Developing A Teacher Rating

Scale to Identify Shy and Anxious Children aged Five to Seven Years

by

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Excessive anxiety is a common health problem in children and adults (Kagan, 1988; Kessler, McMonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994). At one time, little information was available about the extent of the occurrence of these disorders in the community. In recent years, there has been an emphasis on epidemiological studies which has produced considerably more information about the prevalence of anxiety disorders (Kessler, et al. 1994; Offord, Boyle, Campbell, Goering, Lin, & Wong, 1996; Roberts, Attkisson, & Rosenblatt, 1998). For the most part, these studies have referred to adult populations.

Studies of the onset of anxiety disorders indicate that often they have an age of onset in childhood or adolescence (Wittchen, Nelson, Lachner, 1998; Wittchen, Kessler, Pfister, & Lieb, 2000). It is only in recent years that large community studies of the epidemiology of childhood disorders have become available (Shaffer, Fisher, Dulcan, Mina, Davies, Piancentini, Schwab-Stone, Lahey, Bourdon, Jensen, Bird, Canino, & Regier, 1996; Wittchen, et al. 1998).

According to the Diagnostic and Statistical Manual IV (1994) (DSM IV), anxiety is characterized by:

- excessive fear, worry or feelings of panic,
- anxiety provoking thoughts or obsessions, and
- a need to avoid fear provoking situations.

Again, according to the DSM IV, anxiety disorders may include, but are not limited to, the following:
• Social phobia (Social anxiety disorder),
• Simple phobias,
• Separation anxiety disorder,
• Overanxious disorder,
• Posttraumatic stress disorder,
• Panic disorder,
• Obsessive compulsive disorder,
• School phobia (School refusal),
• Avoidant disorder, and
• Generalized anxiety disorder.

According to Merrell, anxiety, shyness, behavioural inhibition and depression are internalizing problems. (Merrell, 2001). Further, Merrell states that the following are possible consequences of internalizing problems:

• Diminished self-esteem
• Academic problems
• Poor social relationships
• Chronic mental health problems
• Substance abuse
• Suicidal thoughts, attempts, completion

Difficulties with anxiety tend to start early in life and often persist into later life. (Barlow, 2002). Anxiety disorders early in life have been found to be risk factors for the development of unhealthy behaviours. For example, Patton, Carlin, Coffey, Hibbert,
& Bowes, 1998; Pine, Cohen, Gurley, Brook, & Ma, 1998; and Schatzberg, Samson, Rothschild, Bond, Regier, 1998 found that symptoms of anxiety were associated with a higher than normal risk for the initiation of smoking, due to an increased susceptibility to peer influences. Also, Nelson and Wittchen (1998) found an association between anxiety and depression in adolescents and the establishment of regular smoking. Anxiety disorders also have been related to limited educational and occupational attainment, and limited social support services. (Ialongo, Edelson, Werthamer-Larsson, Crockett, & Kellam, 1995; Lagreca and Lopez, 1998)

Recently, there have been exciting developments in the prevention of anxiety disorders focused on school programs for children 8 years of age and older (Kagan, 1998; Nelson & Wittchen, 1998; Patton et al, 1998; Pine et al, 1998; Regier et al, 1998; Schatzberg et al, 1998). So far, the research into childhood anxiety disorders has been focused primarily on children aged 8 and over. Children under this age have been subjects of much research. The move into the school system is a major transition point in the life of a young child and his or her family. Since Kindergarten and grade One are part of a universal system, this age is ideal for health-related screening programs.

Individuals with considerable risk for developing anxiety problems can be identified during the first years of life (Kagan, 1998). The finding that behavioural inhibition (a characteristic seen from the first years of life) is a strong predictor of later anxiety disorders suggests that there would be advantages to interventions staged very early in the child’s school experience.
Statement of the Problem

A team of researchers from the Anxiety Disorders Clinic at St. Boniface General Hospital has been focusing on anxiety problems in Kindergarten age children. Their research has discovered that, at the moment, there is no method for the early identification of children with anxiety and shyness. To date, there have been no instruments devised for use for this age group. The purpose of this research is to devise an instrument (a rating scale) to be used by Kindergarten and Grade One teachers to assess anxiety and shyness in Kindergarten and grade one children.

Review of Related Literature

In an extensive review of the literature, the research group was not able to identify a scale for use by teachers in rating anxiety among school aged children. It would be helpful to have such an instrument for 2 reasons. First, a teacher rating scale would be helpful in identifying children who are experiencing difficulty with shyness or fearfulness. Teachers have a unique and valuable perspective because of their extensive contact with the child and their ability to compare the functioning of one child to other children at a similar age level. Second, a teacher rating scale would be helpful in evaluating the effectiveness of school-based programs aimed at reducing problems with anxiety. Rating scales should be the beginning component of an assessment, comparable to interview data, not the last word. (Martens, 1992).

Teacher rating scales have been in use for a number of years in a number of other areas related to mental health. They have been widely used in evaluating behaviour problems in the classroom, and attention deficit and hyperactivity problems. Their efficacy is well established and consequently their use is widespread. Some instruments
do include a number of questions that comprise an anxiety scale as part of a rating system for a broad range of behaviours. Two of the most common rating scales in use that are well known and widely used instruments are The Conners’ Rating Scales (CRS) and the Child Behaviour Checklist (CBCL). The Conners’ Rating Scales are “…among the most widely used assessment instruments for childhood problem behaviors in the world.”

Goyette, C.H., Conners, C.K., & Ulrich, R.F. (1978). The Child Behavior Checklist is a widely used instrument designed to obtain parents’ ratings of their children’s problems and competencies. Each of these rating systems has a rating scale version designed specifically for use by teachers.

There are hundreds of studies, critiqués, evaluations, and reports about these two instruments. The CBCL checklists and syndromes as well as the CRS have become a standard against which many other clinical decision-making tools are compared. (Doll, 1998). Some of the areas to which comparisons are made by other instruments to the CBCL and the CRS are ease of administration (including scoring and interpretation), validity, reliability, and economy of design.

Unfortunately, these instruments, although widely used, have a small number of items focussed on anxiety and do not provide sufficient information for research applications. Although these instruments are widely used and accepted, they put less emphasis on anxiety that would be required for treatment and intervention.

**Statement of the Goal**

Research appears to indicate that using a teacher administered rating scale can be an efficacious method of obtaining information about shy/anxious and nervous children. A rating scale has advantages over the use of other forms of assessment. Rating scales
cover a longer observation period than most other assessment instruments. The information obtained by rating scales is provided under a more naturalistic condition than most other assessments. Rating scales are often more objective than some other instruments. Rating scales also have the advantage of being less time consuming than the present method of identifying an anxious child. There is no special training required of the teacher, as the instructions will be self-explanatory. Also, the teacher rating scale has another advantage in that it does not unnecessarily alert the child or parents to the concerns of the educators. (Wilson, & Bullock, 1989).

It is helpful in assessing a problem to have several perspectives. In assessing young people, there is often an attempt to obtain perspectives from the child, the parent, and the teacher. Teachers have an advantage in that they meet with many students over the years and have a very useful perspective of being able to compare one child to many other children seen in a school context over the years. Also, there are some behaviours that are more commonly seen in the school than in the home. One such example is seeing how a child interacts with other children in large groups. Other behaviours are more frequently seen in the home.

Rating scales are commonly developed through questions being generated by people interested in a particular area of behaviour. Questions are generated to help in describing what the behaviour is like. The research team at St. Boniface General Hospital suggested a list of items. The team then reviewed these. After this step, it was decided that information would be gathered from teachers. The information would be twofold. First, teachers were asked about what they considered to be typical of fearfulness or shyness in this age range in the classroom. Then the teachers were asked to rate how
typical the items that we generated were, of these behaviours. Once the information has been gathered from the teachers, it will which of the original items should be retained (the teachers will have judged them to be characteristic of anxiety in this age range). Further, the information gathered will be analyzed to see whether some additional items should be added or removed based on the suggestions of the teachers surveyed. These questions will then be sorted so as to obtain a more accurate list of questions. The Number of questions will likely be reduced to make the eventual questionnaire more readily usable. People in the area that the questionnaire is designed for will then use the resulting form.

Method

Subjects

The subjects for this study were selected from a list of schools that have Kindergarten and Grade One teachers. The sample was selected because of the teachers’ experience in interacting with children at this age and early grade school level. Approximately 16 schools have been identified at this time, which have indicated a desire to be part of the research. This means that 25 to 35 teachers will be interviewed.

The method being used for this study, is essentially the same as that described in the previous paragraph. The principal investigator generated questions about the characteristics that a teacher may see in a shy and anxious child. These questions were then presented to the research group, the Anxiety Disorders Program, at St. Boniface General Hospital. This group added some questions and deleted others. Kindergarten and Grade one teachers were recruited and interviewed. A draft version of the rating scale was presented to the teachers to be field-tested. The results of this field test will be
analyzed once all teachers have been surveyed. The results will then be used to construct a final version of the rating scale, which these same teachers will then be asked to administer. The teachers are considered to be the experts here as they asked for their opinions about the test items and the procedure of administering the scale.

**Instrument**

A structured interview consisting of 6 questions and a draft rating scale consisting of about 50 items form the survey for this study.

**Procedure**

Near the end of the school year, schools were selected that had Kindergarten and Grade One teachers. The principals were sent a letter describing the purpose of the study and requesting their assistance in locating teachers on staff who may be interested in participating in the study. The principals were called within few weeks of receiving the letter and any interested teachers were identified. These teachers received/will receive a letter describing the purpose of the study and the way in which they will participating. Some of the teachers were contacted, others will be contacted and interview times established. The teachers will be asked to sign a letter of consent This letter is explained to them before it is signed and witnessed. Out of this whole process will come a final version of the Teacher Rating Scale for Identifying Shy and Anxious Children aged Five to Seven Years.

**Conclusion**

This will be the first part of the study. The goal of this study is to obtain information that will allow a Teacher Rating Scale to be devised that will be valid, reliable, easy to
administer and interpret, and that will be of use to Kindergarten and Grade One teachers in helping to identify these children.
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