

Addressing Emotional Difficulties of Primary School Children with the Use of a Primary Intervention Program

Agoritsa P¹, Chryssafidou E² and Maria Z^{2,3*}

¹Educational Psychology, Department of Preschool Education, University of Thessaly, Greece

²Department of Psychology, University of Roehampton, London

³Clinical Psychologist, Department of Preschool Education, University of Thessaly, Greece

*Corresponding author: Zafiropoulou Maria, Clinical Psychologist, Professor Emeritus, Department of Preschool Education, University of Thessaly, Greece, Tel: +30 6944635565; Fax: +30 2108075978; E-mail: zafiropouloumm@gmail.com

Rec date: Jul 28, 2015, Acc date: Aug 17, 2015, Pub date: Aug 25, 2015

Copyright: © 2015 Agoritsa P, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

The paper presents the evaluation study of a psycho-educational 10 week long primary prevention program for children aged 9-12 years, which took place in 11 main stream schools in Greece with 326 participants in total. The program is delivered through classroom based activities (eg narratives and games), which are based on the cognitive behavioral therapy theory (CBT). The rationale of the program is to promote emotional resilience, believed to be related to better self-regulation of emotions and improved coping skills in stressful situations. The effectiveness of the program is investigated on the basis of its impact on anxiety measured through the Spence Children's Anxiety Scale (SCAS) and on self-esteem measured by the Self Image Profile for children (SIP-C0 Data were collected over a period of one and a half school academic years, from a pilot study, with 67 students (32 experimental and 35 control) and from the main study, with 259 students (137 experimental and 122 control) aged 10 years old. We found that self-esteem improved significantly over time, for both the pilot and the main study participants, while the levels of overall anxiety reduced significantly. The successful implementation of the psycho-educational program is presented in terms of its structure and content and its motivation is to adapt to the local, social, cultural and educational context.

Keywords: Emotional resilience; Primary prevention; Anxiety; Self-esteem; Psycho-educational program at school

Introduction

Research in the prevention of mental health problems among young people and children is multifaceted [1,2]. Research activities and established programs are seen as part of public mental health priorities, community-based and school-based initiatives informed by research in developmental, cognitive and clinical psychology [3-5]. Research suggests that prevention through psychoeducational and school-based programs can help children to deal with a number of psychological and emotional problems and improve their emotional well-being [5,6]. This is observed, because schools are organized administrative agencies, which offer the possibility to systematically apply programs that can contribute to children's behavioral and cognitive development [7,8]. Particularly the model of mental health interventions in schools: a) primary prevention, which relates to the preventive efforts, that can be developed at three levels, take place in the school setting through psycho-educational material aiming to promote the development of social and emotional skills, b) the secondary prevention, which focuses on the formulation of small groups and particularly on students who need more support to improve social and emotional skills, c) "High risk" prevention, which aims at students, with diagnosed mental health problems [9,10].

The approach presented in this study covers the first and second level of prevention. Most mental health related issues have their onset at young ages [11]. Early prevention and diagnosis can effectively revert a trajectory towards chronic illness [12]. In order to meet the

needs of the targeted population, it is necessary to design evidence-based and theory informed mental health programs [13,14]. Programs based on the cognitive and behavioral treatment therapies are widely implemented in school settings, following the contemporary trend of intervention programs [15,16]. Cognitive-behavioral therapy is based on the triptych Thought-Emotion-Behavior. Therapists within this orientation state that the people's feeling and behaviors are manifested as a result of how they think and perceive the world. The core of this treatment is to reconstruct the person's thinking, which will then make changes in emotion and behavior [17,18]. Cognitive-behavioral therapy as individual or of group therapy treatment, can serve both preventive and therapeutic purposes [19].

Organizing a preventive intervention aims at tackling the emotional and psychological difficulties that children face during their school years [20,21]. Difficulties such as learning disabilities [22], attention deficit and hyperactivity [23,24], disobedience and general behavior problems [25,26] were found to be treated effectively by applying the techniques of cognitive behavioral therapy [27]. Children with such learning difficulties are very likely to develop emotional difficulties [28]. Emotional difficulties are divided into two major groups: a) anxiety disorders (e.g. neurosis) and b) mood disorders (e.g. depression) [11,29]. Anxiety and anxiety related problems are among the most common emotional difficulties that people face [11]. In everyday life, when adults and children refer to anxiety they often describe a feeling of worry or fear. Lazarus defined anxiety as an emotional state, which is uncomfortable and characterized by feelings of imminent danger, tension and anxiety [30]. Anxiety is also described as a multisystem response to protect the body against risk stimuli or threat.

Amongst children, emotional difficulties are usually associated with academic difficulties and negative developmental trajectories, namely crucial transitional stages in their lives, where new challenges appear, such as building and maintaining relations with friends and with opposite sex [31]. It is recorded that 3-10% in children's population presents anxiety disorders. Anxiety disorders recorded in childhood are identified under categories with specific terminology and diagnostic criteria accordingly [11,29]. The American Psychiatric Association distinguishes the types of anxiety disorders that occur in childhood as listed below: Separation Anxiety, Generalized anxiety Disorder, Panic Disorder, Phobias, Social Phobia, Special phobia, Selective mutism, Agoraphobia [11,29].

During middle childhood, emotional difficulties are mainly associated with the child's social interaction and integration [31]. Young people exhibit behaviors of concern and fear to unknown peers, to new situations or even express concern about the degree of acceptance by peers [32]. The child's age is playing a key role in developmentally distinguishing a behavior as functional or dysfunctional [33]. A deteriorating trajectory is observed starting from increased and intense anxiety, then exacerbated chronic symptom and eventually turned into a developmental dysfunction [33-35].

As a result, the prevention of emotional difficulties in childhood is the first step in reducing the proportion of children who will develop anxiety as adults and this is the goal of many primary intervention programs for children and young people [36]. A preventive cognitive-behavioral therapy program can be very effective when the intrapersonal factor underpins the organization and design of such programs [37,38]. The intrapersonal factor refers to: a) being aware of own feelings, which ultimately defines behavior [39], b) the developmental stages, which are defined by two interacting factors, the stimuli that the child processes from the environment, and the interpretation of them at different chronological age [40,41] and c) cognitive state, namely the cognitive development stages, where each stage is constructed on the basis of the successful completion of the previous stage [42,43].

Many preventive psycho-educational program address the concept of emotional resilience. According to Bernard [44] emotional resilience in children is defined as the ability to use coping skills in stressful situations (e.g. distraction, change of thinking, practice in searching reinforces, etc.), which may help them regulate the intensity of negative emotions, which are experienced in circumstances of adversity. Furthermore, an emotionally resilient person has a good perception of himself, which helps himself to recognize stress generating factors and mobilize appropriate strategies and coping skills [45,46]. Emotional resilience and stress are two factors that indirectly affect the perception one shape for oneself, one's abilities and the degree of adequacy to face the various challenges of life. The targets set by everyone and the possibility of achieving them depends largely on how well he or she knows himself/herself [44,45]. People who adapt easily to different environment are individuals who have a positive image about themselves and are confident in their judgments, who freely express their opinions and are assertive in their pursuits [47,48].

Psycho-Educational Programs

There is a number of psycho-educational programs targeted to school-aged children [49,50]. "Coping Cat "[51,52] is one of the most well-known programs, which was designed following the Cognitive Behavioral Therapy approach. The PENN PREVENTION program is

based on the principles of Positive Psychology is program [53] and aims to enhance children's well-being, to promote optimism, to teach flexibility in dealing with adversity, to increase self-confidence, to boost creative thinking, to support decision making, and to introduce the concept of relaxation. There are also programs which target emotional resilience: the PATHS program [54], which focuses on learning and applying skills of problem solving and cognitive restructuring, the STRESS INOCULATION TRAINING program [55] and the I CAN DO program [45,56], which introduces children to practical techniques that can be useful in stressful situations, such as parental divorce, change of environment, and loss of a loved one. Finally, FRIENDS For Life [57] is a prominent preventive program, implemented widely at school level, in Australia, in the UK and in Canada, in order to help children manage anxiety symptoms they face in their daily lives [58]. There is strong evidence of successful implementation with positive impact of the program on anxiety and self-esteem [59,60].

As shown above, there is a plethora of psycho-educational programs, but to effectively apply any of them in a specific context, such as the primary educational system of an urban area in Greece, one needs to carefully adapt it and acclimatize it according to the local environment and needs. A sophisticated methodology for designing and localizing a preventive primary program takes into account a number of factors, e.g. the socio-educational context, the appropriate linguistic level, and other pragmatic factors. This methodology is described in steps:

The first step is the definition of the problem and the understanding of the context. In this stage, information is gathered about the needs and abilities of students, teachers, school staff, parents and the community. At the same time, the people involved in the design and implementation of the program, realize the importance of the historical and socio-cultural framework in which the program will be implemented. Furthermore, the program designers acquire a good understanding of the values and perceptions of the participants in relation to psychological difficulties and disorders, of the values and perceptions of the head teachers, the school pastoral care teams, as well as, the attitudes of the families and the community. The formulation of this framework helps with providing ecological validity in the intervention program [7,61].

The second step encompasses the development and use of a theoretical-empirical basis. It is necessary to use a theoretical-empirical basis that will inform the content and the application of an intervention program. The theoretical-empirical framework helps to define the objectives of the program helps operationalized the impact and the hypothesized outcomes [7,62].

The third step is the action plan of the prevention program in order to create an action plan which includes: a) procedures and practices, b) roles, responsibilities and relationships of the staff, c) a description of activities d) and schedule of activities per school term. The length of the activities and the total duration of the program are likely to affect the impact of the program [61].

The fourth and last step is the implementation of the program. It is the process in which the intervention takes place implementing the goal of the program according the decided priorities and procedures [62].

Taking into the above mentioned methodology, we designed and implemented our primary preventive program. The program targets school children, aged 9-10 years and through teaching coping

strategies for dealing with adverse situations. The program is based on the theory of cognitive behavioral therapy and has been designed with the main objective to promote emotional resilience of children. The design of this program is loosely based on the emotional resilience program Friends for Life [56]. It has been adapted and adjusted with the needs and priorities of the Greek primary education system in mind, following the steps presented above.

The concept emotional resilience plays an important role in understanding and investigating the impact of the program. Research indicates that the promotion of emotional resilience reduces the stress levels and enhances the positive perception of one's self [44,45]. Consistently to this finding, the evaluation of the program is based on measures of anxiety and self-esteem [1,2], taken as soon as the program is completed, and, at a three- month follow up (in the case of the pilot study). The main research questions in this study explore whether there will be a reduction in the anxiety levels and an enhancement of self-esteem level, after 10 weekly sessions, in which students engage with games, storytelling and other activities.

Method

Participants

The process of implementing the program is divided into two research stages. In the first stage, which includes the pilot study, the sample consists of 67 students recruited from an urban area, aged 9 (C grade). The sample was randomly allocated to the experimental group (N=32) and the control group (N=35). The selection of the schools was random, using the list of all primary state schools in the area of Magnesia, Greece. Through random allocation of classroom groups to conditions. In the Greek system classroom, groups are created on the basis of alphabetical order of the students' surname. The classroom groups were randomly allocated to either the experimental or the control group, after tossing a coin. The second stage of the research involved a sample of 259 students from the same area, aged 10 years (D grade), with 129 participants in the experimental group and 130 in the control. The control group was engaged in flexible zone school activities, such as music, drawing and handcrafts, and measurements were at the same time as for the experimental group.

Procedure

Before the intervention, both groups were asked to complete the questionnaires, measuring anxiety and self-esteem. Immediately after the completion of the intervention the same questionnaires were given to both groups. There was a follow up assessment three months after the completion of the intervention, in the case of the pilot study only.

The duration of the intervention was 10 weeks and was delivered in classroom over one school period (60 minutes), thus, amounting to 10 hours in total.

The program starts with the familiarization of the pupils with the basic principles of cognitive-behavioral therapy and the introduction of coping skills. It consists of ten sessions, with individual themes, gradually introducing the students to the principles of cognitive-behavioral therapy.

In the first session the children complete a worksheet and answer questions in relation to themselves and their interests. Then, they get to talk about their stress, anxiety and fear through storytelling, involving the heroes of the program. The program features ten children-

characters and one cat, who are introduced to the children through real life stories, with which the children can identify. While learning and talking about these heroes, the children become aware of their feelings, report them through brainstorming, and are encouraged to formulate statements, in a small groups or in pairs about stress, fear or anxiety.

The second session is the session of emotions. The basic emotions are presented (happiness-sadness-fear-anger) as a game where students show their emotions choosing from a set of game cards. They also, complete a worksheet in which they are asked to describe how they look, what they do, what they say and how they feel when they are under different emotional situations. Role playing and games like "Charades" are used to guess other student's emotions.

The third session presents the relationship between thoughts and feelings. In this session, children complete semi-structured narratives, motivating them to express how they feel and what they think under certain life situations. The fourth session aims to help children deal with their concerns and teach them relaxation exercises. The fifth session introduces students to the kinds of thinking, the recognition of positive and negative thoughts, and the ability of switching between opposite perspectives through games and storytelling. The sixth session helps students to create an action plan for difficult situations. They are also introduced in how to block out negative thoughts and how to practice steps for changing negative thoughts into positive (cognitive restructuring). In the seventh and eighth session, the children learn to decompose an adverse situation following specific steps (e.g. identify the difficult situation, record ideas for resolving ideas, evaluate each idea, etc.). The ninth session is a reviewing session, where the gist of each session is reminded through activities such as painting and role playing. The program closes with the tenth session, in which the children revisit the trajectory through the previous session and discover their strengths, and any change in their self-efficacy.

Materials

Anxiety is measured with the Spence Children's Anxiety Scale (SCAS) [1,62,63] and self-esteem with the Self Image Profile for Children (SIP-C) [2].

The Spence Children's Anxiety Scale is a self-report psychometric instrument which consists of 44 items. Thirty- eight of them contribute to the measurement of 6 sub-scales (while the remaining 6 are filler items for reducing negative response bias). The 6 sub-scales are: (1) separation anxiety, (2) social phobia, (3) obsessive-compulsive disorder (OCD), (4) panic disorder-agoraphobia, (5) generalized anxiety and (6) fear of physical injury. This questionnaire has been translated and validated in Greek [64].

The Self Image Profile for Children (SIP-C) [2] is a multifactorial hierarchical scale, targeting children, who are asked to describe themselves through verbal representations concerning their appearance, social behavior and competition. The SIP-C was translated to Greek and adapted to Greek. The questionnaire was administered to a group of 67 children and found the existence of internal validity (Cronbach $\alpha=0.71$) for positive self- image and (Cronbach $\alpha=0.8$) for the negative self- image.

Statistical Analysis

For the analysis of pilot data, a multivariate analysis of variance (MANOVA) was conducted to assess the impact of the program intervention on participants' scores on the Spence Children's Anxiety subscales (panic-agoraphobia, separation anxiety, social phobia, fear of physical injury, obsessive-compulsive disorder and generalized anxiety), across three time periods (pre-intervention, post-intervention and three-month follow-up). Similarly, for the control group, a multivariate analysis of variance (MANOVA) was conducted to assess the impact of the control condition on anxiety across 3 times. A similar procedure with MANOVA test was followed for exploring the impact on self-esteem (positive self-image, negative self-image and self-esteem). For the analysis of the main study data, a multivariate analysis of variance (MANOVA) was also conducted, separately for the experimental and the control group, as in the pilot study, only this time the measures were collected across two times, before and after the intervention. It has not been possible to collect follow-up measures in the main study due to time constraints imposed by the duration of the project.

Results

The pilot study investigation allowed us to explore the impact of the program on the participants' anxiety and self-esteem immediately after the completion of the program as well as three months later. Statistically significant differences were identified in the experimental group ($F(2,30)=6.44$, $p \leq 0.005$; Wilks' Lambda=0.70; partial eta squared=0.3) in terms of separation anxiety before the intervention ($M=5.3$ $SD=3.6$), after ($M=4.9$ $SD=2.8$) and at follow up ($M=4.8$ $SD=2.7$) and in terms of generalized anxiety disorder ($F(2, 30)=5.55$, $p \leq 0.01$; Wilks' Lambda=0.73; partial eta squared=0.3) before the intervention ($M=5.9$ $SD=3.8$) after ($M.O.=5.1$, $T.A.=3.2$) and at follow up ($M=4.9$, $SD=2.4$). The inspection of the mean scores shows that the score of separation anxiety decreases after the intervention and this decrease is maintained at follow up, while the score of generalized anxiety disorder also decreases after the intervention and decreases even further at follow up (Table 1). Significant differences were also found in the scores of the control group for separation anxiety ($F(2, 33)=3.7$, $p \leq 0.01$; Wilks' Lambda=0.82; partial eta squared=0.2) as well as for panic disorder ($F(2, 33)=5.4$, $p \leq 0.01$; Wilks' Lambda=0.75; partial eta squared=0.25), social phobia ($F(2, 33)=10.3$, $p \leq 0.01$; Wilks' Lambda=0.62; partial eta squared=0.39), and fear of physical injury ($F(2, 33)=6.8$, $p \leq 0.01$; Wilks' Lambda=0.71; partial eta squared=0.3). On closer inspection of the means (Table 1) across these scales, we observe that the control group's means of anxiety increase progressively from before, to after, to follow up measurements, indicating that under control conditions the students' anxiety is in, overall, deteriorating.

In terms of overall self-esteem, a trend of increasing scores is observed in the experimental group. In particular, the self-esteem scores, significantly increase ($F(2, 30)=7.26$, $p \leq 0.001$; Wilks' Lambda=0.67; partial eta squared=0.33) starting from a lower score before the intervention ($M=29.1$ $SD=16.6$), reaching a higher score after the intervention ($M=32.8$ $SD=16.64$) and continuing to increase at follow-up ($M=33.5$ $SD=17.06$). In contrast, the scores of the control group across the three time measurements did not differ significantly ($F(2, 33)=0.03$, Wilks' Lambda, $p \leq 0.99$; partial eta squared=0.002). A very small between times variation confirmed if we look closely at the means (before: $M=26.23$, $SD=21.9$ after $M=26.5$, $SD=18.06$: follow up: $M=25.7$, $SD=15.4$) (Table 2).

Interestingly, while the positive regard of the experimental group does not change at all from before ($M=40.6$ $SD=7.2$) to after the intervention ($M=40.6$ $SD=10.6$) it notably increases at the follow-up measurement ($M=44.1$ $SD=6.2$) (Table 2). This notable improvement of the positive self-regard and self-esteem at follow up could be explained, if we think that it is possible, that we often need time to establish a positive perception about ourselves [65,66]. In contrast, without the preventive program, the scores of the control group did not differ significantly across the three times (before, after follow up). In fact, the scores are showing a steadily decreasing trend of the positive self-regard, starting from a comparable with the experimental group score before the intervention ($M=40.5$ $SD=7.73$), moving on to a decreased score after the intervention ($M=38.7$ $SD=7.4$) and reaching its lowest at the follow up ($M=34.8$ $SD=5.2$). This lack of effect in the control group in terms of self-esteem, in comparison to the population that received the preventive treatment, may indicate that the children's development of self-esteem is not sufficiently supported at conventional school settings.

The second part of this study investigated the efficacy of the program as a primary prevention program in a larger sample of students, in order to ensure the benefits of its implementation. The results in terms of anxiety (Table 3) revealed that children in the experimental group scored decreasing measures over time in all the subscales of anxiety disorders (Table 3). In particular, significant differences were identified in terms of separation anxiety ($F(1.128)=45.9$ before ($M=6.2$ $SD=3.1$) and after the intervention ($M=4.03$ $SD=3.1$), and in terms of generalized anxiety ($F(1.128)=89$, $p \leq 0.001$; Wilks' Lambda=0.6; partial eta squared=0.41) before ($M=7.3$ $SD=3.1$) and after the intervention ($M=4.03$, $SD=3.7$). This finding is consistent with the impact that the program had in the pilot study.

On inspection of the remaining measures of anxiety (panic disorder, social phobia, fear of physical injury, obsessive compulsive disorder) we observe that the symptoms of anxiety disorder overall tend to be less intense after the intervention. Particularly, statistically significant differences were identified in social phobia ($F(1.128)=66.03$, $p \leq 0.001$; Wilks' Lambda=0.66; partial eta squared=0.34) before ($M=10.4$ $SD=3.95$) and after the intervention ($M=6.7$, $SD=4.8$), in terms of fear of physical injury ($F(1.128)=34.7$, $p \leq 0.001$; Wilks' Lambda=0.79; partial eta squared=0.21) before ($M=6.2$ $SD=4.2$) and after the intervention ($M=4.09$, $SD=3.9$), in terms of obsessive compulsive disorder ($F(1.128)=54.8$, $p \leq 0.001$; Wilks' Lambda=0.7; partial eta squared=0.3) before ($M=8.5$ $SD=3.7$) and after the intervention ($M.O.=5.4$, $T.A.=4.1$). The effect of the intervention on each of the above diagnostic criteria of anxiety suggests the great significance of the preventive procedure.

In contrast to the experimental group's findings, we observed a significant increase on the scores of all anxiety measurements amongst the participants of the control group (Table 3). The impact of the lack of preventive treatment, here, than in the pilot study (Table 1). This supports our hypothesis that the preventive psycho-educational program that we implemented helps children control their anxiety feelings.

In the main research there was also a significant improvement on the scores noted in positive self-image as well in self-esteem. The interpretation of statistical analysis, presented in Table 4, suggests that children who participated in the experimental group were able to improve their positive self-image and increase their level of self-esteem. This is also in line with findings of the pilot study. In particular, significant differences were identified in improving the positive self-

image ($F=(1.128)=91,6$ $p \leq 0.001$; Wilks' Lambda=0,6 partial eta squared=0.42) starting with a lower score before the intervention ($M=36.4$ $SD=6.13$) and increasing it after the intervention ($M=43.3$ $SD=7.1$). The enhancement of the self-esteem levels ($F=(1.128)=6,7$ $p \leq 0.001$; Wilks' Lambda=0,95 partial eta squared=0.49) begun with a score ($M=27.2$ $SD=17.6$) which finally increased after the completion of the intervention ($M=32.8$ $SD=19.3$).

Unlike the experimental group, children participating in the control group showed decreasing scores in the measurements of positive self-

image and self-esteem. The findings reveal that there was significant differences in the positive self-image ($F=(1.129)=10,2$ $p \leq 0.005$; Wilks' Lambda=0,93 partial eta squared=0.07) considering the score before the intervention period ($M=38.9$ $SD=5.5$) which decreased after the intervention ($M=33.6$ $SD=4.8$). The scores of control group's self-esteem in Table 4 presents a decreasing tendency in proportions, which indicates that the preventive procedure is absolutely beneficial for children's emotional state.

Anxiety		Experimental Group N=32			Control Group N=35		
Diagnostic features of anxiety disorder		Before	After	Follow-up	Before	After	Follow-up
Panic Disorder/Agoraphobia	Mn.	5,7	6,06	5	5,6	5,9	9,5
	(Sd)	(5,04)	(3,8)	(2,9)	(4,3)	(4,02)	(5,7)
	Λ.	0,93			0,75		
	Wilk	1,08 (2. 30)			5,4 (2. 33)		
	s	0,7 n.s.			0,25**		
	F(df)						
	η ²						
Separation Anxiety	Mn.	5,3	4,9	4,8	6,3	6,5	7,3
	(Sd.)	(3,6)	(2,8)	(2,7)	(4,2)	(3,6)	(3,2)
	Λ.	0,7			0,82		
	Wilk	6,44(2. 30)			3,7(2. 33)		
	s	0,3***			0,2 *		
	F(df)						
	η ²						
Social Phobia	Mn.	7,5	8,44	7,1	7,7	8,1	10,8
	(Sd)	(3,7)	(3,9)	(3,5)	(3,8)	(4,5)	(3,9)
	Λ.	0,92			0,62		
	Wilk	1,34 (2. 30)			10,3 (2. 33)		
	s	0,82 n.s.			0,39 ****		
	F(df)						
	η ²						
Fear of physical injury	Mn.	5,03	5,6	5,34	6,7	6,9	7,11
	(Sd)	(2,6)	(3,3)	(3,02)	(4,25)	(4,6)	(3,8)
	Λ.	0,95			0,71		
	Wilk	0,78(2. 30)			6,8 (2. 33)		
	s	0,05 n.s.			0,3***		
	F(df)						
	η ²						

Obsessive Compulsive Disorder (OCD)	Mn	6,8	6,2	5,4	7,9	7,23	8,23
	(Sd)	(3,7)	(3,4)	(3,06)	(3,6)	(4,12)	(2,8)
	Λ .	0,87			0,94		
	Wilk	2,35 (2. 30)			1,1 (2. 33)		
	s	0,14 n.s.			0,06 n.s.		
	F(df)						
	η^2						
Generalized Anxiety Disorder	Mn	5,9	5,1	4,9	7,43	6,7	7,4
	(Sd)	(3,8) 0,73	(3,2)	(2,4)	(4,1) 0,91	(2,9)	(2,9)
	Λ .	5,55 (2. 30)			1,68 (2. 33)		
	Wilk	0,3 **			0,09 n.s.		
	s						
	F(df)						
	η^2						

*p 0,05 **p 0,01 ***p 0,005 ****p 0,001 n.s. non significant

Table 1: Anxiety: Pilot study and follow-up.

Overall Self-esteem		Experimental Group N=32			Control Group N=35		
		Before	After	Follow-up	Before	After	Follow-up
Positive self-image	Mn.	40,6	40,6	44,1	40,5	38,7	34,8
	(Sd)	(7,2)	(10,6)	(6,2)	(7,73)	(7,4)	(5,2)
	Λ Wilks	0,72			0,83		
	F (df)	5,8 (2. 30)			3,31 (2. 33)		
	η^2	0,28 **			0,17 *		
Negative Self-image	Mn.	22,7	22,5	21,34	21,9	19,6	21,23
	(Sd)	(10,83)	(12,1)	(11,05)	(11,7) (10,6)		(12,7)
	Λ Wilks	0,98			0,97		
	F (df)	0,25 (2. 30)			0,6 (2. 33)		
	η^2	0,02 n.s.			0,03 n.s.		
Self-esteem	Mn	29,1	32,8	33,5	26,23	26,5	25,7
	(Sd)	(16,6)	(16,64)	(17,06)	(21,9) (18,06)	(15,4)	
	Λ Wilks	0,67			0,99		
	F (df)	7,26 (2. 30)			0,03 (2. 33)		
	η^2	0,33 ***			0,002 n.s.		

*p 0,05 **p 0,01 ***p 0,005 ****p 0,001 n.s. non significant

Table 2: Self-esteem: Pilot study and follow-up.

Anxiety		Experimental Group N=137		Control Group N=122	
		Before	After	Before	After
Diagnostic features of anxiety disorder					
Panic Disorder/Agoraphobia	Mn.	7,08	3,7	5,0	7,3
	(Sd)	(4,5)	(4,0)	(4,4)	(5,3)
	Λ. Wilks	0,67		0,74	
	F(df) η2	62,4 (1.128) 0,33****		44,8 (1.129) 0,23****	
Separation Anxiety	Mn.	6,2	4,03	5,06	6,5
	(Sd.)	(3,1)	(3,2)	(3,6)	(3,64)
	Λ. Wilks	0,74		0,81	
	F(df) η2	45,9 (1.128) 0,26****		30,8 (1.129) 0,2 ****	
Social Phobia	Mn.	10,4	6,7	6,5	8,8
	(Sd)	(3,95)	(4,8)	(4,2)	(4,5) (4,5)
	Λ. Wilks	0,66		0,62	
	F(df) η2	66,03 (1.128) 0,34 ****.		67,9 (1.129) 0,34 ****	
Fear of physical injury	Mn.	6,2	4,09	4,1	5,6
	(Sd)	(4,2)	(3,9)	(3,6)	(3,6)
	Λ. Wilks	0,79		0,78	
	F(df) η2	34,7 (1.128) 0,21 ****.		36,9 (1.129) 0,22****	
Obsessive Compulsive Disorder (OCD)	Mn	8,5	5,4	6,06	6,08
	(Sd)	(3,7)	(4,1)	(3,8)	(3,4)
	Λ. Wilks	0,7		0,96	
	F(df) η2	54,8 (1.128) 0,3 ****.		6,1 (1.129) 0,45 *	
Generalized Anxiety Disorder	Mn	7,3	4,3	5,3	7,05
	(Sd)	(3,1)	(3,7)	(3,7)	(3,8)
	Λ. Wilks	0,6		0,8	
	F(df) η2	89,0 (1.128) 0,41 ****		38,56 (1.129) 0,23 ****	

*p ≤ 0,05 **p ≤ 0,01 ***p ≤ 0,005 ****p ≤ 0,001 n.s. non significant

Table 3: Anxiety (main research).

Overall Self-esteem		Experimental Group N=137		Control Group N=122	
		Before	After	Before	After
Positive self-image	Mn	36,4	43,3	38,9	33,6
	(Sd)	(6,13)	(7,1)	(5,5)	(4,8)
	Λ Wilks	0,6		0,93	
	F (df)	91,6 (1.128)		10,2 (1.129)	
	η ²	0,42 ****		0,07 ***	
Negative Self-image	Mn.	20,12	17,7	18,9	19,6
	(Sd)	(10,9)	(10,1)	(13,1)	(12,1)
	Λ Wilks	0,95		0,99	
	F (df)	6,33 (1.128)		0,55 (1.129)	
	η ²	0,047 n.s.		0,004 n.s.	
Self- esteem	Mn	27,2	32,8	31,83	27,9
	(Sd)	(17,6)	(19,3)	(14,7)	(15,8)
	Λ Wilks	0,95		0,95	
	F (df)	6,7 (1.128)		6,4 (1.129)	
	η ²	0,49 ****		0,48 *	

*p 0,05 **p 0,01 ***p 0,005 ****p 0,001 n.s. non significant

Table 4: Self-esteem (main research).

Discussion

The purpose of this research was to design, implement and evaluate a primary prevention program for enhancing emotional resilience in 9-10 years old children. The program was delivered in the classroom, over a 10-week session, during which the students engage in group activities, self-reflection exercises, and storytelling, which draw on the principles of cognitive behavioral therapy (CBT). Through the program the children acquired strategies and skills which, potentially, have helped them with coping with difficulties and anxiety caused by adverse situations in their everyday lives. They were trained in using flexible adaptation skills (e.g. self-awareness, social interaction skills) [67], and in becoming aware of procedures for dealing with everyday adversities (e.g. self-control, problem solving techniques) [68]. When children apply successfully these strategies, their sense of adequacy is strengthened and, concurrently, their self-esteem is boosted. These strategies are known to be effective with enhancing emotional resilience [69,70]. We can argue that the implementation of the program in schools seemed to have contributed sufficiently to the achievement of the objectives, which were the strengthening of children's emotional resilience (aged 9-12 years) [69,70].

Anxiety

The research study has shown that the children who received the preventive treatment reduced significantly their anxiety levels in the values relating to the diagnostic criteria of anxiety disorder (i.e. the six variables of the anxiety instrument). This could be attributed to the cognitive strategies and techniques the students learned and practiced during the program, which can affect the way children perceive and interpret stressful situations in their lives [71]. One of the fundamental goals of the therapy is to help young people overcome their behavioral deviations (e.g. hyperactivity, aggressive behavior) and to handle stressful experiences by adjusting their cognitive processes [72]. The children also learned how to put into practice anxiety management techniques by reflecting on hypothetical adverse situations. More specifically, in relation to separation anxiety, the students learned to recognize the feeling of anxiety caused by the separation from significant others (e.g., parents). They also learned how to identify physical reactions to anxiety, and recurring negative thoughts, and to, then, be prepared to apply relevant cognitive reconstructing processes and techniques [73].

The reduction of separation of anxiety in the study could also be interpreted as result of a change in how children relate to others and to groups, and how secure and confident they feel in the absence of their significant others. According to Erickson's psychosocial development stages [74], young children at around the age of 9, are becoming easier to share with others, and more able to collaborate with peers and enjoy teamwork. In a way, they become more aware of themselves as individuals and as members of a group, and they try respond to their obligations [75]. The program provided many opportunities for teamwork and for supporting the feeling of belonging to the group, while at the same time motivated the reflection on issues that may arise when they find themselves in groups or in pairs.

Our findings are in line with meta-analyses and international guidelines, such as the National Institute for Health and Clinical Excellence (NICE), that support the effectiveness of CBT in treating children with anxiety disorders [76,77]. It is worth noting that the benefits of the intervention were maintained after three months. It is important to have positive results after repeating measures in order to establish the validity of the impact of the treatment [78].

Self-esteem

In the main research, the results presented a significant change in the level of self-esteem of students in the experimental group after the completion of the intervention. The enhancement of positive self-image in the experimental group could be explained by the fact that children feel more capable and self-assured to deal adequately with difficulties or problematic life events, as result of the exercises and activities they experienced during the program. In contrast, the self-esteem of the control group participants deteriorated. Children's self-esteem can be negatively affected when children perceive situations as excessively risky and devalue their capacity to address the threat [56]. An important mediating factor, which reduces the intensity of a stressful event, is the sense of competence, which is a crucial determinant for experiencing emotional wellness. The sense of being competent vis a vis a stressful situation can be enhanced by training on cognitive, behavioral and physiological processes, leading to a reduction of tension from stressful situations and strengthening the skills of self-efficacy [72]. The program helped children to develop new strategies for dealing with problematic and adverse situations, which strengthened the sense of adequacy and boosted their self-esteem. In particular, they were trained in using flexible adaptation skills (self-awareness, interaction skills) [67], and in adopting new procedures for dealing with everyday adversities (self-control, problem solving techniques) [72]. These skills consist an essential component for enhancing emotional resilience [79,80].

An interesting finding in relation to the overall self-esteem is that, while the positive regard of the experimental group does not change at all after the intervention during the pilot study, it notably increases at the follow-up measurement. This notable improvement of the positive self-regard and self-esteem at follow up could be explained, if we think that it is possible, that we often need time to establish a positive perception about ourselves [65,66]. It is possible that in the months after the completion of the intervention, the students thought about, or reflected upon the positive messages of the techniques and activities, or they had the opportunity to try out to relate in more meaningful ways with peers and (significant others), or to observe that they could replace negative thoughts about abilities and performances with positive ones. Such positive psychological education processes may

have helped them feel psychologically empowered and, therefore, more positive and confident about themselves

Children in both groups manifested comparable anxiety measurements at the onset, however, it is also worth noting that the scores of the control group deteriorated at the post-intervention and, further, at follow up measurement. In their everyday life, children as young as 9 and 10 years-old have to confront difficulties concerning their performance at school, their relationship with peers and family and so on. Additionally, they are still developing emotionally and socially so they have not yet acquired the necessary coping skills for bouncing back difficulties and establishing self-efficacy [81]. It appears that without appropriate support and going through a crucial developmental stage, children are very vulnerable to external threats and difficulties.

Conclusion

This preventive program utilized the main features of CBT. It is short-termed, systematically structured with goals and outcomes, instructing the ability to formulate and resolve current problems of the individual [82,83]. Based on the observed impact on reducing anxiety and strengthening self-esteem we can relatively safely argue that the program has been effectively implemented and adapted.

Further research studies are needed to establish what were exactly the processes of cognitive reconstructing that the current program incited. It would also be very interesting to explore the students' opinions and feelings regarding the program, the impact on their academic achievement, and the impact on the school environment in general.

In conclusion, we would like to emphasize that, as in the case of school children, the cognitive-behavioral preventive programs for young learners are a growing field of research, while in Greece, examples of such efforts in a school framework based on the principles of CBT is very rare, if not non-existent.

References

1. Chorpita BF, Yim L, Moffitt C, Umemoto LA, Francis SE (2000) Assessment of symptoms of DSM-IV anxiety and depression in children: a revised child anxiety and depression scale. *Behav Res Ther* 38: 835-855.
2. Butler RJ (2001) *The Self Image Profile for children (SIP-C)* Harcourt Assessment [England], Procter House, 1 Procter Street, London WC1V 6EU England.
3. Bartholomew LK, Parcel GS, Kok G, Gottlieb NH, Fernandez ME (2011) *Planning Health Promotion Programs: An Intervention Mapping Approach*, USA: A Wiley Imprint (3rdedn) 12-35.
4. Durlak JA, Weissberg RP, Dymnicki AB, Taylor RD, Schellinger KB (2011) The impact of enhancing students' social and emotional learning: A meta-analysis of School-based universal interventions, *Child Development Special Issue: Raising Healthy Children* 82: 405-432.
5. Durlak JA, Wells AM (1997) Primary prevention mental health programs for children and adolescents: A meta-analytic review, *American Journal of Community Psychology* 25: 115-152.
6. La Ruso M, Selman R (2011) Early adolescent health risk behaviors, conflict resolution, strategies and school climate, *Journal of Applied Developmental Psychology* 32: 354-362.
7. Meyers J, Nastasi BK (1999) Primary prevention in school settings. In T. B. Gutkin & C. R. Reynolds (eds) *The Handbook of School Psychology* (2ndedn) USA: John Wiley & Sons 764-793.
8. Dariotis J, Bumbarger B, Duncan L, Greenberg M (2008) How do implementation efforts relate to program adherence Examining the role

- of organizational, implementer, and program factors, *Journal of Community Psychology* 36: 744-760.
9. Humphrey N, Kalambaka A, Bolton J, Lendrum A, Wigelsworth M, et al. (2008) Primary Social and Emotional Aspects of Learning (SEAL): Evaluation of Small Group Work. DfES Report No. DCSF-RR064.
 10. Cowen EL, Hightower AD (1990) The primary mental health project: Alternative approaches in school-based preventive intervention. In Gutkin TB, Reynolds CR (eds) *The Handbook of School Psychology* (2ndedn), USA: John Wiley & Sons 775-795.
 11. Barrett PM (2000) Treatment of childhood anxiety: developmental aspects. *Clin Psychol Rev* 20: 479-494.
 12. Kakourou, Maniadaki (2002) *Children and adolescents' Psychopathology: Developmental approach*, Athens: ypothito – G. Dardanos
 13. Hatzichristou Ch (2000) Review of international reality and experience on the organization and operation of mental health services for children and adolescents. In Kalantzi-Azizi and Besevegis (edited) *Themes for training/sensitization of mental health officials for children and adolescents*, Athens: Ellinika Grammata 27-44.
 14. Ashwell HE, Barclay L (2009) A retrospective analysis of a community-based health program in Papua New Guinea. *Health Promot Int* 24: 140-148.
 15. Barrett PM, Ollendick TH (2004) *Handbook of Interventions that Work With Children and Adolescents: From Prevention to Treatment*. London: Vivian Ward Psychology Publishing.
 16. Kendall PC (2000) *Cognitive-behavioral therapy for anxious children therapist manual*, (2ndedn). Ardmore PA: Workbook Publishing.
 17. Kalantzi Azizi A (1999) *The Clinical Psychology at school*. Athens: Ellinika Grammata (5thedn).
 18. Kalantzi Azizi A (1992) *Issues of Behavioural Psychotherapy*. Athens: Ellinika Grammata.
 19. Ronen T (2003) *Cognitive Constructivist Psychotherapy with Children and Adolescents*. New York: Kluwer Academic/Plenum Publishers.
 20. Domitrovich CE, Greenberg MT (2000) The Study of Implementation: Current Findings from Effective Programs that Prevent Mental Disorders in School-Aged Children. *Journal of Educational and Psychological Consultation* 11: 193-221.
 21. Durlak JA, Wells AM, Cotton JK, Johnson S (1995) Analysis of Selected Methodological Issues in Child Psychotherapy Research. *Journal of Clinical Child Psychology* 24: 141-148.
 22. Zafropoulou M, Carba Ch (2002) Cognitive behaviour modification and learning disabilities, In Scrimali T, Grimaldi L, *Cognitive Psychotherapy toward a new millennium: Scientific foundations and clinical practice*, Kluwer Academic/Plenum Publishers: New York 219-222.
 23. Miller M, Hinshaw SP (2012) Attention – deficit/Hyperactivity Disorder In Kendall PC. *Child and Adolescent Therapy*, (4thedn): Cognitive and Behavioral Procedures, The Guilford press 61-92.
 24. Purdie N, Annemarie C (2002) A Review of the Research on Interventions for Attention Deficit Hyperactivity Disorder: What Works Best? *Review of Educational Research* Spring 200272, 61-99.
 25. Lochman JE, Powell NP, Boxmeyer CL, Jimenez-Camargo L (2011) Cognitive-behavioral therapy for externalizing disorders in children and adolescents. *Child Adolesc Psychiatr Clin N Am* 20: 305-318.
 26. Ghafoori B (2001) Effectiveness of cognitive-behavioral therapy in reducing classroom disruptive behaviors. A meta-analysis. *Dissertation Abstracts International: Section B: The Sciences & Engineer in* 61 (11-B) 6133.
 27. Kendall PC, Safford S, Flannery-Schroeder E, Webb A (2004) Child anxiety treatment: outcomes in adolescence and impact on substance use and depression at 7.4-year follow-up. *J Consult Clin Psychol* 72: 276-287.
 28. Weems CF, Scott BG, Taylor LK, Cannon MF, Romano DM, et al. (2013) A theoretical model of continuity in anxiety and links to academic achievement in disaster exposed school children. *Development and Psychopathology* 25 729-737.
 29. Black DW, Gran JE (2013) *Mood Disorders in DSM-5 Guidebook: The Essential Companion to the Diagnostic and Statistical Manual of Mental Disorders*. (5thedn) American Psychiatric Association 89-147.
 30. Lazarus RS (2000) Toward better research on stress and coping. *Am Psychol* 55: 665-673.
 31. Merrell KW, Gimpel GA (2014) Developmental Issues in the Acquisition and Performance of Social Skills. In *Social Skills of Children and Adolescents, Conceptualization, Assessment, Treatment*, USA NY: Psychology Press 29-59.
 32. Muris P, Merckelbach H, Mayer B, Prins E (2009) How series are common fears? *Behaviour Research and Therapy* 38: 217-228.
 33. Berns R (2012) Ecology of peer group: Chrono-system influence: Middle Childhood/Preadolescent Peer Activities, In *Child, Family, School, Community: Socialization and Support* (9thedn) USA: Wadsworth Cengage Learning 268-273.
 34. Barrett PM, Healy-Farrell LJ, March JS (2004) Cognitive-behavioral family based treatment for childhood OCD: A randomized controlled trial. *Journal of American Academy of Child and Adolescent Psychiatry* 43: 46-63.
 35. Black DW, Grant JE (2013) *The essential companion of the diagnostic and statistical manual of mental disorders* (5thedn) (DSM -5 Guidebook), American Psychiatric Association 89-169.
 36. Calear AL, Christensen H (2010) Systematic review of school-based prevention and early intervention programs for depression. *J Adolesc* 33: 429-438.
 37. Afropoulou (2011) Cognitive-behavioral type interventions at school. In: Kalantzi-Azizi A, Zafropoulou M (eds) *Adjustment to school, prevention and treatment difficulties*. Athens: Pedio 6-15.
 38. Cartwright-Hatton S, Roberts C, Chitsabesan P, Fothergill C, Harrington R (2004) Systematic review of the efficacy of cognitive behaviour therapies for childhood and adolescent anxiety disorders. *Br J Clin Psychol* 43: 421-436.
 39. Zazonc RB (1980) Feeling and thinking: Preferences need no inferences. *American Psychology* 35: 151-175.
 40. Berns R (2013) Ecology of peer group in Child, Family, School, Community Socialization and Support (9thedn) USA:Wadsworth, Cengage Learning 247-289.
 41. Cohen R, Meyers AW (1984) The generalization of self-instructions. In: B. Gholson & T. L. Rosenthal (eds) *Applications of cognitive- developmental theory*, New York: Academic Press 95-112.
 42. Neisser U (2014) *The Higher Mental Process in Cognitive Psychology*, USA: NY, Psychology Press 263-288.
 43. Piaget J (1969) *The mechanisms of perception*. New York: Basic.
 44. Bernard ME (2004a) Emotional Resilience in Children: Implication for Rational Emotive Education. *Romanian Journal of Cognitive and Behavioural Psychotherapies* 4: 39-52.
 45. Bernard (2004b) *The You Can Do It! Early childhood education program: A social-emotional learning curriculum 4-6* In Oakleigh, VIC (AUS): Australian Scholarships Group; Laguna Beach, CA (USA): You Can Do It! Education, Priors lee, Time Marque: Telford (ENG).
 46. Landy S (2002) *Pathways to competence Encouraging healthy social and emotional development in young children*. Baltimore, Maryland: Paul A. Brookes.
 47. Everly Jr GS, Lating JM (2012) Resilience: The final frontier. In *A Clinical Guide to the Treatment of the Human Stress, Response* (3rdedn) USA: Springer, New York Heidelberg Dordrecht London 143-154.
 48. Afropoulou, Psyllou A (2007) Come together to build your character. Helping to shape the child's personality. Kalantzi-Azizi Anastasia. *Ellinika Grammata Athens* 2007: 11-15.
 49. Neil AL, Christensen H (2007) Australian school-based prevention and early intervention programs for anxiety and depression: a systematic review. *Med J Aust* 186: 305-308.
 50. Greenberg MT, Domitrovich C, Bumbarger B (2001) *The prevention of mental disorders in school-aged children: Current state of the field. Prevention and Treatment* 4,1. American Psychological Association.

51. Kendall PC, Hedtke K (2006) *Coping Cat workbook*. (2ndedn). Ardmore, PA: Workbook Publishing.
52. Kendall PC, Hedtke K (2006) *Cognitive-behavioral therapy for anxious children: Therapist manual* (3rdedn) Ardmore PA: Workbook Publishing.
53. Domitrovich CE, Cortes RC, Greenberg MT (2007) Improving young children's social and emotional competence: a randomized trial of the preschool "PATHS" curriculum. *J Prim Prev* 28: 67-91.
54. Kusche CA, Greenberg MT (1994) *The PATHS (Promoting Alternative Thinking Strategies) curriculum*. Seattle, WA: Developmental Research and Programs.
55. Meichebaum D, Novaco R (1978) Stress inoculation: A preventive approach, in Spielberger C, Sarason I (eds) *Stress and Anxiety*. Washington: Hemisphere.
56. Bernard ME (2002) *The You Can Do It! Education Mentoring Program*. Oakleigh, VIC (AUS): Australian Scholarships Group; Laguna Beach, CA (USA): You Can Do It! Education, Priorslee, Telford (ENG): Time Marque.
57. Barrett PM (2005) *Friends for Life: Group Leader's Manual for children*. Barrett Research Resources Pty Ltd, Brisbane Australia.
58. Barrett PM, Farrell L, Dadds M, Boulter N (2005) Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: Long-term follow-up and predictors of outcome. *Journal of the American Academy of Child and Adolescent Psychiatry* 44: 1005-1014.
59. Barrett PM, Pahl K (2006) School-based intervention: Examining a Universal approach to anxiety management. *Australian Journal of Guidance and Counselling* 16: 55-75.
60. Barrett PM, Ollendick TH (2004) *Handbook of Interventions that Work With Children and Adolescents: From Prevention to Treatment*. London: Vivian Ward Psychology Publishing.
61. Illback RJ, Zins JE, Maher CA (1999) Program Planning and Evaluation: Principles, Procedures and Planned Change. In: Reynolds CR, Gutkin TB (eds) *The Handbook of School Psychology* (3rdedn) USA: John Wiley & Sons 907-932.
62. Spence S (1998) A Measure of Anxiety Symptoms among Children: A Confirmatory Factor-Analytic Study. *Behaviour Research Therapy* 545-566.
63. Spence SH, Barrett PM, Turner CM (2003) Psychometric properties of the Spence Children's Anxiety Scale with young adolescents. *J Anxiety Disord* 17: 605-625.
64. Mellon RC, Moutavelis AG (2007) Structure, developmental course, and correlates of children's anxiety disorder-related behavior in a Hellenic community sample. *J Anxiety Disord* 21: 1-21.
65. Lawrence D (2006) *Self-esteem and individual differences*. In *Enhancing self-esteem in the classroom* (3rdedn) Sage Publications, London.
66. Wigfield A, Eccles JS, Mac ID, Reuman DA, Midgley C (1991) Transitions during early adolescence: Changes in children's domain-specific self-perceptions and general self-esteem across the transition to junior high school. *Developmental Psychology* 27: 552-565.
67. Hatzichristou Ch (2004) *Social and emotional education at school: Program promotion of mental health and learning: Educational materials for teachers and secondary school students, junior high, high school: Theoretical framework and activities*/Editor: C. Chatzichristou. (1stedn) Athens: Typothito, National and Kapodistrian University of Athens. Centre for Research and Application of School Psychology.
68. Smallwood PL, Christner RW, Brill L (2007) Applying cognitive-behavior therapy groups in school settings. In Christner RW, Stewart JI, Freeman A (eds) *Handbook of Cognitive-Behavior Group Therapy with Children and Adolescents* 97 New York: Routledge.
69. Karadimas E, Kalantzi-Azizi A, Kollia H, Russi-Vergou Ch, Georgiou E, et al. (2004) Stress management programs for children, teenagers and teachers. In: M. Zafropoulou & C. Kleftras (editor), *Applied clinical child psychology* 395-434.
70. Wells J, Barlow J, Stewart-Brown S (2003) A systematic review of universal approaches to mental health promotion in schools. *Health Education* 103: 197-220.
71. Graczyk PE, Domitrovich CE, Zins JE (2003) Facilitating the implementation of evidence-based prevention and mental health promotion efforts in school. In: Weist MD, Evans SW, Lever NA (eds) *Handbook of school mental health: Advancing practice and research* 301-318.
72. Kalantzi-Azizi A (2003) *Cognitive-behavioral approach in Psychotherapy*. National and Kapodistrian University of Athens, School of Psychology-University Notes, Athens.
73. Barrett PM, Rapee RM, Dadds MM, Ryan SM (1996) Family enhancement of cognitive style in anxious and aggressive children. *J Abnorm Child Psychol* 24: 187-203.
74. Erikson E (2015) *Stages of Social-Emotional Development*-childdevelopmentinfo.com. Child Development Institute.
75. Bee H, Boyd D (2009) *The Developing Child* (12thedn) Boston, MA: Pearson.
76. Cartwright-Hatton S, Roberts C, Chitsabesan P, Fothergill C, Harrington R (2004) Systematic review of the efficacy of cognitive behaviour therapies for childhood and adolescent anxiety disorders. *Br J Clin Psychol* 43: 421-436.
77. Compton SN, March JS, Brent D, Albano A, Weersing R, Curry J (2004) Cognitive-Behavioral Psychotherapy for Anxiety and depressive Disorders in Children and Adolescents: An Evidence-Based Medicine Review. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43: 930-959.
78. Tomb M, Huner L (2004) Prevention of anxiety in children and adolescents in a school setting: the role of school-based practitioners. *Children & Schools* 26: 87-101.
79. Hogendoorn SM, Vervoort L, Wolters LH, Prins PJM, De Haan A (2012) Perceived control in clinically anxious and non-anxious children indirectly measured with the Implicit Association Procedure. *Journal of Behavioral Therapy and Experimental Psychiatry* 43: 915-921.
80. Schwarzer R, Warner LM (2013) Perceived Self-Efficacy and the relationship with Resilience. In *Resilience in Children, Adolescents and Adults, USA: The Springer Series on Human Exceptionality* 139-150.
81. Besevegis E (1995) Adolescents' coping strategies as a function of age and gender. Paper presented at VII European Conference on Developmental Psychology, Krakow Poland.
82. Shochet IM, Dadds MR, Holland D, Whitefield K, Harnett PH, et al. (2001) The efficacy of a universal school-based program to prevent adolescent depression. *J Clin Child Psychol* 30: 303-315.
83. Stallard P (2006) *Think good-Feel good. A cognitive-behavioral therapy manual for children and youth*. (Zafropoulou M) Athens: Typothito-Giorgos Dardanos.