GENERALIZED ANXIETY DISORDER AMONGST ORTHODOX JEWISH CHILDREN:
EDUCATING PARENTS OF CHILDREN SUFFERING FROM GENERALIZED ANXIETY
DISORDER

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

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DEDICATION

I would like to dedicate this graduate project to someone who has been there for me throughout my whole life. This person spent endless nights with me and sacrificed her life in order to assure that I would live a good life. I would like to dedicate this graduate project to my loving mama. My mother constantly encouraged me to never give up. She helped me make it through elementary school, high school, college, and now graduate school. She has been the encouraging force that has helped me achieve my goals. I would like to express my utmost gratitude to my mother for investing time, sleep, energy, and so much more to assure that I will live a happy and successful life.
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ABSTRACT

GENERALIZED ANXIETY DISORDER AMONGST ORTHODOX JEWISH CHILDREN: EDUCATING PARENTS OF CHILDREN SUFFERING FROM GENERALIZED ANXIETY DISORDER

By

Brana Ratner-Stauber

Master of Science in Counseling,

Marriage and Family Therapy

The purpose of this master’s graduate project is to develop a twelve-week therapy group for parents in the Orthodox Jewish community who have daughters between the ages of 9-13 who are suffering from generalized anxiety disorder. The purpose of the group would be to provide psycho-education for the parents about generalized anxiety disorder and how they can support their children and help them fight against anxiety. The group would also provide support for the parents who are experiencing similar circumstances in regards to their children. Through the group the parents will hopefully learn to better understand their children and learn new techniques in order to help their children overcome generalized anxiety disorder.
CHAPTER ONE
INTRODUCTION

Statement of Problem

Generalized anxiety disorder (GAD) is common in children ages 13-18. According to the Anxiety and Depression Association of America (2014), with GAD affecting one out of eight children, this has become a significant issue throughout the population. The effects on the children include headaches, stomachaches, and muscle aches, and may lead to chronic depression, substance use and anxiety into adulthood if it is not treated. The National Institute of Mental Health (2014) contends that amongst the people who are suffering from GAD women are 60% more likely to experience an anxiety disorder than men. According to the Child Mind Institute Children’s Mental Health Report (2015), 80% of children with a diagnosable anxiety disorder are not getting treatment. This is especially true within the Jewish Orthodox community, where psychotherapy is frowned upon by a majority of the population (Schnall, 2006).

Purpose of Project

The purpose of this project is to develop a therapy group/workshop for parents who have daughters between the ages of 9-13 who are suffering from generalized anxiety disorder. The purpose of the group would be to provide psycho-education for the parents about anxiety and how they can support their children and help them fight against anxiety. The group would also provide support for the parents who are experiencing similar circumstances in regards to their children.

Terminology

In order to better understand the issues presented in this paper, it is important to understand the following terms.
**Generalized anxiety disorder**: According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM 5; American Psychiatric Association [APA], 2013) GAD is excessive anxiety and worry occurring more days than not for at least 6 months, about a number of events or activities (DSM 5).

**Orthodox Judaism**: “A Jew who adheres faithfully to the principles and practices of traditional Judaism as evidenced chiefly by a devotion to and study of the Torah, daily synagogue attendance if possible, and strict observance of the Sabbath, religious festivals, holy days, and the dietary laws” (Dictionary.com, 2015, para. 1).

**Anxiety disorders**: According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM 5; American Psychiatric Association [APA], 2013) “Disorders that share features of excessive fear and anxiety and related behavioral disturbances” (DSM 5, p.189, para. 1)

**Combination therapy**: “The use of two or more therapies and especially drugs to treat a disease or condition” (Merriam-Webster Online, 2015, para. 1).

**Cognitive bias**: “Common tendency to acquire and process information by filtering it through one's own likes, dislikes, and experiences” (Business Dictionary.com, 2015, para. 1).

**Double-blind**: “Experimental procedure in which neither the subjects nor the experimenters know which subjects are in the test and control groups during the actual course of the experiments” (Merriam-Webster Online, 2015, para. 2).

**Talmud Babli**: The collection of ancient Rabbinic writings consisting of the Mishnah and the Gemara, constituting the basis of religious authority in Orthodox Judaism (The Free Dictionary.com, 2015, para. 1).

**Shabbos [Sabbath]**: “The seventh day of the week, Saturday, observed as the day of rest and worship in Judaism and some Christian sects” (The Free Dictionary.com, 2015, para. 1).
Teshuva: Repentance or a return to the original state (Dubov, 2015, para. 1&2).

In order to better understand these issues and develop the workshop described above, it is necessary to review the pertinent research and theories focusing on General Anxiety Disorder within the Orthodox Jewish community, which will be accomplished in the following chapter.
CHAPTER TWO
LITERATURE REVIEW

The following chapter offers literature from a variety of scholarly authors and resources that outline evidence which supports this project. The objective is to provide evidence-based material while engaging and educating the reader in order to further understand generalized anxiety disorder in Jewish Orthodox children. The chapter begins with the information about generalized anxiety disorder in children and then specifically mental health in the Jewish Orthodox community. Next, a question is dissected in order to further understand how GAD looks amongst children. Following is a deeper understanding of the role of the parents. Lastly discussed is how the incorporation of a support group for parents who have children suffering from GAD will assist the family in the overcoming process.

Generalized Anxiety Disorder

According to the Anxiety and Depression Association of America (2014), people suffering from generalized anxiety disorder [GAD] have excessive concern about situations with uncertain outcomes. The anxiety may affect thinking, behavior or physical reactions. Although people experiencing anxiety may want to act upon a threatening entity, the anxiety may actually inhibit them from taking action. If the person feels handicapped and cannot complete daily functions or finds that getting through the day is daunting, counseling may be needed. It may seem that people with GAD worry about things that there is no reason to worry about; therefore, it may keep them from doing everyday tasks, such as going to school (2014).

According to Huberty (2004) GAD is one of the most common anxiety disorders. Its frequency ranges from about 2 to 15% of children and occurs most often in females. GAD develops slowly and often has a high risk of development during childhood and middle age.
Symptoms fluctuate during different times and often get worse during stressful times. If the anxiety level is moderate, the person may be able to function in his or her daily life but if the anxiety is severe, that can be inhibiting (Huberty, 2004).

Research collected from Jewish Connected (2015) indicates that children who are not treated for anxiety are at a higher risk to negatively affect their school performance, social experiences and engage in substance abuse. Children with GAD tend to be hard on themselves and strive for perfection. People with GAD may experience exaggerated worry even if there is no apparent reason for distress. People with GAD encounter excessive worry about a variety of everyday problems for at least six months. The disorder accumulates gradually and can begin at any stage of life, although childhood and middle age are the highest risk. Probable contributions to acquiring GAD are through biological factors, family background and life experiences (2015). The National Institute of Mental Health (2015) points out that researchers are still working on determining the cause for anxiety based on the brain’s functioning in order to create better treatments. Researchers are also focusing on the ways stress and environmental factors may play a role (2015).

In order for parents to distinguish if the child is experiencing GAD, they must be aware of the possible symptoms. Some of the symptoms, according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013), include: restlessness or feeling on edge, easily fatigue, difficulty concentrating, irritability, muscle tension and sleep disturbance. If three of the symptoms are present for more than six months then the parents should determine how they can properly assist their child overcome GAD (APA, 2013). The National Institute of Mental Health (2014) indicates that other symptoms an individual with GAD may have include, headaches, muscle aches, difficulty swallowing, trembling, twitching,
sweating, nausea, lightheadedness, using the bathroom frequently, feeling out of breath and heat flashes. If a person visits a doctor for the physical symptoms and if the symptoms are not a result of an ailment then the doctor may refer the individual to a mental health specialist (2014).

**Generalized Anxiety Disorder Statistics**

According to Anxiety and Depression Association of America (2014), anxiety disorders affect one in eight children. The Child Mind Institute (2015) reports, “The United States Census estimates that in 2015 there are 74.5 million children under 18. Of those children, 17.1 million young people have or had a diagnosable psychiatric disorder. This estimate is extrapolated from Census data and prevalence numbers reported for the NCS-A, GSMS, NHANES, and an analysis of early-childhood severe emotional disturbance by Brauner” (2006, p. 2). Another study conducted by this organization revealed that anxiety disorders were most common in young people ages 13-18. The median age of onset of anxiety disorder is age 6. Out of 49.5% of children estimated to have diagnosable mental illness, only 7.4% in the United States have any mental health visits in a year. 80% of youth with anxiety disorder fail to receive treatment. 90% of young people who commit suicide have a psychiatric disorder (Child Mind Institute, 2015).

The most effective treatment for anxiety disorders is combination therapy, which is cognitive behavioral therapy (CBT) with medication such as antidepressant medications, which include serotonin reuptake inhibitor or SSRI. Combination therapy has an effectiveness of 81% after 12 weeks of treatment. After 36 weeks of treatment CBT and medication alone seemed to be effective as well (Child Mind Institute, 2015).

**Effects of Generalized Anxiety Disorder on Girls Ages 9-13**

According to noted child psychologist Erik Erikson (1993), girls between the ages 9-13 are transforming from a child to an adolescent. During adolescence they begin to develop
physically and psychologically. They may look different and begin to act different during this stage. According to Erikson ages 9-13 are between the elementary school age and adolescence stages. The conflict that they are encountering is industry (competence) versus inferiority and identity versus role confusion. During the elementary school age stage the child needs to cope with new social and academic stress. When the child succeeds she may gain a sense of competence but if the child fails then she may feel inferior. During the adolescent stage the child is developing a sense of self and personal identity. When children succeed they have the ability to stay true to themselves. Failure, however, can lead to role confusion and a weak sense of self (Erikson, 1993).

According to National Institute of Mental Health (2014), women are 60% more likely to experience an anxiety disorder than men. If a child is suffering from anxiety and it goes untreated, he or she may suffer from chronic depression, substance use and anxiety into adulthood. Therefore, as soon as anxiety symptoms manifest, action should be taken to treat it. After about age eight, the types of fears that are anxiety producing are abstract, and less specific such as worries concerning school and friends. Once the child has reached adolescence, the worries are more focused on religious, sexual and moral issues, as well as peer pressure. GAD symptoms and fear of death or danger are common in children ages 10-13 (2014).

A national survey of adolescent mental health reported that about 8% of teens 13-18 have an anxiety disorder, with symptoms emerging around age 6. Of the teens, only 18% received mental health care (National Institute of Mental Health, 2014). In another study conducted in the United States, with individuals 8-17 years of age, the researchers concluded that many of the children/adolescents had high rates of anxiety diagnoses. Amongst the children who were
suffering from an anxiety disorder, females were more likely to be suffering from an emotional disorder than males (National Institute of Mental Health, 2014).

As per research conducted by Child Mind Institute (2015), 80% of children with a diagnosable anxiety disorder are not getting treatment. The researchers found that a grand sum of two hundred and two billion dollars was spent on costs for untreated mental illness later on. The spending is on lost productivity and crime in Americans under the age of 24 suffering from mental illness (Child Mind Institute, 2015).

**Predictors of Generalized Anxiety Disorder in Children**

Many symptoms of anxiety are physical. Therefore Shanahan et al. (2014) contend that a child suffering from somatic symptoms is likely to develop or have an anxiety disorder. As noted previously, children who are suffering from anxiety may have somatic complaints such as headaches, stomachaches, and muscle aches. When children experience somatic symptoms, often they will report it to parents, teachers, school nurses/ counselors, and doctor. Once one of the above adults has been educated about the symptoms, action should be taken to explore the reason and treatment (Shanahan et al., 2014).

Several British cohort studies revealed that people with somatic complaints during childhood are at more risk for psychiatric symptoms as an adult. A study was also conducted in the United State on individual’s ages 8-17 who had high rates of anxiety diagnoses. The result of the study found that emotional disorders that manifest in children suffering from somatic symptoms occur more in females than males (Shanahan, et al., 2014).

According to Kerns, Siener and Brumariu (2011), children who have an introverted temperament are reactive to novel situations and people and therefore may be at risk for the development of anxiety. Often if the child is inhibited during preschool, anxiety may be apparent
during middle childhood. Symptoms of anxiety may then decline during the middle childhood years. Behaviors such as excessive use of avoidant coping, low child competence, cognitive biases or distortions, rejection or criticism by others, and parental overprotection or rewarding of anxious behaviors may exacerbate or cause anxiety symptoms. If the parents are controlling, the child’s perception of control may be linked to anxious behaviors. Early entrance to puberty may expose children to more stress, which may lead to development of anxiety. Even if the child does not develop anxiety at a young age, parent-child relationships, negative life events and maternal anxiety are predictors of later anxiety (Kerns, et al., 2011).

According to Huberty (2004), anxiety may co-occur with depression at a high percentage of 50-60% of the time. When the two occur together, often anxiety precedes depression. When the two mental health disorders co-occur, the likelihood of suicidal thoughts is heightened. Often attention deficit hyperactivity disorder (ADHD) will be mistaken for anxiety. If the child is suffering from ADHD, the signs will appear around age four or five. But if the child is suffering from anxiety, the symptoms may occur during time of school entry. In order to properly treat the child’s disorder, the child should undergo a thorough psychological and educational evaluation by qualified professionals. If the child is showing signs of perfectionism, or the contrary, has difficulty concentrating and remaining organized, then the child may be suffering from anxiety. In later years, substance abuse may appear to be an anxiety disorder only until discovered otherwise (Huberty, 2004).

**Parental Role in Helping Children**

Parental influence has a strong impact on the well-being of the child. Usually the first person to recognize the symptoms of anxiety is a parent although the symptoms may be linked to other problems as well. Barton (2012) reveals that there are two main questions a parent should
ask himself or herself in order to determine if the child is suffering from anxiety. The first is if the child seems to be more shy or anxious than other children his or her age. The other question is if the child seems more worried than other children. If the parents’ answer “yes” to the questions then they should take a closer look rather than assuming it is anxiety. Parents who have suffered from anxiety themselves are better able to detect if the child is displaying unusual behavior. The parents should be careful in labeling the child with anxiety disorder, and accepting unacceptable behavior that is irrelevant to anxiety disorder (Barton, 2012).

Kerns et al. (2011) indicate that the security of children’s attachment and the quality of parenting are two specific aspects of parent-child relationships that are linked to anxiety. According to Bowlby’s theory, the absence of security can lead to free-floating anxiety. If children have a secure base and have confidence in the parent’s abilities, they have the freedom to explore with less likelihood of developing anxiety. The validity of insecure attachment being identified as a risk factor for developing anxiety disorders in children has been verified (Kerns et al., 2011).

Another trait that helps the child reduce the development of anxiety is parental acceptance. If the parent is accepting, the child may learn to regulate his or her emotions and the child may feel safe to accept parents’ assistance. If the parents are sensitive, they will be responsive, accepting, cooperative and non-interfering. If the parents grant autonomy too early and do not provide proper monitoring or supervision, the child may develop anxiety (Kerns, et al., 2011).

Being over controlling is another trait that the parents may possess, which can instill anxiety within the child. If the parents are over controlling, they may be interfering in the child’s sense of self-efficacy, which decreases the child’s control and increases the likelihood to develop
anxiety. Another factor that contributes to heightened anxiety in children is if the parents are anxious and therefore exposing the children who may already have a genetic predisposition to anxiety. Therefore the parent could benefit from psycho-education and related strategies to reduce parental anxiety and control and in turn help prevent or reduce child anxiety. If the child’s environment is unsafe or stressful, that can leave the child feeling the world is unpredictable and difficult (Kerns et al., 2011).

According to Becker, Ginsburg, Domingues, and Tein (2010), anxiety disorders are seven times more likely to appear in children who have parents suffering from anxiety disorders. If the parent has anxious characteristics, it may affect the child. For example, if the parent is over-protective and highly involved in decision making then the autonomy of the child is decreased which leaves the child feeling vulnerable. The child may feel that there is a constant threat and he cannot manage it on his own (2010). Manassis and Bradley (as cited in Becker et al., 2010) suggest maternal control behavior may be more strongly associated with child anxiety than with maternal anxiety (as cited in Becker, et al., 2010).

When working with a child who is suffering from anxiety, Huberty (2004) asserts that there is certain skills the parents may utilize to help the child. Some of the skills include, being consistent in handling problems and discipline. Being patient and listening are important because the child may not be willfully misbehaving and may be unable to control the behavior. The parents should not put pressure on children to be perfect but rather maintain realistic and attainable goals and expectations. When the child achieves the goal the parent should praise and reinforce effort. Consistency balanced with flexibility for routines such as homework, chores and activities is helpful. If the child is having a fear of a specific event such as public speaking then practicing with the child will ease the anxiety. Helping the child learn strategies to cope with
anxiety is optimal. Teaching organizational tools, creating scripts as what to do and say internally or externally and learning relaxing techniques are all ways parents can assist children deal with anxiety. Parents should have open and nonjudgmental communication with the child on a regular basis (Huberty, 2004).

According to the Anxiety and Depression Association of America (2014), in order for the child to feel secure the parents should reassure her that they would do everything they can to keep her safe. The parents should encourage the child to talk, ask questions, and feel she can be open about her feelings. Helping children stick to daily routine puts consistency into their lives, which reduces anxiety of unpredictability. Asking for forgiveness from the child reduces anger, which may reduce anxiety. When the child sees the parents admit to their mistakes, such as using anger to discipline, the child can regain trust and hopefully reduce anxiety (2014). If the child can regain trust in the parents, the child can feel more secure and have less fear in his or her daily life (Marital Healing, 2005).

According to Anxiety and Depression Association of America (2015), parents can help their child by paying attention to the child’s feelings and staying calm when the child becomes anxious. When the child accomplishes small tasks the parents should recognize and praise him or her. The parents should be flexible and should modify expectations especially during stressful periods. It would be helpful if the parents maintained a normal routine and plan for transitions. The parents should recognize that the child’s anxiety disorder is not a sign of bad parenting (Anxiety and Depression Association of America (2015).

In addition, according to Worry Wise Kids (2015), parents who have other children at home who do not have anxiety should have equal expectations for all of the children. The parents should realize that the child with anxiety might need them to prepare and break down the steps
so the child could more easily accomplish the goal. Allowing the child with anxiety to accomplish goals on his own may contribute to the child’s personal strength. Helping the child accept and express feelings will allow for anxiety to be something less daunting. The parents should work towards presenting a situation from a neutral stance rather than instilling fear into the child. If the child does express fear the parents should not laugh or minimize it. However the parents should teach the child that laughing at times when mistakes happen can be appropriate. The parents should be consistent in their ways of handling the child’s anxiety and therefore utilize love and acceptance along with proper consequences for misbehavior, exclusive from anxiety (Worry Wise Kids, 2015).

Barton (2012) posits that the parents can help the child in treating the anxiety by explaining that worries are caused by something called anxiety. The parents should then help the child observe the shallow rapid breathing that occurs during anxiety and should learn how to exchange it with slow breathing into the belly. The parent should help the child replace “red light” thoughts, which are negative thoughts with “green light” thoughts, which are more helpful and realistic. The parents could also help the child gradually face his or her fear in a systemic manner (Barton, 2012).

**Treatment for GAD**

Maria (2005) contends that one of the most successful treatments that has been scientifically proven to treat anxiety is cognitive behavioral therapy (CBT), which is a type of talk therapy. CBT focuses on utilizing methods to identify and replace negative thinking patterns and behaviors with positive ones. Learning the difference between realistic and unrealistic thoughts and homework are a few other techniques utilized. CBT is a short-term therapy with long term benefits that can be maintained through the help of the family and support group.
Some useful techniques for CBT are anxiety management and gradual exposure to anxiety-provoking situations (Maria, 2005).

According to Mayer, Van Acker, Lochman and Gershman (2009), CBT is based on the cognitive triad in which cognitions, behaviors and emotions interact to create their vision of the world. Since the target population is school-aged children it is important to focus on the apparent symptoms they may display. For example, a child with GAD may fall into the pattern of school refusal. If the child avoids a fearful stimulus, such as going to school, then cognitive biases are confirmed; therefore, disabling the child to handle unpredictable situations. Although parents may think they are fostering their children by allowing them to avoid their fears, ultimately it is causing them to further fear and avoid the situations. Once the child begins the pattern of missing school she may fall behind in academic studies, lose contact with friends, increase dependency on parents and have trouble with familial relationship (Mayer et al., 2009).

Mayer et al. (2009) point out that CBT for youth focuses on maladaptive cognitions and their effects on behaviors and emotions. The first effective intervention for the parents and child to learn is the basic education of the relationship between the physiological, cognitive and behavioral components. Once they are both educated, they can proceed in utilizing the advantageous interventions CBT has to offer. Utilizing behavioral parent training focuses on the parents’ role in helping the child reduce GAD symptoms. The most important factor is modifying the parents’ cognitions or behaviors that influence or maintain the anxiety within the child (Mayer et al., 2009).

According to Mayer et al. (2009), CBT has proven to be an empirically supported theory for reducing anxiety within youth. Although CBT is an efficient therapy for youth to utilize, the outcomes are improved if the family is involved. Family-based CBT views the family
environment as the prominent factor in changing the child’s maladaptive cognitions. The parents play an integral role in reducing the child’s anxiety by modeling exposure to new situations and adaptive processing. Parents who reinforce adaptive behaviors and cognitions encourage new behavioral patterns and alleviate anxious symptoms. When the parents are involved in the therapeutic process the effectiveness and conceptualization of treatment is enduring (Mayer et al., 2009).

According to Jewish Connected (2015), another type of therapeutic approach is acceptance and commitment therapy (ACT), which uses strategies of acceptance and mindfulness as a way to cope with the unwanted thoughts, feelings and sensations. By living in the moment and experiencing things without judgment the child is better capable of dealing with the anxiety. Another helpful tool for overcoming anxiety is prescription medications. Two types of medications that are commonly used are anti-anxiety and antidepressant medication (Jewish Connected, 2015).

The National Institute of Mental Health (2015) posits that certain types of medications create an immediate response and those should not be taken for a long period of time. Antidepressants can be used to treat GAD but may take a few weeks for the person to respond. The dose is slowly increased in increments to avoid side effects such as suicidal thoughts or suicidal attempts, nausea, headaches and difficulty sleeping. If side effects occur then a doctor should be consulted before stopping to take the medication. Abruptly stopping medication can cause a negative reaction. The best treatment for GAD is a combination of talk therapy and medication, usually SSRI for children under 12 (National Institute of Mental Health, 2015).

Through a study measuring the safety and efficacy of Sertraline, conducted by Rynn, Siqueland and Rickels (2001), treatment for GAD through an antidepressant/ anti-anxiety
medication proved to be significantly effective by week 4. In conclusion the results of the double-blind, placebo-controlled trial implies that Sertraline at the daily dose of 50 mg is safe and efficacious for the treatment of generalized anxiety disorder in children and adolescents (Rynn et al., 2001).

According to the National Institute of Mental Health (2015), other forms of treatment are self-help or support groups for people who are suffering from anxiety. The Internet can be a resource if utilized with caution. Speaking to friends or clergy may be helpful but are not a substitute for therapy. Stress management, meditation and exercise may have a calming effect. Most importantly having the support of the family is crucial in the child’s recovery (National Institute of Mental Health, 2015).

Children who are suffering from transient anxiety may respond well to reassurance and support. Being exposed to brief educational interventions with the parents can be helpful. The parents may be encouraged to utilize gradual exposure to the anxiety-provoking situation with the supervision of the pediatrician or therapist (Maria, 2005).

The Jewish Orthodox Community

In general it is crucial for psychotherapists to be culturally sensitive. According to Sperry (2014), a therapist who is culturally sensitive is able to recognize, respect and respond in a proper manner, using appropriate words and actions according to the individual’s ethnic, social class, gender, age or religious background. Within the concept of cultural sensitivity there is cultural knowledge, cultural awareness, cultural sensitivity and cultural action. Cultural knowledge is the appreciation and understanding of the intricate details of another culture. Cultural awareness is an understanding of another culture’s problems and also being aware of personal cultural biases. Having cultural sensitivity means to be respectful, empathic and
welcoming to someone of a different culture. Finally, cultural action is the ability to respond by making appropriate decisions and skillful responses with effective actions in a given situation (Sperry, 2014).

Wieselberg (1992) indicates that when working with various ethnic groups such as Hispanics, American Indians and other minorities in the United States there may be a tendency for the clients to distrust the effectiveness of therapy, lack the knowledge of mental health resources, and often the disinclination to acknowledge the need for help. Amongst the therapist and client there may be cultural and social differences and language barriers. Of the different ethnic groups, the strongly religious clients may be reluctant to seek therapy out of fear of having their value systems viewed as neurotic or as an obsession (Wieselberg, 1992).

When psychotherapists work with a cultural minority, such as Orthodox Jews, it is important to have patience and flexibility. Margolese (1998) asserts that patience is crucial in allowing the client to adjust to the therapeutic process in order to gain trust in the therapist. The therapist should also be patient and flexible in allowing the client to find comfort within the session, for example, by leaving the door ajar if the therapist is of the opposite sex (Margolese, 1998).

Often Orthodox Jews are hesitant to accept mental health treatment because they feel that the Torah/Bible has all of the answers to recovery. They may feel that they can utilize their religion in order to overcome their mental health illness. According to Hoffman (2014), psychotherapy and the Torah should be viewed as separate entities. Studying and observing the Torah are means to create an awareness and service towards the Creator but are not necessarily treatments for psychopathology. Often when people are suffering from a mental illness the mental illness may impair them from serving G-d and studying the Torah. The goal of the
The therapist is to restore the health of the individual in order for them to be able to live their lives how they would like. The goal of the therapist is not to influence the client on how to live his or her life but rather to help the client maintain a healthy and stable life (Hoffman, 2014).

Although some people in the community may feel the need to seek therapy, they may have reservations due to confidentiality. Loewenthal (2013) notes that they may fear consulting a counselor from the same background or community due to a possible breach of confidentiality. Often the rabbinical leaders suggest faith and prayer to cope with mental disorders. If an Orthodox Jew decided to seek therapy a fitting therapist would be someone knowledgeable in the Jewish Orthodox customs. There are numerous areas in which Orthodox Judaism may seem to conflict with psychotherapeutic work. Therefore Orthodox rabbis may be reluctant to endorse the use of therapy. The therapist who is working with the Orthodox Jewish community should have proper training and be in close contact with the rabbi in order to be endorsed by the community. The therapist’s acceptance of the client’s cultural background improves trust and positive outcomes (Loewenthal, 2013).

Researchers such as Schnall (2006) are starting to recognize the mental health needs amongst the Orthodox Jewish community, especially since the population is growing immensely due to high rates of reproduction. This research has discovered that minority groups tend to underutilize mental health services. According to Schnall, 90% of Orthodox mental health professionals reported that the mental health needs of their community are poorly met and many Orthodox Jews fear the stigma attached to seeking psychological help. The labels that may be assigned to people who seek therapy are “crazy” or “insane.” If the person has obtained such a reputation, it may affect the chances of finding a suitable match for marriage in the family. Schnall states, “Jews have been largely attributed an invisible status in the fields of counseling
and psychology in general and within the multicultural counseling movement in particular” (2006, p.276). There is evidence that Orthodox Jews suffer increased rates of severe psychiatric disorders. Often Orthodox Jews will not receive psychological help because it may indicate that Judaism does not have all the answers and therefore they are incapable of dealing with issues on their own (Schnall, 2006).

It is crucial for counselors to be properly educated about the Orthodox Jewish culture in order to further assist them in treatment. Often the therapist may treat the clients as any other Caucasian American due to the fact that they have white skin and look similar. However they may be different and seek different needs (Ginsberg & Sinacore, 2013). If the clients feel that the therapist does not respect the values that are important to the community, they may resist going to therapy.

One example is that a client may not feel comfortable seeing a therapist of the opposite sex. The therapist must be sensitive to the culture and understand the religious practices in depth in order to differentiate between religion and anxiety characteristics. Schnall (2006) posits that some of the Jewish laws of purity, prayer and dietary requirements, which come from the Torah, may seem to be symptoms of obsessions or compulsions when in reality it may only be religious practices. In order for the therapist to determine whether the actions of the client are based in religion it may be helpful to speak to rabbis or other community members to better understand the cultural rituals. Having a connection to the rabbis can also be a good resource for referrals and collaboration during treatment. Consulting with a rabbi when Jewish laws seem to conflict with therapeutic needs can be helpful as well (Schnall, 2006).

According to a prominent book in Judaism, the Talmud Babli in the tractate of Sanhedrin, states “If a man has worry in his heart-let him speak of it to another” (p.100b). Therefore it is
advisable for an individual to seek guidance during a time of need. Often Jewish Orthodox people may turn to a rabbi or mentor to speak about their problems. Therefore, if a rabbi recommends an individual to seek mental health counseling, he or she may be more susceptible to the idea.

There are limited studies on the impact of religious rituals on mental health. According to Dein and Loewenthal (2013), rituals can create a structure for emotional expression, reduce anxiety and uncertainty, create meaning, foster personal identity, enhance social support and help overcome ambivalence. For example, Shabbos/Sabbath is a weekly ritual that creates social bonds between family and friends. As noted by researchers, religious involvement has benefits in regards to mental health and well-being. Having a relationship with G-d may contribute to positive mental health, while negative religious coping may be detrimental to mental health (Dein & Loewenthal, 2013).

According to Bert (2011), children with mothers who are religious had less internalizing and externalizing problems at age 10. The maternal religiosity has an effect on the child’s level of religiousness and adjustment. Incorporating religion and spirituality into one’s life can assist the mother and child in developing socio-emotional regulation, which increases positive social engagement (Bert, 2011).

Schnall (2006) states that utilizing a religious belief, such as “teshuva/repentance,” may be useful in discouraging despair because it instills hope for change. Since many theories coincide with the idea of focusing on the future rather than the past, the client may be more compliant to accept the treatment. One of the theories being cognitive behavioral therapy, which is a present-oriented psychotherapy directed toward solving current problems and modifying dysfunctional belief or behavior, as previously discussed (Schnall, 2006). According to Schnall,
Pecovitz, & Fox (2013), researchers have recently determined that the Orthodox Jewish community is developing greater awareness of mental health needs and willingness to accept appropriate care. The numbers in therapy are certain to rise because the Jewish Orthodox community is awakening to the reality of their mental health needs (Schnall et al., 2013).
CHAPTER THREE

PROJECT DEVELOPMENT

This workshop aims to provide psycho-education for the Jewish Orthodox parents who have daughter(s) ages 9-13 who may be suffering from generalized anxiety disorder. The lack of mental health education within the Jewish Orthodox community demonstrates the strong need for psycho-education and support groups (Schnall, 2006). Since mental health is not widely acknowledged or extolled in the community, there is a demand for a group that will educate the Orthodox Jewish parents of girls ages 9-13 who have generalized anxiety disorder (GAD).

Speaking about mental health issues may be shameful or taboo; therefore, it will be helpful to see other participants in the group. This will normalize the individual’s fears. The parents will recognize that they are not the only ones struggling with children that have GAD. Creating a group for these parents is exceptionally beneficial. When individuals join as a group they are able to contribute their unique developmental history, hopes and fears and different resources (Drum, 1990). The members are able to receive empathy from other individuals because each member is enduring similar experiences (Counselman, 2008). Not only will the parents benefit but the children will benefit as well. The children may realize that they are not alone in this battle, due to the fact that they will have their parents supporting them as well as other families in the community that are fighting the same battle.

Development of Project

My strong desire to create a psycho-educational workshop for parents that have children with generalized anxiety disorder (GAD) came from personal experience. Beginning at a very young age I was faced with one of the biggest challenges of my life. I began developing generalized anxiety disorder and it felt like it was never going to end. As my anxiety began to
progress it slowly defeated me to the point where I was unable to leave my house. This meant I
could no longer go to school and had to transfer to home schooling. I felt that my whole world
was crashing at such a young age. I felt as if I was drowning in the middle of the ocean and there
was no way to be rescued. Going from one psychologist to the next was exhausting and
disappointing. I began the search for help at the age of 9 years old after a traumatic event that
occurred. I tried cognitive therapy, psychodynamic therapy, behavioral therapy, and even sand-
play therapy, as well as many other kinds of therapies, but my anxiety began to become
uncontrollable and my agoraphobia was not improving.

After going to therapy for thirteen years I still felt that I did not have control over my
anxiety. Those thirteen years felt like a roller coaster ride. Once I began my masters program at
Cal State University, Northridge, I was able to reduce my anxiety through different methods. I
realized that there are a lot of people who are suffering from anxiety as well but like I had done,
they hide it, which may leave them feeling alone. At that point I wished that my parents, had
been better educated on how to help me at a young age. I realized that the longer I was suffering
with GAD the longer it would take to treat it. If there was a workshop such as the one I am
proposing, it is possible that I would have stayed in school and improved developmentally rather
than becoming agoraphobic.

**Intended Audience**

The population that will be targeted for this group will be Jewish Orthodox parents who
have female children between the ages of 9-13 who are suffering from GAD. The school faculty
will recruit the parents based on several factors. If the faculty is concerned that a child may have
GAD then they will specifically recommend the support/psycho-educational group to the parents.
A strong indication of GAD in the child is if the child is absent from school often due to school
refusal. If a teacher is concerned about a child's GAD, he or she can discuss it with the parents at a parent-teacher conference.

The significance of confidentiality may be especially emphasized since the Jewish Orthodox population may feel shame in seeking mental health services. Another sensitivity that must be considered is not making the group co-educational because individuals may not feel comfortable in attending a group with the opposite sex. To accommodate the sensitivity of not mingling with the opposite gender, the facilitator will be the same sex as the participants of the group. Therefore there will be separate groups for men and women.

**Personal Qualifications**

Growing up in a Jewish Orthodox community and suffering from generalized anxiety disorder at a young age has given me personal experience with the project I have created. More importantly, I am currently a marriage and family therapy (MFT) advanced graduate student at the California State University, Northridge. I have completed the Board of Behavioral Science (BBS) trainee requirements for face-to-face client hours at the Mitchell Family Counseling Clinic on the campus of California State University, Northridge. Most of the hours I have acquired have been spent with middle school children suffering from anxiety disorders or depression. I plan on completing my Master of Science in Marriage and Family Therapy in the College of Education program at California State University, Northridge in December of 2015.

**Environment and Equipment**

Each session will be one hour long. The meeting will be once a week for three months, for a total of 12 sessions. The environment in which the group meets should be conducive to their needs. One of the ways to make the environment conducive to the participants needs is by making the location easily accessible to the group. The school in which the child attends may be
a sufficient location for the parents (Jacobs, et al., 2012, p. 43-50). Being that the parents are participating in order to better their skills and knowledge of dealing with GAD, it would be helpful to bring a writing utensil and paper to take notes so they can implement them into their lives and for the homework assigned. The presenter should have a laptop computer and projector to show the videos. When a handout is needed for the group, the presenter should provide it for the group along with paper and writing utensils.

**Project Outline**

1. Meeting one- create a therapeutic alliance and develop a better understanding of generalized anxiety disorder.
4. Meeting four- introduce automatic thought record intervention
5. Meeting five- further psycho-education on GAD
6. Meeting six- facilitate an art therapy technique
7. Meeting seven- focus on gaining support from group members
8. Meeting eight- discuss Cognitive behavioral therapy (CBT) as a treatment for GAD
9. Meeting nine- discuss coping skills
10. Meeting ten- teach mindfulness meditation to be implemented with children
11. Meeting eleven- discuss future goals
12. Meeting twelve- discuss gains from the group and referrals
CHAPTER 4
CONCLUSION

Summary of Project

This project is a composition of a literature review that addresses generalized anxiety disorder (GAD) in Jewish Orthodox girls, ages 9-13. The purpose of the project is to propose a psycho-educational and support group for Jewish Orthodox parents that have female children between the ages of 9-13 that are suffering from GAD. One of the topics that is covered in the literature review is an in-depth explanation of GAD along with statistics. Following the definition of GAD is the effects of GAD on girls, ages 9-13. After the delineation of the effects GAD has on the children, a description of predictors of GAD has been provided in order for parents to be able to confirm that their children have GAD. Once the parents have verified their assumption that their children may be suffering from GAD an explanation of parental roles in helping their children is spelled out. The last two topics are the overall treatment for GAD and a portrayal of the culture, which is the Jewish Orthodox community. The ultimate goal is to create a warm therapeutic group that will help the parents better understand GAD and therefore ultimately help their children overcome this challenging disorder.

Recommendations

There are many aspects that can be further researched and addressed in regards to generalized anxiety disorder amongst children. In future studies it may be beneficial to do research on GAD in males. It may also be beneficial to examine different age groups since different causes and symptoms may be established.

The psycho-educational/ support group that has been developed aims to educate the parents of children who are suffering from generalized anxiety disorder. It may be advantageous
to create a group for the faculty of Jewish Orthodox day schools. Although the parents may inform the faculty about the needs of the children, the faculty may be able to better understand and facilitate success in the children suffering from GAD with the proper psycho-education.

**Conclusion**

Generalized anxiety disorder could be debilitating and stressful for the children suffering from GAD and their families. Implementing a group where parents could help their children overcome GAD would be extraordinary. Therapists who educate parents, faculty and anyone involved in the children’s lives, may help create a fulfilling life for the children who are suffering from GAD. By educating the parents about GAD, the effects it may have on their children, its signs, and treatments, parents will be better equipped to help their children overcome GAD.
References


APPENDIX A

Group Schedule

Meeting 1:

- 7:00- Facilitator introduces self & group
- 7:15- Getting to know the group- Ice breaker and discuss rules of the group
- 7:30- Show video about GAD in children. Basic education on GAD & Signs of GAD.  
  http://www.youtube.com/watch?v=4VbxjsO9IYI
- 7:45- Questions and Closing. Discuss what it was like for parents to watch it and  
  similarities they see in their child to determine if they think their child has GAD based on  
  their opinion. At the end of the meeting the facilitator will contribute SCAS, SCARED or  
  Monitoring and Blunting Scale for Children, assessments that will allow for the parents to  
  verify their child has GAD and therefore are a good fit for the group.

The goal of this meeting is to create a therapeutic alliance and for the group to feel a sense of  
comfort and belonging. Another goal is for the group to begin to understand what GAD is and if  
their child fits the criteria.

Meeting 2:

- 7:00- Check in, see how the past week was
- 7:15- Explain the developmental stage of girls ages 9-13. Facilitator will educate the  
  group on the prevalence of GAD in girls ages 9-13
- 7:30- Members share their understanding of their child’s stage of development
- 7:45- Give homework to have parents spend at least 10 minutes with the child asking  
  what changes they have been noticing physically, emotionally and psychologically. This  
  assignment should be simplified for the child by giving examples such as: are any body
parts changing that you want to discuss, are you starting to think about things you did not pay attention to such as boys, or physical looks, or are you having negative thoughts, etc.

Meeting 3:

- 7:00- Check in to see how the homework of speaking to child about development in different aspects was.
- 7:15- Members contribute their understanding of GAD
- 7:35- Read narrative of a child that has GAD. Give pamphlet about GAD
- 7:50- Questions and closing

This meeting will focus on psycho-education of GAD. There will also be a pamphlet that the parents could take home with them so they can bring tips home to remember.

Meeting 4:

- 7:00- Check in and find out how interacting with child was after better understanding GAD. Open to share observations, stories, etc.
- 7:20- Introduce assignment for child and parents to do automatic thought record. Give worksheet for child and parent to complete
  [http://media.psychology.tools/Worksheets/English/CBT_Thought_Record.pdf](http://media.psychology.tools/Worksheets/English/CBT_Thought_Record.pdf)
- 7:30- Utilize dyad role-playing to practice ways the parent could counter the negative thoughts the child may have.
- 7:50- Closing

Automatic thought record allows for the parents to challenge the negative thoughts the child is having by replacing them with positive thoughts. This allows for the child and parents to see the
positive traits in the child. The parents could help guide the child create an activity monitoring journal. This assignment will allow for the child to be aware of the times that anxiety enters in his or her life in order to possibly recognize what sets off the anxiety. This will also allow for the parents to understand antecedents that lead to anxiety in the child, which the parents and child could hopefully diminish.

Meeting 5:

- 7:00- Check in
- 7:15- Show video http://takingcare.knowledge.ca/tv_documentary.swf (Alana’s story). Discuss video
- 7:50- Closing

Showing a video about GAD allows for the parents to see other children struggle with GAD and see how the children overcame GAD in order to instill hope.

Meeting 6:

- 7:00- Check in
- 7:15- Activity: Have parents draw a picture of how their child looks with anxiety on one side of the paper and on the other side a picture of how the child will look without anxiety. Then have parents share if they are comfortable.
- 7:50- Closing

The activity of drawing how the child looks to the parents allows the parents to bring the understanding of their children out on paper, which gives them a new perspective on the child. Although the parents are adults, drawing can be therapeutic and can help them get their thoughts and feelings out.

Meeting 7:
• 7:00- Check in
• 7:15- Discussion of what it is like for the parents to have children with GAD. Discuss any positive changes or if things are staying the same.
• 7:50- Closing

This will be an emphasis on the support portion of the group. The parents could discuss their experiences of having a child with GAD. It will also allow for the parents to reflect on the child’s improvement, if there is any.

Meeting 8:
• 7:00- Check in
• 7:15- Begin to discuss cognitive behavioral therapy (CBT) theory and the importance the family plays
• 7:35- Dyads to discuss their feelings about implementing CBT into their lives
• 7:50- Closing

This portion of the group focuses on the psycho-educational aspect of treatment for GAD. The goals is to help the parents further understand the theory and their role in treatment, which can be empowering. Encouraging the group to discuss it in dyads may help them to feel comfortable being more open one-on-one and therefore creating a space for the concept to linger within their minds.

Meeting 9:
• 7:00- Check in
• 7:15- Discuss ways the parents cope with their own stresses and encourage the parents to share this with their child.
• 7:35- Have group brainstorm ways the child can cope with anxiety.
Having the parents discuss how they have coped allows them to put themselves in their child’s shoes to an extent. It allows for them to recognize ways they have coped which may be a helpful tool for their child. Having the group discuss coping strategies can help other parents by sharing ideas that can be useful to them.

Meeting 10:

- 7:00- Check in
- 7:15- Guided mindfulness meditation
  
  http://anxietyfreechild.com/mindfulness-guide/ - education on mindfulness
  
  http://www.youtube.com/watch?v=cDflNqo0TQs - guided mindfulness
  
  
  http://www.amsa.org/healingthehealer/musclerelaxation.cfm

Teach parents how to use mindfulness meditation and how they could use for their children and possibly creating their own recordings for their children.

- 7:50- Closing

Mindfulness meditation gently helps the child be more present and to be aware that there are no dangers present. It allows them to practice acceptance without judgment. It enhances their ability to focus and learn. This is a technique that the parents could use for themselves and use as a tool to help their child through anxiety.

Meeting 11:

- 7:00- Check in
- 7:15- Discuss what has worked and what has not worked for the child
- 7:30- Develop plan for continuing helping the child overcome anxiety
As the group will be coming to an end shortly, it is important that the parents have tools they can continue to utilize once the group has ended. Once the parents discuss their needs to further help their child, then they can express these needs to the group so it can be addressed in the last meeting. The group will provide tools for the parents at the last session so they can feel better equipped to help their child once the group has ended.

Meeting 12:

- 7:00- Check in
- 7:15- Discuss what everyone has gained from group
- 7:35- Discuss resources that the parents can access to help their children. Provide referrals -
groups for child with anxiety, individual therapy, websites, etc.

http://takingcare.knowledge.ca/

http://www.kidsmentalhealth.ca/parents/anxiety.php

http://www.forcesociety.com/

http://preventyourpanic.com/what-to-do-when-you-have-a-panic-attack#more-983

- 7:45- Closing, last thoughts

Discussing the gains from the group allows for the parents to have a recap so that they can use the tools they have gained in the past few months. Providing referrals is crucial so that the parents could find the appropriate resources to further help their child overcome GAD.
APPENDIX B

Pamphlet For Week Three: Anxiety Problems in Children and Adolescents

APPENDIX C

Week Four: Automatic Thought Record Assignment

http://media.psychology.tools/Worksheets/English/CBT_Thought_Record.pdf