group members will be encouraged to keep confidential all that is shared by other participants during sessions. Each participant will be asked to sign a confidentiality agreement as part of their assent form. All teachers and therapists that are aware of the participants' inclusion in the study will be urged to keep such information confidential. The content of discussions between the researcher and participants' teachers or therapists will be limited to content that is relevant and useful to the support of the participants.

1.4.3 Procedure

Teachers and therapists of Grade 4-7 learners at the particular school where the project will take place will be asked to report to me learners who, according to their observations, present with signs of performance anxiety.

Parents will be informed personally if their child's teacher had given his/her name to me. During this interview, parents will be given a thorough overview of the study together with a consent form, (which will include all information about the study). This specific consent form will ask for their permission for their child to participate in the project.

With the parents' written informed consent, their child will be invited to a brief meeting during which the study will be explained and his/her informed assent to participate will be asked for. An assent form will be provided to the child. Provided the child gives his informed assent, he/she will then be asked to participate in another individual meeting with me. During this meeting, the child will complete the Spence Children's Anxiety Scale (SCAS). The child's parent(s) will be asked to complete the parent version of this questionnaire in order for me to determine their perspective on their child's symptoms.

After all questionnaires have been completed by the relevant participants and their parents, and once participant suitability has been confirmed by the results of the

questionnaires, the therapeutic intervention will commence. Group therapy will take place on a weekly basis. The amount of sessions will be dependent on the participants' needs and progress. After the last group session, or after approximately three months, individual follow-up interviews will be held with the participants and their parents. The interviews held with the participants will be semi-structured, and specific feedback in terms of their experiences of role reversal will be sought. Unstructured interviews with the parents will allow me to provide feedback regarding their child's progress, while their own views on the matter will be sought as well.

During the study I will be in close consultation with the teachers and other school-based therapists of the participants in order to assist the personnel in developing opportunities for the participants to act as peer helpers in their own classes at school, and to obtain continuous feedback on how they perceive the learners' progress. Additional role reversal activities will be incorporated into the group therapy sessions and will entail the participants assisting learners at the school's aftercare facility with their homework.

1.5 DEMARCATION OF THE RESEARCH

This research project will include learners between Grades four and seven who suffer from performance anxiety (specific social phobia). The project will exclude learners who suffer from generalized anxiety disorder or any other type of anxiety disorder. Although all anxiety disorders share the common features of anxiety and panic as well as the same biological and psychological vulnerabilities, they differ in the focus of anxiety (Barlow & Durand, 2002:117). This study focuses exclusively on the fear of social evaluation.

1.6 CLARIFICATION OF CONCEPTS

In support of the accurate interpretation of the research question and findings of this study, the following key concepts need to be clarified before embarking on the literature review following in Chapter 2.

- **Learner**

According to the Merriam-Webster thesaurus (2013) the term 'learner' is synonymous to 'student' and 'scholar'. These terms refer to *"one who attends school".* For the purpose of this study, the term 'learner' will thus refer to a school-going child. The study will focus particularly on learners between the ages of nine and thirteen years.

- **Performance Anxiety**

For the purpose of this study, the term 'performance anxiety' will refer to the anxious, fearful mood state typically experienced by a learner in situations during which the performance of a specific task is going to be observed or evaluated by other people.

- **Role reversal**

For the purpose of this study, the concept of 'role reversal' will refer to the learner taking on the helping role in a peer-tutoring relationship.

1.7 CHAPTER DIVISION

Chapter One: Overview and rationale

This chapter consists of a general summary of the study. In provides the motivation for the study and its aims, as well as an overview of the methodology that is to be followed in the empirical investigation. The concept of performance anxiety is discussed with its general causes, effects and possible treatment techniques. Additionally, the idea of role reversal as a possible treatment technique is explained in terms of its origin, purpose and possible application within the school environment.

Chapter Two: Literature review

This chapter provides a more detailed description of the nature of performance anxiety as part of a larger pattern of social phobia. The content of the chapter will focus on the etiology of the disorder, as well as the effects of the disorder on the individual on a biological, psychological and social level. The negative cycles that often arise in response to these factors will be conceptualized. Furthermore, the chapter will focus on current treatments for individuals suffering from the disorder. The concept of role reversal will be elaborated on and the chapter will be concluded by an overview of the theoretical perspectives held in this study.

Chapter Three: Research methodology

Chapter Three describes the empirical process which is to be followed in order to answer to the research questions involved in this study. The research aims, the design and methods of data collection and analysis are explained in detail, along with the ethical guidelines that will be followed throughout the process.

Chapter Four: Research findings

In this chapter, the research findings are presented, analysed and interpreted in an effort to answer the research questions. The relevant literature, as reported on in Chapter Two, are reflected on and integrated with the findings of the empirical study.

Chapter Five: Conclusions, recommendations and limitations

A conclusion regarding the information obtained from the literature- and empirical study will be provided in this final chapter. Relevant contributions and limitations to the study will be stated and recommendations for further study are made.

1.8 SUMMARY

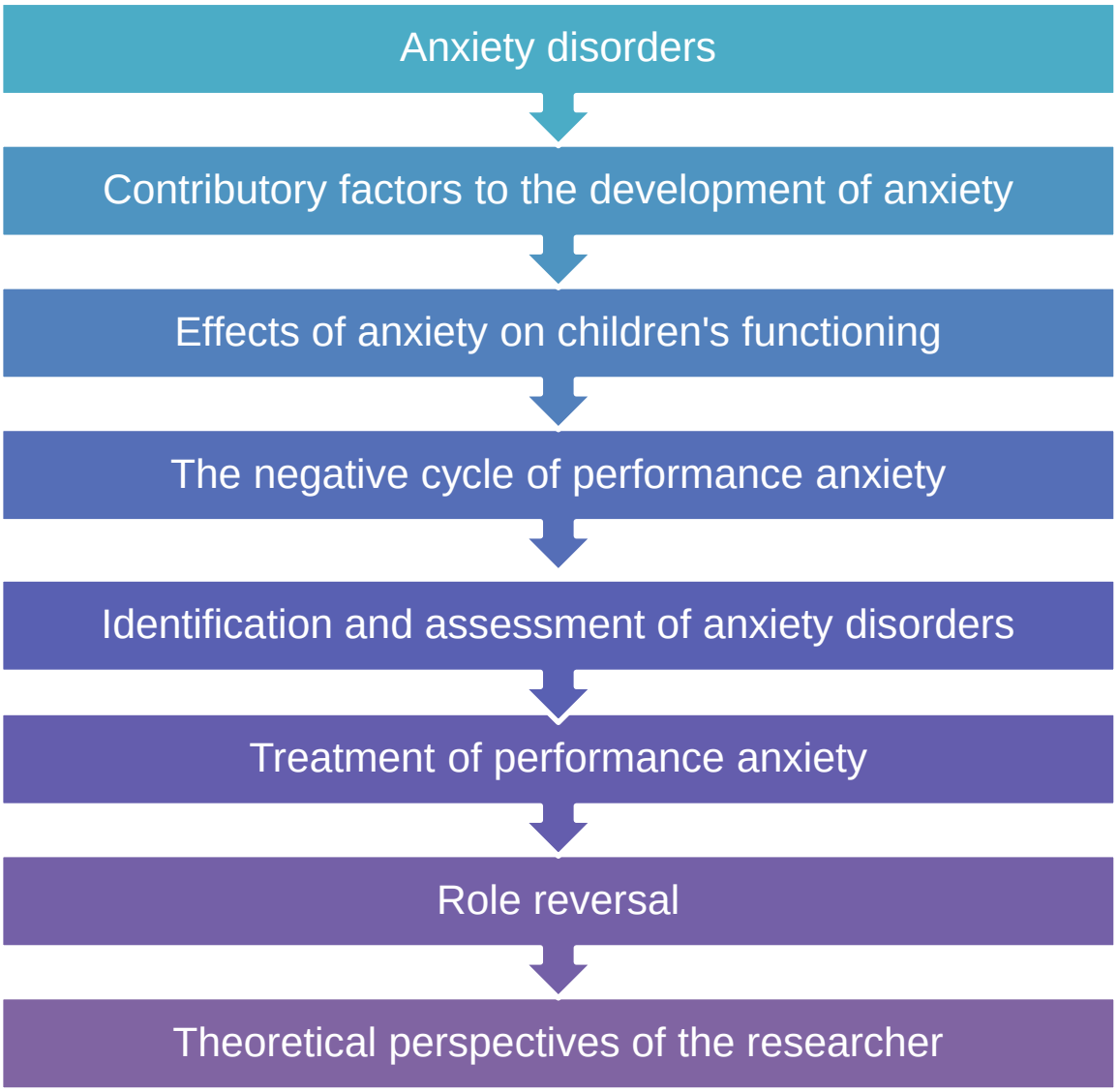
This chapter entailed a general overview of the study, explaining the aim and focus thereof. It provided an overview of performance anxiety as part of a pattern of social phobia - a disorder which negatively affects an individual's ability to perform a specific task due to the fear of being negatively evaluated by others. According to the literature the prevalence of social phobia is not only high, but also appears to be on the increase.

Various researchers advocate the value of school-based programs for the treatment of social phobia. This study will empirically investigate a possible school-based treatment technique in which teachers can become more involved in helping learners overcome their fears of negative social evaluation, manifested as performance anxiety in the school environment.

The following chapter will focus on the phenomenon of performance anxiety in a more detailed way. Its classification in relation to the various anxiety disorders of childhood will be explained, together with the various possible factors that may lead to the development of performance anxiety. Furthermore the effect of anxiety on a child's functioning will be explored, as well as ways in which this disorder can be identified and treated in children. Practices similar to that of role reversal, known in the literature as peer tutoring, will be investigated in terms of its general purposes and application, as well as the effect it has shown to have on children in terms of their emotional, social and academic functioning. Lastly, relevant theories underlying the concept of role reversal will be described.

CHAPTER 2
LITERATURE REVIEW

This chapter will provide an in-depth description of anxiety, and specifically performance anxiety as a form of specific social phobia. The possible causes, effects, various treatment methods and other relevant factors, as it relates to children, will be explored. A specific existing intervention named peer tutoring will be discussed, and the chapter will be concluded with the researcher's theoretical stance in terms of the conceptualization and treatment of performance anxiety. The literature reported on in this chapter is preceded by a schematic representation of the chapter in its entirety.



2.1 ANXIETY DISORDERS

Anxiety is defined as *"a negative mood state, characterized by bodily symptoms of physical tension and apprehension about the future"* (American Psychiatric Association, in Barlow & Durand, 2002:113). Barlow and Durand (2002:151) further define anxiety as being *"a future-oriented state characterized by negative affect, in which a person focuses on the possibility of uncontrollable danger or misfortune"*. The term anxiety thus refers to the fear of something bad that might occur in the near or distant future.

Anxiety disorders are the most common psychiatric disorders of childhood (Smallwood *et al.*, 2007:98). According to the findings of various researchers (Albano *et al.* & Pine *et al;* Kendall; Chorpita & Barlow in Southam-Gerow & Chorpita, 2007:347) anxiety amongst youth appears to run a chronic course into adulthood, with symptoms worsening over time and possibly leading to depression or substance disorders. Other problems reported by various studies to often co-occur with anxiety disorders in youth are poor school performance, social problems, familial conflict, disruptive behavior problems or additional anxiety disorders (Southam-Gerow & Chorpita, 2007:347). Anxiety thus negatively impacts on a person's psychological, social and academic (or professional) development and functioning.

Before looking at performance anxiety within the broader context of anxiety disorders, a brief overview of the different types of anxiety disorders will be given.

According to the fourth, text revised version of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association in Southam-Gerow *et al.*, 2007:348) children may be diagnosed with any one of the nine currently identified anxiety disorders.

a) Separation anxiety disorder (SAD): Characterized by *"excessive anxiety and fear concerning separation from home or from those whom the child is attached"* (Southam-Gerow *et al.,* 2007:348).

b) Panic disorder (PD): Characterized by the occurrence of panic attacks. In addition to panic symptoms, concomitant agoraphobia may be displayed by the child (Southam-Gerow *et al.,* 2007:352).

c) Agoraphobia: Defined as *"the fear of being in situations from which escape may be difficult or embarrassing, or in which help is not readily available in the event of a panic attack"* (Kearny *et al.;* Masi *et al.* in Southam-Gerow *et al.*, 2007:352).

d) Generalised anxiety disorder (GAD): Characterized by *"excessive and uncontrollable worry about multiple topics that lasts at least 6 months".* The focus of the youth's worries is thus not restricted to only one type of situation or event (Southam-Gerow *et al.,* 2007:349).

e) Social Phobia (Social Anxiety Disorder): Characterized by *"a marked and persistent fear of one or more social or performance situations in which the person fears that embarrassment may occur"* (Southam-Gerow *et al.,* 2007:350). Performance anxiety falls under this category, and is also known in literature as 'specific social phobia' (Wehrenberg & Prinz, 2007:190).

f) Specific phobia: Characterized by *"a marked and persistent fear of a specific object or situation"*. The feared stimuli however cannot include social situations, the fear of having a panic attack, or separation concerns, as these would lead to different diagnoses (Southam-Gerow *et al.,* 2007:351).

g) Obsessive compulsive disorder (OCD): Characterized by *"recurrent and intrusive obsessions and compulsions that are time-consuming (greater than 1 hour per day) and cause marked distress or significant functional impairment for the child"* (APA in Southam-Gerow & Chorpita, 2007:351). Typical obsessions in youth include contamination fears, sexual or religious themes, or aggressive/violent images, with typical compulsions including washing, checking and arranging (March, Franklin, Leonard & Foa; Piacentini & Langley, in Southam-Gerow & Chorpita, 2007:351).

h) Post-traumatic stress disorder (PTSD): Characterized by severe and long-lasting reactions to trauma, with symptoms of re-experiencing the event, avoidance of stimuli associated with the trauma and persistent symptoms of increased arousal (Wicks-Nelson & Israel, 2003:136).

i) Acute stress disorder: Fletcher (2007:409) explains that this disorder also occurs in reaction to a trauma, but posttraumatic reactions are restricted to 1 month after traumatic exposure. These reactions include the absence of emotional responsiveness, a general sense of detachment or emotional numbing. Survivors of trauma might experience a reduction in their awareness of their surroundings, feel as if 'in a daze', and forget some or all aspects of the traumatic experience. De-realization (a feeling that their experience could not have been real) or depersonalization (a feeling that what they are living is not really happening) may occur.

The schematic representation on the following page might aid in understanding performance anxiety as part of a larger pattern of social phobia, within the broader context of anxiety disorders of childhood.

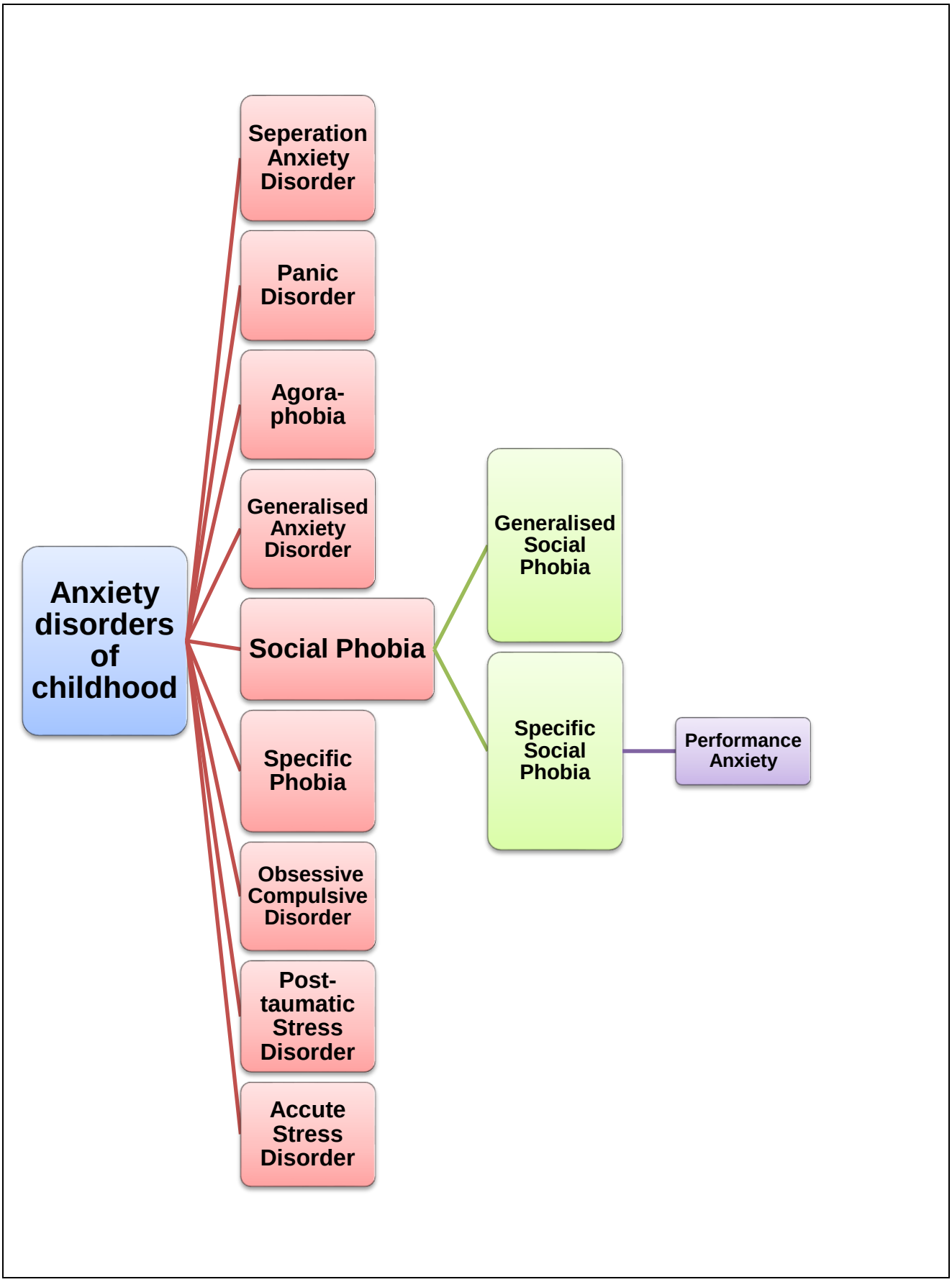


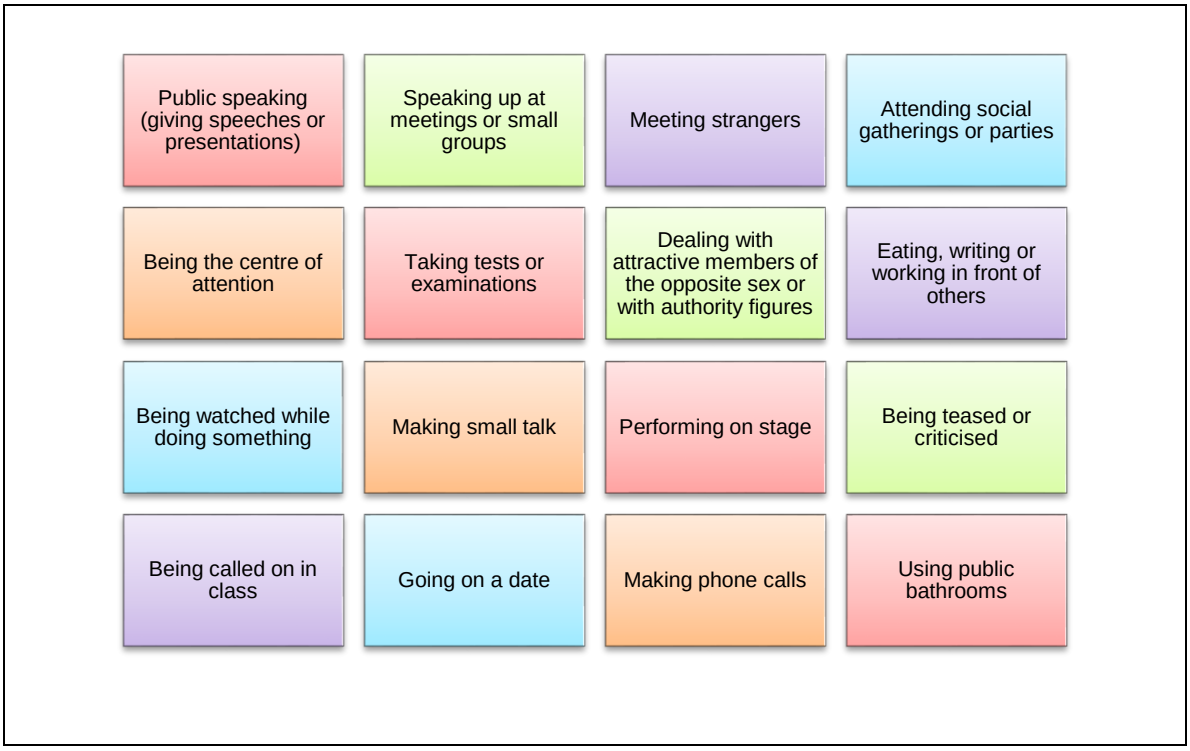
Figure 2.1 Anxiety disorders of childhood

2.2 PERFORMANCE ANXIETY

As was noted in Chapter One, the term 'performance anxiety' is, in some contexts, also referred to as 'stage fright'. It is generally known as the anxiety, fear or persistent phobia which may be aroused in an individual in response to an activity that involves self-presentation, such as public speaking for example (Wikipedia, 2013). Performance anxiety may, in certain cases, form part of a larger pattern of social phobia. In such a case, performance anxiety would be referred to as 'specific social phobia' – a subtype of 'social anxiety disorder' or 'social phobia'. However, the American Psychiatric Association (1994:416) cautions that performance anxiety (as well as stage fright and shyness) in social situations that involve unfamiliar people, should not be diagnosed as social phobia, unless the associated anxiety or avoidance leads to clinically significant impairment or marked distress. This is because children commonly exhibit social anxiety, particularly when interacting with unfamiliar adults. Only if the social anxiety is also evident in peer settings, and persists for at least six months, can a diagnosis of social phobia be made.

2.2.1 Clinical description

Many people occasionally feel shy or self-conscious and become nervous in social situations. It is, for example, normal for people to 'get the jitters' before giving a speech. However, if an individual experiences such tremendous and debilitating distress in social or performance situations, that it actually interferes with his or her normal routine and functioning, the individual presents with symptoms of social anxiety disorder/social phobia (Smith & Jaffe-Gill, 2012). According to Oakman (2001) and Smith and Jaffe-Gill (2012) people with social phobia typically worry about and/or avoid situations such as the following.



List 2.2 Situations typically feared by people with social phobia

According to the American Psychiatric Association (1994:414) most people with social phobia fear public speaking. However, somewhat less than half fear speaking to strangers or meeting new people, while other performance fears such as eating, drinking or writing in public, or using a public restroom, appear to be less common. Furthermore, in clinical settings, most people with social phobia fear more than one type of social situation.

According to Grohol (2011) the anxiety an individual experiences upon exposure to the feared social situation may become so intense that it may take the form of a situation-bound panic attack. In children, the anxiety may additionally be expressed by crying, tantrums, freezing or shrinking from the feared social situation (Grohol, 2011).

Social phobia has two basic subtypes as described in the Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association in Wehrenberg & Prinz, 2007:190), namely Generalized Social Phobia and Specific Social Phobia.

2.2.1.1 General social phobia

Individuals who are extremely shy in almost all situations meet the criteria for the subtype generalized social phobia, also known as 'social anxiety disorder' (Barlow & Durand, 2002:139).

2.2.1.2 Specific social phobia (performance anxiety)

In the case of specific social phobia, the experience of anxiety is limited to situations in which the performance of a specific task is going to be observed or evaluated. Individuals who suffer from this anxiety disorder usually do not experience difficulty with social interaction, but they become anxious the moment they need to do something in front of people. Anxiety takes over and they focus on the possibility that they will embarrass themselves (Barlow & Durand, 2002:138). The anxiety thus causes them to battle with the execution of a task which they would normally be able to do when not being watched (or evaluated) by others. An example of specific social phobia is test anxiety. Suinn (in Whitaker, Jolyn, Lowe & Lee, 2007) defines test anxiety as "*an inability to think or remember, a feeling of tension, and difficulty in reading and comprehending simple sentences or directions in an examination*". According to Smith and Jaffe-Gill (2012) the most common specific social phobia is the fear of public speaking or performing in front of an audience.

2.2.2 Prevalence

According to Hofmann *et al.* (2006) social phobia is the third most common psychiatric condition in the United States after major depression and alcohol abuse. Prevalence rates for social phobia in the South African population specifically could not be identified in the literature. Prevalence studies have however been conducted in other countries. According to a recent study on cross-cultural prevalence rates for social phobia, it was found to have a lifetime prevalence of 12.1% and a 12-month prevalence of 2.8% (Marques & Robinaugh, 2011). Similar prevalence rates were found to exist across European countries as well as the Israeli population, while lower rates appear to occur in many non-European countries (Marques & Robinaugh, 2011).

While many studies seem to yield different results in terms of prevalence, some statistics reveal that social phobias are found in approximately 5-10% of children (Smallwood *et al.*, 2007:98). Similar to these statistics, the American Psychiatric Association (1994:414) states that epidemiological and community-based studies have reported a lifetime prevalence of Social Phobia ranging from 3-13%, depending on the threshold used to determine the distress or impairment, and the number or types of social situations specifically surveyed. Rates are reportedly generally higher for older youth and females (Southam-Gerow & Chorpita, 2007:350). In some studies, up to 92% of youth with social phobia meet the criteria for the "generalized" type (Beidel, Morris & Turner; Hofmann *et al.* in Southam-Gerow & Chorpita., 2007:350), which would imply that specific social phobia is less common than generalized social phobia.

2.2 CONTRIBUTORY FACTORS TO DEVELOPING SOCIAL PHOBIA

Barlow and Durand (2002:61) suggest that one considers the interaction of many relevant factors when aiming to identify the causes of psychological disorders. The various possible causes of anxiety disorders in general, as were identified in the literature, are summarized in the following schematic representation where after it will be discussed accordingly.

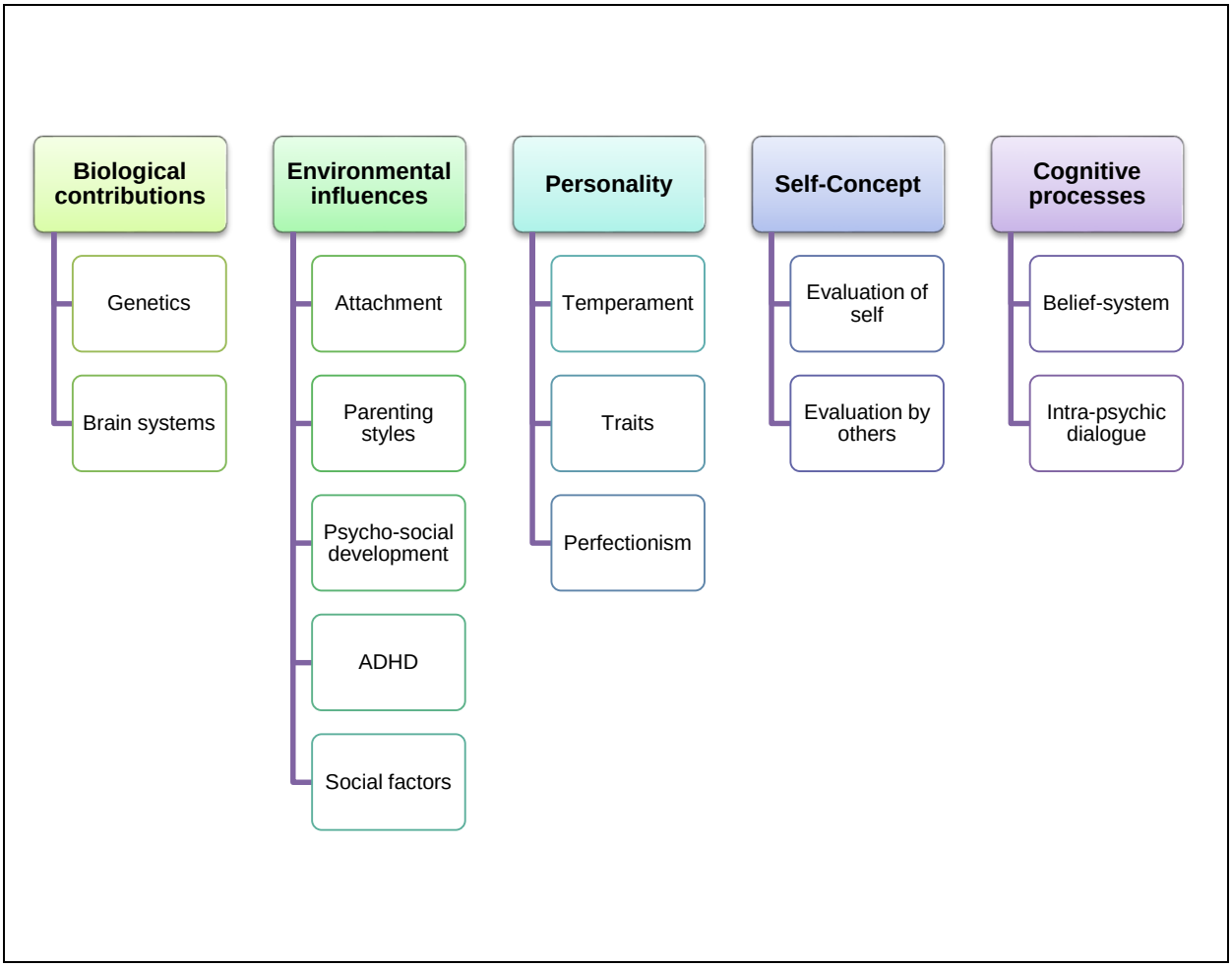


Figure 2.3 Contributory factors to the development of social phobia

2.3.1 Biological contributions

2.3.1.1 Genetics

According to the literature, genetics play a definite role in the development of anxiety disorders. Numerous twin studies have demonstrated that genetics account for approximately 30-40% of the variance in anxiety symptoms and disorders (Flannery-Schroeder, Sieberg & Gosch, 2007:204). While no single gene seems to cause anxiety, *"weak contributions from many genes in several different areas on chromosomes, collectively make us vulnerable to anxiety"* (Kendler in Barlow & Durand, 2002:115). According to the diathesis-stress model (Barlow & Durand, 2002:61) individuals inherit certain genetic vulnerabilities that make them susceptible to develop a disorder when a certain kind of environmental stressor comes along. The greater the underlying genetic vulnerability, the less stress is required to trigger a disorder.

In order to conceptualize the development of performance anxiety according to the diathesis-stress model, one might take the case of a child who inherits a vulnerability to develop an anxiety disorder. She would be different from her friend who has not genetically inherited this vulnerability. During their school career, both are often exposed to public speaking tasks. Both experience it as stressful and both are sometimes penalised for making some errors during their speeches, but only the child with the genetic predisposition starts developing a psychological disorder – in this case, a chronic, dysfunctional fear of social evaluation (social phobia).

2.3.1.2 Brain systems

- *Neurotransmitters*

According to Barlow and Durand (2002:115) various brain systems and neurotransmitter systems are implicated in anxiety. These involve the GABA-benzodiazepine system, the noradrenergic system, the serotonergic neurotransmitter system, the corticotrophin releasing factor (CRF) system, the limbic system and the behavioural inhibition system (BIS). The limbic system, which acts as a mediator between the brain stem and the cortex, is the area of the brain that is most often associated with anxiety (Davis; Gray & McNaughton; LeDoux, in Barlow & Durand, 2007:115). A more detailed discussion of these systems is beyond the scope of this dissertation. It is however important to be cognizant of the fact that such biological influences indeed exist, which will be revisited later during the discussion of pharmacological interventions for anxiety.

- *Developmental factors*

According to Southam-Gerow and Chorpita (2007:347), the onset of social phobia is typically in early adolescence. During this developmental stage, also known as puberty, dopamine activity increases while serotonin activity decreases (Walker, in Hill & Coulson-Brown, 2007:46). Both of these neurotransmitters have an effect on mood regulation. Serotonin influences many other functions as well, while dopamine additionally affects impulse control and the 'pleasure circuit' (reward pathways) in the brain. These changes

may cause an increased susceptibility to the development of mood disorders during puberty (Hill & Coulson-Brown, 2007:46).

The prefrontal cortex continues to develop through adolescence and is the last part of the brain to mature (Hill & Coulson-Brown, 2007:45). This part of the brain is responsible for higher order cognitive and executive functions such as prioritising, decision making, inhibition (impulse control) and emotional control, among other functions (Casey, Giedd & Thomas, in Hill & Coulson-Brown, 2007:45). According to LeDoux (in Hill & Coulson-Brown, 2007:46) the amygdala, part of the limbic system (also known as the 'emotional brain'), matures more quickly that the prefrontal cortex does. As a result, an adolescent would process emotion in the amydala, without employing the higher-order functions of the prefrontal cortex.

A study that used functional magnetic resonance imaging (fMRI) showed that children and adolescents between the ages of 10 and 18 years old, who viewed faces with fearful expression, processed this information in the amygdala and not in the prefrontal cortex, as 20- to 40-year-olls did (Baird, Gruber, Cohen, Renshaw & Yureglun-Todd in Hill & Coulson-Brown, 2007:46). This might explain why adolescents may 'over-react' or tend to experience more intense, and less controlled emotions, adding to their increased vulnerability to the development of anxiety disorders such as social phobia.

2.3.2 Environmental influences

As previously mentioned, the diathesis stress-model suggests that a genetic vulnerability in combination with sufficient environmental stressors may lead to the development of psychological disorders. In this section a variety of environmental factors which may contribute to the development of anxiety disorders will be discussed.

2.3.2.1 Attachment

Insecure early attachment is related to the development of anxiety disorders (Manassis; Warren, Huston & Egeland, in Southam-Gerow & Chorpita, 2007:354). According to Bowlby (in Cozolino, 2002:201), the early interactions and bonding between children and consistent caretakers create attachment schemas in the brain of the growing infant. These schemas, based on experiences of safety or danger, provide predictions concerning subsequent human interactions, and become implicit memories that organise within networks of the social brain. Infants develop either feelings of trust or mistrust in response to the degree in which significant others provide in their basic physical and emotional needs (Barlow & Durand, 2002:117). If parents respond positively and predictably when their child communicates his needs to them, the child learns that he has a sense of control over his environment and that his responses have an effect on his parents and wider environment. Subsequently, a sense of controllability develops within the child. If, however, parents or significant others fail to react positively and predictably to the child's communicated needs, the child may learn that he has no control over what happens in life (Barlow and Durand, 2002:117).

Early attachment thus plays a significant role in the development of a growing individual's view of himself and the world around him. It determines whether he or she will trust or

mistrust others, how he or she will predict future human interactions, and whether he or she will develop a sense of controllability or helplessness.

2.3.2.2 Parenting styles and modelling

Parents' degree of protectiveness over their child, as well as the behaviours they allow and the examples they set themselves, have been associated with the development and maintenance of anxiety in children. According to Ginsburg (in Nauert, 2009) children of parents diagnosed with an anxiety disorder, are up to seven times more likely to develop an anxiety disorder than children with non-anxious parents. The increased risk may be ascribed to genetic components as well as parental styles and modelling.

As explained by Barlow and Durand (2002:117), a healthy sense of control and competence develops when parents allow their children to explore their world and develop the necessary skills to cope with unexpected occurrences. When parents are overprotective or over-intrusive, always protecting their child from adversities, the child never learns to cope with adversity when it does come along later in life. What the child really needs is to develop feelings of adequacy instead of helplessness in order to cope with adversities in life. If not, negative self-talk (intra-psychic) dialogue will occur. The child might say to himself: "I will do poorly on the next exam and there is no way I can pass this course". In such a self-statement, the child firstly believes that he has no control over his environment (uncontrollability, as discussed in 2.3.2.1), and secondly, that he is unable to cope with (or overcome) adversities. Intra-psychic dialogue will be discussed in more detail later in this chapter. The development of social skills may additionally be hindered by parental overprotection, which may result in lower social competence and higher social anxiety and avoidance (Brook & Schmidt, in Festa & Ginsburg, 2011).

According to the "Two-Factor Theory" (Mowrer in Flannery-Schroeder *et al.,* 2007:206), the lessened anxiety in children resulting from avoidant behaviours actually reinforces their anxiety in the long run. Put simply, the more a social situation is avoided, the more frightening it becomes (Smith & Jaffe-Gill, 2012). This may be further reinforced by parents or other adults in the lives of these children who allow avoidant or dependent behaviour (e.g. letting the anxious child stay at home instead of going to school, or doing things on behalf of the child). A study conducted by Dadds *et al.* in Muris (2010:38) revealed that *"parents of anxious children indeed show the tendency to encourage the fearful avoidant behaviour of their offspring"*. According to Chorpita *et al.* in Southam-Gerow & Chorpita (2007:354) problem-solving styles that emphasize avoidant strategies appear to be consistent within families of youth with anxiety disorders. Parents may additionally model anxiety-based avoidant strategies to their children. According to the Social Learning Theory (Bandura in Flannery-Schroeder *et al.,* 2007:206), children can learn specific anxiety responses by witnessing anxious symptoms in adults, or hearing adults talk excessively about potential harm.

2.3.2.3 Psychosocial developmental stages

According to Erikson's model of psychosocial developmental stages, children may either develop, or fail to develop, qualities of trust, autonomy, initiative and industry (adequacy)

during the first twelve years of their life. Specific developmental crises that are crucial for the development of these skills according to Erikson's model, is outlined by Corey (2005:63) and will be briefly discussed.

- Autonomy versus shame and doubt

In early childhood (ages one to three), toddlers either develop a sense of autonomy, or a sense of shame and doubt. Here it is important that parents provide opportunities which will promote independence, otherwise the child's sense of autonomy and capacity to deal with the world will be hampered.

- Initiative versus guilt

Pre-schoolers (aged three to six) develop a sense of either initiative or guilt. If children are given the freedom to select personally meaningful activities, they develop a positive view of self. They learn to follow through on their projects and become willing to take an active stance and initiative, which leads to the development of a sense of competence.

- Industry versus inferiority

Children between the ages of six and twelve find themselves in the stage or developmental crisis of *"Industry versus inferiority"* (Corey, 2005:63). During this stage the child needs to, among other things, learn the basic skills required for school success. The basic goal here is to achieve a sense of industry, which refers to setting and attaining personal goals. Failure to do so results in a sense of inadequacy.

If, for some reason, children do not successfully work through the aforementioned three stages of psycho-social development, they may develop a sense of dependence, self-doubt, incompetency and an inability to cope. As previously noted in 2.3.2.1, feelings of incompetency and poor coping are associated with the development of anxiety disorders.

2.3.2.4 The effects of Attention Deficit and Hyperactivity Disorder (ADHD)

According to Olivardia (in Tartakovsky, 2011) thirty to forty percent of people with ADHD have an anxiety disorder, which may include obsessive compulsive disorder, generalized anxiety disorder, phobias, social anxiety disorder (social phobia) and panic disorder. Tartakovsky (2011) attributes these anxiety symptoms to the fact that ADHD can be very intrusive, in that it causes forgetfulness, impulsive behaviour and disorganisation. Such behaviours may lead to frequent situations of failure or disappointment (Tuckman in Tartakovsky, 2011).

2.3.2.5 Social factors

Factors such as social acceptance and support, as well as friendship quality, have been linked to social anxiety (Festa & Ginsburg, 2011). According to Leary and Kowalski (in Festa & Ginsburg, 2011), *"low perceived social acceptance may directly contribute to feelings of anxiety due to the failure to make desired impressions on others".* Klineberg, Clark, Bhui, Haines and Viner (in Festa & Ginsburg, 2011) adds to social acceptance the importance of social support, in that "*the less social support one has available, the greater*

their risk for psychological maladjustment". In a study conducted with an adolescent community sample, Lopez (in Festa & Ginsburg, 2011) established that higher levels of perceived social support were related to lower levels of social anxiety, while adolescents with higher social anxiety reported having fewer friendships.

Another study conducted with an adolescent community sample (LaGreca & Harrison in Festa & Ginsburg, 2011) revealed that more positive social interactions (friendships) and approval were associated with a lower level of social anxiety. Children with poor social skills and poor peer relationships thus appear to be more prone to the development of social phobia.

2.3.2.6 Trauma

According to Flannery-Schroeder *et al.* (2007:206) several researchers have suggested that the occurrence of stressful life events in childhood (e.g. earthquakes, fires, storms, parental separations or divorce, starting a new school, death of a family member) has been found to be associated with an increased risk for developing an anxiety disorder. Research has indicated that the most stressful life events (traumas) that trigger people's biological and psychological vulnerabilities to anxiety are interpersonal (social) in nature, e.g. marriage, divorce, loss, difficulties at work, and so forth (Barlow & Durand, 2002:17).

Social pressures, such as to perform well at school might, according to Barlow and Durand (2002:117), provide sufficient stress to trigger anxiety. Children may not always be able to live up to the expectations of significant others in their lives, which may lead to feelings of shame. Shame can be like trauma when experiencing one small social humiliation after the other in performance or social tasks (Wehrenberg and Prinz, 2007:198) Humiliations like these can be 'small things' like an insensitive remark from a teacher in front of one's peers. Social trauma can thus play a significant role in the development of social phobia.

2.3.2.7 Conditioning

Anxiety responses may be learnt by means of classical conditioning, where an isolated experience of social embarrassment may be generalized to other social situations. When looking at panic attacks specifically, Barlow and Durand (2002:17) refer to conditioning involving a true alarm and subsequent associated internal and/or external cues. A strong fear response may initially be caused by a truly dangerous situation or extreme stress (the 'true alarm'). This emotional response then becomes associated with "external cues" (e.g. places or situations similar to the one where the original fear response occurred) and/or 'internal cues' (e.g. rapid rate or respiration, even when caused by normal circumstances such as excitement or exercise). These external and internal cues serve as triggers to the initial fear response and may cause a panic attack when there is no real threat or danger. According to Bouton *et al.* and Le Doux (in Barlow & Durand, 2002:17) this possibly occurs because the cues or triggers may travel from the eyes directly to the amygdala (or "emotional brain"), without going through the cortex, the source of awareness.

Anxiety responses may thus be conditioned to become automatic on a physiological level. A child may learn to associate a specific social- or performance situation with the

physiological symptoms of anxiety or panic, causing the physiological responses to re-occur in similar future settings, even in the absence of a real threat or trauma.

2.3.3 Personality

Personality is defined as "*a dynamic and organized set of characteristics possessed by a person that uniquely influences his or her cognitions, emotions, motivations and behaviours in various situations"* (Wikipedia, 2013). In relation to the development of anxiety disorders, in particular social phobia, specific constructs and concepts relating to personality will be discussed.

2.3.3.1 Temperament

Relevant to the development of an anxiety disorder is what is known as an 'inhibited temperamental style', or *"the tendency to withdraw from novel or social experiences"* (Southam-Gerow & Chorpita, 2007:354). Another description for the temperament construct of behavioural inhibition is given by Kagan, Reznick and Gibbons (in Hill & Coulson-Brown, 2007:55) as *"a temperamentally based disposition of children to react consistently to unfamiliar events, both social and non-social, with initial restraint"*. Shy individuals are more prone to easily feel embarrassed or ashamed in response to failure. Some infants are born with an inherited temperamental profile or trait of inhibition or shyness that becomes evident as early as four months of age, and evidence suggests that individuals with excessive behavioural inhibition are at increased risk for developing phobic (anxious) behaviour (Kagan & colleagues in Barlow & Durand, 2002:139).

2.3.3.2 Trait anxiety

According to Pargman (2006:40) personality refers to a collection of behavioural dispositions (or traits) that are unique to an individual. Examples of such traits are introversion, aggressiveness or anxiety. Spielberger *et al.* in Pargman (2006:41) distinguish between trait anxiety and state anxiety. State anxiety refers to temporary, situation-bound anxiety which would be experienced by most people in such a situation (e.g. when receiving the diagnosis of a life-threatening disease). Trait anxiety, however, occurs in individuals who always experience high levels of anxiety. Thus, while state anxiety is a transitory emotional state, trait anxiety is a stable personality characteristic (Spielberger in Whitaker *et al.*, 2007). Individuals with trait anxiety seem to be predisposed to respond stressfully to particular environmental stimuli (Pargman, 2006:41), which then makes them more vulnerable to the development of an anxiety disorder.

2.3.3.3 Perfectionism

Perfectionism is *"a personality disposition characterized by an individual striving for flawlessness and setting excessively high performance standards, accompanied by overly critical self-evaluations and concerns regarding others' evaluations"* (Stoeber & Childs; Flett & Hewitt in Wikipedia, 2013). Perfectionists have also been described as "*those who strain compulsively and unceasingly toward unobtainable goals, and who measure their self-worth with their productivity and accomplishment*" (Parker & Adkins, in Wikipedia, 2013).

According to Knaus (2012) perfectionism is a risk factor for the development of performance anxiety. However, Gnika, Jeffrey and Noble (2012) caution counsellors against assuming that all perfectionism is pathological. Rather, perfectionism should be viewed as a multidimensional construct with both adaptive and maladaptive components. In their study, Gnika *et al.* (2012) established that participants with adaptive perfectionism had significantly lower levels of anxiety than those with maladaptive- and even non-perfectionism. According to their findings, clients presenting with maladaptive perfectionism use ineffective coping strategies, which result in higher levels of anxiety. Such ineffective coping strategies typically entail clients distancing themselves from a task or potential stressor by means of avoidance or procrastination.

Due to the fact that such clients foster very high, rigidly imposed standards, they may be "*plagued by a sense of helplessness*" (Burns in Gnika *et al.*, 2012). They also have a tendency for self-criticism (Hamachek in Gnika *et al.*, 2012), so accepting responsibility for their actions actually becomes detrimental. They might think, for example, "*I am responsible and my responses or coping actions are less than perfec*t" (Gnika *et al.*, 2012). In maladaptive perfectionism, there is thus a strong cognitive component in terms of irrational expectations and self-judgments. Later in this chapter, in section 2.3.5, the cognitive processes underlying anxiety will be discussed in more detail.

2.3.4 Self-concept

The self-concept, according to Donald, Lazarus and Lolwana (2002:223) refers to what people believe about themselves in terms of their important attributes (e.g. female, tall), as well as the value they attach to these attributes (e.g. good/bad, desirable/undesirable). Important to note is that the self-concept is based on a person's perception – and thus subjective judgement – of the self, which may be realistic or unrealistic, and positive or negative (Venter, 2008:16-17).

2.3.4.1 Self-evaluation

In the context of the school environment, it is important to remember that the child's perception or interpretation of his own school performance is important, and not only the performance in itself. Cuisinier (2011:73) reports that there is relatively little research on the impact of school achievement on emotion. Rather, some studies revealed that the link seems to be stronger between emotions and self-evaluation of academic competencies, than between emotions and actual school performances (Gumora & Arsenio in Cuisinier, 2011:73). In other words, even when a child gets a B-symbol for his exams, which might be regarded as good by his teacher, he may still negatively evaluate his performance if he fosters unrealistically high expectations. A construct which has been identified among test-anxious students is that of negative self-evaluation (Swanson & Howell in Whitaker *et al.*, 2007).

Closely related to the self-concept is self-confidence – the degree to which one believes in one's capacity to succeed (Pargman, 2006:103). A history of personal success or failure contributes to the development of one's self-confidence. A negative (or low) self-concept

leads to feelings of inadequacy and inferiority, which manifest as insecurity and a lack of self-confidence (Venter, 2008:17). This in turn, may lead to the development of anxiety. For example, Hodapp (in Whitaker *et al.*, 2007) views a lack of self-confidence as one of the constructs of test anxiety.

Results of a study conducted by Bryan *et al.* in Whitaker *et al.* (2007) revealed that students with learning disorders were more test anxious than learners without learning disorders. Kovach (in Whitaker *et al.*, 2007) ascribes this to the fact that such students are more likely to have had less positive experiences in testing situations, such as repeated failing on tests. Due to past experiences of failure, they are more anxious when taking tests.

2.3.4.2 Evaluation by significant others

The formation of a child's self-concept is additionally influenced by his interpretations of others' views of him or her. The Reflected Appraisal Theory, which is based on the social constructionist perspective, assumes that self-perceptions are formed from internalizing others' attitudes and communications (Gergen in Narcie & Norwich, 2004). If negatively evaluated by others, the child may thus evaluate him- or herself negatively as well, which in turn will impact negatively on his or her self-concept.

2.3.4.3 Comparison to peers

According to the Social Comparison Theory (Festinger in Narcie & Norwich, 2004), *"comparisons with those of similar abilities will result in positive self-perceptions, while comparisons with those of high abilities will lead to less positive self-perceptions"*. This implies that, if a child compares himself to his peers and sees himself as the one who is often incapable and in need of support, his perception of himself will most likely be quite negative. However, if he sees himself as equal or even stronger in terms of ability, his self-perception will most likely be positive. This theory supports the idea of role reversal, where the aim is to provide children with opportunities that will support positive self-perception.

To summarize the section on the self-concept, a learner's scholastic performance, his or her own evaluation thereof, other's evaluations and feedback, and lastly the way in which a child views himself in comparison to his peers, are important factors to consider when investigating the possible origins of performance anxiety. This particular facet will also receive a great deal of attention in this research project, as the focus is on the treatment of performance anxiety in the school environment.

2.3.5 Cognitive processes

2.3.5.1 Belief-system

The cognitive model of anxiety (Beck & colleagues in Smallwood *et al.,* 2007:89) is based on the premise that emotional as well as behavioural reactions to stressful events are produced and stimulated by the individual's interpretation of the situation as being threatening in some way. Take note here of the word 'interpretation', which specifically

refers to the individual's own beliefs about the situation or event. Beliefs may however sometimes be irrational.

Various authors have identified and described such irrational beliefs, also termed 'cognitive distortions' or 'information processing biases'. Four core irrational beliefs are highlighted by Dryden (in Vernon, 2007:110), namely *"demands"*, *"awfulizing"*, *"depreciation"* and *"low frustration tolerance"*. A demand is described by Dryden (in Vernon, 2007:110) as *"a rigid belief where the person dogmatically insists that certain conditions must or must not exist"*. Such demands may be directed towards oneself, others, or the conditions of the world. Certain demands in turn lead to other irrational beliefs, as explained by Vernon (2007:110):

- 'Awfulizing' beliefs – thinking that things are terrible, or the end of the world.
- A 'demand' that people or life's conditions must conform to one's desires, causes 'depreciation' beliefs which may relate to self, others or life conditions.
- Lastly, 'low frustration tolerance' is the notion that *"frustration should not exist and it cannot be tolerated"* (Vernon, 2007:110).

Greene (2002:19) identifies other negative thought patterns which he classifies into three categories namely *"doomsday thinking"*, *"weird thinking"* and *"obsessing about results"***.**

- 'Doomsday thinking' refers to considering and eventually imagining the ultimate results of a specific performance in the worst possible term, for example, *"I am going to blow this performance"*.
- 'Weird thinking' includes strange things that might occur during a performance situation, for example an oboist may imagine that the side keys will start falling off her instrument during a solo.
- 'Obsessing about results' refers to the pressure put on oneself to achieve certain results, for example*, "I must get at least 90% for this test"*.

To add to the above, Stewart, Christner and Freeman (2007:11) list and explain 11 common cognitive distortions of children and adolescents:

- Dichotomous thinking: The child views situations in only two categories rather than on a continuum. The world is either black or white with no shades of grey. For example, "*I'm either loved or I am hated*".
- Overgeneralization: The child sees a current event as being characteristic of life in general, instead of one situation among many. For example, *"Because she didn't invite me to the party, I'll never be invited to anyone else's either"*.
- Mind reading: The child believes he or she knows what others are thinking about him or her without any evidence. For example, *"I just know that my mother is disappointed in me*".
- Emotional reasoning: The child assumes that his or her feelings or emotional reactions reflect the true situation. For example, "*I feel like no one likes me, so no one likes me*".

- Disqualifying the positive: The child discounts positive experiences that conflict with his or her negative views. For example, *"Doing well on those quizzes was just because the teacher helped me and I got lucky*".
- Catastrophising: The child predicts that future situations will be negative and treats them as intolerable catastrophes. For example, *"I'm going to strike out and no one will want me on their team"*.
- Personalization: The child assumes that he or she is the cause of negative circumstances. For example, *"Michelle wouldn't talk to me in the hall today, I must have done something to make her so mad at me*".
- Should-statements: The child uses words like 'should' or 'must' to describe how he/she or others are to behave or act. For example, *"I must always say yes when my friends ask for my help, because I shouldn't be selfish*".
- Comparing: The child compares his or her performance to others. Oftentimes, the comparison is made to higher performing or older children. For example, *"I can't read as well as my older sister. She must be smarter than me*".
- Selective abstraction: The child focuses attention to one detail (usually negative), and ignores other relevant aspects. For example, *"My teacher gave me an 'unsatisfactory' on the last assignment, so this means I must be one of his worst students*".
- Labelling: The child attaches a global label to describe him or herself rather than looking at behaviours and actions. For example, *"I'm a loser"* rather than *"Boy, I had a bad game last night".*

Muris (2010:22-35) explains different forms of typical biases regarding anxious children's interpretations of internal and external ambiguous stimuli. In short, he concludes that *"anxious children and adolescents tend to interpret ambiguity in a threatening way (i.e. interpretation bias), require less information before perceiving threat (i.e. RED bias), view physical symptoms as a forecast of impending danger (i.e. emotional bias) and may judge threatening events as more likely to occur in the future (i.e. probability bias)"* (Muris, 2010:37). A more detailed discussion of each of these biases, and how they may manifest in youths, follows.

- Interpretation bias: Anxious individuals tend to interpret ambiguity as potentially dangerous, which in turn further promotes anxiety and instigates children to employ avoidant coping strategies. One way to assess this tendency in children is through the use of an ambiguous vignette paradigm, which makes use of short descriptions of everyday situations that may occur in children's life and simply asks children to indicate how these situations will proceed. An example of a social threat vignette is provided (Barret *et al.* in Muris, 2010:23).

You see a group of children from another class playing a great game. As you walk over and want to join them, you notice that they are laughing. Which of the following explanations is most likely?

a) They are telling secrets about you.
b) They will soon ask you to join in.

c) One of them is likely to rush up and push you away.
d) One of them is likely to notice you and smile.

Results from research conducted by Barret *et al.* (Muris, 2010:25) showed that anxious children more frequently perceived ambiguous situations as threatening than did normal controls, and more often chose avoidant outcomes (in other words reacting to the situation by means of avoidance).

- RED (Reduced Evidence for Danger) –bias: Anxious children require little information before deciding that a situation is dangerous. Similar to this type of bias are two cognitive errors or distortions, as described by Beck (Muris, 2010:26). Firstly, 'arbitrary interference' relates to an unjust conclusion in the absence of evidence. Secondly, 'selective abstraction' pertains to focusing on a detail while ignoring other important features of a situation. This type of bias is typically assessed by means of ambiguous vignettes (scenarios or 'stories') which are presented to children sentence by sentence. After each sentence the child is asked whether the story is going to be scary or not. This enables one to determine how much information the child needs before deciding that the scenario will be threatening.

One particular study, which was done by Muris *et al.* in Muris (2010:27), demonstrated that high levels of social anxiety were accompanied by an early detection of threat, not only in children's responses to ambiguous vignettes but also in their responses to the non-threatening scenarios. From this, Muris *et al.* (in Muris, 2010:28) concluded that *"anxious children seem to have a motto that can be summarised as 'Danger is lurking everywhere', which manifests itself in threat perception abnormalities that even occur in relatively non-threatening situations"*.

- Emotional reasoning: Anxious children tend to use internal information such as anxiety-related bodily sensations (e.g. palpitations, sweating and trembling), for evaluating threat in their environment. In other words, danger is inferred from physical anxiety responses rather from an objective threat. This leads to an unrecognised 'false alarm' which in turn causes anxiety to persist. A child may, for example, be asked to interpret a certain scenario such as the following (Schneider *et al* in Muris, 2010:29):

  Lena is lying on her bed. Suddenly she notices that her heart is pounding and she is dizzy and short of breath. What has happened?

  a) Lena is afraid. She thinks that she is seriously sick and needs a doctor (*anxious*).
  b) Lena has just arrived from school. She has run the whole way home and she is tired (*neutral*).
  c) Lena is very excited. It's her birthday and her classmates will be coming to her party right away (*positive*).

Past studies have been somewhat contradictory in terms of responses obtained from youths and adults, in that emotional reasoning occurred also in non-clinical youths while, in adult populations this reasoning bias was only present in patients with anxiety disorders (Rauner & Van den Hout in Muris, 2010:31). According to Muris (2010:31), while more studies are required, it appears at this stage as though a developmental pattern may be present. Research so far indicates that anxiety-response information sensitizes all children to potential danger, and while this phenomenon gradually dissipates as children grow older, emotional reasoning may persist in some children as part of a general vulnerability to develop anxiety problems.

- Co-variation bias: The reasoning process of co-variation detection refers to the ability to discover that two stimuli tend to co-occur in a regular and consistent way. This capability enables people to understand and predict the world. However, *"the co-variation bias occurs when people observe an illusory correlation between two stimuli that in fact are correlated to a lesser extent or not related at all*" (Harvey in Muris, 2010:31). In terms of anxiety this relates to an overestimation of negative outcomes in response to anxiety-relevant stimuli.

During a study conducted in 2007, Muris (in Muris, 2010:33) developed a computer game which assessed spider-fear-related co-variation bias in youths between 8 and 16 years of age. Pictures of spiders, guns and flowers were shown in a random order and each picture type was equally often followed either by a happy, sad or neutral smiley face. For each type of face, real candy could either be earned, lost or unaffected. The participants were led to believe that they actually won or lost candy directly in relation to the various picture types. According to the results, youths displayed an inclination to link a negative outcome to more negatively valenced pictures (i.e. they believed that they more frequently lost candy following pictures of spiders and guns). It was further found that the higher the child's level of spider fear was, the higher was his/her tendency to (inaccurately) estimate a negative outcome in response to the spider-pictures.

When applied to the anxiety response, a child may start to believe that two stimuli – for example maths and anxiety – tend to co-occur. Without realising, the child associates maths with the feeling of fear, and believes that the two will always occur together.

- Probability bias: This type of bias relates to the inclination of an individual to estimate or expect that future negative events are likely to occur. According to Cizek and Burg (Whitaker *et al.*, 2007), test-anxious children and adolescents *"do not approach a task such as a test with a positive outlook or expectation of success, but with dread regarding the potential for negative evaluation or failure"*. The expectation of failure and dread may have an impact on the investment of effort and behavioural choices with regard to prospective future situations (Harvey *et al.* in Muris, 2010:35). For example, a child who fears public speaking and who believes that he will fail anyway, may put less energy into his preparation, or a child with test anxiety who believes that he will fail his math exam regardless of how hard he studies, may neglect to put sufficient energy and time into his preparation for the

test. Subsequent underperformance would only elevate feelings of failure, and in turn reinforce the probability bias of negative expectations.

It is important to note that, while information processing biases do play a role in the maintenance and even exacerbation of anxiety problems in youths (Vasey & MacLeod in Muris, 2010:38), *"no conclusions can be drawn on the cause-effect relation between reasoning biases and anxiety"* (Muris, 2010:38). It is thus often difficult to establish which came first – the reasoning bias or the anxiety. Rather, it would appear as though the two constructs continuously reinforce one another.

2.3.5.2 Intra-psychic dialogue

Closely related to the irrational beliefs and expectations discussed in the foregoing subsection is the intra-psychic dialogue. The intra-psychic dialogue can be explained as "*the way in which people think about themselves*" (Venter, 2008:19) and is also known as self-talk. It is, in other words, what one says to oneself when interpreting and dealing with a particular scenario. It goes without saying that an individual's intra-psychic dialogue will be influenced by the beliefs and reasoning biases which he or she fosters. Evidence shows that anxious youth engage in negative thinking when confronted with a (potentially) dangerous stimulus or situation (Muris, 2007:153). Examples of negative (and irrational) negative self-statements are *"People will always notice my embarrassment and respond negatively"* or *"The worst possible outcome will always occur"* (Muris, 2007:153).

2.3.6 Conclusion

With such a large variety of factors that play a role in the development, maintenance or exacerbation of anxiety, it is difficult to establish a definite cause-effect pattern, a predictable sequence of events, or a 'recipe' for the development of anxiety. It rather appears as though many factors, both internal and external to the individual, interact with one another in a complex manner. According to Hill and Coulson-Brown (2007:50) the diathesis stress-model is valuable in the understanding of the development of anxiety, which becomes a product of *"the interaction of a genetic predisposition with multiple possible environmental and experiential factors"*. A holistic approach should thus be followed when attempting to understand the origin(s) of a child's performance anxiety.

2.4 THE EFFECTS OF ANXIETY

According to Beidel, Turner and Morris; La Greca and Lopez; Beidel and Turner; Beidel *et al.*; Beidel; Spence, Donovan and Brechman-Toussaint; and Kearny (Southam-Gerow & Chorpita, 2007:350) children with social phobia present with higher levels of depressed mood, lower perceptions of cognitive competence, higher trait anxiety, higher self-reported state anxiety during an evaluative task, impaired social skills and a likelihood of becoming oppositional. In terms of the more specific symptoms of anxiety, certain physiological, cognitive and behavioural responses tend to occur. The schematic representation on the following page summarises these symptoms or effects, where after it will be discussed in more detail.

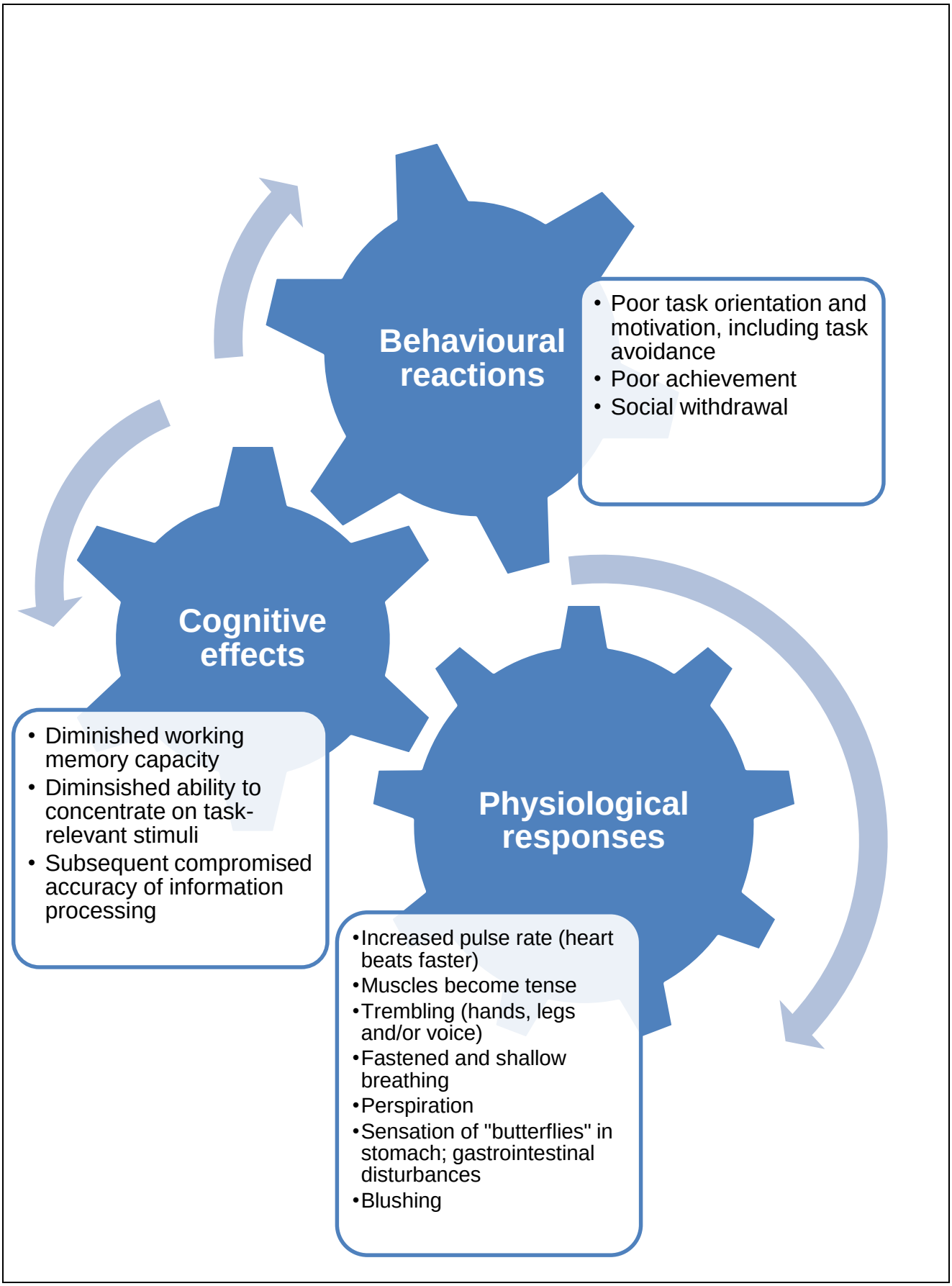


Figure 2.4 The effects of anxiety

2.4.1 Physiological responses

Recent studies used the term 'physiological hyper-arousal' to refer to the physiological arousal produced by anxiety (Beidel in Whitaker *et al.*, 2007). As Pargman (2006:71) explains in his book about performance stress, the sympathetic nervous system kicks in when a person is under threat or stress, preparing the body for fight or flight. Greene (2002:17) refers back to this *"primitive fight-or-flight reaction"* as a consequence of adrenaline which is released into the bloodstream, priming the human body to either fight or flee from an encountered danger. Greene (2002:17) continues to explain that, unfortunately, one's body cannot tell the difference between a real threat (like a tiger) and a self-perceived threat (like a math test), and so the physiological reaction to fear remains the same:

- The pulse rate increases.
- The increased heart rate sends more energy to one's large muscles and extremities.
- Muscles become tense.
- One's hands start to shake.
- Breathing gets faster, higher up in the lungs and shallower.
- Increased stomach acid produces the feeling known as 'butterflies'.
- One starts to perspire

In addition to the above, gastrointestinal disturbances such as nausea and diarrhoea might occur, as well as blushing and voice tremors. Certain physiological reactions (such as blushing and a shaky voice) are often visible to other people, which then adds to the embarrassment experienced by the already socially anxious individual (Wehrenberg & Prinz, 2007:191-194).

2.4.2 Cognitive effects

With regards to emotional arousal and its impact on cognitive functioning, Cusinier (2011:73) refers to the theories of Piaget as well as Yerkes and Dodson. Piaget acknowledged the fact that the intellect needs emotional arousal to speed up its development. Yerkes and Dodson further postulated the importance of the appropriate level of arousal in order to achieve an optimal level of cognitive performance. The functional relation which they identified between arousal and task demands was this: the more difficult the tasks, the lower the level of emotional arousal required for optimal performance. However, as Pargman (2006:108) explains, "*if the arousal level is moved out of its optimal range for performance of a particular skill, efficiency and accuracy may diminish*".

The effects of emotional arousal in the form of anxiety, specifically with regards to its effect on cognitive functioning, will be discussed in more detail as follows.

2.4.2.1 Working memory

Working memory is "*the ability to actively maintain information in conscious awareness, perform some operation or manipulation with it, and produce a result*" (Wechsler, 2003:8).

According to the Processing Efficiency Theory, as proposed by Eysenck and Calvo (in Fales, Barch, Burgess, Schaefer, Mennin, Gray & Braver, 2008), anxiety may lead to worry and ruminative thoughts which are believed to intrude on normal cognition by taking up working memory resources and distracting the individual from focusing on the task at hand. Sarason (in Whitaker *et al.*, 2007) explains that worry is believed to absorb some of the processing capacity of working memory. Zeidner (in Whitaker *et al*, 2007) adds to this the fact that, as worry increases, more effort and spare processing capacity are devoted to the solution of the anxiety problem, at the expense of solving the real problem (such as the question or problem in a test).

Thus, anxiety may diminish the capacity of the working memory and the individual may subsequently experience an increased level of difficulty when required to execute complex mental operations. This could explain why a child may cope well with a Math problem in class, however when this skill is being tested, anxiety may cause a deficiency in his ability to perform the same type of task with equal speed and accuracy.

2.4.2.2 Attention and concentration

Pargman (2006:112) defines attention, in this particular context, as *"concentration upon stimuli that are relevant to the particular problem, issue, task, or challenge at hand"*. Pargman (2006:112) explains that *"attentional focus"* is necessary for information processing efficiency, which in turn affects performance. According to Greene (2002:20) stress can cause attention problems which take one's focus away from immediate performance, to other times or places. Concentration problems have, for example, been found to occur in students who suffer from test-anxiety (Swanson & Howell in Whitaker *et al.*, 2007). Anxiety further affects cognitive functioning in the sense that it can prevent pupils from exercising all of their capacities in order to execute functions, such as mathematical reasoning for example (Cusinier, 2011:74).

Attentional problems caused by anxiety can have detrimental effects on learners' performance during tests or exams. The worry component of test anxiety lowers test performance because thought patterns concerned with worrying cause cognitive obstruction (Hembree in Whitaker *et al.*, 2007). Hodapp (in Whitaker *et al.*, 2007) defines cognitive obstruction as "*the degree to which (test) anxiety disrupts the ability of an individual to organise his or her thoughts or to concentrate on the task at hand*".

2.4.3 Behavioural reactions

2.4.3.1 Task-orientation and motivation

Anxiety and past failure may cause a pupil to become de-motivated. It may become easier for the child to avoid anxiety-provoking situations. For example, poor motivation has been found among test anxious students (Swanson & Howell in Whitaker *et al.*, 2007). Unfortunately, as Muris (2007:153) explains, biased and negative thinking when confronted with a (potentially) threatening stimulus or situation, promotes avoidant coping strategies, and in the long run maintains fear and anxiety.

2.4.3.2 Achievement

Compromised attention and working memory capacities negatively impact on the quality of an individual's output during task-performance. For example, the Hembree meta-analysis (in Ashkraft & Krause, 2007) summarizes the outcomes of various studies exploring the correlation between math anxiety and performance. The outcome of these studies revealed that the higher one's Math anxiety, the lower one's Math learning, mastery and motivation. Simply put, *"as Math anxiety increases, math achievement declines"* (Ashkraft & Krause, 2007). A higher rate of grade retention (Hembree in Whitaker *et al.*, 2007) and school dropout (Tobias in Whitaker *et al.*, 2007) has been associated with students who specifically suffer from test anxiety.

2.4.3.3 Social functioning

As mentioned earlier in the section that dealt with the possible causes of performance anxiety, Lopez (in Festa & Ginsburg, 2011) established that adolescents with higher social anxiety reported having fewer friendships. It is difficult to determine whether this phenomenon is a cause or an effect (or both) of social anxiety. However, one can expect that a child who lacks confidence and who fears social evaluation will, as a result, avoid social interaction. This is confirmed by Smith and Jaffe-Gill (2012), who state that one of the symptoms or effects of social phobia is the avoidance of social situations to such a degree that it limits or disrupts one's life. An individual who suffers from social phobia is also likely to stay quiet or hide in the background in order to escape notice and embarrassment, feels a need to always take a friend a long wherever he or she goes, and may revert to drinking before social situations in order to soothe his/her nerves (Smith & Jaffe-Gill, 2012). If untreated, the condition of social phobia leads to substantial impairments in social (and vocational) functioning (Hofman *et al.,* 2006).

2.5 THE NEGATIVE CYCLE OF PERFORMANCE ANXIETY

As Cusinier (2011:75) puts it, the various studies done on the relationship between emotion and cognition make it difficult to know which is actually antecedent. For example, the anxious person might reason *"I am anxious, which makes me focus my attention on threatening information, which in turn reinforces my anxiety, which in turn makes me focus on threatening information"* (Cusinier, 2011:75).

In the previous sections, thought processes associated with expecting bad things to happen were not only reported as a contributory factor to the development of anxiety, but also as an effect of anxiety. It seems almost impossible to establish which came first – the thoughts or the anxiety. Just as the two components of emotion and cognition constantly influence one another, so do other components of anxiety appear to do the same, as will be briefly discussed in the following sub-sections.

2.5.1 Physiological responses and anxiety

The physiological sensations associated with anxiety have been reported in the literature as being not only responses to the emotion of anxiety but often also become conditioned internal cues that may cause new episodes of anxiety.

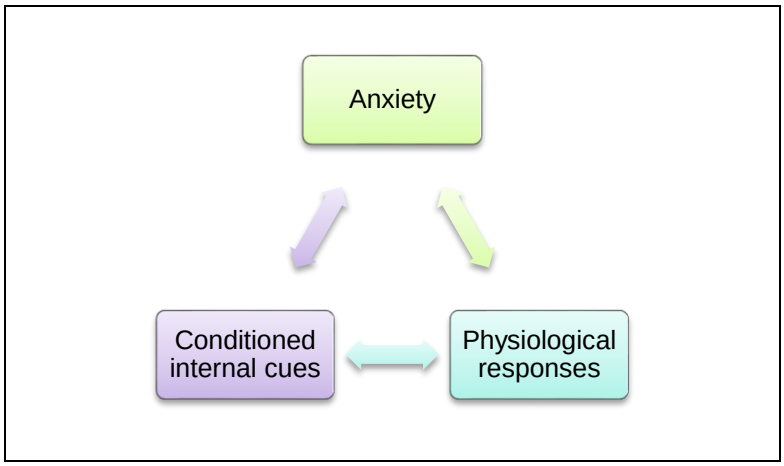


Figure 2.5 Physiological responses and anxiety

2.5.2 Task avoidance and anxiety

Task avoidance have been reported in the literature as being a response to anxiety but also as an ineffective coping strategy that may exacerbate fear and anxiety in the long run.

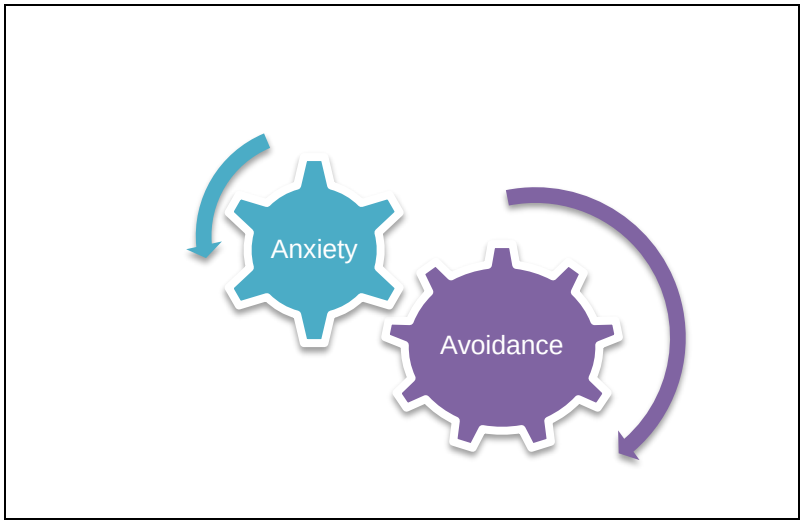


Figure 2.6 Avoidant behaviour and anxiety

2.5.3 Negative self-talk and anxiety

Negative self-talk (for example expecting to make a mistake) has been reported as a response to anxiety and failure, but in turn may also cause new episodes of anxiety.

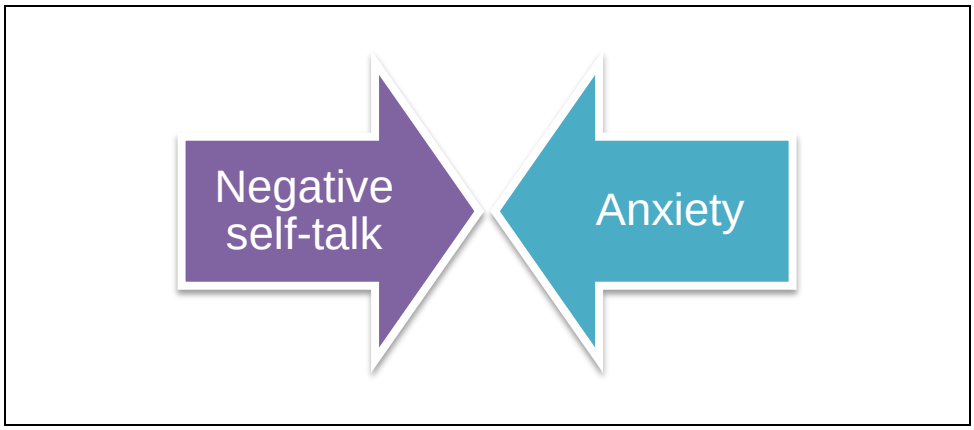


Figure 2.7 Negative self-talk and anxiety

2.5.4 Failure and anxiety

According to Erikson's psychosocial developmental theory, an inability to reach success in life causes feelings of failure, inferiority and self-doubt. This may contribute to a negative self-esteem, poor confidence and ultimately performance anxiety. The diminished ability to focus on task-relevant stimuli which is often caused by anxiety leads to poor processing ability and accuracy of output and ultimately more experiences of failure which only exacerbates the level of anxiety.

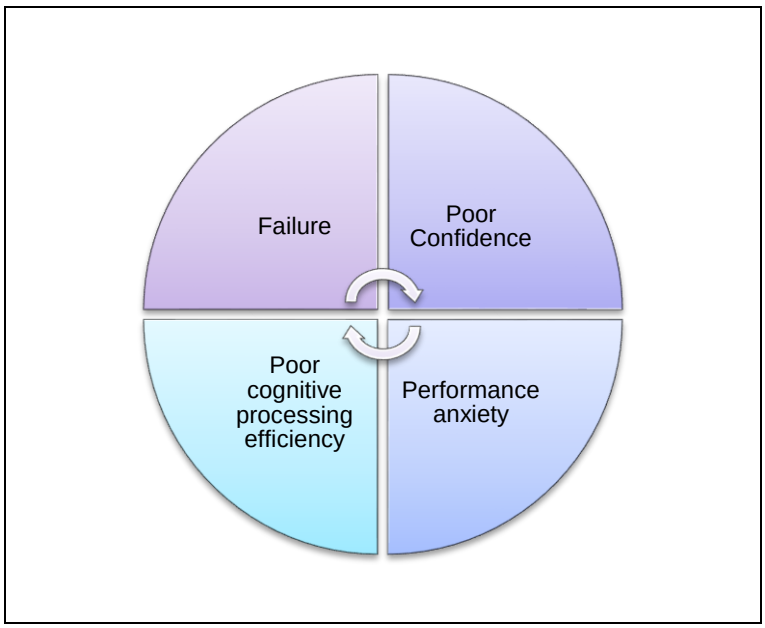


Figure 2.8 Failure and anxiety

2.5.5 Social inhibition and anxiety

A shy, inhibited temperament has been reported as being a possible contributory factor to developing social phobia. In turn, the social embarrassment associated with performance anxiety reinforces social inhibition and avoidance. Similarly, a perception of low social

acceptance and little social support reportedly increases to the risk of developing anxiety, while it has also been reported as consequences of social anxiety. Thus, impaired social skills and social withdrawal do not only possibly lead to developing social phobia, but is also worsened by social phobia.

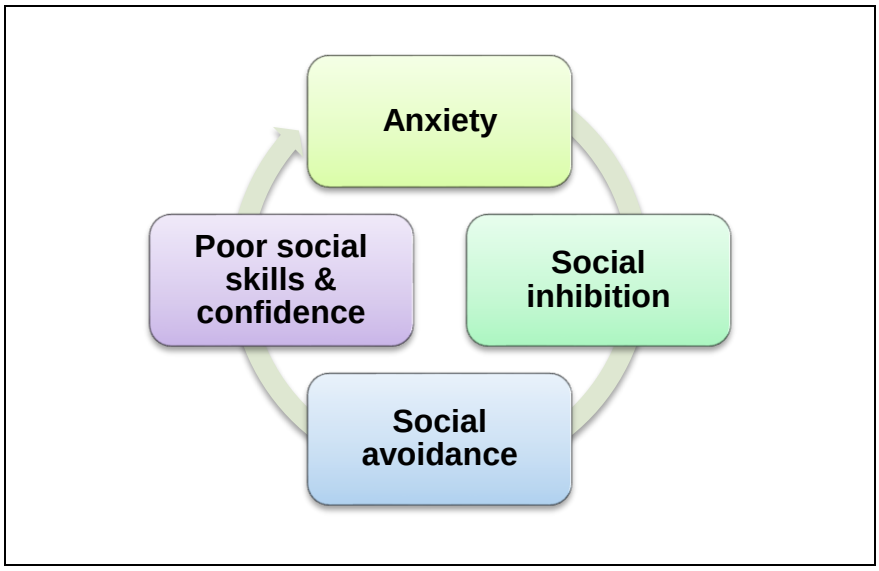


Figure 2.9 Social inhibition and anxiety

2.5.6 Conclusion

In light of the above, it appears as though the factors associated with anxiety should not be viewed as 'causes' or 'effects', but rather as a variety of factors that may become part of a negative cycle or interaction, continuously maintaining or even exacerbating the problem. This calls for a holistic conceptualization of anxiety and in particular social phobia (which often manifests as performance anxiety in the school environment). Figure 2.10 on the following page summarizes those factors in an aim to support such a holistic understanding of the phenomenon.

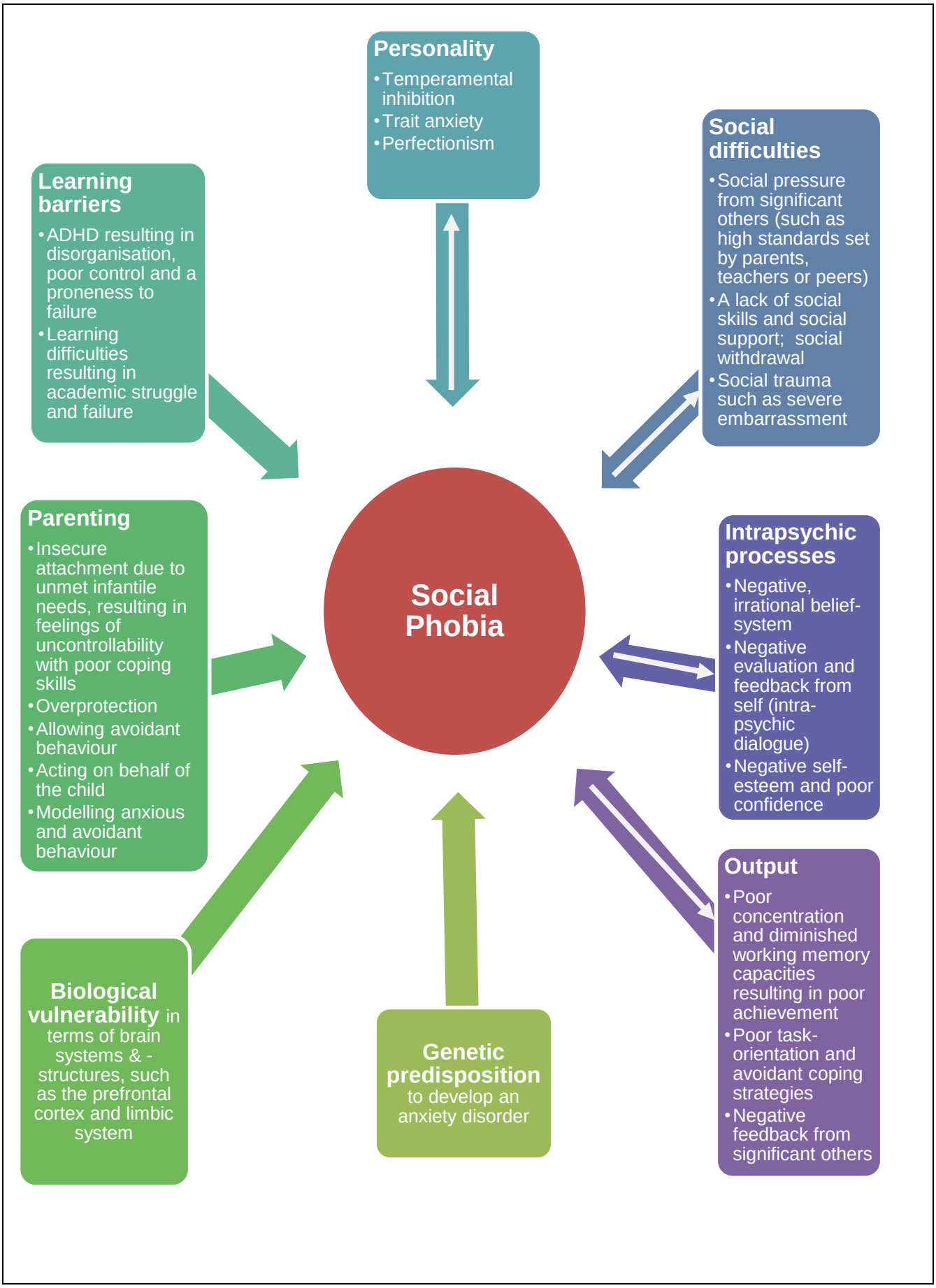


Figure 2.10 *Holistic view on the factors associated with social phobia*

2.6 ASSESSMENT OF PERFORMANE ANXIETY

When attempting to assess a child's anxiety, it is important to remain cognizant of the fact that children do not always present exclusively with one anxiety disorder. Often the anxiety is accompanied by some co-morbidity. Evidence revealed that the majority of youth with anxiety disorders are likely to have at least one co-morbid disorder (Brady & Kendall; Russo & Beidel in Southam-Gerow & Chorpita, 2007:352). Co-morbidity among the different anxiety disorders is especially common, with generalised anxiety disorder, separation anxiety disorder and social phobia frequently co-occuring (Southam-Gerow & Chorpita, 2007:352). Performance anxiety as a form of social phobia may thus not always necessarily appear in isolation from other disorders.

2.6.1 Assessment procedures

According to Flannery-Schroeder *et al.* (2007:202) "*accuracy in assessment is critical to proper diagnosis, case formulation, treatment planning, and evaluation*". There reportedly exists considerable debate about who is able to provide the most accurate report of the child's inner distress - the parent or the child - although Flannery-Schroeder *et al.* (2007:202) consider children's self-reports as crucial in accurate assessment. In order to conduct a comprehensive clinical assessment, a multi-method assessment approach is recommended by the aforementioned authors, where child-, parent-, teacher- and even peer-reports regarding the child's behaviour, over a variety of contexts, are taken into account (Flannery-Schroeder *et al.*, 2007:203).

Southam-Gerow and Chorpita (2007:357-360) briefly describe the primary methods used to assess child anxiety, including the advantages and disadvantages of each method. These assessment methods will be summarised in the following sub-sections.

2.6.1.1 Questionnaires

Examples of questionnaires that may be used to assess a variety of anxiety disorders in children are the SCAS (Spence Children's Anxiety Scale), the SCARED (Screen for Child Anxiety Related Emotional Disorders) or the LOI-C (Leyton Obsessional Inventory – Child Version), among many others (Southam-Gerow & Chorpita, 2007:364-365).

Advantages:

- Questionnaires are the most thoroughly researched assessment methods;
- They permit a high degree of respondent privacy, in the sense that the responded needn't reveal personal feelings by speaking them, face to face, to another person.
- Questionnaires often have multiple versions, enabling the inclusion of multiple reporters when assessing children.

Disadvantages:

- Questionnaires lack a systematic way in which to clarify responses in order to ensure validity. For example, if a respondent misunderstands a question, his respond will be invalid.

- The information obtained from the assessment is limited to what is asked.
- Questionnaires require respondents to be literate in the applicable language.

2.6.1.2 Diagnostic interviews

Examples of diagnostic interviews that may be used to assess anxiety disorders in children are the ADIS-C/P (Anxiety Disorders Interview Schedule for Children and Parents) or the DISC (Diagnostic Interview Schedule for Children) (Southam-Gerow & Chorpita, 2007:376). Compared to unstructured clinical interviews, structured diagnostic interviews

- yield more objective and quantifiable data,
- facilitate comprehensive assessment of a range of disorders, and
- increase the specificity of the information gathered (Costello, Egger & Angold; Shaffer *et al.* in Southam-Gerow & Chorpita, 2007:358).

A reported disadvantage of the structured diagnostic view however is the lengthy administration time, which may take up to five hours when both parent and child are interviewed (scoring and interpretation excluded).

2.6.1.3 Observational methods

Due to the fact that observational procedures, such as the Behavioural Avoidance Test (BAT), were designed for specific, idiographic purposes, they do not possess the same evidence base as questionnaires and interviews do. Southam-Gerow and Chorpita (2007:358) recommend that observational procedures rather be used as a means of assessing treatment progress and outcome.

Advantages listed for the BAT specifically are that it

- is a straightforward procedure,
- has direct relevance to desired outcomes, and
- allows for concurrent monitoring of different types of responses (e.g. physiological responses and motor behaviour).

Disadvantages for the BAT and other observational methods include the following:

- The accuracy of observational methods cannot be ensured, as an objective criterion often doesn't exist.
- The mere presence of observers can influence the behaviour being observed (Tyron in Southam-Gerow & Chorpita, 2007:359), leading subjects to act differently than normal. This is referred to as reactivity. There are however some methods for minimizing reactivity, such as using participant observers, using video cameras or tape recorders, minimizing subject-observer interaction, and allowing enough time for reactivity to lessen (Haynes & Horn in Southam-Gerow & Chorpita, 2007:359).
- Factors such as expectancies and observer drift (the tendency of observers to rate the same events differently over time) may bias the reports of observers.
- Observational methods are more challenging to practically apply or administer.

- There is little chance that observational methods will have the same scope of dissemination and penetration as standardized questionnaires and checklists.

2.6.1.4 Physiological assessment

Anxiety and stress have clear physiological manifestations in terms of heart rate, blood pressure, cortisol levels or galvanic skin response – which can all be physically measured.

Advantages:

- Physiological assessment eliminates the reliance on potentially subjective reporting.

Disadvantages:

- Anxiety-focused research on such measures with children is rare (Beidel & Turner in Southam-Gerow & Chorpita, 2007:360).
- The measures used are likely to gauge constructs broader than anxiety alone (Beauchaine; Thayer & Lane in Southam-Gerow & Chorpita, 2007:360).

2.6.1.5 Psycho-analytical methods

One psycho-analytical method to apply in the assessment of anxiety, mentioned by Pargman (2006:120), is the method of hypnosis. He explains that the most beneficial use of hypnosis in assessing stress (or anxiety) is breaking down unconscious barriers that may prevent a client from revealing the identity of his real stressors. Hypnosis can reportedly also be helpful in clarifying the reasons behind the client's physiological manifestations of anxiety. Other psycho-analytical assessment methods include projective instruments such as the TAT (Thematic Apperception Test) for example. Projective instruments enable subjects to indirectly report their perceptions, thoughts, attitudes or feelings. It should be noted however that a projective test like the TAT or a sentence completion test do not measure anxiety alone, but rather provides the individual with the opportunity to make known any other needs and interests that he might have. A skilled examiner needs to analyse the individual's responses (Pargman, 2006:120).

2.7 TREATMENT OF PERFORMANCE ANXIETY

The literature yields various approaches to the treatment of anxiety disorders. Broadly, psycho-therapeutic interventions, pharmaceutical interventions, or a combination of both seem to be typically employed.

2.7.1 Psychotherapeutic interventions

Anxiety disorders in general can be treated individually or in groups. According to DiGiuseppe (in Vernon, 2007:121), Ellis (who has been a strong proponent of Rational Emotive Behaviour Group Therapy), has suggested that "*groups are most helpful for children with social difficulties because exposure to others help them develop social skills*". Smith and Jaffe-Gill (2012) urge sufferers of social phobia to join supportive social environments such as a social skills class or an assertiveness training class. Flannery-Schroeder *et al.* (2007:200) report on the benefits of group therapy. These benefits

reportedly include, but is not limited to, improved cost-benefit ratios, social interactions with peers (i.e. positive peer modelling), and opportunities to be exposed to multiple anxiety-provoking situations.

Group therapies can be administered in a variety of settings, namely school settings, classrooms, outpatient settings, inpatient settings, residential treatment settings and medical settings. This research project focuses mainly on the implementation of intervention within the school setting. School Settings have been argued to be ideal for providing mental health interventions, firstly because of the convenience of accessibility to students, and also because of the social aspects "*that create a laboratory for students to practice newly learned skills*" (Smallwood *et al.,* 2007:102).

2.7.1.1 Cognitive-behavioural Therapy (CBT)

According to Beck, Rusch, Shaw and Emery in Stewart *et al.* (2007:9) the aim of CBT in general is "*to identify and restructure irrational or distorted beliefs and schema related to the self, others, and the world that produce emotional distress and maladaptive behaviours*". Flannery-Shroeder *et al.* (2007:205) explain the three dimensions of anxiety (physiological, cognitive and behavioural) according to the CBT-model as follows: On the physiological level, anxiety alerts the child to impending danger via activation of the autonomic nervous system (ANS). This leads to physiological responses such as sweating, tightening of muscles, headaches and stomach pains as the child's body prepares for 'fight or flight' (Albano & Kenall in Flannery-Schroeder *et al.*, 2007:205). On cognitive level, the child perceives the dangerousness of the situation through estimations of his own ability to cope. If he believes that he cannot cope, these beliefs manifest behaviourally through avoidance of the anxiety-provoking situation or crying.

Research has indicated the effectiveness of a cognitive behavioural approach to addressing anxiety disorders. According to Baer and Garland (in Friedberg, 2007:132), who conducted a pilot study of community based group-CBT, adolescents with social phobia showed symptom reductions on objective and subjective reports after the course of therapy. Muris and colleagues (in Friedberg, 2007:132) established that CBT treatment was superior to emotional disclosure groups in reducing anxiety (and depressive) symptoms in 9-12 year old children. Of all the professional treatments available, CBT has reportedly been shown to be the most effective approach for the treatment of social phobia (Smith & Jaffe-Gill, 2012). Examples of established, researched CBT-programs which can be used to treat social phobia are the following:

- Social Effectiveness Therapy for Children (SET-C) is a cognitive-behavioural treatment approach for socially anxious youth. Research has demonstrated the effectiveness of this approach in children 7 to 13 years of age (Friedberg, 2007:132).
- Kendall's Coping Cat anxiety program can be adapted for a variety of anxiety disorders in youths (Gosch & Flannery-Schroeder, 2006:68-69).
- The FRIENDS for Life program is an evidence-based, cognitive-behavioural anxiety program for children and youth (Barrett in Barret & Pahl, 2006:55-75).

- The Coping Koala program (Barret in Smallwood *et al.*, 2007:99) is another cognitive-behavioural program that has been employed in group format for the treatment of childhood anxiety disorders.
- The Worry Wars: A Protocol for Treating Childhood Anxiety Disorders, is an intervention that integrates cognitive-behavioural concepts and methods with therapeutic storytelling (narrative therapy) and play therapy (Goodyear-Brown, 2011:129).
- Exposure Therapy can be delivered in either individual or group therapy format and involves exposure to increasingly challenging social performance situations (e.g. public speaking) while practicing the skills learnt during CBT. Exposure therapy is thus quite similar to systematic desensitisation. It has been reported to be one of the most effective forms of psychotherapy for social phobia (Hofmann *et al.*, 2006).

Campbell (2009) is of the opinion that CBT-programs do not work with all anxious children, and especially not with younger children, possibly because of the verbal and abstract language that is often used in such programs. Young children's vocabulary is more limited, and even more so when the child has a language-based learning disability. Also, young children may have difficulty in understanding some of the abstract concepts presented in CBT. In order to overcome such barriers, Campbell (2009) suggests that one incorporates other modalities such as play therapy techniques into a CBT framework. Play therapy provides the opportunity to enhance communication by means of non-verbal techniques, whilst also engaging children to express themselves and learn coping skills in a safe environment. Other proposed therapeutic techniques which may be incorporated into a CBT-framework are sand-play, puppets and painting (Campell, 2009).

2.7.1.2 Rational Emotive Behavioural Therapy (REBT)

REBT (Rational Emotive Behavioural Therapy) rests on the principle that "*emotional problems result from irrational beliefs about the event, rather than the event itself"* (Vernon, 2007:109). The aim of REBT is to dispute such irrational beliefs, so that more moderate, healthy feelings and productive behaviours may be instilled in the client (Vernon, 2007:109). An integral component of this is the *"A-B-C-D-E-F-paradigm"*, which involves the following components (Dryden & Neenan; Dryden, DiGiuseppe, & Neenan, in Vernon, 2007:109-110):

A – Internal or external **a**ctivating event

B – Irrational or rational **b**eliefs

C - **C**onsequences (feelings and behaviors)

D – **D**ispute irrational beliefs.

E – Achieve **e**ffective new philosophy and

F – New **f**eeling

Children are taught to identify the activating agent, their own irrational beliefs and subsequent feelings and behaviours. They then practice changing (disputing) irrational

beliefs by replacing it with more positive and rational beliefs, in order to arrive at a new, more positive feeling.

According to Cusinier (2011:62), research indicates that it is more beneficial to reappraise emotion-eliciting stimuli than it is to suppress an emotional reaction that has already occurred. This is because controlling (suppressing) this emotional response is effortful and takes up resources that could have been dedicated to cognitive processing. REBT allows for such reappraisal of emotion-eliciting stimuli.

2.7.1.3 Relaxation training

Relaxation training can be used as part of a cognitive-behavioural approach to the treatment of anxiety, as CBT focuses on, among other things, the physiological aspects of anxiety. According to Smith and Jaffe-Gill (2012), learning to slow down one's breathing can help in bringing one's physical symptoms of anxiety back under control. In addition, regular practice of other relaxation techniques such as mediation, yoga and progressive muscle relation can also help one gain control over the physical symptoms of anxiety (Smith & Jaffe-Gill, 2012).

2.7.1.4 Narrative therapy

According to White (in American Mental Health Counselor's Association, 2009) narrative therapy views clients' problems as dominant stories, and therapy aims at "*replacing problem-maintaining dominant stories with preferred narratives about their lives"*. A fundamental principle of this therapeutic approach entails externalizing and naming the problem. This linguistically separates the problem from the client and encourages them to see that "*they are not the problem, the problem is the problem*" (White & Epston in American Mental Health Counselors Association, 2009).

2.7.1.5 Cross-age tutoring

Cross-age tutoring is a form of peer tutoring, and involves older students helping younger students learn new skills or concepts. This approach is closely related to the idea of role reversal. Many studies have reportedly shown that a cross-age tutoring relationship can benefit both tutor and tutee academically, socially and affectively (Campbell, 2009). A pilot study that used cross-age peer tutoring as a method of intervention for anxious adolescents, revealed that secondary school students who were acting as tutors decreased their scores on anxiety self-report measures (Campbell, 2008). The use of cross-age tutoring as well as other forms of peer tutoring will be discussed in more detail later section 2.8.

2.7.2 Pharmacological interventions

As was discussed earlier in this chapter, various factors contribute to the development and maintenance of anxiety disorders. Among these factors are the neurotransmitter systems in the brain, as were briefly outlined in 2.3.1.2. In order to address chemical imbalances within these systems, various forms of medication may be used. Smith and Jaffe-Gill

(2012) briefly describe three types of medication that are normally used in the treatment of social phobia.

2.7.2.1 Beta blockers

Beta-blockers are used for relieving performance anxiety, and they work by blocking the flow of adrenaline which is normally released during episodes of anxiety. Beta-blockers specifically control the physical symptoms of anxiety, such as shaking hands or voice, sweating and rapid heart rate. They however do not affect the emotional symptoms of anxiety (e.g. excessive self-consciousness, intense worry and fear) (Smith & Jaffe-Gill, 2012).

2.7.2.2 Antidepressants

Antidepressants are also known as selective serotonin reuptake inhibitors (SSRI's) and can be helpful when social phobia is severe and debilitating. Examples of antidepressants are Paxil, Effexor and Zoloft. These antidepressants have been approved by the U.S. Food and Drug Administration for the treatment of social phobia (Smith & Jaffe-Gill, 2012). It usually takes approximately six to eight weeks to work (Grohol, 2011).

2.7.2.3 Benzodiazepines

Benzodiazepines, which are fast-acting anti-anxiety medications, are only prescribed when the aforementioned types of medication for social phobia have not worked. This is because they are sedating and addictive (Smith & Jaffe-Gill, 2012).

2.7.3 Combining psychotherapeutic and pharmacological interventions

Whilst medication can be used to relieve the symptoms and possible physiological causes of social phobia, it is not a cure and it does not tap into the other causes (environmental and psychological) of the disorder. Symptoms generally return after discontinuing the use of medication (Smith & Jaffe-Gill, 2012). Combining medication and psychotherapy may help prevent such re-occurrence of symptoms. As Wehrenberg and Prinz (2007:235) state, medication addressing the physiology of social phobia can be administered in order to support the effectiveness of psychotherapy. Numerous outcome trials have demonstrated efficacy for CBT and pharmacotherapy applied in combination with each other (Hofman *et al.,* 2006).

2.7.4 Involvement of family

Parental guidance or family therapy may be helpful in addressing some of the environmental risk factors associated with the development of anxiety disorders. Parental behaviours that contribute to the development and/or maintenance of anxiety symptoms in children may be addressed in family-based CBT, as was established through a study reported by Nauert (2009). The program used in the aforementioned study consisted of hour-long weekly sessions which were designed to help parents identify and change behaviours believed to contribute to anxiety in the children. Such behaviours included overprotection, excessive criticism and excessive expression of fear and anxiety in front of

the children. At the same time, the children were taught coping and problem-solving skills, and risk factors such as avoiding anxiety-provoking situations, as well as anxious thoughts, were targeted. Reportedly, anxiety symptoms decreased by 40 percent in the year following the program (Nauert, 2009).

2.7.5 Involvement of schools and teachers

Cusinier (2011:73) argues that researchers and professionals in education and psychology need to develop methodologies to improve emotional competencies within school settings by introducing emotional competencies in curriculum. Such emotional competencies refer to "*the abilities to experience, recognize, express, control the expression of, regulate the experience of, and understand emotions"* (Cusinier, 2011:73). Ellis (in Vernon, 2007:125) has emphasised the importance of a prevention curriculum, where all young people can be empowered to help themselves by learning positive mental health concepts. According to Vernon (2007:125), evidence suggests that REE (Rational Emotive Education) can be employed in a school setting through a structured curriculum, teachable moments, integration into the existing curriculum and also through small-group counselling.

With regards to treating social phobia in particular, various researchers advocate the value of school-based programs, as the school environment has many available resources (e.g. access to teachers, peers, real-life exposure) which can aid in such programmes (Klein, 2010; Menutti *et al.*, 2006:65; Gosch & Flannery-Schroeder, 2006:77). However, most school-based techniques identified in the literature are employable only by school psychologists or school counsellors. This leaves little left to do for the teachers, who have the unique opportunity of spending more or less 6 hours per day with their learners, observing their behaviour in real-life situations.

A challenge regarding the treatment of social phobia is the fact that the disorder often goes unnoticed due to various reasons, such as children's inability to express their emotions adequately or teachers' unfamiliarity with the disorder, (Wicks-Nelson & Israel, 2003:128; Wehrenberg & Prinz, 2007:230; Gosch & Flannery-Schroeder, 2006:65). Even when these anxious youths are identified, Campbell (2008) notes the difficulty in providing sensitive programs that do not stigmatize them within the school setting. However, one method that may engage such students in a more positive manner, while additionally including their teachers in the treatment program, is that of cross-age peer tutoring (Campbell, 2008). As was briefly mentioned in 2.7.1.5, cross-age peer tutoring relates closely to the concept of role reversal, which will be further discussed in the following section.

2.7.6 Summary

Based on the literature that were reported on in sections 2.6 and 2.7, there exists a variety of approaches to follow when it comes to assessing and treating anxiety disorders of childhood. The following schematic representation serves to summarize such approaches, with particular reference to the identification and treatment of social phobia.

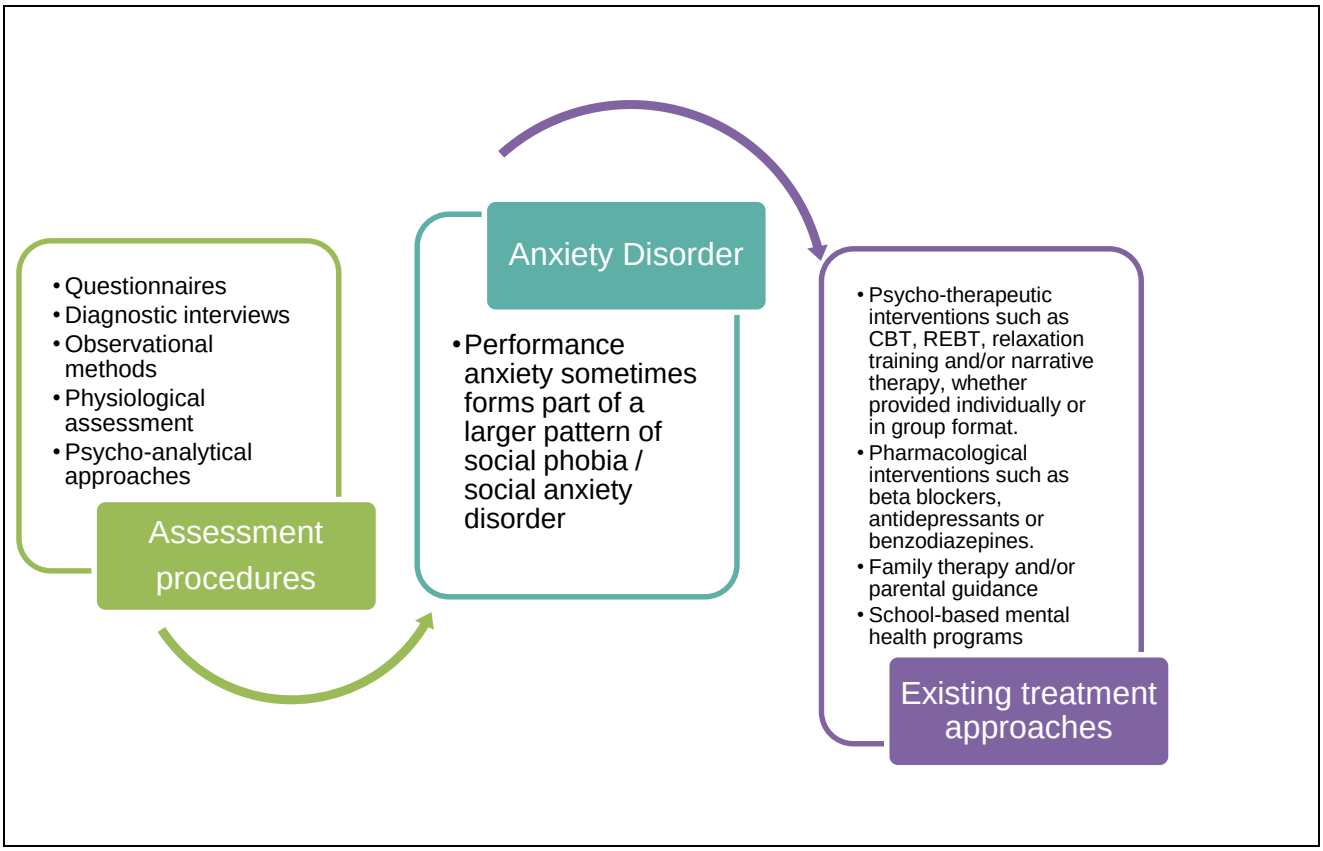


Figure 2.11 Assessment and treatment of anxiety disorders of childhood

2.8 ROLE REVERSAL

'Role reversal' is an idea that was originally discovered through my own personal experiences, as were described in Chapter 1. From there, while conducting the literature search for this study, the concept of peer tutoring was discovered. This concept is quite similar to the idea of role reversal, in that learners are given the opportunity to 'tutor' or teach (and thus help) their peers.

2.8.1 Peer tutoring

2.8.1.1 Definition and types of peer tutoring

Peer support is defined by Charlton (in Ellis, Marsh & Craven, 2009) as "*those planned practices where young people have been given, and are often trained to undertake, a defined task of offering a learning experience to another young person or group*". In peer tutoring, peers serve as "*the instructional agent for other students*" (Harper, Maheady & Malette, in Stenhoff & Benjamin, 2007). Peer tutoring is also known as peer mediated instruction and intervention (PMII), and more specifically, as PMII Dyads (Hall & Stegila, 2003). There are several variations or forms of peer tutoring. These include, according to Utley, Mortweet & Greenwood in Stenhoff & Benjamin (2007):

a) Heterogeneous grouping, in which tutees are taught by tutors in the same grade level with a higher level of knowledge or skill.
b) Homogeneous grouping, in which tutees are taught by tutors with similar skills.

c) Cross-age tutoring, in which a tutor teaches a younger tutee. More specifically, older students help younger students to learn new skills or concepts (Jacobson *et al.* in Campbell, 2008), serving as role models with first-hand experience of what is confronting their tutees (Gaustad in Campbell, 2008).
d) Reverse-role tutoring, in which students with disabilities tutor other students with or without disabilities.

In addition to the aforementioned types of peer tutoring, Hall (2003) adds reciprocal tutoring, where students take turns to play the roles of both the tutor and the tutee.

2.8.1.2 Purpose of peer tutoring

Peer tutoring in general is used for many purposes, although its main purpose appears to be that of supporting the transference and acquisition of specific academic skills amongst students. According to Spencer (2006) findings from various studies suggest that peer tutoring can be a beneficial intervention strategy for enhancing academic functioning for elementary students in the areas of Math, language and specific skills in reading.

Hall and Stegila (2003) outline an additional goal in the use of cross-age or reverse role PMII dyads (tutoring pairs), namely for the older student to learn tutoring behaviours. According to data from research in this area, both students (tutor as well as tutee) benefit interpersonally or socially from the interaction involved in reverse-role tutoring (Top & Osguthorpe in Hall & Stegila, 2003) and cross-age tutoring (Maher in Hall & Stegila, 2003).

2.8.1.3 Peer tutoring with learning disabled children

Campbell (2008) states that students selected to be tutors need not necessarily be the highest achievers academically. Nugent (in Campbell, 2008) found that students with mild learning difficulties were able to successfully tutor younger students who also had learning difficulties (also known as reverse-role tutoring). According to Stenhoff and Benjamin (2007), peer tutoring in secondary settings results in improved academic performance of students with mild disabilities, and could be classified as an evidence-based practice.

2.8.1.4 Peer tutoring with socially- and emotionally challenged children

According to Spencer (2006), research exploring peer tutoring specifically with students who have emotional or behavioural disorders, covers a period of 30 years. The effectiveness of peer tutoring for such students is evidenced in the literature (Blake, Wang, Cartledge & Gardner; Harrigan; Spencer, Scurggs & Mastropieri in Spencer, 2006).

For example, two studies that focused on social behaviours, on-task behaviours and language involving fourth-grade students with behavioural disorders as sign-language tutors of gifted students, revealed positive effects on the attitudes of the tutors as well as the tutees (Shisler *et al.* in Spencer, 2006). Spencer (2006) further notes that *"the teachers and students' comments regarding peer tutoring programs were positive, indicating high treatment acceptability"*.

Three other studies that focused on social and emotional behaviours (Blake *et al.*; Lazerson in Spencer, 2006) yielded positive results in promoting positive peer interactions,

while teachers reported improvements in students' social behaviours. Students also expressed pleasure with the tutoring program, with the tutors commenting that they enjoyed the opportunity to assume the role of the teacher.

Campbell (2008) reports on writers who have conducted studies on cross-age peer tutoring for non-academic skills. For example, Noll (in Campbell, 2008) implemented a program for developing social skills, involving ninth-grade volunteers tutoring learning disabled seventh-grade students, with results indicating significant gains in social development amongst the seventh-graders. Another study conducted by Ellis *et al.* (in Campbell, 2008), which focused on the effects of cross-age peer tutoring on students' self-concept, revealed that students reported a greater capacity to cope with change and seek social support when faced with difficulties.

After having studied various research projects on cross-age peer tutoring, Campbell (2008) identified a need for research to examine cross-age peer tutoring in relation to students with anxiety issues. Campbell (2008) subsequently conducted a small pilot study using the Worry-busters program (developed by Campbell) in a cross-age peer tutoring mode. One group of anxious secondary school students were trained in the Worry-busters program, where after they tutored a group of anxious primary school students in the program. This challenged them to practise their new coping skills in a situation with the potential to elicit anxiety: the act of teaching others. The results of the study indicated a reduction in some of the anxiety symptoms experienced by the adolescents (tutors) and children (tutees).

2.8.1.5 Benefits of peer tutoring

Peer tutoring provides numerous potential benefits for both tutee and tutor (Maheady in Spencer, 2006), such as the following:

- Tutoring increases students' time on tasks, resulting in more opportunity for practice.
- A positive learning environment is created by the additional assistance and support as well as the immediate feedback on academic performance.
- Peer tutoring provides numerous ability levels within the classroom, thus enhancing instructional time for all students.

In addition to the above advantages of peer tutoring, Maheady (in Spencer, 2006) reported that an emerging body of evidence suggests that social and interpersonal benefits may result from the use of peer tutoring.

Various researchers have reported benefits for the peer tutors specifically, such as:

- Academic gains (Maheady, Harper & Mallette in Stenhoff & Benjamin, 2007)
- Cognitive gains (Potter in Campbell, 2008)
- Improvement in communication skills (Noll in Campbell, 2008)
- Improvement in organizational skills (Noll in Campbell, 2008)
- Reduced school absences (Maheady *et al.* in Stenhoff & Benjamin, 2007)
- Increased positive social interactions (Maheady *et al.* in Stenhoff & Benjamin, 2007)

- Improved attitudes towards subject matter (Cohen, Kulik & Kulik in Hall, 2003)
- Increased appropriate classroom behaviour (Hogan & Prater in Stenhoff & Benjamin, 2007)
- Acceptance of greater responsibilities and increased independence in class (Gensemer in Campbell, 2008)
- Improvements in self-concept (Cohen, Kulik & Kulik in Hall & Stegila, 2003)
- Increased self-esteem in students with disabilities when they were in the teacher role during reciprocal tutoring (Hall & Stegila, 2003)
- Development of personal leadership skills (Potter in Campbell, 2008)

2.8.1.6 Children's experiences of the helping role

As discussed in the previous subsections, various research studies have explored the effects and benefits of peer tutoring. Reports stating that peer tutoring can hold many benefits for both the tutee and the tutor appear to be consistent amongst a variety of studies. In studying the various research reports, I was especially interested in the benefits that peer tutoring held for the child taking on the role of the tutor.

As previously noted, some studies have revealed that children who presumed the role of the tutor (in other words, the helping role), revealed that they enjoyed the assuming "*the role of the teacher*" (Blake *et al.*; Lazerson in Spencer, 2006). In the study conducted by Campbell (2008) as was described in the previous subsection, the ability to help also appealed to the adolescent's sense of altruism. The International Encyclopedia of the Social Sciences defines psychological altruism as *"a motivational state with the goal of increasing another's welfare"* (Wikipedia, 2013).

Little more information regarding the tutees' experiences, and in particular the experiences of anxious tutees in the helping role, could be identified in the literature. It is hoped that this research project will reveal meaningful empirical data, which may aid in establishing performance anxious children's experiences of tutoring (role reversal) as a treatment technique for performance anxiety.

2.8.2 Systematic desensitization and exposure therapy

Role reversal shares some similarities with the technique of systematic desensitization. Barlow and Durand (2002:16) define systematic desensitization as a behavioural therapy technique used to diminish excessive fears, involving gradual exposure to the feared stimulus paired with a positive coping experience, usually relaxation. With role reversal, the act of taking on a helping role might become the positive experience for the individual while being exposed to the potentially anxiety-provoking stimulus (the perceived difficult academic task). Role reversal is also very similar to exposure therapy - a technique used to help clients face their fears in real life settings. The difference is that with role reversal, the learner is placed in a situation where the spotlight is actually taken *off* him, possibly making it easier for him to practice and become accustomed to those activities that he normally fears and avoids, such as written expression for example.

2.8.3 Final thoughts on the idea of role reversal

The idea of role reversal rests on the Reflected Appraisal Theory as well as the Social Comparison Theory. As were discussed earlier in this chapter (section 2.3.4.2), the Reflected Appraisal Theory is based on the social constructionist perspective and assumes that self-perceptions are formed from internalizing others' attitudes and communications (Gergen in Narcie & Norwich, 2004). If that is indeed the case, then one could expect that a child who helps his peers learn, and on whom his peers then automatically depend, might internalize such peers' positive regard of him or her as 'the capable one'. Additionally, as were discussed in section 2.3.4.3, according to the Social Comparison Theory (Festinger in Narcie & Norwich, 2004) *"comparisons with those of similar abilities will result in positive self-perceptions, while comparisons with those of high abilities will lead to less positive self-perceptions*". Based on this theory, it is expected that the peer-helper might start to view himself as more capable than the ones whom he is tutoring, which might then result in a more positive perception of himself and his competency in the relevant skill.

2.9 THEORETICAL PERSPECTIVES OF THE RESEARCHER

The relevant psychology theories which shaped my conceptualization of the phenomenon under investigation as well as my approach to offering therapy to the relevant clients (research participants) will be discussed in this section.

2.9.1 An eclectic approach

In this study, an eclectic theoretical approach will be followed in attempting to understand and support children who suffer from performance anxiety. An eclectic approach is an integrative psychotherapeutic approach, which attempts to *"look beyond and across the confines of single-school approaches to see what can be learned from other perspectives",* and which is open to various ways of integrating diverse theories and techniques (Corey, 2005:464). According to Corey (2005:464) there is a trend towards psychotherapy integration, due to the recognition that "*no single theory is comprehensive enough to account for the complexities of human behaviour*". Rather, one attempts to synthesize the best of a few theoretical approaches, under the assumption that the outcome will be richer than either theory alone.

2.9.2 Cognitive-behavioural perspectives

I base many of my views on the cognitive-behavioural perspectives of Ellis, Beck and Meichenbaum. Corey (2005:470) summarizes CBT as a psycho-educational therapeutic model which emphasizes therapy as a learning process. This learning process includes acquiring and practicing new skills, learning new ways of thinking (possibly supported by success-experiences during role reversal activities), and acquiring more effective ways of coping with problems.

2.9.3 Michael White's Narrative therapy

In order to support clients in coping with and managing their problems, I am in agreement with Michael White's technique of externalization (American Mental Health Counsellors Association, 2009). By externalizing the feeling of anxiety and turning it into a metaphoric being that is removed from the child, it is envisaged that the child will be better able to understand the problem in terms of when it is present, which thought processes and behaviours typically accompany it, how it varies or changes in intensity across different situations, and how it can be managed.

2.9.4 Victor Frankl's Existential therapy

Victor Frankl believes in the client's ability to choose what to make of his or her circumstances (Corey, 2005:131). According to the existential view of human nature, humans are able to continually re-create themselves through their projects (Corey, 2005:136). This suggest that children who foster a negative self-concept, or hold faulty negative beliefs about themselves, should be able to change their belief system, if they are provided the right kind of opportunities and support to do so.

The aim of existential therapy or counselling is increasing self-awareness in clients, which includes awareness of alternatives, motivations, factors influencing the person, and personal goals (Corey, 2005:138). The therapist not only assists clients in discovering how they are avoiding freedom, but also encourages them to learn to risk using it. In role reversal, the researcher envisages that the anxious youths, who generally doubt their own abilities, will risk engaging in tasks that might allow them to discover their true potential regarding their academic as well as their interpersonal skills.

2.9.5 Carl Rogers's Person-centred therapy

As a researcher but also as a counsellor, I hold a positive view on human nature, as do Carl Rogers. According to his person-centred therapy, humans have an inclination toward becoming fully functioning. In the context of the therapeutic relationship, the client can actualize his potential and move toward increased awareness, spontaneity, trust in self, and inner-directedness (Corey, 2005:470).

2.9.6 Fritz and Laura Perlz's Gestalt therapy

Like Fritz and Laura Perlz, I am interested in the client's ability to integrate his thoughts, feelings and actions (Corey, 2005:470). The In Gestalt therapy, the therapeutic content has to do with the present here-and-now and emphasizes the client's freedom and responsibility to make choices.

Role reversal might be regarded almost as a variation of the empty chair technique. This technique was developed by Gestalt therapist Fritz Perlz (Corey, 2005:211). It basically involves a dialogue taking place between two opposing roles. These roles can either be those of the client and someone else whom he is in conflict with, or it can represent two opposing sides of himself. Through this role playing exercise, the client can get in touch

with a feeling or side of himself that he may be denying (Corey, 2005:211). With role reversal, the opposing roles would be that of the learner who *can* and the learner who *can't* do the task at hand. Only in this case, it is not a role play exercise but a real life experience, where the client literally becomes the helper, the one who *can,* thereby discovering that part of himself that is capable and confident.

2.9.7 Erik Erikson's psychosocial development theory

As discussed earlier in this chapter, according to Erikson's model of psychosocial development, children between the ages of six and twelve find themselves in the psychosocial stage of 'Industry versus Inferiority'. During this stage the child must learn the basic tasks required for school success in order to develop a sense of adequacy. Role reversal activities have the aim of providing children in this age group with opportunities in which to feel adequate, thereby possibly supporting them in mastering the ego-strength of industry or competence.

2.9.8 Summarizing the eclectic approach

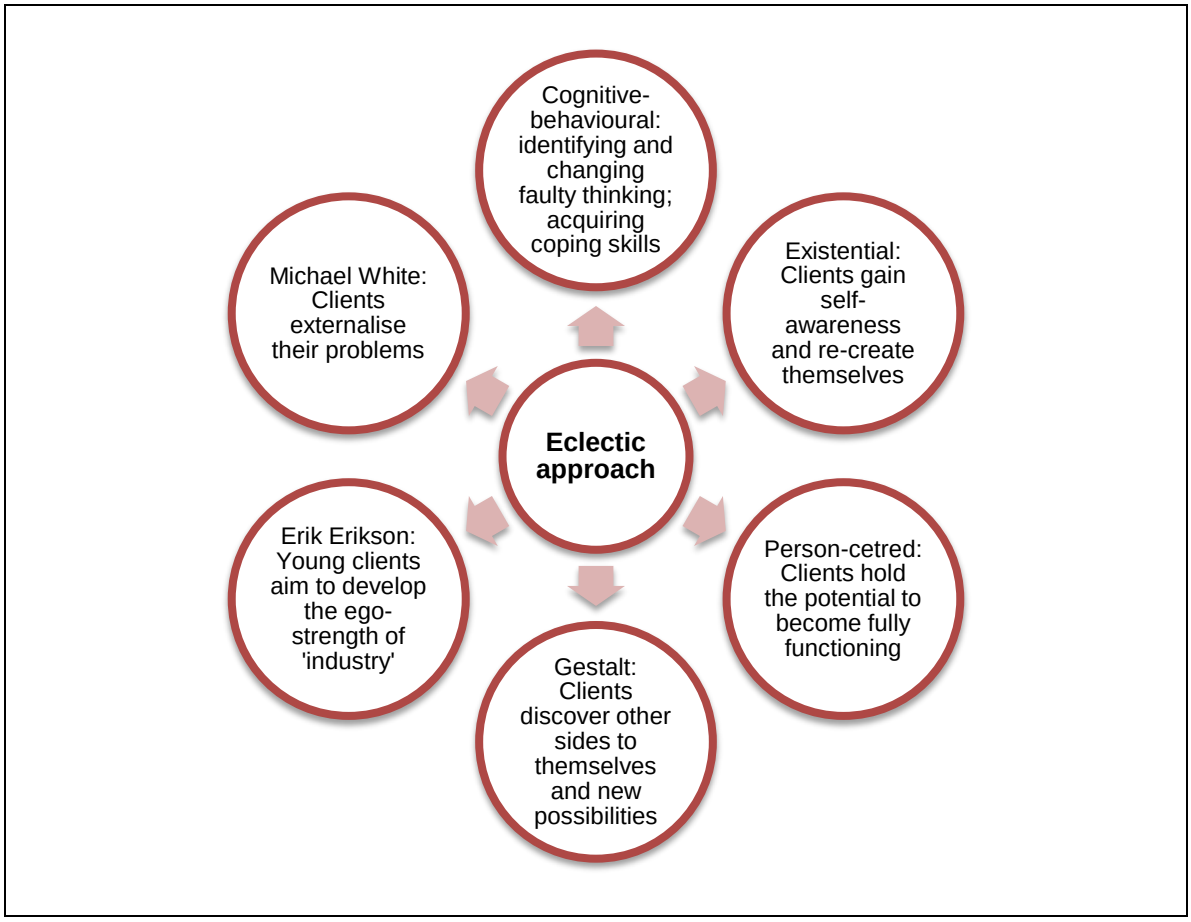


Figure 2.12 Theoretical perspectives of the researcher

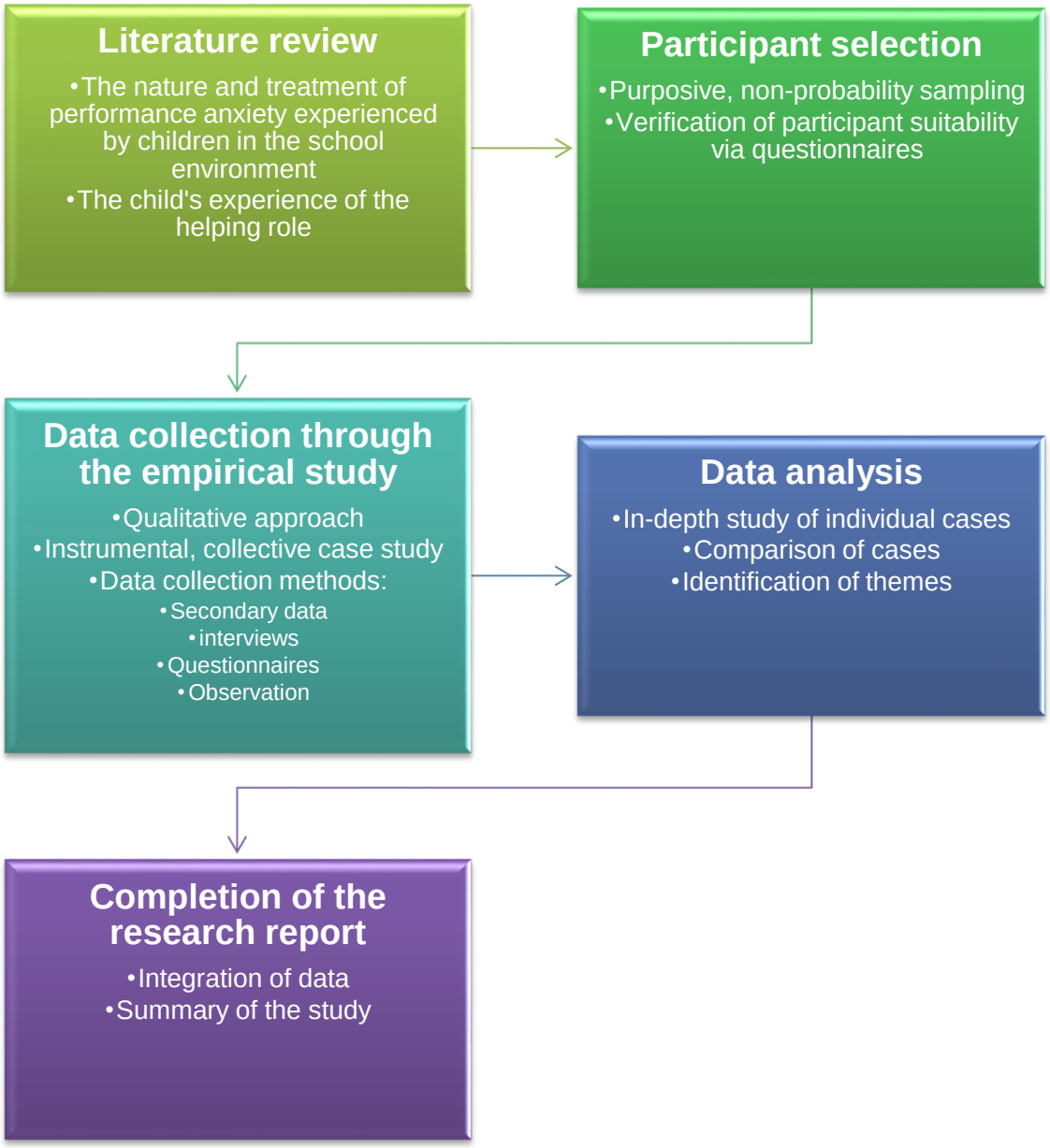
2.10 CONCLUSION

This chapter provided an in-depth discussion of performance anxiety within the broader context of social phobia and anxiety disorders in general. The possible causal factors of

anxiety, the effect of anxiety on a child's functioning, and the tendency of these supposed 'causes and effects' to continuously impact on one another, were discussed. Specific focus was given to environmental, physiological, emotional and cognitive aspects of anxiety. Existing assessment and treatment options for anxiety, and particularly performance anxiety (social phobia), were explored.

In addition to the phenomenon of anxiety, the researcher explored an intervention known as peer tutoring, which links to role reversal as a possible treatment technique for performance anxiety. While many authors have reported on the benefits of peer tutoring, not only for the tutees but especially also for the tutors, very little has been reported with regards to anxious youths' personal experiences of the helping role. The researcher aims to explore the personal experiences of these learners, as well as the usefulness of the technique of role reversal, by means of an empirical investigation. Chapter Three will provide an in-depth discussion of the research methodology to be followed in this regard.

CHAPTER 3
RESEARCH METHODOLOGY



3.1 INTRODUCTION

The term 'research' is defined by Leedy and Omrod (2005:2) as "*a systematic process of collecting, analysing and interpreting information (data) in order to increase our understanding of the phenomenon about which we are interested or concerned*". This chapter describes the systematic process which was followed in order to answer to the research questions and –goals involved in this study. The research aims, design and

methods are explained, along with the ethical guidelines that were followed throughout the process.

3.2 AIMS OF THE STUDY

The aim of this study was to explore the effects and usefulness of a proposed technique for the treatment of performance anxiety experienced by children in school environment.

More particular aims of this study involved the following:

- Embarking on a comprehensive literature review in order to establish which knowledge is available regarding the nature and treatment of performance anxiety experienced by children in the school environment.
- Exploring and discovering, through an empirical investigation, the experiences of children who suffer from performance anxiety when their role becomes that of a helper to other learners in the school environment.
- Learning more about the usefulness and application of role reversal as a treatment technique in the school environment.
- Ideally making a positive contribution to the various techniques typically applied in psychology when supporting children who suffer from performance anxiety within the school environment.

3.3 RESEARCH DESIGN

The research design constitutes the general strategy for solving the research problem, by providing the overall structure for the procedures to be followed, the data to be collected and the manner in which such data are to be analysed (Leedy & Omrod, 2005:85). The design, in other words, acted as the guide which was followed in order to achieve optimal value from this study.

3.3.1 Qualitative research

According to Leedy and Omrod (2005:133), qualitative research approaches focus on studying phenomena that occur in natural settings (in other words the "*real world*"), in all their complexity. Qualitative researchers recognise that different individuals may hold different perspectives, and they aim to reveal these multiple perspectives. The qualitative study assumes an interpretive research approach. As Jacobson, Gewurtz and Haydon (2007) describes, the interpretive research process involves researchers "*immersing*" themselves in participants' worlds, seeking to *"understand and give voice to their perspectives"*.

According to Peshkin (in Leedy & Omrod, 2005:134-135) a qualitative approach can be useful when the researcher wishes to describe, interpret, verify or evaluate phenomena. More specifically, such an approach can enable the researcher to evaluate or judge the effectiveness of particular policies, practices or innovations. In this particular study, the aim was to evaluate a particular method for the treatment of performance anxiety within a real-life school setting. The more specific aim was to discover the personal meanings (perspectives) or experiences that individual children ascribed to their exposure to the

particular treatment approach within their scholastic environment. Thus, a qualitative research approach was considered to be most helpful to gather rich, meaningful data in this study.

3.3.2 Case study

There are different types of qualitative research. Johnson and Christensen (2004:361) believe that phenomenology, ethnography, case study and grounded theory are the four most important types. The case study will be further explained in the following section, as it is the type of research that will be followed in this study.

Case study research is used to provide a detailed account and analysis of one or more cases (Johnson & Christensen, 2004:376). According to Banyard and Grayson (2008:461), case study research is an example of the idiographic approach to research. This approach is concerned with learning about a large number of psychological variables from a small number of cases (Banyard & Grayson, 2008:461). Three different kinds of case studies exist according to Stake (in Johnson & Christensen, 2004:376), namely the intrinsic case study, the instrumental case study and the collective case study. Relevant to this research project are the instrumental and collective case study types.

According to Fouché (2002:267) the instrumental case study is used to elaborate on a theory or to gain a better understanding of a social issue. The case study serves the purpose of facilitating the researcher's gaining of knowledge about the issue under investigation. However, with the use of a single case study, one cannot be sure that the findings can be generalized to other situations (Leedy & Omrod, 2005:135). To overcome this risk, more than one case may be studied in one research study, which would then become what is known as a collective case study. Johnson and Christensen (2004:378) outline a few advantages to studying more than one case, one of which is the use of replication logic. Replication logic is said to have taken place if similar results are obtained from multiple cases (Yin, in Johnson & Christensen, 2004:378). In this study, replication logic contributed to the likelihood that a similar result may happen in a new case.

With this particular research project, children's experiences of a proposed treatment approach for performance anxiety was under investigation. The goal was to achieve the depth of data and analysis normally associated with a single instrumental case study, while also obtaining results that may be generalized to other situations as well, as would be supported by the investigation of more than one case. Therefore, it was ultimately decided that the technique of a collective case study, studied instrumentally, would serve best to gain optimal results from this qualitative research project.

3.4 METHODOLOGY

3.4.1 Ethical measures

The conduct of research with humans has the potential for creating physical or psychological harm, and therefore the treatment of the research participants is the most important and fundamental issue to be confronted by researchers (Johnson & Christensen, 2004:98). Research ethics are defined by Johnson and Christensen (2004:96) as "*a*

guiding set of principles that are to assist researchers in conducting ethical studies". Such guidelines are set by various professional organizations in order *to* ensure the well-being of research subjects (Barlow & Durand, 2002:110). Johnson and Christensen (2004:101-112) provide such guidelines for ethical research with humans. These guidelines were carefully considered in the planning of this research project, and will be elaborated on in the following subsections.

3.4.1.1 Informed consent and assent

Informed consent (from adults) and assent (from minors) refer to the respondents' agreement to participate in the study after having been informed of its purpose, procedure, risks, benefits, alternative procedures and limits of confidentiality (Johnson & Christensen, 2004:102). With this study, the respondents were included as participants only after their parents' consent and their own assent had been given. See Addendums 2 and 3 for the consent and assent forms that were used, which clearly outlined all that was discussed with the children and their parents prior to seeking consent and assent from them.

3.4.1.2 Freedom to withdraw

AERA (The American Educational Research Association) in Johnson and Christensen (2004:110) states that "*participants have the right to withdraw from a study at any time, unless otherwise constrained by their official capacity or roles*". It was made clear to the participants (as well as their parents) that refusing to participate, or withdrawing from the study, would not have any adverse effects on them.

3.4.1.3 Protecting participants from mental and physical harm

As stated earlier, Johnson and Christensen (2004:111) see this principle as the most important principle to be adhered to by researchers. Upholding this principle was strived for by carefully considering all aspects of the study, and particularly aspects that related to the therapy sessions and the manner in which role reversal activities was conducted. The implementation and monitoring of such activities were based on my observations of each participant's functioning in terms of individual temperament, emotional state, peer-helping skills etcetera. Participation in any activity was never compulsory and thus participants had the freedom to choose to refrain from participating in any activity that may have made them feel uncomfortable.

In order to avoid 'labelling' from taking place, other learners in the school were not made aware of the fact that the participants' performance anxiety were being addressed during role reversal activities. Teaching staff and school-based therapists were urged not to make public the child's diagnosis or involvement in the study. During role reversal activities in homework class or normal class-time, the message portrayed to the rest of the peer group was that the teacher believed in the respondent's ability to be of assistance to fellow learners. Nothing was mentioned about the respondents' anxiety or their participation in the study. The participants were thus portrayed by their teachers as helpers (which likely implicated competency) and not as anxious (which may have implicated struggling).

3.4.1.4 Confidentiality and anonymity

Johnson and Christensen (2004:112) define confidentiality and anonymity as follows.

- Confidentiality: The participant's identity is known only to the researcher (or research group) and is not revealed to others.
- Anonymity: The participant's identity is not known to the researcher.

In this study, confidentiality was the appropriate ethical principle. Participants were given the opportunity to make up their own names (pseudonyms) to be used in the research report. The school where the research was conducted was not named in the research report.

With the participants' assent, all group sessions were audio recorded. According to Johnson and Christensen (2004:112) such recordings normally create permanent records which may pose a threat to confidentiality. However, in this qualitative study, such recordings were necessary in order to support me in properly reflecting on and documenting the sessions. In order to overcome the threat to confidentiality, each recording was saved on a password-protected computer, where after it was deleted from the recording device. Back-up recordings were saved on an external storage device which was locked away. All completed questionnaires and field notes were locked away and were only available for viewing by myself and my study leader.

With regards to the confidentiality of information disclosed by participants and their parents, the code of conduct for psychologists (Department of Health, 2006:25) was be adhered to. Prior to the onset of therapy, respondents and their parents were made aware of the fact that all information shared by the child as participant would be kept confidential, unless harm to any person was suspected or anticipated, in which case the participant's parents would be informed. Such disclosure however would only be made with the child's prior knowledge. As set out in the various consent forms (Addendums 2 & 3), confidentiality issues were explained in full to all participants and their parents.

Group members were encouraged to keep confidential all that was shared by other participants during sessions. Each participant was asked to sign a confidentiality agreement as part of their assent form. All teachers and therapists who were aware of the participants to the study were urged to keep the child's participation confidential. The content of discussions between the researcher and participants' teachers or therapists were limited to content that was applicable and useful in supporting the participants (therapy clients).

3.4.2 Measures to ensure trustworthiness

In order to strengthen the trustworthiness of the observations, interpretations and conclusions relating to the data obtained, certain steps were taken which included the following.

3.4.2.1 Supervision

I consulted with my study leader on a frequent basis regarding the progress of the study in terms of the processes followed and the data obtained.

3.4.2.2 Data trail

All contact with participants and other role players (such as the participants' parents and teachers) were recorded in the data trail. Notes, reflections and observations of non-verbal communications such as body language or other behaviours were made during, or as soon as possible after such contact. Such contact included all therapy sessions with participants, scheduled interviews with participants, their parents or their teachers, as well as any incidental contact made with the aforementioned parties, whether in person or telephonic. The data trail is provided in section 3.4.4.

3.4.2.3 Validity

Leedy and Omrod (2005:97) define validity as "*the accuracy, meaningfulness and credibility of the research project as a whole*". Validity can also be termed "*credibility, dependability, confirmability, verification and transferability*" (Leedy & Omrod, 2005:100). Validity in research methodology can be categorized as either internal- or external validity. Internal validity refers to the extent to which the research design and data "*allow the researcher to draw accurate conclusions about cause-and-effect and other relationships within the data*", while external validity refers to "*the extent to which conclusions drawn can be generalized to other contexts*" (Leedy & Omrod, 2005:97-99). Different strategies for achieving or supporting validity exist. In qualitative research, triangulation is especially common, while several additional strategies are often employed.

- Triangulation

This method refers to comparing multiple data sources. The researcher might engage in many informal observations in the field while also conducting in-depth interviews, and then look for common themes. (Leedy & Omrod, 2005:99). In this study, I conducted informal observations (during role reversal activities) as well as interviews with the participants, their parents and their teachers. The child- and parent formats of the Spence Children's Anxiety Scale provided additional reported feelings or perceptions fostered by the participants and their parents. Common themes were identified with regard to the participants' as well as their parents' and teachers' verbal and non-verbal responses.

- Extensive time in the field

With this method, the researcher spends several months studying a particular phenomenon, forms tentative hypotheses and continually looks for evidence to support or disconfirm those hypotheses (Leedy & Omrod, 2005:100). The empirical part of this study was conducted over a period of approximately three months, during which the participants were observed and interviewed (unstructured) on a weekly basis. The extensive time in the field provided me with rich data, which challenged me as the researcher to continuously reassess and adapt my interpretations and conclusions.

- Feedback from others

With this method, the researcher seeks the opinion of others in the field, such as colleagues, to determine whether they agree or disagree with the researcher's interpretations and conclusions (Leedy & Omrod, 2005:100). During the course of this study, frequent discussions with the participants' parents and teachers were held. Discrepancies as well as correlations between my own and the aforementioned parties' observations and opinions supplied meaningful and more objective data. This supported the process of accurate data analysis and interpretation.

- Data trail

According to Richards (2005:43) a data trail can assist in backing up validity claims. As were previously noted, a log or data trail was kept of all contact made with participants and other role players that were involved in the study, including the respondents' parents, teachers and school-based therapists.

3.4.2.4 Literature

As Boote and Penny (2005) so clearly puts it, "*a substantive, thorough, sophisticated literature review is a precondition for doing substantive, thorough, sophisticated research*". They add to this the fact that research should be cumulative – it must learn from, and build on, prior research about the topic at hand.

The initial purpose of the literature review conducted in this study was for me to establish what had been done before in terms of studying the phenomenon under investigation. I further aimed to establish the implications that such prior knowledge might have had for the study at hand, and whether there were areas in which this research project could contribute to the existing body of knowledge. Various sources were approached, such as books and journals obtained via the UNISA library, as well as other internet-based sources. During the analysis and interpretation of the empirically collected data, an attempt was made to either support or challenge my findings and to avoid inaccurate interpretation, by reviewing and staying cognizant of the relevant literature.

3.4.2.5 Influence of the researcher

In research, data may become distorted as a result of bias. Bias is defined by Leedy and Omrod (2005:208) as "*any influence, condition, or set of conditions that singly or together distort the data*". During an interview, for example, the researcher's personality, tone of voice or inflection while asking a question, may influence how the participant responds. Leedy and Omrod (2005:151) further state that the interpretation of data in a qualitative study "*will inevitably be influenced*" by the researcher's biases and values, prior expectations and opinions, but that the extent to which this occurs may be minimized through the use of strategies. Such strategies include:

- collecting two or more different kinds of data;
- getting multiple and varying perspectives on an issue;
- looking for evidence that contradicts one's hypothesis; and
- acknowledging any biases one has in the final research report.

The aforementioned strategies were applied in this study. Data were obtained from four different sources, namely previous scholastic, assessment and/or therapy reports on the participants (secondary data), interviews with participants and other role players (participants' parents, teachers and therapists), questionnaires and observation. Multiple perspectives were gained and considered by means of informal, conversational interviews as well as formal interviews with the participants' parents, teachers and other school-based therapists who were involved with the participants during the course of the study.

My hypotheses continued to adapt as supporting and contradicting evidence arose. Personal reflection throughout the study allowed for my influence in terms of expectations, opinions, biases and values, to be noted and taken into account. The results of the study were reported irrespective of whether they supported or contradicted the expected outcomes. As the researcher, I remained committed to research in general and to the relevant subject.

3.4.3 Data collection

3.4.3.1 Sample

A sample in qualitative research refers to the sources from which the researcher draws his/her data, and sampling refers to the process by which the sample is selected (Leedy & Omrod, 2005:144). In qualitative research, *"the researcher purposely selects people to interview and/or observe"* (Johnson & Christensen, 2004:361). This is done through the technique of purposive sampling. In purposive sampling, *"people or other units are chosen, as the name implies, for a particular purpose"* (Leedy & Omrod, 2005:206). Purposive sampling falls under the broader category of non-probability sampling. In non-probability sampling, it is impossible for the researcher to forecast or guarantee that the sample will represent each element of the population (Leedy and Omrod, 2005:206). This may be seen as a disadvantage to the external validity of the study. In order to overcome this barrier to validity, strategies to support the validity of the study were employed, as were previously discussed in 3.4.2.3.

Children from a defined, limited population were considered as possible participants to the study. These children attend a remedial school, as they experience learning difficulties. The possible participants were identified through professional contacts of the researcher at the school, including fellow therapists as well as teachers. Parents of the possible participants were invited to meet with me. During this interview, parents were given a thorough overview of the study together with a consent form, (which included all information about the study). This specific consent form asked for their permission for their child to participate in the project.

The sampling process was guided by specific inclusion and exclusion criteria:

- Participants were to be between grades four and seven.
- Both male and female participants were regarded appropriate for the study.
- Due to the fact that this study focused exclusively on the treatment of performance anxiety, the participants must not have been diagnosed with an anxiety disorder other than performance anxiety.

- The aforementioned point of criteria was verified by having the possible participants and their parents fill out the SCAS questionnaires (child and parent reports). If the questionnaire results indicated that the possible participant presented with symptoms typically associated with an anxiety disorder other than that of performance anxiety, the possible participant was not regarded appropriate for the study. The SCAS questionnaires are attached as Addendums 4 and 5.

3.4.3.2 The researcher as instrument

In an interpretive study, the researcher becomes the instrument which gathers information (Jacobson et al., 2007). Especially when making use of qualitative information as a data collection method, the researcher is said to be the data-collection instrument. Here the researcher must decide what to consider as important data to record (Johnson & Christensen, 2004:188). The results of the study will then rely on the researcher's ability to interpret what he or she sees (Leedy & Omrod, 2005:133).

3.4.3.3 Data collection methods

Johnson and Christensen (2004:162) define a data collection method as a "*technique for physically obtaining data to be analysed in a research study*". Case study methodologists advocate the use of multiple methods and sources to collect data, implying an eclectic approach (Johnson & Christensen, 2004:379). In this study, data was collected through the use of four different methods namely questionnaires, secondary data, interviews and observation.

- *Questionnaires*

A questionnaire is a self-report data-collection instrument filled out by participants as part of a research study, so that researchers can obtain information about their thoughts, feelings, behavioural intentions, etcetera (Johnson & Christensen, 2004:164). Questionnaires were employed in this study, firstly to identify and verify appropriate participants and secondly to learn more about the participants' focus and levels of anxiety at the onset of the study. The Spence Children's Anxiety Scale (SCAS) (child and parent formats) were employed.

The SCAS is a DSM-based questionnaire for youth, which discriminates between youths with and without anxiety disorders, and within youths suffering from different anxiety disorders (Muris, 2007:196). This rating scale was developed to assess the self-reported intensity or severity of anxiety symptoms and assesses six domains of anxiety, including generalized anxiety, panic/agoraphobia, social phobia (under which performance anxiety falls), separation anxiety, obsessive compulsive disorder and physical injury fears. The scale has reportedly been widely used in clinical contexts, not only for assessment purposes but also to evaluate the impact of therapy on anxiety symptoms in children and adolescents. (Spence, 2012). The SCAS has sound psychometric properties, with high internal consistency (0.92) for the total score. It has further been found to exhibit reliability (0.60) and high convergent validity (0.71) (Naude *et al,.* & Spence, in Campbell, 2008).

- *Secondary data*

Johnson and Christensen (2004:192) explain secondary data as "*existing data originally collected or left behind at an earlier time by a different person for a different purpose"*. Several types of secondary data can be located and used by the researcher. The type of secondary data that used in this study, were official documents in the form of student records and reports that were previously created by public or private organizations (such as schools) and other professionals (such as psychologists, teachers and therapists).

The purpose of this specific data collection method was to obtain additional background information regarding each participant's scholastic, social and emotional history and functioning. A comprehensive understanding of these factors supported my ability to accurately conceptualize and report on the unique profile of each case study. Such records were kept in pupil's files at the institution where the research project was conducted, and as a staff member of this institution, I had automatic access to these records with the knowledge and consent of the participants' parents.

- *Interviews*

In-person interviews (interviews conducted face to face) comprised the third method of data collection. Through the use of qualitative interviews, in-depth information regarding the participants' thoughts and feelings could be obtained. According to Johnson and Christensen (2004:178), the interview carries the advantage that a researcher can freely use probes in order to obtain response clarity or additional information. Examples of such probes, which will be employed during group sessions and semi-structured interviews, will be "How do you mean?" or "Can you tell me more?"

While different types of interviews can be used in research, the informal conversational interview formed part of each weekly therapy session. This is, according to Johnson and Christensen (2004:183), the most spontaneous and loosely structured interview type, where the researcher discusses the topics of interest and then follows all leads that emerge during the discussions. Other unexpected or unscheduled informal conversational interviews occurred from time to time between myself and the respondents' teachers or therapists at the school. Interviews conducted during therapy sessions were audio-recorded, whereas field notes were made immediately after conducting unexpected conversational interviews with participants' teachers or therapists.

Semi-structured interviews were held with the respondents after approximately three months of therapy. The purpose of these interviews was to obtain specific feedback from the participants in addition to the information freely shared by them during the course of the study. The semi-structured interview guide which was used is attached as Addendum 6.

Although structured diagnostic interviews were considered to be employed before and after the intervention, I decided against this due to the lengthy administration time typically associated with such interviews (Southam-Gerow & Chorpita, 2007:358).

- *Observation*

Observation as a data collection method was used in conjunction with the aforementioned questionnaires and interviews, in order to obtain additional qualitative data. Observations were made during all interviews, therapy sessions and role reversal activities. Close attention was paid to aspects such as the physiological and behavioural responses of the respondents, as well as verbalized self-talk and/or other relevant statements or behaviours demonstrated by the participants. Field notes were made during or straight after such observations.

3.4.4 Data processing

Qualitative researchers typically rely on the inductive mode of the scientific method – they study a phenomenon in an open-ended way, without prior expectations, and then develop hypotheses and theoretical explanations according to their interpretations of what has been observed (Johnson & Christensen, 2004:306).

3.4.4.1 Method

With this qualitative collective case study, the data was categorized and interpreted in terms of common identified themes. Each case was firstly examined in its totality, where after the separate cases were compared in a cross-case analysis for similarities and differences (Johnson & Christensen, 2004:379). Eventual synthesis into an overall portrait of the cases was aimed for. Creswell's data analysis spiral was followed as a guide to achieve this, which basically entailed the following steps (Leedy & Omrod, 2005:150):

1. Data recorded in writing was typed and organised electronically into various folders.
2. The data was perused several times to get a sense of what it contained as a whole. In the process, a few memos that suggest possible themes or interpretations were jotted down.
3. General themes and subthemes were identified, and each piece of data was classified accordingly.
4. The data was finally integrated and summarized.

A more detailed description of the data analysis process, as it was applied in this study, follows in section 3.4.4.3.

3.4.4.2 Data trail

Following is a log of all contact that was made with the participants, possible participants and other role players, which involved the relevant parents, teachers and school-based therapists. The reported contact entails telephone calls, unstructured interviews and meetings (planned and incidental), semi-structured interviews (as were held with each participant near the conclusion of the study) and group therapy sessions.

PP = Possible participant (prior to inclusion in the study) P = Participant included in study

Date	Description and outcome
2012/09/25 10:00-11:00	Phoned parent of PP1. Single mom. Interested in hearing more about the study. Meeting arranged for 2012/09/27 at 13:30, to further discuss.
	Phoned parent (mom) of PP2. Interested in hearing more about the study. She and her husband will come to a meeting on 2012/09/28 at 07:00.
	Phoned parent (mom) of PP3. Sounds sceptical, will get back to me.

	Phoned parent (mom) of PP4. Very interested. Will meet with me later the same day, time arranged for 13:15
	Phoned parent (mom) of PP5. Sounds interested. Will discuss with child and get back to me.
	Phoned parent (mom) of PP6. Interested. Will meet with me on 2012/09/28 at 10:00 to hear more.
	Phoned parent (mom) of PP7. Interested. Will meet with me on 2012/09/26 at 07:30 to hear more.
	Phoned parent (mom) of PP8. Very interested. Will meet with me on 2012/10/02 at 07:30 to hear more.
2012/09/25 13:15-13:40	Met with mom of PP4. Very interested and excited to possibly have her child included in the study. She provided me with some background regarding her child's anxiety, academic struggles and behaviour. Took consent form home. Filled out SCAS questionnaire (parent version).
2012/09/26 07:30-08:00	Met with mom of PP7. Quite interested in the study. Took consent form and SCAS (parent version) home to complete.
2012/09/27 13:30-14:00	Met with mom of PP1. Very interested in the study. She even asked if her younger daughter (Grade 0) may be included as well. I explained to her that this study is only for learners attending this particular school, and only for learners in grades 4-7. In response to the mother's report of her younger daughter presenting with anxiety, I referred the mother to speak with any of the psychologists at the school who also run private practices. The mother (single parent) signed the consent form for her older daughter and took the SCAS (parent version) home to complete.
2012/02/28 07:00-07:30	Met with both parents of PP2. They are very interested in the study and appeared to be desperate and willing to try any form of intervention to help him with his performance anxiety. They took the consent form and SCAS (parent version) home to complete.
2012/09/28 10:00-10:30	Met with mom of PP6. Seemed interested although slightly guarded. Took SCAS (parent version) and consent form home to complete.
2012/10/02 07:30-07:33	Mom of PP5 phoned and told me that while she was interested in having her child included in the study, she spoke with her child and he didn't feel up to it. Mom sounded quite anxious and apologetic. I assured her that it was in order and that her child was entitled to say no. Having him participate against his will would have been unethical.
2012/10/02 08:30-09:00	Met with mom of PP8. Very interested and willing to have her child included in the study. Took consent form and SCAS (parent version) home to complete.
2012/10/08 10:00-10:04	Phoned parent of PP3 to follow up. Still sounds quite sceptical, but agreed to meet with me to further discuss. Meeting arranged for 2012/10/12 at 12:30
2012/10/08 10:30-11:00	Met with PP8 to discuss the study and gave her the assent form to take home with her, discuss with parents, and bring back to school as soon as she has decided whether to participate or not.
2012/10/12 12:30-13:00	Met with parent (mom) of PP3 to discuss study. Appeared slightly nervous and guarded at first, but eventually seemed to become more relaxed and started showing more interest and positivity towards the study in general. She took the consent form and SCAS (parent version) home to complete.
2012/10/15 07:30	Parent of PP3 sent an SMS and declined her child's participation in the study, due to the fact that exams were around the corner and she would prefer her child to focus on preparation.
2012/10/15 10:00-10:20	Met with PP1, after having received the completed consent form signed by his mother, to discuss possible inclusion in the study. Explained information obtained in the assent form. PP1 assented and completed the SCAS.
2012/10/15 10:30-10:45	Met with PP4, after having received the completed consent form signed by his mother. I explained the study and the assent form to him. He was quite talkative and appeared to be excited about partaking.
2012/10/15 10:50-11:10	Met with PP6 after having received the signed consent form and completed questionnaire from his mother. Explained the study and the assent form to him. He appeared quite interested, although he mentioned that the possible day for group sessions (Wednesday afternoons) might interfere with his soccer, which he did as an extra-mural activity Wednesdays after school.
2012/10/15 11:30-12:00	Met with PP2, after having received the completed consent form and SCAS (parent version) from his parents (consent given). Explained the study and the assent form to him. He appeared to be quite shy and guarded, yet interested in participating. He

	took the assent form home to discuss with his parents.
2012/10/16	Met with PP1 for the second time to explain to her that from her answers in the SCAS, as well as the answers of her mother, it seems that joining the performance anxiety group might not be helpful to her, and she might benefit more from individual therapy to address her other worries as well. PP1 was happy to rather see me for individual therapy.
2012/10/17 12:30-13:00	Met with PP2 for the second time, after he returned the completed assent form. Assent was given. The researcher gave him the SCAS questionnaire to complete and went through each question with him to assure that he correctly read and understood it.
2012/10/24	Met with PP4 for the second time, after he returned the completed assent form in which he gave his assent to be included in the study. PP4 was then given the SCAS questionnaire to answer. I went through each question with him in order to ensure that he correctly read and understood it.
2012/10/30 12:30-13:00	Met with PP7 after receiving the completed consent form and SCAS (parent version) from his mom (consent given). He is experiencing mixed feelings with regard to participating. I assured him that he is under no obligation to participate. PP7 asked for more time to decide, and said that he would get back to me should he decide to participate. He never responded, so it was decided to accept this as a decline from PP7.
2012/10/31 13:40-14:40	Session 1 Group 1 (Discussed in Chapter 4)
2013/01/16	General handover meeting at school, where learners' former teachers meet with their new teachers in order to provide a general background of each learner. Relevant notes relating to participants are reported on in Chapter 4.
2013/01/18 08:30-08:34	Phoned mother of PP9 to schedule a meeting with her and her husband. Their child was referred to me for therapy at the school as his former psychologist had resigned. His reported problem upon referral was anxiety relating to school work and tests.
2013/01/18 08:35-08:39	Phoned mother of PP10 to schedule a meeting with her and her husband. Their child was referred to me for therapy at the school as his former psychologist had resigned. His reported problem upon referral was anxiety relating to school work and tests.
2013/01/18 08:40-08:44	Phoned mother of PP11 to schedule a meeting with her and her husband. Their child was referred to me for therapy at the school. He had not received therapy from a psychologist before. His reported problem upon referral was anxiety relating to school work and tests.
2013/01/23 12:00-12:10	P2's teacher came to me to report that he had, according to his mom, experienced something like a panic attack the night before (22 January) while he was completing his homework. He was crying. Mrs F reported that she finds J to be very anxious in class. His Math teacher had apparently told her that he cried during his Math lesson (Noted in Chapter 4)
2013/01/23 13:40-14:40	Session 2 Group 1 (Discussed in Chapter 4)
2013/01/24 07:30-07:35	Telephonic contact with P2's mother – Discussed in Chapter 4.
2013/01/24 13:30-14:00	Met with mother of PP9. I introduced myself as their child's new school-based counsellor. We discussed their child's background and current issues. I explained the study to her and asked if she would be interested in letting their child become a participant. She seemed positive, and took the consent form and SCAS questionnaire home to complete.
2013/01/25 09:00-09:30	Met with mother of PP11. I introduced myself as their child's school-based counsellor. We discussed their child's background and current issues. I explained the study to her and asked if she would be interested in letting their child become a participant. She seemed very positive, and took the consent form and SCAS questionnaire home to complete.
2013/01/28 07:30 – 08:00	Met with parents of PP10 (Both mother and father were present). I introduced myself as their child's new school-based counsellor. We discussed their child's background and current issues. I explained the study to them and asked if they would be interested in letting their child become a participant. They seemed very positive, and took the consent form and SCAS questionnaire home to complete.

2013/01/28 11:30-12:10	Session 1 Group 2
2013/02/04 11:30-12:10	Session 2 Group 2
2013/02/05 10:00-10:02	Incidental interview with Mrs P, Afrikaans subject teacher of P4. Noted in Chapter 4.
2013/02/06 13:40-14:40	Session 3 Group 1 (Discussed in Chapter 4)
2013/02/07 07:30-07:35	Incidental interview with Mrs F (Class teacher of P2, Homework tutor and former class teacher of P4). Noted in Chapter 4
2013/02/11	Session 3 Group 2
2013/02/13 13:40-14:40	Session 4 Group 1 (Discussed in Chapter 4)
2013/02/18 11:30-12:10	Session 4 Group 2: Explained study and went through assent forms with them. They took their forms home to complete. They all seemed very excited, and reported that their parents had already informed them of the study.
2013/02/20 13:40-14:40	Session 5 Group 1 (Discussed in Chapter 4)
2013/02/27	Meeting with teachers and therapists of Group 2
2013/02/27 13:40-14:40	Session 6 Group 1 (Discussed in Chapter 4)
2013/03/04 11:30-12:10	Session 5 Group 2: Read through SCAS questionnaires with them (one question at a time). Each sat at his own desk so that they could not see one another's responses.
2013/03/06	Session 7 Group 1 (Discussed in Chapter 4)
2013/03/11 11:30-12:10	Session 6 Group 2
2013/03/13 13:40-14:40	Session 8 Group 1 (Discussed in Chapter 4)
2013/03/25 07:40-07:42	The HOD (Head of therapy department) at the school informed me that P4's mom phoned earlier. Discussed in Chapter 4.
2013/03/25 11:30-12	Session 8 Group 2
2013/03/28 09:30-09:32	Phoned P4's mom to arrange a feedback meeting for the following week. The meeting has been arranged for Friday, 5 April at 11:00.
2013/03/28 09:35-09:37	Phoned P2's mom to arrange a feedback meeting for the following week. The meeting has been arranged for Friday, 5 April at 07:00.
2013/03/28 10:05-10:06	Briefly gained feedback from P2's class teacher in terms of how he had coped with the recent cycle tests. This is noted in Chapter 4.
2013/03/28 11:55-12:00	Briefly gained feedback from P4's class teacher in terms of how he had coped with the recent cycle tests. This is noted in Chapter 4.
2013/04/03 13:40-14:30	Session 9 Group 1 (Discussed in Chapter 4).
2013/04/03 14:35 – 15:00	Semi-structured interview with P4 (Discussed in Chapter 4)
2013/04/05 07:00-07:30	Individual meeting with P2's mother (Discussed in Chapter 4)
2013/04/05 07:30-07:50	Attendance of end-of-term parent feedback meeting held by teacher and school therapy team: P2. Discussed in Chapter 4.
2013/04/05 11:00-11:30	Individual meeting with Flash's mother (Discussed in Chapter 4)
2013/04/08	Session 9 Group 2
2013/04/09	Planned semi-structured interview with George. Cancelled due to a change in the school program. Interview postponed until after the school holidays.
2013/04/10 08:20-08:40	Attendance of end-of-term parent feedback meeting held by teacher and school therapy team - Flash (Discussed in Chapter 4)
2013/04/10 12:40-13:00	Attendance of end-of-term parent feedback meeting held by teacher and the school therapy team: P10. Main issues reported by teacher involve task-avoidance strategies and slow work pace, which is impacted by a delay in his processing speed, as well as distractibility and purposeful task-avoidance.

2013/04/11 10:40-11:00	Attendance of end-of-term parent feedback meeting held by teacher and the school therapy team: P9. Teacher reports him as being helpful, polite, eager to please and consisting over leadership qualities. Does well in spelling tests (learnt spelling) but poor application (poor long term memory for spelling). Good Math. Mom reports that he struggles with writing in Afrikaans. Also that he compares himself to his younger brother (who is cognitively very strong), and he recently cried (realising that his brother, who is younger, is stronger academically). Mom asked for guidance with study skills. I will provide this next term in preparation for June exams.
2013/04/12 08:00-08:20	Attendance of end-of-term parent feedback meeting held by teacher and the school therapy team: P11. Mom comes across quite strongly in the meeting, almost leading the meeting with her questions, concerns and comments. Teacher reports that he begins lessons with focus and motivation. Strong in Math. Struggles with language skills in terms of written expression and reading. Tries hard to read, puts in a lot of effort even though it takes up a lot of time. Parents want to understand why he struggles so much with reading, and asked whether he has dyslexia. Occupational therapist will e-mail mom tracking exercises as he struggles with this. It was additionally reported by teacher that P11 doesn't have as many physical complaints (e.g. sore tummy, headache, etcetera) as previously.
2013/04/30 12:00 – 12:15	Semi-structured interview with P2 (Discussed in Chapter 4)
2013/05/07 08:45-08:47	Incidental discussion with P4's Afrikaans teacher (Discussed in Chapter 4)

3.4.4.3 Steps in data analysis

The following steps were followed in the analysis of the data.

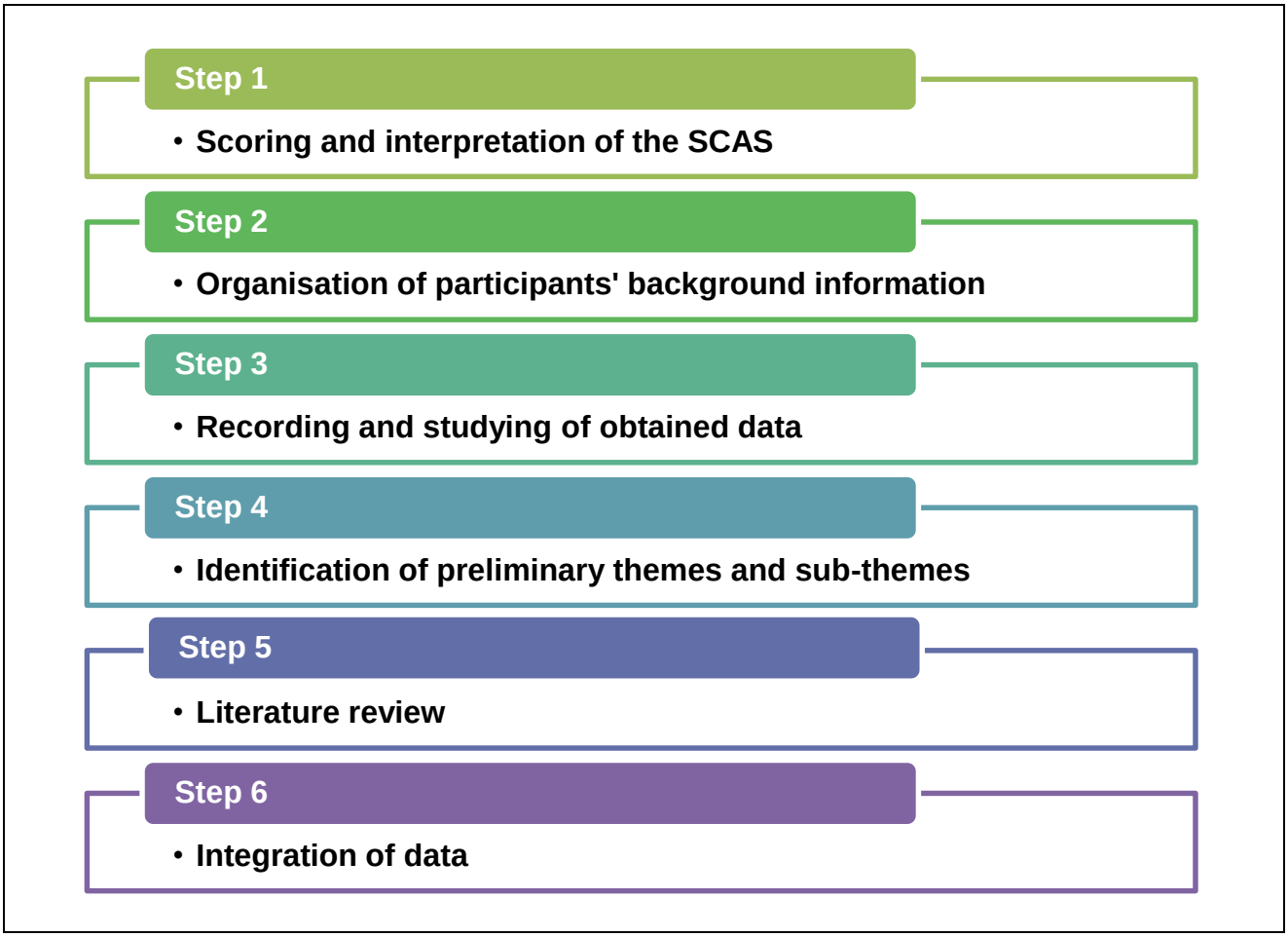


Figure 3.1 Steps in data analysis

Step 1 involved the scoring and interpretation of the SCAS parent- and child questionnaires according to the standardized scoring sheets provided by Spence (2012). Firstly it was established whether the possible participants indeed presented with symptoms indicative of social phobia. Secondly it was established whether the possible participants presented with symptoms indicative of other anxiety disorders, in which case such a participant would be excluded from the study. Thirdly, the child and parent responses were evaluated qualitatively in order to gain insight into each individual participant's specific focus and severity of anxiety in terms of feared social situations.

In **Step 2** I organized the participants' background information. Sources of information included secondary data (existing academic and therapeutic progress reports of participants) as well as reports from the participants' teachers and parents as were provided during unstructured interviews. I initiated this as soon as the participants were finalized (see Step 1) and then also continued to add relevant detail as more information was gathered during the course of the study. The participant's background information was reported on in Chapter Four in section 4.2.3. My choice of specific information to report on was based on the issues that were considered relevant to each participant's individual development and experiences of performance anxiety. This included relevant birth history, early formation of relationships, applicable developmental crises and scholastic achievement, personality traits, current developmental phases, and current manifestations of performance anxiety.

In **Step 3** I recorded and studied the qualitative data that was obtained through the various data collection methods as were discussed in 3.4.3. Obtained data was audio-recorded and/or field notes were taken, where after it was typed and saved in relevant folders on my computer. This data is later revealed in Chapter Four, section 4.3, which also includes the qualitative information that was obtained from the SCAS questionnaires. As suggested by Creswell's analysis spiral (Leedy & Omrod, 2005:150) I then perused the recorded data several times to get a sense of what it contained as a whole.

After having studied the data in its entirety as described in Step 3, **Step 4** involved studying each case individually. I searched for significant statements, in other words statements that had particular relevance to the phenomenon under study (Johnson & Christensen, 2004:367). Feedback regarding each individual participant's progress and emotional functioning, as were obtained from their parents and teachers as well as their own self-reports, were compared in order to establish differences and similarities. The same comparisons were made between the aforementioned sources of feedback and my own observations. Thereafter the cases were compared with one another in order to establish relevant similarities and differences. These processes enabled me to identify general preliminary themes and subthemes, which were also guided by the research aims and question, the participants' personal experiences of the helping role (including positive as well as negative or challenging experiences), therapeutic gains made by the participants, and the practicality of role reversal as a school-based, group-therapeutic approach to the treatment of performance anxiety from a counsellor's point of view.

Step 5 involved the literature review. As an important part of data analysis and report writing, the researcher's findings should be related back to similar findings in literature

when possible (Johnson & Christensen, 2004:379). Previous studies on the use and effects of peer tutoring were consulted and compared to my own findings. Additionally the symptoms and behaviours typically associated with performance anxiety (social phobia) were re-visited and compared to the participants' identified symptoms and behaviours.

In **Step 6** I finalised the themes and subthemes which I used for the data interpretation of this study. Initial symptoms and areas of progress were summarised, together with the effects of role reversal as were revealed by the empirical data. This will be discussed in Chapter Four. The information in its totality was finally integrated and summarised in Chapter Five.

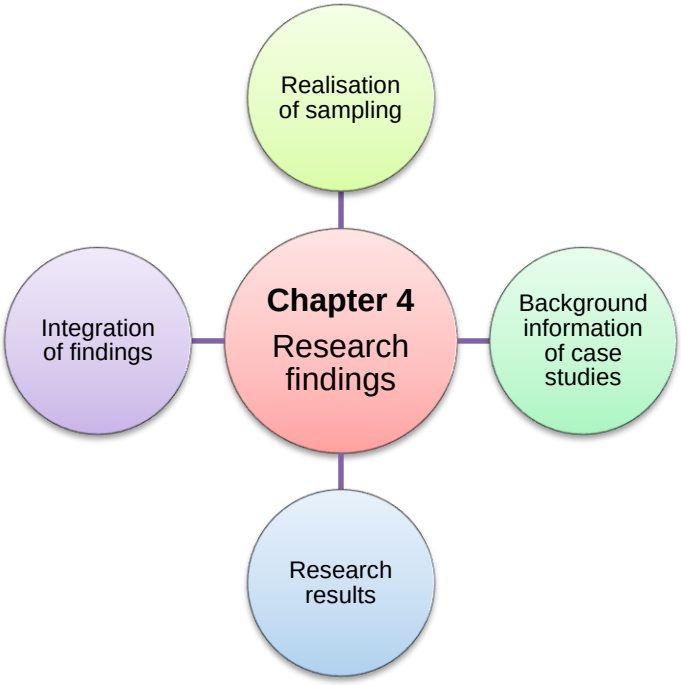
3.5 CONCLUSION

This chapter described and motivated the researcher's choice of methodological approach to conduct the study. The research design and techniques which are to be applied throughout the study – from identifying and selecting participants, to obtaining, analyzing and interpreting data – were discussed comprehensively. Important aspects such as the ethical considerations and validity measures which will serve to guide the methodological approach were addressed as well. The following chapter will describe the implementation of the methodology, as well as the results that were obtained.

CHAPTER 4
RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter describes the implementation of the empirical part of research study. It reveals the data that was obtained and the way in which this data was analyzed and interpreted.



4.2 REALISATION OF SAMPLING

As mentioned in the previous chapter discussing the methodology of the study, participants were identified and selected according to a purposive, non-probability sampling approach. The names and contact details of possible participants were obtained through professional contacts at the school, including fellow therapists and teachers. A total of 11 possible participants were identified. Specific inclusion and exclusion criteria were followed as was set out in Chapter Three. After the process of seeking consent and assent, and subsequent application of the SCAS questionnaires (child- and parent versions) to verify participant suitability, a total of seven respondents were regarded appropriate for the study. Of those seven respondents, six became participants to the program. One of those six participants withdrew from the study at an early stage.

4.2.1 Included participants

PPs (Possible Participants) 2, 4, 8, 9, 10 and 11 became participants of the study. For now, they will be referred to as P(Participant) 2, P4, P8, P9, P10 and P11. Later, when the specific case studies are discussed, pseudonyms will be used. P2, P4 and P8 were seen

together in one group (Group 1) and P9, P10 and P11, who were younger than the participants in Group 1, were seen together in a separate group (Group 2). P8 was only able to participate in the initial stages of the study. This was because she concluded Grade seven in 2012. When the study continued in 2013, she had started high school and her afternoon schedule had changed to such an extent that she withdrew from the study. As a result it was not possible to collect useful data relating to this participant's experience of role reversal. However, the initial involvement of this participant is still acknowledged as will be seen later in this chapter, when the group sessions will be discussed.

Due to the limited scope of this dissertation and the vast amount of data gained regarding each participant, it was impossible to report on all of the case studies. It was therefore decided to provide an in-depth discussion of the data obtained from Group 1 (P2, P4 and P8). The involvement of the participants from Group 2 is acknowledged in the data trail (section 3.4.4.2). P2 and P4 chose their own pseudonyms to be used in the writing of the research report. They will, from here on, be referred to as "George" (P2) and "Flash" (P4). Due to her early withdrawal, P8 never had the opportunity to decide on a pseudonym.

4.2.2 Excluded participants

The following PPs (possible participants) were excluded from the study, and due to the following reasons:

PP 1: Both this participant and her mother gave their consent for her possible involvement in the study. However, according to the participant's responses on the SCAS, it appeared that her symptoms of anxiety stretched further than performance (social) anxiety alone. According to the inclusion and exclusion criteria as set out in Chapter Three, participants were not to suffer from anxiety disorders other than performance anxiety. Based on her self-reported areas of anxiety, she could not be regarded as a child who mostly showed symptoms of performance anxiety. In order to still provide her with support, I saw her for individual therapy to address her identified areas of anxiety.

PP3: After carefully considering PP3's inclusion in the study, her mother declined consent as she felt it to be of greater importance that her child spends her time studying for the upcoming exams.

PP5: Even though PP5's mom was quite interested in the study, he was unwilling to participate and so both consent and assent were declined.

PP6: This possible participant's parents consented and he gave his assent as well. Based on the results of the SCAS, he met the criteria for inclusion in the study. Unfortunately, the time of the group sessions ended up clashing with his soccer practice, and given a choice, he decided to rather continue with soccer. This child was already in therapy with a different psychologist at the school, and thus he still continued to receive support for his anxiety.

PP7: This possible participant's mother was in favour of him doing the program and she gave her consent, however he was indecisive and eventually declined.

4.2.3 Background information on the case studies

This section will provide an overview of the relevant background information pertaining to the two participants from Group One who completed the program. The information was obtained from a variety of sources including interviews conducted with the participants' parents, previous reports created by teachers and therapists that have been involved with them (secondary data), and the SCAS questionnaires (child and parent reports) that were completed at the onset of the empirical study.

4.2.3.1 Participant 2: George

George lives with his mother, father and older brother. He has been diagnosed with concentration- and learning difficulties and is being medicated with Ritalin for Attention Deficit and Hyperactivity Disorder (ADHD). George's mother reported that she is prone to anxiety. This indicates a possible genetic vulnerability which may have contributed to the development of George's anxiety (Flannery-Schroeder *et al.*, 2007:204). The symptoms associated with his ADHD may have additionally contributed to his feelings of anxiety (Tartakovskry, 2011).

George was born prematurely at 32 weeks and remained in hospital for a period of three and a half weeks in order to stabilise his weight. It is not possible to establish the effect of this in terms of his early attachment and development of trust. Whilst insecure attachment has been reported in the literature as a possible contributory factor to the development of anxiety disorders (Manassis *et al.* in Southam-Gerow & Chorpita, 2007:354), one can merely speculate about this in terms of its relevancy to the development of George's anxiety. According to his mother, George has always been a quiet, shy and sensitive boy. This is indicative of an inborn inhibited temperament – a personality trait which may have always made George prone to easily feel embarrassed or ashamed in response to failure, and which may have increased his risk for developing phobic (anxious) behaviour (Kagan & colleagues in Barlow & Durand, 2002:139).

George's learning difficulties became evident during Grade 0, when he started requiring assistance with his formal school work. Relevant therapies followed and he was placed in a remedial class at a mainstream school for Grades 1 to 4. During this time, according to the theory of Erikson (Corey, 2005:63), George would have found himself in the psychosocial developmental stage of "*industry versus inferiority*", where he would have attempted to achieve, amongst other things, the skills that were necessary for reaching academic success. Failure to do so in certain areas of his learning may have contributed to feelings of inferiority and incompetency, possibly impacting negatively on the development of his self-esteem and confidence.

A psycho-educational assessment which was conducted in April of George's Grade 4 year revealed that he was functioning within the Average range of intellectual ability although he presented with delays in certain skills relating to perceptual reasoning and working memory. As noted in Chapter Two, working memory refers to the ability to actively

maintain and perform some operation with information in conscious awareness (Wechsler, 2003:8) and anxiety has been known to have a debilitating effect on this function (Eysenck & Calvo in Fales *et al.,* 2008). Upon recommendation of the Educational Psychologist who conducted the aforementioned assessment, George was enrolled in a remedial school in the second term of his Grade four year. He continues to attend this school. At present, George's learning difficulties mainly manifest at school as problems with written expression and in particular spelling. His poor spelling skills inhibit his confidence and ability to express in writing, as reported, his original ideas, outstanding oral comprehension and excellent vocabulary. Reading used to be an additional area of difficulty although this has reportedly improved.

Numeracy is an area of strength for George. It was however reported by his former Grade five teacher, that he was sometimes overcome by anxiety which leads to careless mistakes. According to Cusinier (2011:74) anxiety can prevent pupils from exercising all of their capacities to execute mathematical reasoning. The literature further postulates that anxiety prevents one from exercising one's working memory capacities sufficiently (Sarason in Whitaker *et al.*, 2007) and may contribute to problems with attention (Greene, 2002:20). George's learning difficulties contribute to his proneness towards test anxiety. Whitaker *et al.* (2007) have found students with learning disorders to be more test anxious than learners without such disorders, possibly due to less positive past experiences in testing situations (Kovach in Whitaker *et al.*, 2007).

George has been described in previous reports from teachers and therapists as having a mature work ethic and being well-behaved, but comments have often been made about his anxiety and poor confidence. He has experienced panic attacks in the past when he became overwhelmed by his homework. When looking at the relevant literature, the recurrence of such panic attacks may have possibly been caused by a combination of classical conditioning and emotional reasoning. The physiological symptoms associated with the anxiety brought on by difficult homework, such as an increased pulse rate, may have become conditioned internal cues. Such internal cues, in combination with the conditioned external cue of challenging homework, would give the false impression that the situation is unbearable and that a panic attack is underway (Barlow & Durand, 2002:17). This is quite similar to the emotional reasoning bias explained by Schneider (in Muris, 2010:29), where danger is inferred from internal anxiety-related bodily sensations rather than from an objective threat.

Being a young adolescent, George has, according to the literature, become increasingly vulnerable to the development of a mood disorder. This is due to the changes in serotonin- and dopamine levels that typically occur within the brain during this developmental stage (Walker in Hill & Coulson-Brown, 2007:46). George's immature pre-frontal cortex may be regarded as an additional risk factor. This part of the brain, which only reaches maturity at the age of approximately 20 years, plays an important role in controlling impulses and regulating emotion (Casey *et al.* in Hill & Coulson-Brown, 2007:45). As a young adolescent, George may thus not yet consist over the neurobiological capacity to sufficiently control his impulses and regulate his emotions.

On a more positive note, George excels at swimming which has, according to his mother, assisted in enhancing his self-esteem. George is currently in Grade six. He was 11 years old and in Grade five when he entered the role reversal program.

4.2.3.2 Participant 4: Flash

Flash lives with his mother, father and older sister. He was diagnosed with Attention Deficit and Hyperactivity Disorder (ADHD) at the age of six and is medicated for this with Ritalin. The symptoms associated with his ADHD may have contributed to the development of Flash's anxiety (Tartakovsky, 2011).

The pregnancy, birth and early infancy were normal. Flash reached his mobility milestones within normal limits, although he never crawled. His speech-language development was delayed. He only said his first word by the age of 18 months, and started combining two or more words by the age of three. According to Erikson (Corey, 2005:63) children between the ages of one and three strive to reach a sense of autonomy and independence, and failure to do so may lead to feelings of shame and doubt. Experiencing difficulty in expressing himself independently might thus, according to this theory, have contributed to the development of a certain degree of self-doubt.

Flash's mother reported that he was inclined to play on his own as a toddler. This is normal for young toddlers, although it may have been additionally associated with his difficulty in communicating adequately. Nevertheless, Flash did gradually become more sociable as he matured. He was enrolled in a mainstream school for Grade one. However, he experienced difficulty keeping up with his peers in the areas of reading and spelling. As with George, according to the theory of Erikson (Corey, 2005:63), Flash would have found himself in the psychosocial developmental stage of "*industry versus inferiority*" at this time, where he would have attempted to achieve, amongst other things, the skills that were necessary for reaching academic success. Failure to do so in certain areas of his learning may have contributed to Flash developing feelings of inferiority and incompetency, which possibly impacted negatively impacted on the early development of his self-esteem and confidence.

Flash underwent a Psycho-Educational assessment during his Grade one year. The results revealed that he was generally functioning with the Average range of intelligence although there was a slight delay in his verbal reasoning skills, some variance in his perceptual reasoning skills and an unusual variance in his processing speed. The assessment results additionally confirmed a delay in the development of his reading and writing skills. Remedial placement was recommended. Flash was subsequently enrolled in a remedial school the following year for Grade two. He continues to attend this school.

Flash's mother reported that he tends to be rigid in his thinking and sees things as either "black" or "white". According to Stewart *et al.* (2007:11) this type of thinking is known as *"Dichotomous thinking"*, where the child views situations in only two categories rather than on a continuum. It may be viewed as a possible contributory factor to anxiety based on irrational thought processes.

At school, Flash struggles with spelling and handwriting, and thus written expression is an area of difficulty for him. He used to struggle with oral reading although this has reportedly improved. Flash however sometimes misreads or misinterprets questions during tests or exams. Additionally, while he can usually answer literal comprehension- or exam questions, he experiences difficulty answering questions that involve application or inferential reasoning. This may be related to his "black or white" thinking style as was referred to earlier, while additionally indicating a possible general difficulty with verbal reasoning.

Flash only answers an exam- or test question if he is absolutely certain of the answer and he refrains from guessing, or attempting to formulate answers when there is a chance that he might be wrong. Subsequently there are often many untouched questions in his exam papers and this negatively affects his marks. This type of behaviour may be seen as maladaptive perfectionism, where Flash distances himself from a potential stressor (a difficult question) by means of avoidance (Gnika *et al.*, 2012). Additionally, the avoidance of situations that might lead to negative evaluation (such as possibly providing answers that might be marked as incorrect) is a typical symptom of social phobia, and Muris (2007:153) warns that such avoidant coping strategies actually maintain fear and anxiety in the long run. It should be additionally noted that Whitaker *et al.* (2007) have found students with learning disorders to be more test anxious than learners without such disorders, possibly due to less positive past experiences in testing situations (Kovach in Whitaker *et al.*, 2007).

During the course of the study it became evident that Flash's mother possibly holds unrealistically high expectations of him. Flash additionally tends to compare his marks to those of his older sister, who is academically very strong. "*Comparing*" is listed by Stewart *et al.* (2007:11) as one of the several cognitive distortions commonly exercised by children and adolescents. According to the social comparison theory (Festinger in Narcie & Norwich, 2004), *"comparisons with those of high abilities will lead to less positive self-perceptions".*

As was the case with George, being a young adolescent heightened Flash's vulnerability to experiencing intense emotions such as anxiety. As explained earlier, this is due to the changes in serotonin- and dopamine levels that typically occur within the brain during this developmental stage (Walker in Hill & Coulson-Brown, 2007:46), as well as the immaturity of the pre-frontal cortex. Flash is currently in Grade seven. He was 12 years old and in Grade six when he entered the role reversal program.

4.2.3.3 The SCAS questionnaires

With regards to the SCAS child and parent reports that were completed at the onset of the study, there were some slight discrepancies between the child and parent reports, as is often the case (Flannery-Schroeder *et al.*, 2007:202). However, the additional reports of therapists and teachers, as were reflected on in the previous sections, aided in gaining a comprehensive and accurate picture of each participant's functioning (Flannery-Schroeder *et al.*, 2007:203). The relevant qualitative information that was derived from these

questionnaires will be noted in 4.3.2.1, when a summary of each participant's symptoms is provided.

4.3 DISCUSSION OF RESEARCH FINDINGS

4.3.1 Data gathered

The empirical data under discussion had a variety of sources, and will be discussed under the applicable headings.

4.3.1.1 Group therapy sessions

Following is a summary of the sessions conducted with Group One, who also named themselves "The Helpful Island Pitchers Crew", or "CHIP".

<table>
<tr><td colspan="3">Session 1: Introduction and welcome 31 October 2012</td></tr>
<tr><td colspan="3">SUMMARY OF ACTIVITIES

• The participants were welcomed and thanked for joining the group.
• The purpose of the group was revised (to help the researcher write a 'book' which will be about helping children manage anxiety).
• The term "anxiety" was explained ("It's a feeling, like being nervous or worried. It visits everyone now and again. The feeling can sometimes be big and at other times small. Important to know is that one can learn ways of controlling it".)
• The term "adrenaline" was explained (It's "a special substance that is released into our bodies when we feel either anxious or excited. It can be helpful, e.g. it can make us think and act faster and stronger. It can help with sports and with tests, as long as it is controlled - not too little, and not too much)". The explanation was accompanied by an example of cavemen who used to need adrenaline to either fight or flee from dangerous animals.
• Members were asked to draw "anxiety", as if it is a "thing". This was an externalization technique (Goodyear-Brown, 2011:132).
• A short, humorous board game was played in order for the participants to get to know each other better.
• The members brain-stormed about a possible group-name.
• The importance of confidentiality was discussed, and members signed their confidentiality contracts.</td></tr>
<tr><td colspan="3">RELEVANT VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS</td></tr>
<tr><td><u>Participant 8</u>
• To resemble "Anxiety", she drew a tiny, nervous-looking girl in the bottom quarter of the page.</td><td><u>George</u>
• To resemble "Anxiety", he made a quick drawing of a ghost-like figure and said, "It's like a bug that's not supposed to be there".</td><td><u>Flash</u>
• To resemble "Anxiety", he made a drawing of a caveman being attacked by an elephant. At first the man thought he would be trampled, but as soon as</td></tr>
</table>

• Idea for group name: The Helpful Crew – help us to chase our anxiety away.	• Couldn't think of or share an idea for a group name.	adrenaline kicked in, he believed he could defeat the elephant. • Idea for group name: The Island Pitchers
• After brainstorming, the members decided to combine the ideas of Participant 8 and Flash, and came up with "The Helpful Island Pitchers Crew" as a group name, with the jumbled acronym CHIP.		
RELEVANT OBSERVATIONS AND INTERPRETATIONS		
Participant 8 • Slightly nervous at first, but soon became quite talkative. Appeared to feel at ease with the boys, who were slightly younger than her. • Her idea for a group name suggests a good grasp of what the therapy program will be about.	George • Quiet, doesn't say much and gives short responses when spoken to. Reluctant to share ideas - indicative of a shy, inhibited temperament as was reported by his mother as well. • During the board game he was helpful towards Flash, who became stuck. This may be suggestive of a non-verbal, indirect way of initiating positive social contact with a boy he had just met.	Flash • Quite talkative from the start. • Became a bit nervous and upset when he got stuck during board game – may be quite competitive and possibly wishes to avoid the negative evaluation associated with 'failure'. • His understanding of 'anxiety' and 'adrenaline' appears to be slightly literal. He didn't quite personalize the drawing to his own, subjective emotional experience of anxiety.

.....Year-end exams and holidays.....

Session 2: Adrenaline	**23 January 2013**
SUMMARY OF ACTIVITIES • Welcome back • Explained P8's withdrawal from the study to other group-members • Discussed holidays, new grade and 'new year's resolutions' • Revised purpose of group and concepts discussed in Session 1 • Discussed physiological experiences of Adrenaline and participants indicated, by colouring pictures, where in their bodies they normally feel it. • Designed poster of group name	
VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS	

George	Flash
• Adrenaline from worry is felt in his head (it causes headaches) • Adrenaline from excitement is felt in his legs (it feels almost as if it trembles) • Sometimes adrenaline makes his heart beat faster. • Verbal expressions: He really likes his new teacher, but they're getting lots of homework. • In terms of helping, he said that he might be able to help with Math homework because he is "quite good at it" (His words). • Poster: Wrote the acronym CHIP and decorated it with different colours marker pens.	• Adrenaline from worry is felt in his heart and legs, and he sometimes feels butterflies in his tummy when he's worried. • Adrenaline from excitement is felt in his arms, legs and heart. • Said that he would be willing to help other children with their homework although he might not be able to help with everything. I told him that when that happens in homework class he needn't worry because I will be there to give a hand as well. He joked and said, "Helping the helper!" • Mentioned that he had battled with Afrikaans last year and got approximately 40% for it. His new years' resolution is to get an overall average of 70-75%, so that his parents will buy him a WII after Term one. • Poster: Made a drawing of a caveman on an island, fighting a storming elephant.

RELEVANT RESEARCH OBSERVATIONS AND INTERPRETATIONS

George	Flash
• Still quite reserved but didn't seem to feel as uneasy or nervous as in the first session. • He seemingly enjoyed the creative activity of designing the poster and did not rush as with his previous drawing in Session 1, which indicates that he possibly feels more at ease than before. • He was more willing to share his own ideas today, further indicating that he is starting to feel more comfortable with being here. NOTE His teacher reported that he had had experienced something like a panic attack while doing homework the night before, as was reported to her by his mother. Based on what he had said in the session about homework, I suspect that he became overwhelmed by the work. Additionally George's class teacher reported to me that, according to the Math teacher, George became tearful in class the day before although he didn't talk about what had upset him. It thus seems that, although he describes himself as being quite good at Math, he may still become overwhelmed by challenging work.	• Came in seeming very relaxed and being quite chatty again. Displayed a sense of humour. • He expects to come across work that he won't be able to do when helping with homework – indicative of some self-doubt. • Setting high and possibly unrealistic standards for himself in order to be awarded by his parents. • While he appears aware that he has limitations in terms of what is able to do and help with, he still aims for unrealistically high marks at the same time. There might thus be some incongruence in terms of his expectations. His parents' expectations appear to be quite high, and wanting to please them, he most likely internalizes these expectations. This needs to be monitored as such social pressures have been reported in the literature to provide sufficient stress to trigger anxiety (Barlow & Durand, 2002:117).

Session 3: Exploring and externalizing emotions **31 January 2013**

SUMMARY OF ACTIVITIES

- Exploring and externalizing three feelings: anxiety, calmness and excitement. The third feeling, excitement, was brought in to reinforce within the participants a positive association with adrenaline. Externalization was applied for the purpose of giving form to the abstract emotional concepts (Goodyear-Brown, 2011:132). This technique was repeated partly due to the amount of time that had elapsed since session 1 (when anxiety was previously externalized), and also in order to help Flash externalize anxiety as he did not really manage to do this in session 1.
- Participants made drawings of times when they felt anxious, calm and excited.
- They were then asked to draw 'anxiety', 'calmness' and 'excitement' as animals.
- After having drawn and discussed each feeling, participants could choose where in the therapy room to leave the animal-drawings before leaving.

VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS

George	Flash
• Times when he feels... Calm: When he watches TV Excited: Before going on holiday Worried: Before a test, he worries that he didn't learn enough. • The feelings are like: Calm: A dog Excited: A cheetah Worried: An attacking elephant • Places where 'feelings' (animals) were left: Calm (dog): In the little window pane above the door to of the therapy room. Excited (cheetah): On the shelf between some toys. Worried (elephant): Up on the high window pelmet.	• Times when he feels... Calm: When watching television Excited: Before his birthday Worried: When writing exams • The feelings are like: Calm: A sheep Excited: A dog Worried: A piranha • Places where 'feelings' (animals) were left: Calm (sheep): In the sand tray Excited: Also between the toys but on a different shelf. Worried (piranha): Flash copied George by climbing up the window's burglar bars to leave it on the pelmet. .

RELEVANT OBSERVATIONS AND INTERPRETATIONS

George	Flash
• Seemed to feel quite excited and confident today. Spontaneously climbing up the high window bars to the pelmet in order to leave his worry-animal up	• Seemed to be in a calm and happy state. • Was quite chatty as always,

there. This behaviour indicated that he felt comfortable with attracting attention towards himself and confident enough to share his unique idea. • Based on the places where he left his calm and exited animals, it would appear as though he has a positive connotation to the toys in the room (revealing some of his childlike playfulness), and a connotation of calmness and possibly safety with the entrance of the room. Anxiety is something that he wants to be far away, where it almost can't be reached, and where it can't be seen by anyone else. • Group therapy appears to be beneficial to George. Despite his initial inhibited behaviour, he now feels safe enough to become involved in the therapy process. He revealed even more of his personality today, was able to speak honestly about his emotional experiences, and showed a lot of initiative, creativity and humour.	although not overly. • May sometimes follow others' ideas as he did some of George's, although he still had his own ideas as well. • He seemed excited to see the more spontaneous, 'fun side' of George today and responded positively towards him. • Today he demonstrated a better grasp of the abstract concepts of emotion, and it would seem as though the externalization technique using animal metaphors helped him in this regard.

Session 4: "Fact or Fiction" & lending a hand	**6 February 2013**
MAIN ACTIVITIES • Discovering thought processes (ideas), and learning to discriminate between true or false thoughts ("fact or fiction") • Linking thoughts to feelings through further use of the animal metaphors. ○ Example: (Question) "Which of your animals would probably say something like "I can't handle tests and I will get many answers wrong"? (Answer) "The piranha/elephant". (Question) "What could your calm animal say instead?" (Answer) "I can handle tests and I might get quite a few questions right". • This was also the first day of helping children in the homework class. Before leaving to go and help, participants were asked to either write or draw what they expected it was going to be like. Afterwards they were asked to report on what it was like. • Helped in the Junior homework class today (a mix of Grades 1-4 learners).	
VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS	
<u>George</u> • Was able to identify and dispute (change) the given examples of negative, irrational beliefs, and to link it to the appropriate animals (feelings) <u>Role reversal</u> • When he heard we were going to help, he said, "That's something I	<u>Flash</u> • Was able to identify and dispute the given examples of negative, irrational beliefs and to link it to the appropriate animals (feelings). <u>Role reversal</u> • Reacted in a fairly similar way to George when he heard that we were going to help

wasn't looking forward to". When asked to draw or write about his expectations, he wrote "It is going to take a lot of time explaining". Afterwards he wrote, in big letters, "O.K." He explained that initially he was worried that it might take up a lot of time explaining things to the children, but that in the end he didn't have to give long explanations because they were little. He didn't report disliking anything or finding anything hard. • In the homework class, he stood around looking quite a bit nervous and self-conscious, fidgeting with his fingers. As soon as a child called on him for help, he stopped fidgeting and concentrated on the homework of the child. He was patient and kind, and after a while appeared to become more relaxed.	in homework class today. Before we left, he made a drawing of himself explaining work to a child, and wrote in a speech bubble, "Bla-bla-bla". Afterwards he made the same drawing again, only this time without the "Bla-bla-bla". His verbal feedback was that he initially thought he was going to help with English, but he ended up helping with Math and reading. He added that before they went, he expected that it was going to be a bit of fun. Afterwards he felt that it was fun to help. What he liked most was that the child was actually trying (in other words not just passively waiting for an answer). There was nothing that he found to be hard, or disliked. • Didn't seem too nervous once we got to the homework class, and actually seemed to feel quite confident and proud of being there to help.
RELEVANT OBSERVATIONS AND INTERPRETATIONS	
<u>George</u> • George's inclination to become nervous and shy when talking to children he doesn't know, might explain why he was concerned about having to do a lot of talking (explaining). Campbell (2008) similarly established that the act of helping elicited a level of anxiety in adolescent tutors. Nevertheless, George coped well. Focusing more on the homework task of the child that he was helping, and less on the idea of doing a lot of talking with an unfamiliar peer, possibly helped him to forget about his own concerns. He became visibly more relaxed, and explaining the work came naturally to him.	<u>Flash</u> • Although he was slightly nervous before we went to the homework class, once we got there he actually appeared to feel confident and proud about being there to help.

Session 5: More "Fact or Fiction" & helping	**13 February 2013**
MAIN ACTIVITIES • Matching more examples of thinking-phrases with feeling-animals • Rephrasing (disputing) thoughts that could cause worry. • Reflecting on recent times or experiences when the worry-animals were present. • Helping in the Junior homework class (Grades 1-4).	

VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS	
<u>George</u> • Said at one stage, in response to an anxiety-provoking thought-card "You have to freak out in some tests, else the worry-fluid builds up. It's like tears that have to come out". • Was well able to rephrase worrying thoughts into more realistic and positive thoughts. • Recently felt worried when it appeared as though it might rain on Sunday, which meant they wouldn't be able to go bird-watching as planned. <u>Role reversal</u> • Said that he didn't mind which group we went to help. • After entering the homework class he seemed slightly uncomfortable again during the first few minutes, until he started helping. He then appeared to relax. • When no one else called on him for help, he went to Flash and assisted him in helping a Grade 2-girl with her phonics homework.	<u>Flash</u> • Coped well with rephrasing negative, irrational thoughts. • Mentioned that Afrikaans is his least favourite subject, although he didn't say that it specifically causes anxiety for him. • Recently felt worried about the fact that his phone's battery keeps dying. <u>Role reversal</u> • Wanted to go to the Junior group again. • Helped a Grade 2-girl with her phonics homework (she had to make up her own words using specific sounds). Afterwards he reported that he found it hard to think of short, easy words that would be easy for her to write. He said, "I had to reverse a few grades".
RELEVANT OBSERVATIONS AND INTERPRETATIONS • After helping the younger children again today, both George and Flash were in agreement that it might actually be easier to help older children who were closer to their own grade-level, as it was challenging to try and think as a younger child would.	
<u>George</u> • Realizes that anxiety is something that affects the body, and that it is important that there is outlet for this, as it builds up over time. He thus understands that suppressing emotions is not good and that it is okay to give expression to it – even if not necessarily using words to do so. • Doesn't associate anxiety with school work only. Possibly has difficulty coping when things don't go according to plan (e.g. rain interfering with bird-watching) – might be somewhat rigid in terms of his expectations regarding his routine. This correlates with his mother's report that he doesn't cope well with changes in his routine. • Becoming more and more spontaneous during the therapy activities. He makes jokes and chats away, sometimes hardly giving Flash a chance to complete a sentence! • Appears to already feel more comfortable with	<u>Flash</u> • Seems positive and excited about coming. Loves to chat and to make jokes, obviously enjoying the social contact. • Was very patient whilst assisting the Grade 2-girl, although he seemed to get slightly worried when he couldn't think of the right words to help her. • Possibly suppressing or denying anxiety related to the subject which he battles with most – Afrikaans. • Like George, he doesn't only associate anxiety with school work.

helping. He possibly feels self-conscious when he just stands around, but less exposed when he is involved in the helping role.	

Session 6: Learning the "ABC's" ; more helping 20 February 2013

MAIN ACTIVITIES

- Checking in: How are you feeling today?
- Creating cardboard ABC-chains:
  - **A**ctivating agent or situation, for example a test → **B**elief → **C**onsequence (feeling and action).
  - Color-coding each link (red for negative and blue for positive thoughts, beliefs, feelings and actions).
  - The chains visibly demonstrate how negative beliefs about a situation lead to negative feelings and actions, for example: Writing a test → believing that mistakes are unacceptable or that you should have studied harder → feeling anxious → having difficulty concentrating, rushing and making unnecessary errors. The chain repeats itself because negative consequences reinforce negative beliefs, causing a vicious cycle.
- The participants were physically involved in handling the cardboard, stapler and paint in order to create chains.
- Helping in homework class: all age-groups (today the children in homework class were not split into groups according to their age, and so each group consisted of children between Grades 1 and 7).
- Reflecting on their expectations of helping before going to help, and on their experiences of helping upon our return to the therapy room.

VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS

<u>George</u> • Feeling "mediocre" today (not very good or very bad, just in the middle) • Interested and involved in the "ABC"-activity. <u>Role reversal</u> • Before: "I don't know what to expect... I feel curious". • After: "It was good. I enjoyed helping the first boy most, because I didn't have to do much". • Assisted, amongst other children, a Grade 2 boy with his Math. He appeared to be quite confident and patient in	<u>Flash</u> • Feeling "fine" today. • Was equally interested and involved in the "ABC"-activity. <u>Role reversal</u> • Before: "It's going to be easier today". • After: "It was easier. Even though I couldn't help with everything, it was mostly fine". • Was helpful to many and appeared to enjoy it. At one stage, the only boy who asked for assistance was doing Grade 6 Afrikaans homework. At first Flash said that he is not good at Afrikaans and would rather see if someone in one of the other groups needed help. However, just as we were about to leave the classroom, he spontaneously changed his mind and said that he'd try helping with Afrikaans. He ended up being very patient,

doing so. He later joined Flash in helping a Grade 6 boy with Afrikaans, but left most of the explaining to Flash, who was doing very well in helping the boy understand the work.	and taught the boy a few 'tricks' which he had thought up by himself (to change a sentence from present to past tense). He said afterwards that it was easy to help, because the work was easy, but mentioned that Grade 7 Afrikaans is much harder.

RELEVANT OBSERVATIONS AND INTERPRETATIONS

- Both appeared to enjoy making the cardboard chains. They both grasped that one negative cycle can lead up to repetitive negative cycles, and the same goes for positive cycles. They grasped, in other words, that how you interpret and act on a situation today, will influence how you will interpret and act on similar situations in future. Changing you interpretation can change the whole cycle.
- At first, both George and Flash appeared to be slightly nervous about possibly helping some of the senior learners today. They had gotten used to helping the younger children, and being helpers to peers of their own age possibly seemed somewhat frightening. However, once they were there and started helping, they both seemed to relax again.

George	Flash
• From his report on how he experienced helping today, it would appear as though a part of him is still actually a bit resistant, and he believes that the less he has to explain, the better. His verbal feedback is slightly contradictory to my observation of his body language the moment he starts helping – he stops fidgeting and his whole body just seems to relax. Although he handles the helping role well, being kind and patient, a part of him still wants to avoid having to make social contact with unfamiliar children. This is most likely explained by his shyness and lack of social confidence in new, unfamiliar situations.	• Feeling more confident now that he has been a helper in the past (He has seen that he can do it). This made him willing to attempt something risky – helping with the subject which he finds hardest. He is thus developing courage and confidence in himself and his skills. There is however still an element of self-doubt in his Afrikaans skills in general, as he describes Grade 7 Afrikaans as being hard.

Session 7: Reflection **27 February 2013**

MAIN ACTIVITIES

- Rating feelings: Anxiety, Calmness and Excitement
  - "Scale": 0=anxious - 5=calm – 10=excited
- Reflecting on recent times when the above feelings were present
- Reflecting on role reversal experiences up to date (in sessions as well as during class-time)
- Helping Intermediate and Senior learners in homework class (Grades 4-7)

VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS	

<u>George</u>
• On 5 (calm)
• Recent experiences of feelings
  ○ Excited: Going to the Kruger Park for the mid-term break.
  ○ Calm: Driving in the car in the Park.
  ○ Worried: When Grandma went for an eye operation.
(What kind of things did you think/say to yourself?) "What if she can only see out of one eye"? "What if something goes wrong?"
(How much did you think about and worry about that?) "Not too much".
• Has recently helped a girl in his own class with her homework. Has also been marking his friends' work in Math (his teacher asked him to).
• (Is there anything you don't like about helping?) - "If I have too much homework."
• (What advice can you give to other helpers?) - George couldn't give any advice of his own, but said that he would agree with Flash's advice (this was after Flash had given his own advice).
<u>Role reversal</u>
• At first he shied away from the girls and seemed slightly nervous, but eventually became more at ease.
• He got a bit flustered when he was unsure of how to help with Math. It was a specific skill from Grade 4 which he had forgotten, but he was willing to come and ask me for help.
• He helped quite a few children today, and responded immediately whenever someone put up their hand.
• After helping, he moved to 5.8 on his scale, in the direction of excitement, but his score still mostly indicates a feeling of calmness.
	<u>Flash</u>
	• On 7 (Between calm and excited)
	• Recent experience of feelings
	  ○ Exited: Nothing exciting to recall, states that he has been mostly calm.
	  ○ Worried: Wrote a test in class. Said to himself: "I can do this test. I can think of this question". It reportedly made a bit of a difference to the anxiety.
	• Has recently helped two children in his own class at school. Often helps other children in his own small homework group which he attends each afternoon.
	• (Is there anything you don't like about helping?) - "It gets a bit annoying if I have to re-explain."
	• (What advice can you give to other helpers?) - "Some kids are lower-minded so you must lower yourself to it. Also ask for help if you can't figure it out. Don't be embarrassed".
	<u>Role reversal</u>
	• Appeared to be very relaxed and confident, whether helping boys or girls.
	• He asked me to assist if he was unsure of how to help.
	• After helping, he moved up to 7.5 on his scale (closer to excitement). He said that it was easy to help today, because the type of work was easy.
	• Flash's word-choice ("lower-minded") was interpreted merely as a lack of a better word – he said it in a gentle, respectful way.

RELEVANT OBSERVATIONS AND INTERPRETATIONS	
<u>George</u> • Helping a variety of children in class at school and possibly becoming quite used to it now. • As previously, he didn't report feeling anxious in a school situation. He might be purposefully avoiding admitting specific episodes of anxiety at	<u>Flash</u> • Even though Flash occasionally needed my help (and thus didn't have all the answers), he generally experienced the work as being easy. This indicates

school. Alternatively, he generally does not associate anxiety with school only, but also with situations out of school. Today's reported anxiety in response to his grandmother's recent operation can be regarded as a normal reaction. The actual degree of anxiety and how it affected him at the time is unclear, although he didn't report it as being serious. • George may feel tense or frustrated when having to help others when feeling overwhelmed by his own work load. • Today he was willing to ask for my help – something he was reported to avoid by his previous teacher. Helping others might be making him more aware of the fact that it is not unacceptable or uncommon to become 'stuck' or confused sometimes. He might also be learning from Flash's example, who easily asks for my help. • The positive shift on his self-rating scale after helping possibly indicates that he enjoys being a helper.	that he did not become overwhelmed or overly concerned about work that he couldn't do. Rather, he was more aware of what he actually could do. • Admitting the anxiety that he felt with a recent test indicates an awareness of his emotions and the willingness to express it. • According to his self-report, he remembered to apply the skill of positive self-talk. • He is aware that his patience decreases after a while of repetitive explaining. • The positive shift on his self-rating scale after helping possibly indicates that he enjoys being a helper.

Session 8: Relaxation training	**6 March 2013**
MAIN ACTIVITIES • Check-in: How do you feel today? • Reflecting on more role reversal experiences • Breathing exercise (relaxation training). ○ The participants practiced inhaling and exhaling for longer periods at a time by increasing the amount of seconds (e.g. inhale for three seconds, then exhale for three seconds – keeping count with fingers and trying to push out chests and tummies when inhaling). According to Smith and Jaffe-Gill (2006), learning to slow ones breathing down can help bring the physical symptoms of anxiety back under control. • Free play as a means of relaxation and releasing unwanted feelings and associated adrenaline levels. (They chose to play with the toy parachute and took turns in throwing the figurine as high as possibly up in the air for the other one to catch).	
VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS	
• Coincidently both felt angry today. • Both absolutely loved the free play outside today and they were able to release a lot of negative energy.	
<u>George</u> • Angry because he has been given a lot of Afrikaans homework and he	<u>Flash</u> • Angry because his whole class was punished for the wrongdoings of a specific

has to re-do something. On a self-rating scale, he reported 8 out of 10 for anger. • Has recently helped a boy in his class with highlighting important sentences, as this boy had lost his place during the lesson. It felt "Goodish" helping. On a scale from 1-5 (1=bad, 5=good), it was a 4. • After the deep breathing and free play, he reported his anger to have come slightly down on the scale, from 8 to 7,5.	group of boys. On a self-rating scale, he reported a 6,5 out of 10 for anger. • Has been helping quite a few kids in his own homework group. He mostly liked helping with Math. "It feels like I'm doing good, helping another person". • After the deep breathing and free play, he reported his anger to have come slightly down on the scale, from 6,5 to 5,8.
RELEVANT OBSERVATIONS AND INTERPRETATIONS	
The breathing exercise proved to be very useful in this session. Although it was initially intended to be taught as a coping skill for controlling anxiety and its associated adrenaline, today it could be applied to anger – an emotion that was actually present in both boys.	
George • Was well-focused during the breathing exercise and appeared to take it seriously. • He greatly enjoyed running around outside, trying different methods and tricks with the toy-parachute. • It was interesting that he reported 'anger' and not 'anxiety' as the emotion he felt in response to being given a vast amount of homework. This indicates that he possibly feels pressurized and annoyed by the work, but not necessarily scared.	Flash • Appeared to enjoy the breathing exercise as well. He welcomed the challenge of increasing the amount of seconds of inhalation and exhalation to 10 seconds. • Like George, Flash greatly enjoyed the free play. • Flash feels strongly about fairness and had difficulty accepting that he had been unrightfully punished.

Session 9: Reflection & more helping	**13 March 2013**
MAIN ACTIVITIES • Check-in • Self-report on helping tasks outside of therapy, and on application of coping skills in anxiety-provoking situations. • A short period of free play until the commencement of homework class. • Helping in homework class.	
VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS	
Free play while waiting for homework classes to begin: The boys played with the swords in the therapy room. Their spontaneous, fun-loving sides came out again. Both created	

'rules' to the game, and both were able to be assertive without becoming angry or annoyed with one another.	
<u>George</u> • On a scale from 1-10 for each feeling, he feels an 8/10 for relaxed, a 6/10 for exited and a 5/10 for worried • Recently helped a boy in his class catch up on a writing activity. • While doing revision for the upcoming cycle tests, he came across work which he had recently explained to someone in his class. Upon questioning about how he felt about the work that he had previously explained, he said that he thought to himself "I can actually do it". • Recently felt anxious about heavy thunder and lighting. He used the breathing technique to calm himself <u>Role reversal</u> • Helped a Grade 4 boy with a close comprehension exercise. His vocabulary and problem solving skills are good.	<u>Flash</u> • Reports that he is feeling "neutral". On the scale, he reports a 9/10 for relaxed, a 0/10 for excited and a 0/10 for worried. • Recently wrote a test and did some positive self-talk to keep calm. He hasn't recently helped someone in his own class at school and explained that he is only allowed to help others when his teacher deems it appropriate. <u>Role reversal</u> • Helped a younger boy to categorise given words. He gave good prompts and clues. Some words were unknown to him, and so he asked me to help at times. When I didn't know either, we asked the homework teacher to help.
RESEARCH OBSERVATIONS AND INTERPRETATIONS	
<u>George</u> • According to his self-report there is still a sense of anxiety present within him, although he reports that the other two feelings (relaxed, excited) are stronger. • Positive self-talk ("I can actually do it") was brought on by his memory of himself explaining specific school work to someone else. • George still hasn't reported any specific school-based anxiety-provoking situations, other than what he mentioned in the SCAS and in the second session, when he said that he generally feels anxious before a test.	<u>Flash</u> • According to his self-report, he is in a calm, relaxed state. • Possibly not being given as much opportunity as George to help in his own class at school, although I am aware that his homework teacher tries to provide him with daily helping-tasks in his group.

No group meetings for the following two weeks due to cycle tests.

Session 10: Concluding Term One	**4 April 2013**
MAIN ACTIVITIES • Reflecting on the highlights and challenges of the past school term.	

- Pretend-interviews conducted by a "journalist", done in comic strip format (in order to determine the participants' perceptions of how other people view them).
- Deciding together on the way forward.

VERBAL AND NON-VERBAL EXPRESSIONS OF PARTICIPANTS

George	Flash

• Highlight of the term: Break (eating and playing).
• Biggest challenge of the term: Getting up for school as he goes to bed late at night (due to daily swimming practice and homework). When asked how he coped with this, he said that he brings mint sweets to school. It helps a bit when he's feeling tired.
• Goal for next term: To steady his hand so that he can write neatly – his hand "wobbles".
• J's reported perceptions of significant others' views of him:
  ○ Mom: "He is good."
  ○ Teacher: "He keeps quiet."
  ○ Friend: "He is a good friend."
  ○ Person who received help from him: "He explains in a way I understand."
	• Highlight of term: Standing for "House Captain" and doing well with his "House Captain speech". (The Grade 7 learners do this every year, just before Sports Day). He reported that doing the speech was hard, but he did it anyway because he really wanted to become House Captain. He felt happy after having given his speech. He reported that his teacher said that his was the most fluent of all the candidates' speeches.
	• If he could give some tips on public speaking, it would be: "Be fluent". "It's not the end of the world if you mix up a word". "Just be calm". .
	• Biggest challenge of the term: The cycle tests. When asked how he coped, he said that he kept calm and didn't think about the possibility of failing.
	• Goal for next term: To raise his marks by studying and working harder.
	• R's perceptions of significant others' views on him:
	  ○ Teacher: He is a good student. He is good at reading.
	  ○ Dad: He is a good boy.
	  ○ Friend: He is a good friend.
	  ○ Mom: He is a great student.
	  ○ Person who received help from him: He is good at Math.

RELEVANT OBSERVATIONS AND INTERPRETATIONS

George	Flash
• Today he was quite reserved when it came to reflecting on and sharing information of emotional quality. He limited his disclosures to the minimum and additionally exhibited task-avoidant behaviors (playfully throwing Flash with a rubber instead of writing in the various speech bubbles during the 'Journalist-activity'). He	• Responsive and expressive, comfortably talks about his experiences. • Voluntarily standing for House Captain and making a speech indicates that he has developed a level of confidence in his leadership skills, his public speaking skills and his social functioning in general. • He remembers the positive feedback which he got from his teacher. • Having been able to give a fluent speech indicates that he coped well with controlling the anxiety

possibly didn't feel at ease with the nature of the task (which involved handwriting and spelling) as well as the personal content involved. • His responses in terms of the highlights and challenges of Term 1 indicate the experience of fatigue. • Although George's perceptions of significant others' view of him may have partly been a projected wish, other meanings may also be derived from his responses: It appears as though he believes that his teacher expects of him to be quiet (and sees him as being good/well-behaved). He additionally possibly feels confident in the way that he can explain work to others, indicating a positive change in terms of his initial anxiety regarding this form of social interaction.	typically related to public speaking. • As in Session 2, the impression is given that Flash sets high goals for himself in terms of his academics. Greene (2002:19) identifies this negative thought pattern, which he names *"Obsessing about results"*. It refers to the pressure put on oneself to achieve certain results. When Flash cannot reach these results, he believes that he didn't work hard enough. Gnika *et al.* (2012) warn against this tendency to self-criticism, where the acceptance of responsibility actually becomes detrimental. Flash maintains his goals rather than reflecting on its' realism – a typical trait of perfectionism (Parker & Adkins in Wikipedia, 2013). This needs to be addressed as it could continue to reinforce feelings of incompetency and failure. • Although Flash's reported perceptions of how significant others view him may have partly been a projection of his wishes, it might also be interpreted as a real belief that others view in him a positive light.

4.3.1.2 Progression of feedback from participants' parents and teachers

George

2013/01/23 12:00-12:10	George's class teacher came to me to report that he had, according to his mom, experienced something like a panic attack the night before (22 January) while he was completing his homework. He was crying. She further reported that she finds George to be very anxious in class. Additionally, his Math teacher had apparently told her that George had cried during his Math lesson the day before.
2013/01/24 07:30-07:35	I phoned George's mom to let her know that I had been informed by his teacher of his anxiety episode two nights before, and to find out how he was doing at home. George's mother reported that he seemed better and had slept through the previous night. He didn't go to swimming practice and only finished what he could in terms of homework. Mom mentioned that George gets like this in the beginning of every year as he struggles to cope with the change in classroom, teacher and academic demands. Mom feels concerned that he might develop a stomach ulcer in response to his high levels of stress.
2013/02/07 07:30-07:35	Incidental discussion with George's class teacher: George is reportedly difficult to read (he is reserved) within the bigger group. He often incidentally helps the girl who sits next to him. The Afrikaans teacher reported to George's class teacher that she noticed him crying in class the day before. He just sat there quietly and didn't

	make a scene.
2013/03/28 10:05-10:06	Passing by George's teacher at the school, I asked her how he had coped with the recent cycle tests. She briefly reported that he had obtained good results, and that he did not display overt signs of anxiety during the tests.
2013/04/05 07:00-07:30	Individual meeting with George's mother <u>Summary</u>: George's mother reported that this had been a challenging term for him, due to many changes (his older brother had gone to high school, mom and brother comes home late, George went to a new class and teacher in a different section of the school). George generally experiences difficulty adjusting to change. She does however see a remarkable decrease in his anxiety, although it is still present. Mom is noticing a bit more irritability and anger in George lately and she is unsure of where this is stemming from. <u>Note:</u> George's reported irritability and anger might be partly explained by an irrational belief named "*low frustration tolerance",* which is the notion that *"frustration should not exist and it cannot be tolerated"* (Vernon, 2007:110). He might foster this belief when he does homework.
2013/04/05 07:30-07:50	Attendance of end-of-term parent feedback meeting held by George's class teacher, Math teacher and remedial therapist. <u>Class teacher:</u> George coped well academically with class work and cycle tests this term. She will push him a bit harder next term regarding the quality of his homework. George has become more accepting of help and more willing to ask for it, whereas in the beginning of the term he was quite resistant with this. His greatest difficulty lies with written expression and he is held back by his poor spelling. <u>Math teacher</u>: George has "*toughened up*" (quote). In the beginning of the year he kept to himself and often cried when work got tricky. He is now far more relaxed in class. He still sometimes cries but not as much, and asks for help more easily. He can even become quite argumentative about how he believes a math problem should be solved, which indicates confidence. His class performance was better than his test performance, possibly due to a remaining degree of test-related anxiety. George portrays more social confidence than in the past. He recently brought special elastics to school and explained to his peers how to braid it as one would a rope. <u>Remedial therapist</u>: George attends remedial sessions with one other boy in his class. Although George was quite reserved at first, he has come out of his shell and is revealing his personality in therapy sessions. They are working on specific language and reading skills. He attempts tasks more positively than he did in the beginning of the year and he is making progress. He is quite possibly dyslexic. In future (e.g. in his career one day) he will need to have someone who can check his spelling. He needs to learn how to use spell check as well as he can, and possibly in future learn to use the Dragon Reader program or something similar to help him communicate his ideas in writing. <u>Mother</u>: Although the recent cycle tests were written in class, the exams that were

	written in the school hall last year was hard for him to cope with, as this was a different area than his familiar classroom. Nevertheless, she wants him to write in the hall again this year (upcoming exams - Term 2) and hopes that he will cope better this time. The team and mom agreed that when the time comes, I could possibly see him after completion of a paper to check how he coped. Everyone in the meeting agreed that from next term on, George will be granted concessions for spelling and he will be constantly reminded that spelling doesn't count. He needs to understand that his ideas are important, and that this is what he needs to share when he writes. The whole class will be exposed to Dragon Reader at some stage. Knowing that there are technological ways of overcoming spelling difficulties might provide George with a sense of relief and hope. Role reversal will continue next term. <u>Relevant observations and impressions</u>: George's mother is very aware of his functioning and she is willing to speak honestly and openly about it. She does seem to be slightly nervous herself. She listens to feedback from others, but is also willing and able to voice her own observations and concerns. She doesn't encourage avoidant behaviour in George (such as him receiving amanuensis for exams in a separate room instead of writing in the school hall together with the rest of the group). She thus understands that avoidant behaviours are in fact detrimental and only maintains anxiety, as noted in the literature as well (Mowrer in Flannery-Schroeder *et al.*, 2007:206).

Flash

2013/02/05 10:00-10:02	Incidental discussion with Flash's Afrikaans subject teacher. She reported that he works very slowly and that he often gets stuck – he can't move on to something else when he is confronted with a difficult question or task. Procrastination is noted in the literature as a symptom of maladaptive perfectionism (Gnika *et al.*, 2012).
2013/02/07 07:30-07:35	Incidental interview with Flash's current homework group tutor, who also used to be his Grade 6 class teacher: She is reportedly starting to notice a shift in Flash. He is showing a sense of confidence and caring with regards to his homework, and is more open to being helped when he is on the wrong track. In the past he was inclined to become argumentative and resistant when being corrected.
2013/03/25 07:40-07:42	The HOD (Head of therapy department) at the school informed me that Flash's mom phoned earlier. Flash had received amanuensis (for scribing) for his Science cycle test on Wednesday 20 March. He reported to his mom that he felt "on the spot", that he "couldn't think" and that he "messed up". He asked to rather write the rest of his cycle test papers by himself without the help of a scribe, and his mother asked whether this would be possible. Flash's class teacher agreed to give him a chance to write by himself and see how he copes with putting his ideas and answers to paper independently.
2013/03/28 11:55-12:00	I asked Flash's class teacher how he had coped with the recent cycle tests, especially after discontinuing amanuensis for scribing. She briefly reported that even though she was able to decipher his handwriting, he did not obtain very good

	results, and that she is unsure of whether this is because of poor concentration, underlying anxiety or low cognition. She further reported that he did not appear to be visibly anxious during the tests.
2013/04/05 11:00-11:30	Individual meeting with Flash's mother. <u>Summary</u>: Flash's mother reported that he is getting better at understanding himself and his feelings. He can now verbalize his feelings - something he was unable to do in the past. With tests, he is slowly starting to attempt answering questions of which he is unsure, although he still leaves some questions out. In the past he wouldn't attempt such questions at all. He is more willing to take risks. He stood for House Captain at school and gave a speech which he wrote by himself. He did this by choice – no one asked him to do it. He was able to acknowledge his disappointment when he didn't win, but he could also compartmentalize this and didn't let it affect him in other areas of his functioning. Being a helper to other children has been beneficial to him (Mother's words: "*What helps him most is being a role model to others*"). Flash's mother is adamant that he goes to an IEB (Independent Examinations Board) high school with small classes. In her words, "*passion is more important than talent".* <u>Observations and impressions</u>: Flash's mom is quite outspoken and very passionate about both of her children's potential. She might foster some unrealistic expectations. She is quite strong-willed and holds strong beliefs, and she might not be open to 'critique' or concerns voiced by professionals regarding Flash's cognitive potential and specific areas of difficulty. I'm concerned that Flash might really struggle to cope in an IEB high school next year and that his confidence might take a blow when he measures himself against other children without learning difficulties. Mom might not be aware that Flash will still be able to go to university from certain GDE main stream high schools that offer learner support. Mom spoke a lot, also about her own struggles during high school and university. It sounds like she sees a lot of herself in Flash. I feel worried that through her expectations she might, unknowingly and unintentionally, be adding to Flash's anxiety. I am also concerned about Flash comparing his school report to that of his older sister, who reportedly obtained an average of 84% for this past term.
2013/04/10 08:20-08:40	Attendance of end-of-term parent feedback meeting held by Flash's class teacher. <u>Summary</u>: The interview started late and I could regrettably not stay until the end as I had another meeting to attend. During the time I was present, Mom mainly spoke about her intentions of enrolling Flash at a specific IEB mainstream high school. She appears to be anxious about this and almost seemed to be trying to convince herself that this will be the right decision for Flash. She mostly mentioned the workload as a possible problem area in relation to his ADHD, but disregarded the possible effects of his proneness to anxiety, as well as his specific difficulties related to written expression and verbal reasoning. Flash's teacher didn't seem to be convinced that he will cope well in that particular high school. She said quite

	little but her body language revealed that she was possibly feeling uncomfortable about the matter.
2013/05/07 07:45-07:47	Incidental discussion with Flash's Afrikaans teacher. She reported that she has lately seen a positive change in Flash's confidence and that he approaches tasks more positively. His term mark (term 1) was still below the grade average, but it was the highest mark he has ever gotten for Afrikaans. While there are still areas of difficulty that need to be worked on, she reported feeling very happy with his progress.

4.3.1.3 Feedback from participants in individual semi-structured interviews

The individual semi-structured interviews that were held with each of the participants by the end of Term 1, revealed the following information regarding their self-reported personal experiences of the intervention, and more specifically of the helping role. Where deemed necessary, the participants own words are quoted.

George

George generally felt "*good"* about helping. While he initially thought it might be a bit "*boring"*, he later "*started to like it"*. Helping others made him feel like he "*was doing something good and nice".*

While helping other children with their school work, George came to the realization that he was not the only one who was sometimes "*confused*". He reported that helping others also helped him in the sense that now, when he gets confused, he doesn't *"feel so bad because other people also got confused".*

Something he occasionally experienced as difficult or challenging while helping was the fact that that he could not always find the right words to help the child understand. There were additionally times when he himself didn't quite understand a specific question that he was asked to help with. Nevertheless, if he could choose between incidental helping and prepared helping (knowing what type of work he would help with beforehand) he would choose incidental helping (*"Just see whatever they need help with"*).

To other children who get anxious or nervous about their school work, he would say, *"Don't worry, if you get it wrong, it's okay".*

To other children, who also want to become helpers, he would say, "*Just give it a try and see if you like it".*

To teachers who want to let children help other children in class, he would say, *"Even if they don't know, just at least let them try. If they don't know, then it's okay".*

If George had to describe himself to someone he just met, he would say that he is a loyal, friendly and fair person.

Flash

Flash liked the idea that he got to help other children, and that "*they got to know their work".* Helping others made him feel "*happy",* that he was "*doing really good – doing a nice thing".* He mostly felt like this from the start.

Helping others reportedly also helped him. Firstly, he sometimes got to learn new things as well ("*They maybe told me something that I never knew. Like when I'm explaining something, they might tell me something that I didn't know about that work*"). Something else that he got from helping was "*experience"*, and more specifically learning how to be a helper. He explained that "*Now when I have to work when I'm older, I actually know how to help people around the place*".

He felt quite confident in his own knowledge and skills while helping others *("I think I might know it, or I might not, but I'll probably know it").*

Through helping other children, Flash realized that he consisted over better skills and knowledge than he initially gave himself credit for ("*The work I thought I didn't know, or thought I wasn't good at, I'm actually pretty good at*").

It sometimes became annoying to Flash when he had to explain something over and over again. In that sense, Flash liked it better when he helped older children who were closer to his own age-level, as he felt that they understood him better than the younger children did ("*my brain thinks on a more scientific level than theirs*").

As a helper, Flash would personally prefer prepared helping above incidental helping, although he doesn't mind incidental helping. He explained that "*If you know* (what you will be helping with), *you are ready... ... but if you can't know, it's still okay").*

To other children who get anxious or nervous about their school work, he would say, *"Think of something calm. It's okay to make mistakes, you're not perfect. Try and get the best you can. You might sometimes get everything correct, but sometimes you won't".*

To other children who also want to become helpers, he would give the following advice: Firstly, it is not necessarily easier to help the little children as one might initially think. Secondly, *"It's okay to ask for help – you don't have to think you have to know everything".*

To therapists like me who want to do the same type of program with other children, he would give the following advice: If they (the helpers) become stuck, the therapist should try and assist. If the therapist doesn't know what to do either, he or she should ask the teacher ("*It is okay if you get stuck*").

If a teacher wanted to let children help other children in class, Flash would advise her to choose those children that are kind, generous and patient to be the helpers.

If Flash had to describe himself to someone who just met him, he would say that he is helpful, nice, not a trouble maker and not easily influenced (negatively) – "*I'm me, you can't change me. You can't make me do something I won't do".*

He lastly described adrenaline as something that can be helpful as long as it is not too much, and that one is in control of adrenaline and not the other way around ("*If it's just enough, you'll be great... ...You are in control").*

4.3.2 Data analysis and interpretation

4.3.2.1 Summary of initial symptoms

Behaviour	Flash	George
A tendency to be quiet and withdrawn, especially in new, unfamiliar social settings (Smith & Jaffe-Gill, 2012).		√
A tendency to make careless errors when feeling anxious, such as during tests (Swanson & Howell in Whitaker *et al.*, 2007)	√	√
Procrastination (Gnika *et al*, 2012).	√ Especially during difficult Afrikaans work	√ Especially during written tasks due to a spelling barrier
Avoids attempting questions when he feels unsure of the answer as it might lead to negative evaluation, (Muris, 2007:153).	√	
Poor confidence in academic abilities (Hodapp in Whitaker, *et al.*, 2007).	√	√
Being fearful of taking tests (Smith & Jaffe-Gill, 2012).	√	√
Worrying about what others think of him and being afraid of making a fool of himself in front of others (Barlow & Durand, 2002:138).	√	√
Feeling afraid of public speaking (American Psychiatric Association, 1994:414).	√	√
Worrying that he will do badly at school.	√	√
At times complaining of a funny feeling in his stomach (Greene, 2002:17)	√ "butterflies"	√
Increased heart rate when anxious (Greene, 2002:17)	√	√
Getting a headache when worried		√
Has a history of experiencing difficulty in understanding and expressing his emotions.	√	
Fidgets when feeling nervous or self-conscious.		√
	√	

When he feels put on the spot, he has difficulty recalling learnt information.		
History of panic attacks when he becomes overwhelmed by his homework (Grohol, 2011).		√
Dichotomous thinking (Stewart *et al.*, 2007:11)	√	
Tendency to cry in class when work becomes difficult (Grohol, 2011) although he sits quietly and tries not to attract any attention (Smith & Jaffe-Gill, 2012).		√
Avoids asking for assistance in class (Smith & Jaffe-Gill, 2012).	√	√
Responds anxiously to changes in his normal routine.		√

Table 4.1 Summary of participants' symptoms

4.3.2.2 Summary of therapeutic gains in response to the intervention

The following themes were identified with regards to the therapeutic gains that were made by the participants.

Positive changes in self-concept Helping others to master certain concepts or skills, made the participants become aware of and voice their own capabilities, which lead to a more positive way in which they thought about themselves and their abilities. "*I can actually do it*" – George. "*Things I thought I couldn't do, I'm actually quite good at"* – Flash. Cohen *et al.* (in Hall & Stegila, 2003) have similarly reported on improvements in peer tutors self-concepts as well as improved self-esteems in students with disabilities when they were in the teacher role.
Incidental learning Teaching others provided the participants with opportunities during which they themselves could learn something new or revise something they had forgotten. Reported academic benefits for tutors through cross-tutoring is consistent in many studies (Campbell, 2012; Maheady *et al.* in Stenhoff & Benjamin, 2007). "*... when I'm explaining something, they might tell me something I didn't know about that work*." – Flash

Academic progress

Flash's overall gain in confidence appears to have affected his performance in the subject which he finds most challenging (Afrikaans), and he reportedly achieved the highest mark he has ever gotten before for this particular subject.

Improved social confidence and courage

The participants developed the courage to embrace, rather than avoid social situations that might hold the risk of negative evaluation.

- Both participants became more comfortable with being the centre of attention within a crowd, as were demonstrated by Flash's House Captain speech and George's "elastic rope demonstration".
- Both participants became more willing to ask for help, even though that meant revealing their own areas of weakness.
- As a naturally shy type of child, George portrayed growth in the confidence with which he approached the task of explaining school work to children whom he did not know well.

The literature similarly reports on the social and interpersonal benefits that peer tutoring hold for the tutor (Campbell, 2012; Top & Osguthorpe in Hall, 2003; Maher in Hall, 2003). Increased positive social interactions within tutees as a result of peer tutoring have additionally been reported by Maheady *et al. (*in Stenhoff & Benjamin, 2007).

Greater acceptance of imperfections

The participants became more accepting of the fact that they sometimes struggle with their school work.

- "...it doesn't feel so bad because other people also sometimes get confused"; "If you get it wrong, it's okay" - George
- "It's okay to make mistakes, you're not perfect... it's okay to get stuck... you don't have to think you have to know everything." – Flash
- Flash slowly became more willing to risk answering questions of which he wasn't entirely certain of the answer, despite knowing that he might be wrong.

Positive changes in attitude

- George has reportedly become more positive during remedial lessons.
- Flash has reportedly become more caring towards homework and more positive in Afrikaans lessons.

An improved attitude towards subject matter within peer tutors as a result of peer tutoring has been reported by Cohen *et al.* in Hall, 2003).

Development of self-awareness

Participants became more aware of their own skills, knowledge and emotional

experiences. Flash especially learned to identify and voice his feelings.
Improved ability to cope with challenges and demands • Both participants were, on occasion, able to report on their application of learnt coping skills to help them take control of anxiety and adrenaline. • The participants' parents and teachers reported noticing a greater sense of confidence within them, and less visible symptoms of feeling overwhelmed (such as crying or avoiding anxiety-provoking situations). • George did not experience another panic attack after the incident in January. He obtained good results on his report despite having had a challenging and tiring term.
Improved confidence and reduced anxiety • Flash became confident in who he is a person and what he believes in. He even started believing in his own leadership skills in standing for House Captain. • Both participants indicated low levels of anxiety on self-report measures. • Although a degree of anxiety is still present, George's mother reported a reduction in this. His self-reported levels of anxiety during sessions were low as well, and he has reportedly become more relaxed in class. Fash's self-reported levels of anxiety were low as well. Similar to these findings were those of a pilot study using cross-age peer tutoring as a method of intervention for anxious adolescents - the results revealed a decrease in some of the anxiety symptoms experienced by the tutors (Campbell, 2008).

4.3.2.3 Summary of participants' self-reported experiences of the helping role

As were noted in Chapter Two, studies involving peer tutoring programs revealed that the student's comments were positive, in that they enjoyed assuming the role of the helper (Blake *et al.* & Lazerson in Spencer, 2006). After careful analysis of my study's data, I was able to identify the following themes in terms of the participants' personal experiences of the helping role.

POSITIVE EXPERIENCES OF HELPING	CHALLENGES TO HELPING
Altruism **Participants reported that it felt good helping other people – they felt like they were doing something good to others. A study conducted by Campbell (2008) similarly reported that the ability to help others, appealed to the sense of altruism in youths who played the tutor role.**	**Initial nervousness** **The participants initially felt slightly nervous and unsure as to what it would be like becoming helpers. Flash was concerned about not being able to help with all of the homework tasks, while George appeared more concerned about the social interaction involved in helping others.**
Accomplishment **Despite the uncertainty that accompanied the task of becoming helpers, the participants took up the challenge and mostly felt that they were succesful in the ways that they helped other children in their learning.**	**Uncertainty** **There were occasions when the participants didn't understand how to do the work they were asked to assist with. While they may have viewed this as negative, it also created opportunites for learning and becoming more accepting of help themselves.**
Confidence and positive self-evaluation **Explaining work to other children made the participants feel able and confident in the applicable skills and concepts that they were teaching. Additioanlly, as helpers, the participants viewed themself as being people who are friendly and kind to others.**	**Frustration** **The participants sometimes experienced difficulty explaining work to children who were much younger than them. This was due to the difference in their levels of cognitive functioning. Closely related to the aforementioned point, the participants reported that they sometimes felt annoyed when they had to keep explaining something to a child who didn't understand.**

Table 4.2 Participants' experiences of the helping role

4.3.2.4 Continued therapeutic support

While many therapeutic gains have been made, the therapeutic intervention with these participants cannot yet be terminated and will continue despite the finalization of this research report. Both participants continue to demonstrate a level of performance anxiety, even though many symptoms have started to decrease. Therapy will continue to aim at alleviating the participants' specific areas of difficulty.

For Flash, further therapy will focus on

- Continuing to build on his confidence and skills in Afrikaans by generating specific role reversal opportunities during which he will assist younger as well as same-age peers with subject-related skills that he has mastered, as well as skills that he is in the process of consolidating.
- Continuing to reinforce his willingness to attempt answering questions of which he feels uncertain. This might be done by asking him to train younger learners in test-taking skills, which would also involve calming strategies.
- Flash needs to learn to set more realistic, attainable goals. It might be useful to provide parental guidance to Flash's mother in this regard.

For George, further therapy will focus on

- Internalizing the fact that his ideas are more important than his spelling. He needs to overcome his fear of negative evaluation relating to his spelling and handwriting, as this is inhibiting his ability to fully demonstrate his other skills in written tasks. This might be supported by asking him to train a younger learner in approaching a task that involves the written expression of knowledge and ideas.
- A level of test-related anxiety continues to be present, as was revealed by the careless errors which he made in his Math cycle test. Therapy will continue to explore his self-talk as well as his application of other coping skills when writing tests. George might assist Flash with training younger learners in test-taking skills.
- Exploring the prevalence and origin of George's tendency to become angry and irritable, as was reported by his mother.

4.4 INTEGRATION OF FINDINGS

4.4.1 Participants' experiences of role reversal

From the participants' self-reports it became apparent that the helping role appealed to their sense of altruism, which refers to an individual's desire to support others. This concurs to the findings of Campbell (2008). Helping others made the participants view themselves in a positive light in terms of characteristics, such as friendliness and kindness.

Initial feelings of uncertainty and related anxiety were experienced by the participants, although it was not to such an extent that they wished to avoid helping others. For the socially inhibited participant, the idea of interacting helpfully with children whom he didn't know well seemed challenging. For another participant, the social interaction didn't seem as challenging as the fact that he might not always be capable (academically) to help. It thus seems as though the origins and specific focus of each individual child's performance anxiety impacted in unique ways on their expectations and initial confidence regarding the helping role.

Despite their initial uncertainty, the participants took up the challenge of trying to help others. Their confidence as helpers improved as they became more used to assisting

others. The participant who doubted his own academic ability to help in all instances, later volunteered to help somebody else with the subject that he himself often struggled with. The participant with the socially inhibited temperament became more socially at ease as he gradually got to know the children in the homework classes where the help was provided. The participants eventually indicated that they viewed themselves as skilled and confident helpers.

Helping others was not always easy though. The participants realised that explaining work to a much younger child for example was quite tricky and even frustrating at times. One participant correctly attributed this to the fact that they (the helpers) and the younger children were functioning at different levels of cognitive ability. Putting themselves in the shoes of the younger child and understanding their frame of reference, was a challenging task for the participants.

Another challenge was those times when the participants came across work which they themselves were not sure how to do. Although asking for help might seem contradictory to the purpose of role reversal, it ended up making the participants more comfortable with accepting assistance from their teachers – something that they were both initially reported to struggle with at school. In fact, realising through role reversal that many other learners sometimes become stuck and require help, may have lead them to feel like less of a failure for sometimes needing assistance themselves.

The helping role thus had its "pro's and con's" according to the participants, although their reports generally indicated that the positive experiences outweighed the challenges.

4.4.2 Areas of therapeutic growth

SYMPTOMS	PROGRESS
Poor confidence in academic abilities (Both Flash and George) (Hodapp in Whitaker, *et al.*, 2007).	A positive shift in both participants' levels of confidence was reported by their teachers, parents and/or other school-based therapists.
A tendency to be quiet and withdrawn, especially in new, unfamiliar settings (George) (Smith & Jaffe-Gill, 2012).	George became more socially at ease. This was evident in the group sessions and was also reported by the professional staff dealing with him at school, who commented on his growing spontaneity and confidence.
Making careless errors when feeling anxious, such as during tests (George and Flash) (Whitaker *et al.*, 2007)	According to teacher reports, this continues to occur for both participants at this time.
A tendency to procrastinate (Flash – particularly in Afrikaans lessons) (Gnika *et al.*, 2012)	Flashes teacher reported improved work behaviour in the sense that he has started approaching tasks more positively and confidently.

SYMPTOMS	PROGRESS
Avoiding the possibility of negative evaluation by avoiding answer questions when feeling unsure (Flash) (Muris, 2007:153)	While there is still a degree of avoidance present, Flash did attempt to answer some of the questions of which he felt unsure in the end-of-term cycle tests. This indicates the beginning of a shift.
Being fearful of taking tests (Flash and George) (Smith & Jaffe-Gill, 2012).	Both participants' teachers reported after the cycle tests that they didn't display any overt (obvious) signs of anxiety during the end-of-term cycle tests.
Worrying about what others think of them and being afraid of making a fool of themselves in front of others (Flash and George) (Barlow & Durand, 2002:138)	Both participants started executing social behaviours that proved them to be more confident and thus less fearful of making fools of themselves in front of others.
Feeling afraid of public speaking (Flash and George) (American Psychiatric Association, 1994:414).	Both participants proved to have become more confident to speak up in crowds. Flash voluntarily made a House Captain speech. George voluntarily explained a craft technique to a group of peers.
Worrying about doing badly at school (George and Flash).	This feeling could not be objectively measured, although the participants' changed behaviors might indicate a decrease in their performance anxiety in general.
Sometimes complaining of experiencing a funny feeling in the stomach and increased heart rate when feeling anxious (George and Flash) (Greene, 2002:17)	Except for the initial exploration of the participants' symptoms, I was not made aware of such complaints during the further course of the study (although that cannot be said to prove that the symptoms had gone).
Getting a headache when worried (George)	Except for the initial exploration of the participants' symptoms, I was not made aware of such complaints during the further course of the study (although that cannot be said to prove that the symptoms had gone).
Experiencing difficulty with the expression of own emotions (Flash)	Flash's mother reported that he had become able to understand and voice his own emotional experiences.

SYMPTOMS	PROGRESS
Fidgeting when feeling nervous or self-conscious (George),	This was noticed initially just before a helping task, but later dissipated.
Having difficulty recalling learnt information when feeling put on the spot (Flash)	This continues to be a challenge for Flash.
Getting a panic attach when feeling overwhelmed (George) (Grohol, 2011).	George was not reported to have had another panic attack after the one in the beginning of the year.
Crying and withdrawal when overwhelmed (George) (Grohol, 2011; Smith & Jaffe-Gill, 2012).	George was reported to cry less frequently by the end of term, although it still sometimes occurs. He continues to withdraw when this occurs, trying not to attract attention to himself.
Responding anxiously to changes in normal routine (George).	George's mother reported that he had experienced a challenging first term to Grade 6 in terms of having had to cope with many changes (relating to school as well as home). His teachers however reported that he had coped well and achieved pleasing results at school, indicating a better way of coping with the changes that were present.
Avoiding asking for assistance in class (in other words speaking up in class) (George and Flash) (Smith & Jaffe-Gill, 2012).	Both participants became more willing to ask for and accept help.

Table 4.3 Summary of symptoms and progress

4.4.3 Summarizing the positive effects of role reversal

In reflection of the information obtained through this study regarding the effects of role reversal on the participants' functioning, the following summary can be made.

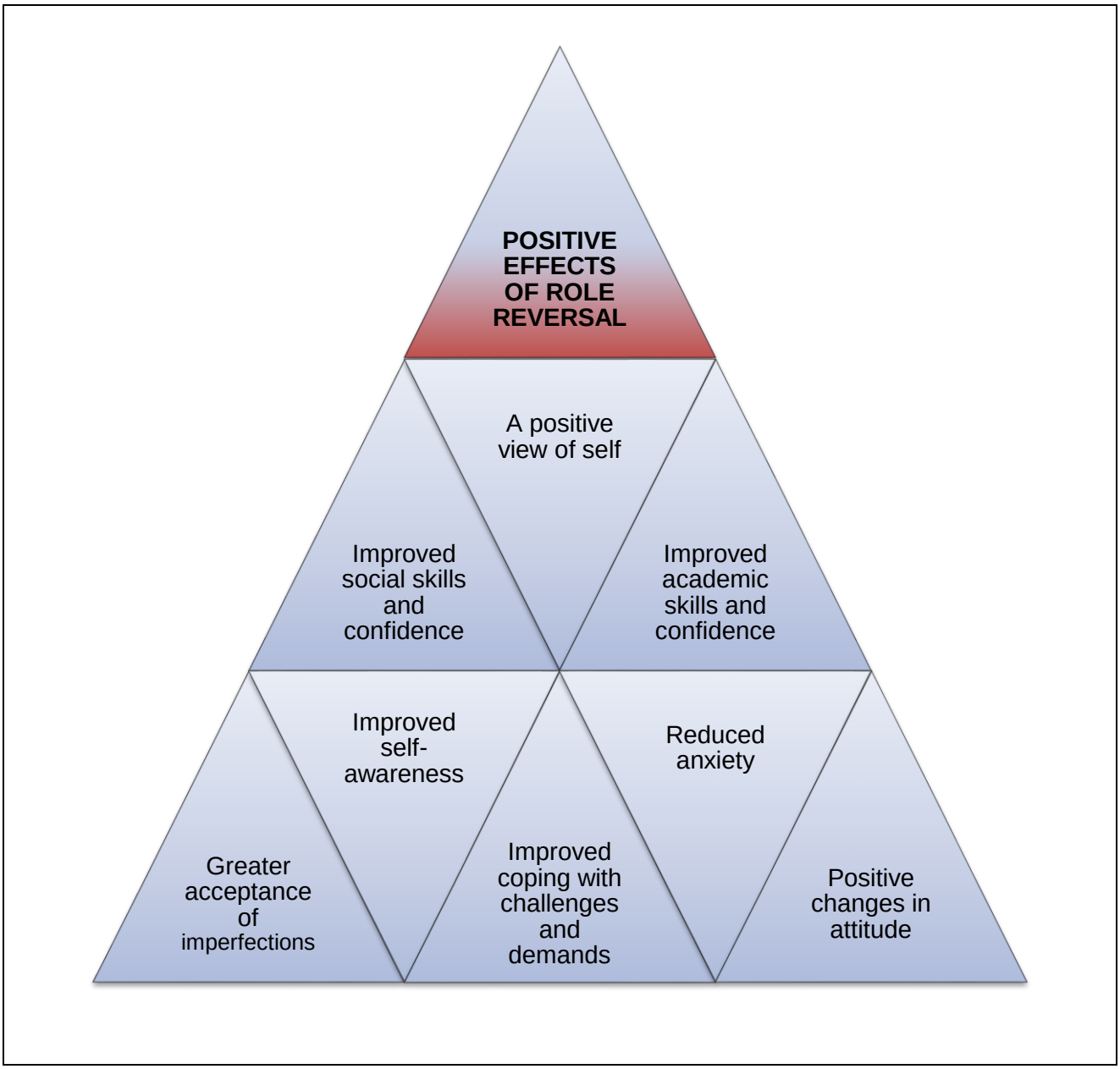


Figure 4.4 The positive effects of role reversal

4.4.4 Adapting negative cycles

The positive changes in the participants' functioning suggest the possibility that the once negative cycles relating to the causes and effects of their anxiety (Figure 1.1 and Figures 2.5 – 2.9) might have been adapted in some way. In an attempt to conceptualize the psychological changes that may have taken place within the participants, a schematic representation of a more positive cycle is presented on the following page.

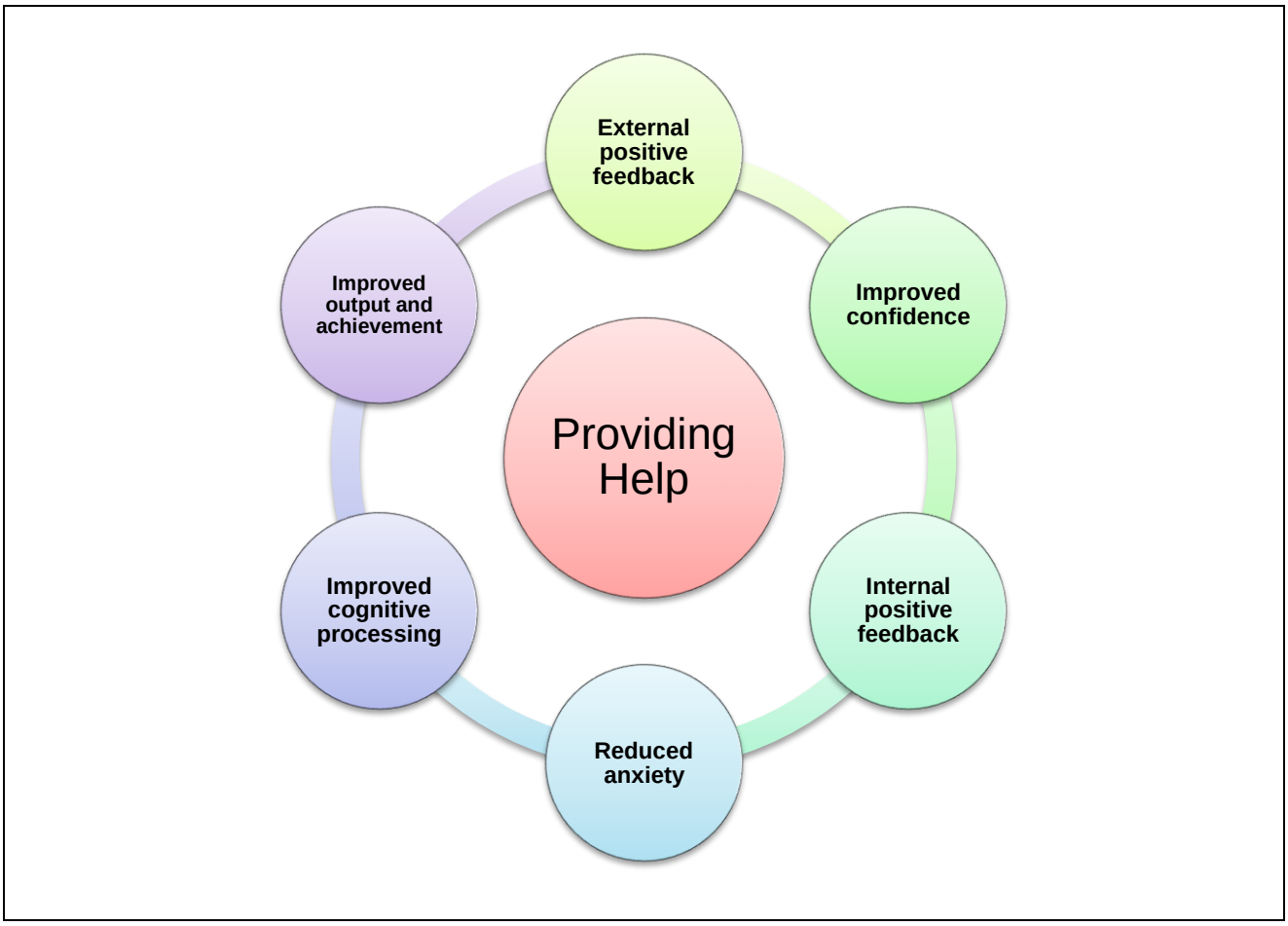


Figure 4.5 Cycle of positive change through the use of role reversal

4.4.5 The use of role reversal from a school counsellor's perspective

4.4.5.1 School-based therapeutic support

As a school-based counsellor, I was able to experience the benefits of school-based interventions for social phobia. These benefits included, as concurred with the literature review, easy accessibility to the clients and their teachers, as well as the opportunity to witness clients' functioning in a real-life setting (Klein, 2010; Menutti *et al.*, 2006:65; Gosch & Flannery-Schroeder, 2006:77).

Having daily access to the participants' teachers made it easy to involve them in the intervention and to obtain valuable feedback from them regarding their learner's progress. The school-based intervention additionally supported the carry-over of skills from the therapy room to the classroom, as the participants (clients) perceived role reversal as a part of school and not as something separate that occurs outside of the school environment.

4.4.5. 2 Group therapy

The group-therapeutic context provided opportunities for the participants to incidentally improve on their social skills and confidence. This is consistent to the findings of Albert

Ellis (DiGiuseppe in Vernon, 2007:121), who argues that the exposure to others within groups, helps children with social difficulties develop their skills. It was additionally observed that the group members appeared to learn from one another. One example of this was when George started asking for assistance after he noticed Flash doing so. Seeing the participants in group-format appeared to take the 'spotlight' off the individuals as my attention was shared between members. The members seemed to bring out one another's spontaneous, fun sides.

4.5 SUMMARY

This chapter reported on the data that was obtained through the empirical investigation. Two case studies were discussed in depth. The data was analyzed and conclusions were drawn regarding the effects of the intervention as well as the way in which these specific participants experienced the technique of role reversal.

The following chapter will provide an overview of the study in its entirety. Final conclusions regarding the research process and the technique that was under investigation will be drawn, including a reflection on the usefulness and appropriateness of role reversal as a school-based, group-therapeutic technique.

CHAPTER 5
INTEGRATION OF FINDINGS, SUMMARY AND CONCLUSION

5.1 INTRODUCTION

This Chapter provides a summary of the study it its entirety. It reflects on previous chapters and integrates the information that was obtained through the study. Conclusions are drawn in terms of the study's contributions and limitations, and recommendations for further study are offered.

5.2 SUMMARY OF THE STUDY

In Chapter One, the motivation and aims for the study were outlined, together with the proposed methodology that was to be followed in this regard. The concept of performance anxiety was discussed with an overview of its general causes, effects and possible treatment techniques. Role reversal as a possible treatment technique was explained in terms of its origin, purpose and possible application within school environment, where teachers might be involved in the intervention with children who suffer from performance anxiety.

Chapter Two explored the relevant literature. Specific areas of interest to this study involved the phenomenon of performance anxiety in terms of its biological, environmental and psychological causes. The way in which these contributory factors and the effects of anxiety may continuously reinforce each other was highlighted. Current treatments methods for performance anxiety as part of a larger pattern of social phobia were explored. The concept of peer tutoring received attention as it relates in some ways to role reversal. The chapter was concluded with an overview of the theoretical perspectives which served to guide the study and intervention.

Chapter Three described the empirical process which was to be followed in order to answer to the research questions involved in this study. The qualitative research design was discussed along with the use of an instrumental, collective case study approach. The means of participant selection as well as data collection and analysis procedures were outlined, along with the ethical principles that were to guide the process.

The data which was obtained from the empirical study was revealed in Chapter Four. Here, the data was analysed and integrated with the relevant existing literature as was reported on in Chapter Two. Specific topics under discussion in this chapter involved the participants' personal experiences of the helping role and the therapeutic gains that were made, along with challenges to the helping role and further therapeutic needs. The usefulness of the technique from a school-based counsellor's point of view is additionally discussed.

This final chapter summarizes the study in terms of its process, findings and final conclusions. Relevant contributions and limitations to the study will be stated and recommendations for further study will be made.

5.3 SUMMARY OF FINDINGS FROM THE LITERATURE STUDY

The literature study, which investigated the nature and treatment of performance anxiety, revealed that this phenomenon sometimes exists as part of a larger pattern of social phobia - an anxiety disorder which is identified by a marked and persistent fear of social or performance situations due to fear of embarrassment or humiliation. Anxiety disorders, of which there are various types (Figure 2.1), are the most common psychiatric disorders of childhood and often co-occur with other problems such as depression, substance abuse, poor school performance, social problems, and so forth.

Figure 2.9 in Chapter Two summarized the variety of factors typically associated with social phobia. It revealed the biological, psychological and environmental factors that might lead to the development of this disorder, as well as the effects of the disorder on a person's functioning. These factors will briefly be summarised.

In terms of the aetiology of social phobia, one might inherit a genetic vulnerability to develop anxiety and/or a biological tendency to be very socially inhibited. This vulnerability might be increased by insecure infantile attachment, resulting in a psychological vulnerability reflected in a sense that stressful events are potentially uncontrollable. During early childhood, learnt helplessness might develop in response to specific parenting styles which include overprotection, doing things on behalf of the child, encouraging avoidant behaviours and/or modelling anxious behaviour. Additionally, insufficient success experiences whilst progressing through various psycho-social developmental stages might contribute to the child developing feelings of failure and incompetence.

Environmental stressors such as high expectations from significant others, learning difficulties, ADHD, poor social functioning, insufficient social support and/or the occurrence of social trauma, may additionally lead to the eventual development of social phobia. Negative evaluation from others may be accompanied by negative evaluation from the self, reflected in a negative self-concept and poor confidence. Negative intra-psychic dialogue, which is based on an irrational belief-system, often plays an important role in the child's perceptions of his or her experiences.

The physiological, cognitive and behavioural symptoms of this disorder often serve to exacerbate the level of anxiety, which in turn exacerbates the symptoms. From this, a variety of negative cycles might arise. Figure 2.4 conceptualized the reciprocal effect between anxiety and its physiological symptoms, which might become conditioned internal cues to the re-experience of anxiety. Figure 2.5 demonstrated how avoidant coping strategies in response to anxiety, serve to increase the level of anxiety associated with the feared stimulus in the long run. In Figure 2.6 one could see the negative cycle of performance anxiety in relation to confidence, processing efficiency and output. Figure 2.7 demonstrated how negative self-talk is not only caused by anxiety, but also leads to new experiences of anxiety. Lastly, Figure 2.8 revealed the negative cycle formed by the

aspects of social inhibition, embarrassment, social withdrawal, poor social skills and diminished social confidence.

All of the aforementioned factors, as were summarized in Figure 2.9, indicated the necessity of a holistic approach when aiming to understand and approach performance anxiety in terms of assessment and treatment. Figure 2.10 summarized the different existing assessment and treatment approaches for social phobia. Such assessment methods include questionnaires and observational methods (as were followed in this study), diagnostic interviews as well as physiological and psycho-analytical assessments. Existing treatment approaches include individual or group-based psychotherapy (which may take a variety of forms in terms of approaches and techniques), pharmacological treatment and/or a combination of psychotherapy and pharmacotherapy.

Young clients' teachers have the unique opportunity of spending up to six hours per day with them, observing and working with them in real-life settings. However, very few school-based approaches that specifically include the involvement of teachers for the treatment of social phobia were identified in the literature. One technique, which shared some similarities with role reversal, was that of cross-age tutoring (section 2.7.1.5), although this intervention was found to be normally employed for the purpose of academic skill transference between pupils, and not necessarily for the treatment of performance anxiety. The empirical investigation of this study aimed to establish the usefulness of a proposed treatment technique for performance anxiety experienced by learners in the school environment. The technique had the aim of including these learners' teachers in the intervention process which involved, amongst other things, providing the learners with success experiences in order to improve their self-confidence.

5.4 SUMMARY OF FINDINGS FROM THE EMPIRICAL INVESTIGATION

This study made use of a collective, instrumental case study as qualitative research strategy to explore the use of role reversal as a technique in the treatment of performance anxiety experienced by learners in the school environment. The two case studies which were reported on in this dissertation were initially identified as possibly suffering from performance anxiety by their parents and teachers. This was confirmed by administering the SCAS child- and parent forms (Spence, 2012) in combination with unstructured interviews held with the participant's parents. Thereafter, the technique of role reversal was implemented as part of a group-therapeutic intervention which continued for a period of approximately three months. Weekly unstructured interviews during group sessions, continuous observation, frequent unstructured interviews with participant's parents and teachers, and semi-structured interviews with the participants enabled me to collect the empirical data.

The data analysis process was guided by Creswell's data analysis spiral (Leedy & Omrod, 2005:150) and concentrated on particular aspects, namely the participant's personal experiences of the technique (including positive experiences as well as challenges), the therapeutic gains in relation to the participant's initial symptoms, and the usefulness of the technique from the perspective of a school-based counsellor. My findings could not be compared to previous role reversal studies as this study was the first of its kind. My

findings were however compared to previous studies on peer-tutoring in terms of the effects thereof on the tutors. Figure 5.1 provides a visual summary of my study's findings.

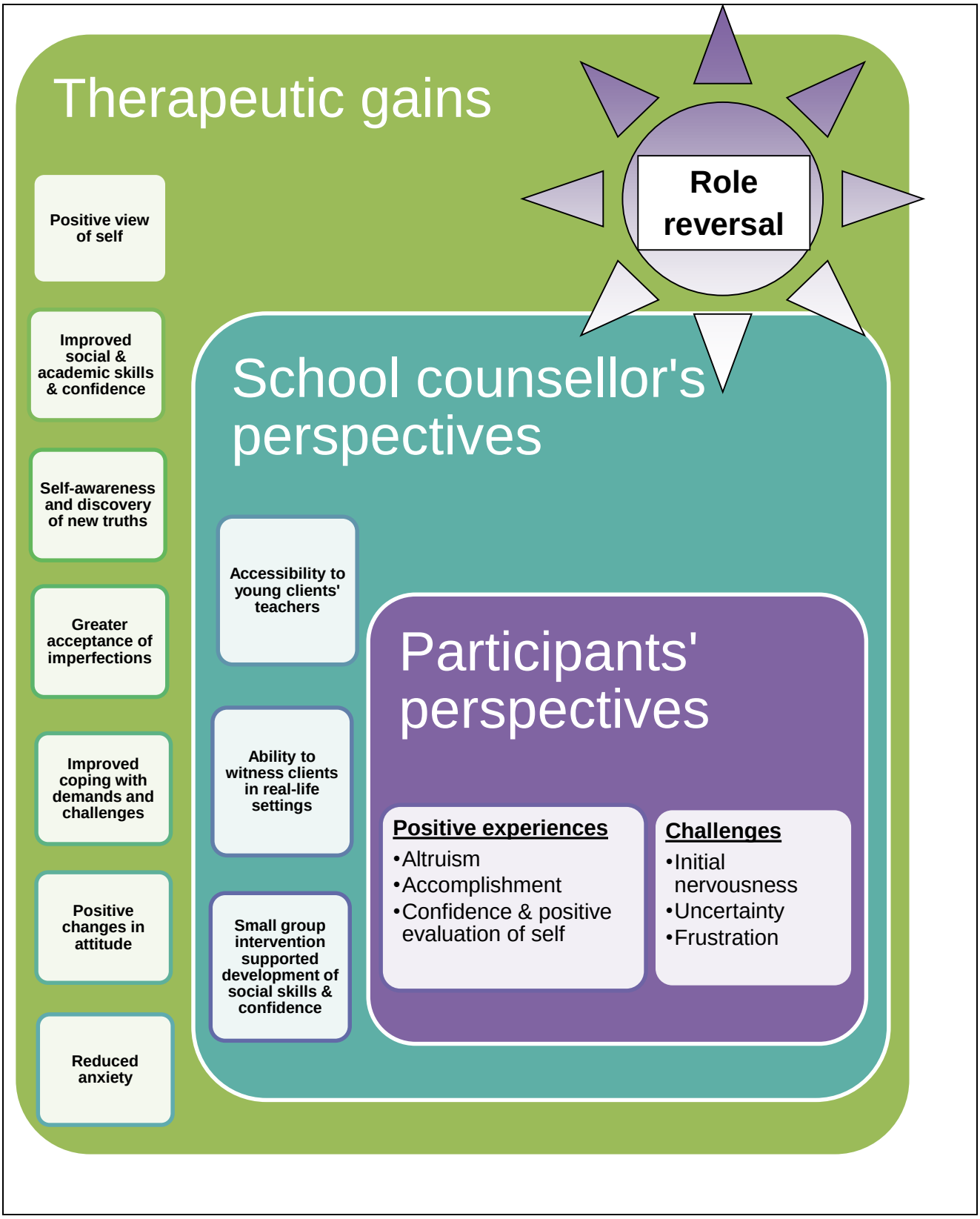


Figure 5.1 Summary: Findings of the empirical study

5.5 LIMITATIONS TO THE STUDY

Due to the fact that a dissertation of limited scope has specific constraints in terms of the length of the report, only a small amount of participants could be reported on in this dissertation. Reporting on more case studies in such a detailed, qualitative manner would have been impossible. The research findings are therefore relevant only to the reported case studies and cannot be generalized to other learners who suffer from performance anxiety. More studies are required to further investigate the effect and usefulness of role reversal in the treatment of learners who suffer from performance anxiety in the school environment.

5.6 CONTRIBUTIONS OF THE STUDY

This study was able to make the following contributions.

- A conceptual framework of the contributory factors and effects of performance anxiety, as well as the negative cycles often caused by these factors, was provided.
- This study was the first of its kind – investigating the use of a new proposed technique for the treatment of performance anxiety experienced by learners in the school environment.
- The research findings in terms of learners' experiences of the helping role contributed to the existing literature relating to the effects of peer tutoring on tutors.
- The research findings in terms of the effects and use of role reversal in the treatment of performance anxiety, contributed to the existing literature relating to treatment approaches for performance anxiety. This especially applies to school-based interventions.
- This study revealed a way in which teachers can become more involved in the treatment of performance anxiety experienced by learners in the school environment.

5.7 RECOMMENDATIONS FOR FURHTER STUDY

- Further investigation regarding the use of role reversal is required due to the limited number of participants that were reported on in this dissertation. The outline of sessions, data trail and data analysis process, which set out the specific steps that were followed, makes replication of this study possible.
- The use of role reversal with learners from different age groups, including foundation phase learners and high school learners, might be investigated in further studies.

5.8 CONCLUSION AND REFLECTION

One of my aims with this research project was to discover a way in which teachers might become more involved in the treatment of learners who suffer from performance anxiety in the school environment. Not only is it impossible for teachers to protect their learners from all anxiety-provoking situations at school, but, according to the literature, such an approach would not be beneficial to the learners' development either, as task avoidance only maintains and even exacerbates anxiety in the long run (Mowrer in Flannery-Schroeder, *et al.*, 2007:206).

In this study, rather than protecting their learners from anxiety-provoking situations, the teachers were able to add positive, success experiences to the daily lives of these children through the application of role reversal. The learners' growing confidence as a result of these experiences, appeared to have improved their abilities to cope with challenges.

Thus, based on the findings of this specific study, the idea of role reversal as part of a school-based, group-therapeutic intervention appeared to be useful. Becoming a helper to others seemed to positively impact on the participants' confidence on both social and academic levels. The technique became a means through which the counsellor and teacher were able work together in supporting the child who suffered from performance anxiety.

I hope that further research will continue to explore the application of this technique, so that it can also be employed by other professionals in such a way that the child will become empowered and able to function closer to his or her potential - not only as a student but eventually as a well-integrated, confident member of society.

"If we treat people as they are, we make them worse. If we treat people as they ought to be, we help them to become what they are capable of becoming".

Johann Wolfgang von Goethe

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ADDENDUM

Addendum 1	Memo to institution requesting permission to conduct the study
Addendum 2	Consent form for use by parents / legal guardians
Addendum 3	Assent form for use by participants
Addendum 4	Spence Children's Anxiety Scale (SCAS) – Child's report
Addendum 5	SCAS – Parent's report
Addendum 6	Semi-structured interview schedule

ADDENDUM 1

MEMO TO INSTITUTION REQUESTING PERMISSION TO CONDUCT THE STUDY

Charleen Crous

Intern Psychologist

Hons B.Ed Endorsement specialisation in school guidance and counselling (UNISA); Hons. B.Ed (NWU); B.Ed Foundation Phase (NWU)

This informed consent form is for Mr … (name removed for confidentiality purposes)**, principal of … School.**

Name of Investigator: Charleen Crous

Name of University: University of South Africa (UNISA)

A copy of the full Informed Consent Form will be provided after all signatures have been given.

PART I: INFORMATION SHEET

Introduction

I am Charleen Crous, a Master's degree student in Educational Psychology at the University of South Africa (UNISA). I am doing research to evaluate the use of a new technique which might help school personnel in their support of learners suffering from performance anxiety. Performance anxiety in the school environment refers to a learner's fear of being negatively evaluated by others during the execution of a certain task.

I am requesting your permission to conduct the research project at … School. The project will entail the following:

Procedure

1. Teachers and therapists of Grade 4-7 learners at ... School will be asked to report to the researcher learners in their class who, according to their observations, present with signs of performance anxiety.
2. Parents will be informed personally if their child's teacher has given his/her name to the researcher. During this interview, parents will be given a thorough overview of the study together with a consent form, (which will include all information about the study). This specific consent form will ask for their permission for their child to participate in the project.
3. With the parents' written informed consent, their child will be invited to a brief meeting with the researcher during which his/her informed assent to participate will be asked for. An assent form will be provided to the child. Provided the child gives his informed assent, he will then be asked to participate in another individual meeting with the researcher. During this meeting, the child will complete a standardized questionnaire called the Spence Children's Anxiety Scale (SCAS).

4. The child's parent(s) will be asked to complete the parent version of this questionnaire which determines their perspective on their child's symptoms.
5. After all questionnaires have been completed by the relevant participants and their parents, and once participants have been confirmed by the results of the questionnaires as suitable candidates for the study, the therapeutic intervention will commence. Group therapy will take place on a weekly basis for a minimum of 8 weeks, although more sessions may be required depending on the groups' progress. Therapy times still need to be determined and will depend on a time after school which suits all learners. The sessions will last for one hour each and take place in the researcher's therapy room at the school.
6. After the last group-session, participants and their parents will be interviewed individually in order to obtain their perspectives on the technique and the participants' progress, and also to provide them with feedback. Additionally each participant's teacher(s) and therapist(s) will be asked for their perspectives on the child's progress.

Voluntary Participation

The parents do not have to agree that their child participate in the study. Similarly the child will have a choice in the matter and even if his/her parents do agree to his/her participation, the child may still refuse. Even if the child initially agrees, he/she may discontinue his/her participation at any time.

Confidentiality

I will not be sharing any specific information obtained through the questionnaires and group sessions with anybody except for my Professor who guides me in my study, and Mrs … (name removed for confidentiality purposes) who acts as my supervisor at the school. I will share the results of the questionnaires with the participating learners and their parents. The child will be informed about whom the results will be shared with, and also of the fact that very specific information may be discussed by the researcher with his teacher and/or therapist(s), so that they can understand and help him/her better. The child may ask me to keep certain parts of the questionnaire or group sessions confidential. Provided that there is no risk of harm to the child or somebody else regarding this information, the child's wish will be respected, as is required by the ethical code of conduct for psychologists. In the case of suspected potential harm, the child's parents will be informed whether with or without the child's consent. Still, no such information will be disclosed to them without the child's prior knowledge.

Who to Contact

If you have any questions you are welcome to contact me.

<u>Contact details</u>

Cell phone number: 084 407 7337

E-mail address: charleen.small@gmail.com

PART II: CERTIFICATE OF CONSENT

I, ... (name removed for confidentiality purposes), principal of ... School, have been asked to give consent to Charleen Crous to conduct a research project at this school. It will involve her assessing and supporting learners who are identified as suffering from performance anxiety. I have read the foregoing information. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction.

I hereby voluntarily give my consent.

Print Name _____

Signature _____

Date _____

Day/month/year

OR

I do not give my consent.

Print Name _____

Signature _____

Date _____

Day/month/year

To be completed by the researcher

I confirm that the principal of …. School, Mr….. (name removed for confidentiality purposes), was given an opportunity contact me in order to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability.

A copy of this Informed Consent Form has been provided to Mr ... (name removed for confidentiality purposes).

Print Name of Researcher taking the consent _____

THANK YOU

ADDENDUM 2
CONSENT FORM FOR USE BY PARENTS/LEGAL GUARDIANS

Charleen Crous
Intern Psychologist
Hons B.Ed Endorsement specialisation in school guidance and counselling (UNISA); Hons. B.Ed (NWU); B.Ed Foundation Phase (NWU)

Informed Consent Form for _____

This informed consent form is for parents of Grade 4-7 girls and boys from ……. School who are being invited to participate in the research study titled "Using role reversal in the treatment of performance anxiety experienced by learners in the school environment".

Name of Investigator: Charleen Crous

Name of University: University of South Africa (UNISA)

You will be given a copy of the full Informed Consent Form after all signatures have been given.

PART I: INFORMATION SHEET

Introduction

I am Charleen Crous, a Master's degree student in Educational Psychology at the University of South Africa (UNISA). I am doing research to evaluate the use of a new technique which might help school personnel in their support of learners suffering from performance anxiety.

After you have read more about the study, and if you agree to let your child participate, I will ask your child for his/her agreement as well. Both of you have to agree independently before I can include your child in the study.

If you have any further questions after reading the information provided in this consent form, you can ask them of me.

Purpose

Performance anxiety entails a fear of being negatively evaluated by others (such as teachers or peers) when performing tasks (such as doing mathematics, writing tests, reading out loud, etcetera). It has a detrimental effect on a learner's ability to employ his/her true capabilities which often leads to underperformance. In turn, the embarrassment which accompany poor performance elevates the level of anxiety felt toward the applicable task, making future execution even harder. It is agreed upon by many professionals that the school is an ideal setting in which to offer treatment. Within a school setting, counselors or

psychologists and teachers can work together as a team. This supports skill transition from the therapy room into the classroom. Role reversal is a specific technique which might be employed within the classroom to support learners suffering from performance anxiety. However, before a new technique can be used in practice, it is important to determine learners' experience thereof and its helpfulness toward addressing their needs.

Procedure

Teachers and therapists at ..... School have been asked to report to the researcher, learners who seem to present with signs of performance anxiety. As you have been informed telephonically, your child's name has subsequently been given to the researcher.

Your child, as well as all of the other identified learners between grades 4 and 7, is being invited to participate in a group-therapeutic intervention. A brief individual meeting will be held with each of these learners prior to the commencement of the intervention. During this meeting, your child will be asked to complete a standardized questionnaire called the Spence Children's Anxiety Scale (SCAS). The questionnaire is designed to be relatively easy and quick for children to complete, normally taking only around 10 to 20 minutes to answer the 44 questions. Young people are asked to rate the degree to which they experience each symptom of anxiety on a 4-point frequency scale. Additionally, you will be asked to complete the parent form of this questionnaire, in order for the researcher to gain your perspective on your child's symptoms of anxiety in different situations. Should it be revealed, either by the SCAS questionnaire or in any other way, that your child presents with symptoms of a different anxiety disorder than performance anxiety, your child will unfortunately no longer be regarded as a suitable candidate for the study, as this particular study focuses exclusively on the treatment of performance anxiety. Your child will be referred for professional support from a different health professional. The researcher will support you in the process of obtaining this support.

After all questionnaires have been completed and the suitability of the participants has been confirmed, the therapeutic intervention will commence. During the intervention I will be evaluating the participants' experiences of a possible adjunct to the current techniques typically used in group therapy with anxious children. This new technique is called 'Role Reversal' and it aims to 'reverse' the child's perceived role of himself from 'one in need of help' to 'one that can provide help' (in other words from 'incapable' to 'capable'). It is hoped that such experience would contribute to the improvement of his/her confidence in the execution of the specific tasks.

More specific detail regarding the therapeutic intervention:

1. Group therapy will take place on a weekly basis for a minimum of 8 weeks, although more sessions may be required depending on the group's progress. Therapy times will depend on a time after school which suits all learners. These times still need to be determined once all participants' consent have been finalised, but should take place on a Wednesday, Thursday or Friday afternoon. Sessions will last 60 minutes each and will take place in the researcher's therapy room at the school.
2. The therapeutic intervention will entail psycho-education and application opportunities. More specifically, the following will happen:
    a. Participants will be taught about the physiological, emotional, cognitive and behavioural aspects of anxiety. They will be taught how to identify and modify negative, unrealistic thoughts with the aim of arriving at healthier emotions, physical relaxation, more functional behaviour and ultimately better

performance. These skills and concepts will be taught to the learners through fun activities during group sessions.

b. Experiences inside and outside of the therapy room will be created in which learners can practice their new skills such as physical relaxation, changing self-talk, etcetera.
c. Additionally, role reversal experiences will be created for each learner and will be based on his/her specific focus of anxiety. These experiences will take place between group members at first, where they will practice fulfilling the helping-role by assisting each other with various tasks during group-activities.
d. This will be followed by similar helping- experiences which will take place in the homework classes at aftercare. Participants will be given the opportunity to assist learners at aftercare with their homework. This will be supervised by the researcher, and participants ('helpers') will be allocated to suitable learners in terms of grade, type of homework, etc.
e. Once a participant copes well with the helping role, classroom-based helping opportunities will be created for him/her in collaboration with his/her teacher(s). *Please take not that the other learners at school or in homework class, who receive assistance from the participants, will not be aware that the helpers are part of a research study for performance anxiety.
f. During group-meetings, participants will be provided with opportunities to talk about their experiences of helping other children. Both positive and negative experiences will be discussed and worked through.

3. After the last group-session, each participant will be seen by the researcher once more, individually, in order to discuss his/her experience of role reversal. Similarly his teacher(s) and therapist(s) will be interviewed briefly in order to obtain their perspectives on the child's progress.
4. You as parents will then be invited for a meeting during which I will provide feedback on your child's progress during the project, while also asking for your own perspective on the matter.

Voluntary Participation

You do not have to agree that your child participates in this study. Even after consent and assent has been given, your child may still discontinue his/her participation at any time and no explanation will be required.

Risks and Discomforts

I am asking your child to share with me some personal and confidential information and feelings, and he/she may feel uncomfortable responding to some of the items of the questionnaire. However your child does not have to answer any question if he/she doesn't wish to do so. The same will apply to you when completing your questionnaire.

Talking about negative feelings such as fear or embarrassment during group sessions may not always be enjoyable for your child, and practicing new skills might be a bit scary sometimes, but he/she will not be forced to share or do anything that he/she doesn't feel ready for. He/she will further receive the support of the therapist in coping with challenging tasks or any uncomfortable emotional experiences that might arise.

Benefits

Your child's participation is likely to help me find out more about learners' experiences of Role Reversal as a technique in the treatment of performance anxiety. Your child may learn more about his/her own thoughts, feelings and subsequent actions. He/she may come to realize that other children also sometimes worry or struggle at school, and that it is okay to sometimes experience negative or uncomfortable feelings. Your child may learn new skills which could help him/her cope better with anxiety-provoking situations in future.

Confidentiality

I will share the results of the anxiety questionnaires with you. Your child will be informed of this. Your child may ask me to keep certain parts of the questionnaire confidential. Similarly, therapy sessions will be confidential and I will not be allowed to share with you any information regarding your child's specific expressions or behaviors as they occur, unless I have his/her consent to do so. In the case of suspected potential harm however, you will be informed thereof, whether with or without your child's consent. Still, no such information will be disclosed to you without your child's prior knowledge.

All participants will be asked to keep group discussions confidential and to not discuss anything relating to your child, or any other participants, with other people who do not form part of the study. The importance of group confidentiality will be explained to the participants. Participants will be asked to sign a confidentiality agreement.

Information shared by myself with your child's teacher(s) and therapist(s) at school will be limited to that which serves the purpose of supporting your child during classroom-based role reversal activities. Your child will be made aware of this.

I will be keeping record (process notes) of each participant's feelings, thoughts, actions, etc. During group sessions, audio recordings will be made with the participants' consent. The recordings relate to all sessions or parts of sessions, in order to help me record all important aspects of the process. The questionnaires and recorded information (audio and written) will be locked up and shared only with my professor who supervises this study, as well as with psychologist (name removed for confidentiality purposes) who supervises all therapies conducted by myself during my psychology internship.

Sharing of Research Findings

The findings of this study will be reported on in the form of a dissertation. After the study, the completed dissertation will be available to the public to read, however no real names or other identifying particulars of the participants will be provided.

Informed assent

If you give your consent for your child to participate, I will additionally need the agreement of your child. He/she will thus be given the opportunity to either give or refuse his/her informed assent as well. An assent form, which will be very similar to this consent form, will be provided to your child during a brief individual meeting in my therapy room. Care will be taken to assure that your child understands all parts of the study before his assent is asked for.

It is advised that, should you and your child agree to his/her participation, he/she attends each weekly session. If for some reason your child could not attend a particular session, I will

try to see him/her individually before the next group meeting in order to bring him/her up to date with what the rest of the group had learned or practiced during the missed session. Although this is advised for the sake of your child's benefit, the decision to participate or refuse with regard to any part of this research, remains his/her and your choice.

Who to Contact

If you have any questions you are welcome to contact me.

Contact details

Work (….. School): ……. (*name and number of school removed for confidentiality purposes)*

Cell phone number: 084 407 7337

E-mail address: charleen.small@gmail.com

PART II: CERTIFICATE OF CONSENT

I, parent/legal guardian of _____, have been asked to give consent for my daughter/son to participate in this research project. It will involve her/him completing one questionnaire and attending approximately 10 group therapy sessions. I will additionally complete a questionnaire about my child. As part of the therapeutic intervention, my child will be guided into acting as a peer-helper at school, with the purpose of attempting to boost his/her confidence. I have read the foregoing information. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction.

I hereby voluntarily give my consent.

Print Name of Parent or Guardian _____

Signature of Parent of Guardian_____

Date _____

Day/month/year

OR

I do not give my consent.

Print Name of Parent or Guardian _____

Signature of Parent of Guardian_____

Date _____

Day/month/year

To be completed by the researcher

Statement by the researcher/person taking consent

I confirm that the parent was given an opportunity contact me in order to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the parent or guardian of the participant. _____

Print Name of Researcher taking the consent _____

An Informed Assent Form will ____ OR will not ____ be completed.

THANK YOU

ADDENDUM 3
ASSENT FORM FOR USE BY PARTICIPANTS

Charleen Crous
Intern Psychologist
Hons B.Ed Endorsement specialisation in school guidance and counselling (UNISA);
Hons. B.Ed (NWU); B.Ed Foundation Phase (NWU)

Informed Assent Form for _____

This informed assent form is for Grade 4-7 boys and girls who attend … School and who I am inviting to participate in the research study titled "Using role reversal in the treatment of performance anxiety experienced by learners in school settings".

Name of Investigator: Charleen Crous

Name of University: University of South Africa (UNISA)

You will be given a copy of the full Informed Assent Form after all signatures have been given.

PART I: INFORMATION SHEET

Introduction

My name is Charleen and I am studying psychology. I am doing a special study on something called 'performance anxiety'. Having performance anxiety means sometimes feeling scared to do certain tasks in front of other people, like reading, math, public speaking or writing tests. I want to find a way which can help children who feel like that at school, to worry a bit less and become more confident. I have a new idea to help with this. In order to find out if it is a good idea, I have to test it by finding out how children feel about it. That is what I want to do with my research project. Today I am going to invite you to be part of this project. There may be some words you don't understand or things that you want me to explain more in this form. I will read through this form with you. Please ask me to stop at any time while we read this form, and I will explain.

Why am I inviting you?

Your teacher has let me know that you sometimes seem anxious or worried during certain activities at school. Your teacher, who cares a lot about you, wants me to try and help you feel more confident and less worried about school tasks.

Role Reversal: What is this idea about?

The idea that I am testing in this research is called Role Reversal. It has never been tested before on any children. I want to test the idea on primary school children who have performance anxiety. The idea of 'Role Reversal' was though up by me. I got the idea from something that happened to me when I was a child. This thing that happened helped me to

feel less afraid of performing at school. I want to find out if the same thing can help other children as well.

What is going to happen to you if you decide to participate in the research project?

Firstly I would like to have a brief meeting with you. During this meeting I will ask you to answer a questionnaire which will help me understand how you feel about certain school tasks or other tasks at home or other places. I will read through the questions with you and explain them if you need me to. It will take approximately 10 to 20 minutes for you to complete the 44 questions. You will only have to circle the answer you choose for each question. Remember, with this questionnaire, you won't have to worry about getting the answers right or wrong. The questions are only about how you feel in different situations. There is no right or wrong answer.

If, from the questionnaire, it seems to me like my technique won't help for the things that make you anxious, I will ask one of the other psychologists at the school to support you. If however it seems like you might be someone who could benefit from role reversal, you will come to my therapy room with the other children who will be joining this research. You will come here once a week in the afternoon after school, for about 8 weeks. We might meet a bit more than 8 times, but we will decide on that a bit later.

In these meetings we will be talking about how we think, feel and act. We will be playing fun games to help us learn about other ways to think, feel and act as well. Once you feel ready, you will be given a chance to help a friend with something in the group. These helping activities will be called "role reversal" activities. Once you feel up to it, you will also get a chance to help somebody else with something that they struggle with. It can be somebody in the homework class or even in your own class at school. You will often help this friend and maybe even other friends too if you'd like to.

With each week's meeting, you will have a chance to tell us how it felt helping somebody else. In our last session we will see if there have been any changes in the way you think, feel and act. We will end our last session off with a special celebration party and you will receive a certificate for taking part in this research project.

Who will I tell about the questionnaire?

Once you have returned your completed questionnaire to me, I will lock it away safely. I won't let other people see your questionnaire. I will however share the results of the questionnaire with your parents. But if there is anything specific that you told me during the questionnaire, and you don't want me to share that with your parents, I won't, as long as it is not something that makes me worry about you or someone else getting hurt. Only if I worry about that, I will have to tell your parents about it. But I won't tell them without discussing it with you first.

Two other people will also know about your answers. The one person is my professor at university. She is helping me to do this research project. The other person is ..... (name removed for confidentiality purposes) who is a psychologist here at the school. She is teaching me how to be a good psychologist, so that I can support you as best I can. Both my professor and ..... (name removed for confidentiality purposes) know that they are not supposed to tell other people about you, so they won't.

Who else will answer questions about you?

A second questionnaire, which will be a lot like the one which you will complete, will be completed by your parent(s).

Will participation in this study be bad or dangerous for you in any way?

Role Reversal will not be dangerous in any way, and neither will any of the other activities that we will be doing in the group. If some activities do make you feel a bit uncomfortable, you can tell me and you won't have to join in on that activity. No one will be disappointed in you. If you want to stop participating altogether because you do not enjoy any of the activities we do, for whatever reason, that is okay. Neither I nor anybody else will be angry with you. If anything happens during the research which upsets you in any way, I will be available to support you as best I can. You will be allowed to discuss any uncomfortable feelings about the activities with your parents or any other adult(s) you trust. You will have the right to ask for support from myself or any other adult, teacher or therapist of your choice.

Benefits: Is there anything good that happens to you?

This research might help me learn more about the usefulness of Role Reversal as a technique.

There are a couple of good things that might happen if you do decide to join.

- You may get to know other children better and may even make one or more new special friends.
- You may learn a lot about your own thoughts, feelings, and how they make you act. You may learn that other children also sometimes find certain tasks difficult at school and that it is okay to sometimes feel confused, tired, scared or angry – and even to make mistakes - everybody does sometimes!
- You may learn new skills which might help you cope better with tasks at school.

Confidentiality

I will not tell other people that you are in this research and I won't share information about you with anyone except for your parents, your teacher(s), therapist(s) and my supervisors. The information that I share with these people will only be things that can help them understand, teach and support you better. If there is anything specific or private that you don't want me to discuss with them, you can tell me and I won't, unless I fear that you or someone might get hurt. Then I will have to talk to your parents, but I will tell you first.

My notes and recordings will be locked up and no-one but myself, …… (name removed for confidentiality purposes) and my professor will be able to see it. Any information about you will have a number on it instead of your name. Only the researcher (me) will know what your number is and it will not be shared with or given to anyone except for my professor and …... (name removed for confidentiality purposes).

The other children, who will attend the group sessions with you, will not be allowed to tell other people about anything that you or anybody else says or does in the sessions. Neither will you! Each child, including yourself, will be asked to sign an agreement, in which you promise not to talk about the research participants with your parents, friends, family or anybody else.

After the research project is completed I will write a report about what I had learned. Some other people who are interested in my research project may read my report, but they won't know that you were in the research because your name will never appear in my report. In my report I will use 'fake' names!

Do you have to do this?

You can choose whether or not you want to participate. I have discussed this with your parent(s)/guardian. They have agreed and they know that I am also asking you for your agreement. But if you do not wish to participate, you do not have to, even if your parents have agreed. If you decide not to be in the research, it is okay and nothing changes. This is still your school, everything stays the same as before. Even if you say "yes" now, you can change your mind later and it will still be okay.

Who can you talk to or ask questions to?

You can ask me questions now or later. You can ask your parent questions. If you want to talk to someone else that you know like your teacher or anybody else, that's okay too. Before you make a decision, you must discuss this with your parents first and show them this form. You can sign the form in a few days' time after you have thought about it.

PART 2: CERTIFICATE OF ASSENT

Statement by the child

I have read this information (or had the information read to me). I have had my questions answered and I know that I can ask questions later if I want to.

*I agree to participate _____

OR

**I do not wish to participate and I have not signed the assent below. _____ (initialled by child/minor)

***Only if child assents:**

Print name of child: _____

Signature of child: _____

Date:_____

day/month/year

Confidentiality statement

I, _____, hereby agree to keep confidential everything that my fellow participants say or do in the group sessions. I understand that I am not allowed to tell private things about my fellow participants to my parents, friends, family or anybody else. I know that my fellow learners are also agreeing not to tell others about what I say or do in the group.

Name: _____ Signature: _____

Statement by the witness (only if child required help with reading)

I have witnessed the accurate reading of the assent form to the child, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness _____

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the child understands that he/she will, by choice, participate in this research study.

I confirm that the child was given an opportunity to ask questions about the procedures, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Print Name of Researcher/person taking the assent_____

Signature of Researcher /person taking the assent _____

Date _____

Day/month/year

Copy provided to the participant _____ (initialed by researcher)

Parent/Guardian has signed an informed consent form ___Yes ___No

_____ (initialed by researcher)

THANK YOU

ADDENDUM 4

SCAS (SPENCE CHILDREN'S ANXIETY SCALE) – CHILD'S REPORT

SPENCE CHILDREN'S ANXIETY SCALE

Your Name: _____ **Date:** _____

PLEASE PUT A CIRCLE AROUND THE WORD THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU. THERE ARE NO RIGHT OR WRONG ANSWERS.

1.	I worry about things	Never	Sometimes	Often	Always
2.	I am scared of the dark	Never	Sometimes	Often	Always
3.	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4.	I feel afraid	Never	Sometimes	Often	Always
5.	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6.	I feel scared when I have to take a test	Never	Sometimes	Often	Always
7.	I feel afraid if I have to use public toilets or bathrooms	Never	Sometimes	Often	Always
8.	I worry about being away from my parents	Never	Sometimes	Often	Always
9.	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
10.	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
11.	I am popular amongst other kids my own age	Never	Sometimes	Often	Always
12.	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
13.	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
14.	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
15.	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
16.	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
17.	I am good at sports	Never	Sometimes	Often	Always
18.	I am scared of dogs	Never	Sometimes	Often	Always
19.	I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
20.	When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
21.	I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
22.	I worry that something bad will happen to me	Never	Sometimes	Often	Always
23.	I am scared of going to the doctors or dentists	Never	Sometimes	Often	Always
24.	When I have a problem, I feel shaky	Never	Sometimes	Often	Always
25.	I am scared of being in high places or lifts (elevators)	Never	Sometimes	Often	Always

26.	I am a good person	Never	Sometimes	Often	Always
27.	I have to think of special thoughts to stop bad things from happening (like numbers or words)	Never	Sometimes	Often	Always
28	I feel scared if I have to travel in the car, or on a Bus or a train	Never	Sometimes	Often	Always
29.	I worry what other people think of me	Never	Sometimes	Often	Always
30.	I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
31.	I feel happy	Never	Sometimes	Often	Always
32.	All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
33.	I am scared of insects or spiders	Never	Sometimes	Often	Always
34.	I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
35.	I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
36.	My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
37.	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
38.	I like myself	Never	Sometimes	Often	Always
39.	I am afraid of being in small closed places, like tunnels or small rooms.	Never	Sometimes	Often	Always
40.	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
41.	I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
42.	I have to do some things in just the right way to stop bad things happening	Never	Sometimes	Often	Always
43.	I am proud of my school work	Never	Sometimes	Often	Always
44.	I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
45.	Is there something else that you are really afraid of?	YES	NO		
	Please write down what it is_____				
	How often are you afraid of this thing?	Never	Sometimes	Often	Always

ADDENDUM 5

SCAS (SPENCE CHILDREN'S ANXIETY SCALE) – PARENT'S REPORT

SPENCE CHILDREN'S ANXIETY SCALE
(Parent Report)

Your Name: _____ **Date:** _____

Your Child's Name: _____

BELOW IS A LIST OF ITEMS THAT DESCRIBE CHILDREN. FOR EACH ITEM PLEASE CIRCLE THE RESPONSE THAT BEST DESCRIBES YOUR CHILD. PLEASE ANSWER ALL THE ITEMS.

1.	My child worries about things.....	Never	Sometimes	Often	Always
2.	My child is scared of the dark.....	Never	Sometimes	Often	Always
3.	When my child has a problem, s(he) complains of having a funny feeling in his / her stomach	Never	Sometimes	Often	Always
4.	My child complains of feeling afraid.....	Never	Sometimes	Often	Always
5.	My child would feel afraid of being on his/her own at home.....	Never	Sometimes	Often	Always
6.	My child is scared when s(he) has to take a test.....	Never	Sometimes	Often	Always
7.	My child is afraid when (s)he has to use public toilets or bathrooms.....	Never	Sometimes	Often	Always
8.	My child worries about being away from us / me.....	Never	Sometimes	Often	Always
9.	My child feels afraid that (s)he will make a fool of him/herself in front of people.....	Never	Sometimes	Often	Always
10.	My child worries that (s)he will do badly at school.....	Never	Sometimes	Often	Always
11.	My child worries that something awful will happen to someone in our family.....	Never	Sometimes	Often	Always
12.	My child complains of suddenly feeling as if (s)he can't breathe when there is no reason for this.....	Never	Sometimes	Often	Always
13.	My child has to keep checking that (s)he has done things right (like the switch is off, or the door is locked)..	Never	Sometimes	Often	Always
14.	My child is scared if (s)he has to sleep on his/her own.....	Never	Sometimes	Often	Always
15.	My child has trouble going to school in the mornings because (s)he feels nervous or afraid.....	Never	Sometimes	Often	Always
16.	My child is scared of dogs	Never	Sometimes	Often	Always
17.	My child can't seem to get bad or silly thoughts out of his / her head.....	Never	Sometimes	Often	Always
18.	When my child has a problem, s(he) complains of his/her heart beating really fast.....	Never	Sometimes	Often	Always

19. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
20. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
21. My child is scared of going to the doctor or dentist	Never	Sometimes	Often	Always
22. When my child has a problem, (s)he feels shaky	Never	Sometimes	Often	Always
23. My child is scared of heights (eg. being at the top of a cliff)	Never	Sometimes	Often	Always
24. My child has to think special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
25. My child feels scared if (s)he has to travel in the car, or on a bus or train	Never	Sometimes	Often	Always
26. My child worries what other people think of him/her	Never	Sometimes	Often	Always
27. My child is afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
28 All of a sudden my child feels really scared for no reason at all	Never	Sometimes	Often	Always
29. My child is scared of insects or spiders	Never	Sometimes	Often	Always
30. My child complains of suddenly becoming dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
31. My child feels afraid when (s)he has to talk in front of the class	Never	Sometimes	Often	Always
32. My child's complains of his / her heart suddenly starting to beat too quickly for no reason	Never	Sometimes	Often	Always
33. My child worries that (s)he will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
34. My child is afraid of being in small closed places, like tunnels or small rooms	Never	Sometimes	Often	Always
35. My child has to do some things over and over again (like washing his / her hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
36. My child gets bothered by bad or silly thoughts or pictures in his/her head	Never	Sometimes	Often	Always
37. My child has to do certain things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
38. My child would feel scared if (s)he had to stay away from home overnight	Never	Sometimes	Often	Always
39. Is there anything else that your child is really afraid of?	YES	NO		
Please write down what it is, and fill out how often (s)he is afraid of this thing: _____	Never	Sometimes	Often	Always
_____	Never	Sometimes	Often	Always
_____	Never	Sometimes	Often	Always

ADDENDUM 6

SEMI-STRUCTURED INTERVIEW SCHEDULE

Semi-structured interview guide (for interviews conducted after completion of the program)

The following questions were used as a guide to interview the participants. The interview process was semi-structured to allow the interviewer to pursue relevant topics in more detail and probe as necessary to enrich descriptions of particular events and experiences shared by participants. Texts in parentheses are alternative phrases to encourage discussion.

Q1: What was good about helping other children in homework class? (What did you like about helping in homework class?)

Q2: What was not good about helping other children in homework class? (What didn't you like about helping in homework class?)

Q3: What was good about helping other children in your own class (What did you like about helping others in your class?)

Q4: What was not good about helping other children in your own class (What didn't you like about helping others in your class?)

Q5: Was there a particular age or grade which you liked helping most? Why?

Q6: Was there a particular age or grade which you didn't like helping? Why?

Q7: How do you feel about helping in general?

Q8: Did you feel like this from the start, or was it different in the beginning?

Q9: What value did you get out of it personally? (How was helping others also helpful to you?) (In what ways did helping others benefit you?)

Q10: What did you learn about yourself that you did not know before this program?

Q11: What has changed in your life since you started this program?

Q12: What advice would you give to other learners who also want to become helpers?

Q13: What advice would you give to therapists like me doing such programs?

Q14: What advice would you give to teachers who want to use children in class to be helpers?

Q15: Would you prefer knowing beforehand what exactly you would have to help with, or would you prefer incidental helping (just helping with whatever the child needs help with, without having known before what you would be doing?)

Q16: What advice would you give to kids who get very anxious about their school work?

Q17: How do you feel about yourself when you give help?

Q18: Is there anything else that you would like to share, or would like for me to write about in the book?

Examples of probing questions:

“What did you mean when you said.....”

“You said... Tell me more about that.”