

Evaluating the Effectiveness of Parents' Emotion Regulation Method on Anxiety and Depression Symptoms of Children

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ABSTRACT — The aim of this study was to investigate the effectiveness of parents' emotion regulation method on alleviating anxiety and depression symptoms of children. Method: 24 mothers (12 in the experiment group and 12 in the control group) of children who suffered from anxiety and depression were selected using convenience sampling method. CSI-4 questionnaire was used as the research instrument in pretest and posttest. Parents' emotion regulation method was implemented in 8 sessions for mothers in the experiment group. MANCOVA test was used for comparing the mean scores differences of two groups in pretest and posttest. Results: The results of MANCOVA showed a significant difference in anxiety and depression symptoms of children in two groups so that children in the experiment group showed statistically significant decline in terms of anxiety and depression symptoms compared to that of control group. Discussion: According to the results of this study, parents' emotion regulation is an effective method for reducing the anxiety and depression symptoms of children.

KEY WORDS: Emotion regulation, Anxiety, Depression

Introduction

Anxiety and depression disorders are the most important types of internalizing disorders in childhood and adolescence. A review of epidemiologic studies suggests that anxiety and depression disorders with a prevalence rate of 5 to 17 percent are one of the most common psychiatric disorders of childhood (Costello & Angold, 1995; Costello, Mostillo, Erkanli and Keller, 2003, Treffers & Silverman, 2001) often experienced by school-aged children (Bell-Dolan and Wessler, 1994; Costello et al., 2003; Spinhoven et al., 2010). Long-term stability of the symptoms of these disorders makes children susceptible to a host of dysfunctions such as poor academic performance, low self-esteem, and drug dependence (Gregory et al., 2005; Treffers et al., 2011). Since anxiety and depression disorders have high comorbidity with other psychiatric disorders in children, they have not been adequately addressed by clinicians (Monga et al., 2000). However, upon the diagnosis of these disorders, girls tend to receive greater attention than boys do and they often respond differently to treatment (Ghamkharfard, Amrolahinia and Azadfalsh, 2012). A review of the literature suggests that several factors are involved in the etiology of childhood anxiety and depression disorders (Franc, Middeldorp, Dolan, Ligthart & Boomsma, 2010). On one hand, significant attention has been paid to the role of genetic factors in the development of this disorder (Eley et al., 2003; Rice, Harold & Tapar, 2002). On the other hand, the results of other studies highlight the role of environmental factors including parental styles in generating and stabilizing the symptoms of such disorders in children (Treffers and Silverman, 2011; Spinhoven et al., 2010). In this context, the crucial role of emotion regulation as one of psychological constructs in creating and maintaining anxiety and depression disorders during childhood has been stressed, as it plays an important role in adapting people to stressful life events (Eisenberg, Fabes, Guthrie, & Reiser, 2000; Gross and Thompson, 2007). According to above definitions, "emotional regulation" is a set of automated and controlled processes intended to prevent, protect and manage the occurrence, severity and duration of experienced emotional states (Webb, Miles & Sheeran, 2012). In other words, emotional regulation is used to mean the awareness, understanding and acceptance of emotions, the ability to control impulsive behaviors and behave according to the desired objectives in face of emotional states and the ability to adopt flexible measures tailored to the situation in order to adjust the desired emotional response aimed at achieving personal agenda and providing appropriate response to environmental demands (Geratz & Roter, 2004). The literature suggests that adaptive emotion regulation is associated with self-esteem and positive social interaction, with enhanced positive emotional experiences leading to the effective management of stressful situations (Gross, 2001; 2002; 2003), increasing the chance of appropriate response to social situations (Alilou, Ghasempour, Azimi, Akbari and Fahim, 2012). Emotion regulation strategies such as reappraisal, rumination, self-report, avoidance and inhibition may be adaptive or maladaptive (Aldao, Nolen-Hoeksema, Schweizer, 2010). Maladaptive emotional strategies have a key role in shaping or persistence of psychological disorders. According to the Gross and Levenson (1977, quoted in Besharat, et al., 2013), more than 50% of Axis I disorder and 100% of Axis II disorders are related to emotion regulation defects. Despite the importance of

emotion regulation in etiology and persistence of symptoms of depression and anxiety, a review of the literature indicates that the impact of various forms of emotional regulation in etiology of psychological disorders has not been adequately addressed (Gross and Thompson, 2007). However, the strategic role of emotion regulation has been the subject of growing attention in psychopathology models over the past years (Aldo et al., 2010; Mennin & Farach, 2007; Berenbaum, Raghavan, Le, Vernon & Gomez, 2003; Greenberg, 2002). In this context, and based on what is called "distress disorders" (Watson, 2005), the symptoms of depression and anxiety disorders are increasingly treated as the outcomes of dysfunctions appeared in the process of emotion regulation (Gross and Munoz, 1995; Campbell-Sills & Barlow, 2007; Mennin, Holoway, Fresco, & Heimberg, 2007, Aldo et al., 2010). There are several pathological theories according to which people who are unable to efficiently manage their emotional responses in everyday life experiences in the face of long-term and intense stress and psychological distress tend to display diagnostic symptoms of depression or anxiety disorders (For example Mennin et al., 2007; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). As mentioned earlier, a perception of emotion regulation strategies is integral to understanding emotional and behavioral correlates of anxiety and depression as well as negative emotional events (Vahedi, Hashemi and Einipour, 2013). Given the prevalence of anxiety and depression disorders in children and adolescents, as well as the effect of these symptoms on the overall performance of these groups including personal, family, academic and social functions, some studies have emphasized the role of emotion regulation dysfunction as one of the underlying causes of this disorder. As such, it appears that failure to apply and modify emotion regulation skills is a predictor of psychological malfunctions in the future, making children and adolescents vulnerable to psychological disorders such as anxiety and depression. In addition, there are assumptions that unsuccessful performance in social interactions, a feeling of shame, violence, impulsiveness and the like are the outcome of inadequate regulation of emotional responses (Gross, 2007). Furthermore, recent studies introduce emotion regulation as one of the variables that the parents of children with anxiety and depression have to contend with (Treffers & Silverman, 2011). Accordingly, to reduce these symptoms in children, special attention has to be paid to the management and regulation of emotion in parents of these children as emotion regulation is fostered in a fertile ground. In this regard, in some treatment approaches, emotion regulation training is one of the interventions used to deal with emotional problems. An example of such interventions is Linehan dialectical behavior therapy, which stresses learning, acceptance and accreditation of emotions (Linehan, 2014). Given the role of emotion regulation deficiency in generating and developing emotional troubles, it seems that training and application of emotion regulation skills can be one of treatment strategies for alleviating the symptoms of anxiety and depression in children and adolescents. Accordingly, the aim of this study is to investigate the effectiveness of emotion regulation training package of parent in reducing anxiety and depression in children.

Method

This is a quasi-experimental study with a pretest-posttest design and control group. The study population consisted of all female students in District 14 of Tehran out of which 24 subjects (12 in experiment and 12 in control groups) who suffered from anxiety and depression were selected via convenient sampling method. The inclusion criteria were: (a) subjects' consent to participate in research; b) a minimum requirement for high school degree; c) no history of a psychiatric disorder other than depression and anxiety for the sampled children; d) no precedent of psychiatric diseases or the use of drugs by parents of children in the sample population. At first, CSI- 4 questionnaire was distributed among the students out of whom 60 subjects with the highest scores were selected. Then, based on the above inclusion criteria and the clinical diagnosis of a psychologist, 24 subjects (12 in the experiment and 12 in the control groups) were selected. In the next step, the emotion regulation training package was implemented for them others of children in the experiment group over eight sessions. Finally, CSI- 4 questionnaire was administered again to examine symptoms of anxiety and depression of children in both groups.

Research instruments

Children symptoms inventory (CSI- 4): This is one of the most common instruments for diagnosis of psychiatric disorders, which is based on the Diagnostic and Statistical Manual of Mental Disorders. The early version of the questionnaire known as Sprafkin, Loney, Unita & Gadow (SLUG) inventory was designed by Sprafkin et al in 1984 in accordance with the third edition of the Diagnostic and Statistical Manual of Mental Disorders. Later, based on the revisions made to the third edition of Diagnostic and Statistical Manual of Mental Disorders in 1987, CSI-3-R version was drafted. In 1994, based on the fourth edition of Diagnostic and Statistical Manual of Mental Disorders, which was published with minor changes by Gadow and Sprafkin, CSI4 was finally prepared. The last revision of CSI consists of two parent and teacher checklists. In the present study, the parent checklist has been used. It consists of 112 items with 41 statements (groups A, B and C) about disruptive behavior and attention deficit disorders with each statement graded on a 4-point scale (never, sometimes, often, most times). For better understanding of parents, some symbolic signs (large and small circles) were also attached to the scale. The characteristics of the group along with the subsets of the disorder are as follow: Group A: hyperactivity/ attention deficit disorder; Group B: oppositional defiant disorder; Group C: conduct disorder; Group D: anxiety disorder; Group E: anxiety disorder and motor tic; Group F: dysthymic disorder; Group G: affective disorder, Group H: pervasive developmental disorder; Group I: anxiety disorder, Group J: separation anxiety disorders and Group K: rejection disorder. There are two scoring methods for this inventory: cutoff score screen and severity of symptoms. Given its greater efficiency and reliability, the former method is commonly used in most studies where the scoring is based on the total count of statements marked as "sometimes and often" (Najafi, Fouladchang, Alizadeh and Mohammadifar, 2009). The validity and reliability of this questionnaire have been confirmed in several studies. In the study of Grayson & Karleson (1991, quoted by Najafi et al., 2009) on CSI- 3- R, the sensitivity of this inventory for oppositional defiant, conduct disorder and attention-deficit hyperactivity disorders were respectively, 0.93, 0.930.77. Other

studies have reported a correlation of 0.66, 0.58 and 0.72 for these three disorders (Gadow and Sprafkin, 1994, quoted by Najafi et al., 2009). Kalantari et al (2001) measured a validity of 0.91 and 0.85 for parent and teacher checklists respectively using bisection method. In the study of Mohammad (2001), the content validity of the questionnaire was approved by nine psychiatrists. According to Tavakolizadeh et al (1997), a reliability of 0.90 was obtained for the parent checklist. Najafi et al (2009) obtained a reliability of 0.92 using Cronbach's alpha coefficient.

Results

Table (1) Mean and standard deviation of scores for the two groups in the pretest and posttest.

Table 1: Mean, standard deviation, minimum and maximum anxiety scores for the two groups in pretest and posttest

Variable	Group	Stage	Mean	SD	Max score	Min score
Anxiety	Experiment group	Pretest	15.92	4.48	0	26
		Posttest	13.91	3.83	0	23
	Control group	Pretest	15.84	4.23	0	25
		Posttest	15.76	4.39	0	25
Depression	Experiment group	Pretest	20.06	5.89	0	34
		Posttest	16.79	4.53	0	32
	Control group	Pretest	20.06	5.06	0	33
		Posttest	19.61	5.66	0	33

To test the hypotheses as well as the significance of difference between the control and experiment groups, multivariate analysis of covariance (MANCOVA) was used. For this purpose, initially two assumptions of covariance analysis including homogeneity of variances and homogeneity of regression were evaluated. In this regard, Levine's test was used to examine the homogeneity of variance, with the results suggesting the homogeneity of variances in Table 2.

Table 2: The results of Levine's test for homogeneity of variances between the dependent variables in the experiment and control groups

Variable	F	df 1	df 2	Significant level
Anxiety	4.34	1	22	0.67
Depression	5.48	1	22	0.39

As the results of Table 2 suggest, the homogeneity of variances for anxiety (p = 0.67 and F =4.43) and depression (p = 0.39 and F =5.48) is not significant. Therefore, the experiment and control groups were not significantly different in terms of depression and anxiety variance, thus confirming the assumption regarding the homogeneity of variances. Table 3 shows the results of homogeneity of regression slopes in the study variables.

Table 3: Results of the homogeneity of regression slopes in the study variables

Variable	F (pretest*group)	Significance level
Anxiety	2.211	0.58
Depression	3.018	0.47

According to Table (3), since F-value for group interaction with the pretest is not significant in the study variables, the slopes of the regression will be homogeneous for these variables. As a result, the assumption of the homogeneity of regression slopes has been kept.

Table 4 shows the results of multivariate analysis of covariance to compare the differences of the two groups in terms of posttest scores.

Table 4: Results of the analysis of covariance on mean scores of anxiety and depression posttest by controlling the pretest

Index	Effect size	P level	df of assumptions	F ratio	Value	Test power
Pillai's trace	0.89	P<0.001	2	9.36	1.016	0.95
Wilk's lambda trace	0.89	P<0.001	2	9.36	0.092	0.95
Hotelling's trace	0.89	P<0.001	2	9.36	9.93	0.95
Roy's largest roots	0.89	P<0.001	2	9.36	6.93	0.95

As shown in Table (4), there is a significant difference between experiment and control groups in terms of the dependent variables post-test with controlled pre-test at the level of P <0/001. Therefore, the main hypotheses of the study are confirmed. Accordingly, it can be concluded that two groups are significantly different in the posttest at least with regard to one of the

dependent variables (anxiety and depression). To demonstrate this difference, two single-trait covariance analyses were performed in MANCOVA, the results of which are presented in Tables (5) and (6).

Table 5: Results of ANCOVA analysis on the average scores of anxiety posttest

Variable	Source of variation	Sum of squares	df	Mean squares	F	Significance level	Effect size	Test power
Anxiety	Pretest	1.996	1	1.996	0.629	0.76	0.0006	0.082
	Group	29.541	1	29.541	8.722	0.0001	0.86	0.96
	Error	105.84	20	52.92				

As shown in Table (5), the experiment and control groups differ significantly with respect to the posttest of anxiety variable by controlling the pretest at the level of $P < 0/001$. Therefore, the first research hypothesis is confirmed. As suggested by the coefficient of effect size, 86% of the difference between two groups is due to the experimental intervention.

Table 6: Results of the ANCOVA analysis in MANCOVA context on the mean scores of depression posttest

Variable	Source of variation	Sum of squares	df	Mean squares	F	Significance level	Effect size	Test power
Depression	Pretest	2.638	1	2.638	0.429	0.72	0.009	0.05
	Group	33.75	1	33.75	12.39	0.0002	0.90	0.98
	Error	410.93	20	15.80				

Table (6) shows that the experiment and control groups differ significantly with respect to the posttest of depression variable by controlling the pretest at the level of $P < 0/001$. Therefore, the second research hypothesis is confirmed. The effect size coefficient demonstrates that 90% of the difference between two groups can be attributed to the experimental intervention.

Discussion

The present study was an attempt to evaluate the effectiveness of parent's emotion regulation training on reducing the symptoms of anxiety and depression in children. The results suggest that strategies of parent's emotion regulation training exert a significant effect on alleviating anxiety and depression symptoms of children. These findings are consistent with earlier studies on the role of emotion regulation strategies in reducing symptoms of depression and anxiety (for example, Lynch, Morse, Mendel & Robbins, 2003; Graz and Anderson, 2007; Granefoski, Rieffe, Jellesma, Terwogt & Kraaij, 2007; Yousefi, 2006; Salehi, Baghban, Bahram and Ahmadi, 2012). In keeping with pathological theories and what is referred to as "distress disorders (Watson, 2005), the symptoms of depression and anxiety disorders are primarily regarded as the consequences of dysfunction in the process of emotion regulation (Gross and Munoz, 1995; Campbell-Sales and Barlow, 2007; Menin, Fresco, Moor and Heimberg, 2007, Aldo et al., 2010). There are a variety of pathological theories contending that people who are unable to efficiently manage their emotional responses in everyday experiences tend to suffer from intense and long-term exposure to stress and psychological distress as well as diagnostic symptoms of depression or anxiety symptoms (For example Menin al., 2007; Nolen-Hoeksema, Wiscoand Lyubomirsky, 2008). The findings of this study confirm the effective role of emotion regulation training offered to the parents' of children with anxiety and depression in alleviating the symptoms of these disorders. It also posits that given the effect of emotion regulation methods on awareness, control and adjustment of negative emotions engendered by interpersonal relationships as well as the importance of practical exercises, workshops and group meetings that enhance effective interpersonal communication, this strategy was effective in reducing symptoms of anxiety and depression of children in the experiment group. In addition to the manipulation of risk factors, considering the importance of constant exposure to the frightening situations in the treatment of many of anxiety disorders, the mothers required to receive necessary trainings in this regard. For mothers to be able to control the negative emotions of their children, they should learn that anxiety is not always traumatic for children. Progressive confrontation coupled with skills to cope with frightening situations as well as adopting the role of a trainer in treatment of children allowed mothers to progress dramatically after one or two successes of their children in managing stressful situations. The parents encourage the adaption of their children to the situation, which may invoke a sense of security derived from attachment and positive interactions in children. In general, parents' education can be treated as a proper treatment for children, as it equips parents with necessary conduct management skills and enhances the mutual relationships between parents and children. A case in point is emotion regulation training, which seems to provide the best treatment for children of this age group, though it requires further study. The theoretical and practical implications of the present study can be summarized as follows:

At the theoretical level, the findings of this study confirm the assumptions of emotion regulation theory about the role of emotion and its interactions with the cognitive system in psychopathology. One of the theoretical implications of this study is providing new ideas and presuppositions about the determinants of mood and anxiety disorders. Such determinants (emotion regulation construct and its pertinent issues) not only enrich theoretical models of psychopathology, but also strengthen the relationship between two types of theories, i.e. Emotion and emotion regulation theories and psychotherapy and psychopathology. At the practical level, this study presents a valuable empirical foundation for formulating an educational and health programs within the framework of emotion management and regulations for children and adolescents with depression and anxiety disorders. It also provides a therapeutic approach, which given its statistical significance in reducing the aforementioned symptoms, can ensure its clinical effectiveness in treating and managing mood and anxiety disorders in children and adolescents suffering from these

disorders. Although it is a preliminary study on the clinical effectiveness of a training package based on emotion regulation in reducing the symptoms of depression and anxiety in adolescents, the findings suggests that further studies are needed in this area. Accordingly, some limitations of this paper can create new venues of research for future studies. The small population of this study hampers the generalizability of the findings, interpretations and etiological attributions of the study variables. Since the participants of this study were selected voluntarily through convenient sampling method, one should be cautious in generalizing the findings to other populations. Other limitations of this study include the possible effects of different socio-economic status, education and family status of participants that might have influenced the results. To obtain accurate results, further studies can control the population by focusing on groups with homogeneous demographic factors. Another major limitation of this study was that samples were not selected from a clinical population but rather from a population that just qualified some symptoms of anxiety and depression. In this regard, we suggest that future research focus on subjects with diagnosed clinical depression and anxiety and subject them to psychotherapy based on training package of emotion regulation. In addition, the repetition of similar research can test the accuracy of the findings of the study, broadening its impact size in theorization and conceptualization within the framework of psychopathology and psychotherapy.

References

1. Aldo, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review*, 30, 217-237.
2. Alilpour, M; Ghasempour, A. Azimi, Z., Akbari, A. & Fahimi, S. (2012). The role of emotion regulation strategies in anticipation of borderline personality traits. *Thought and Behavior*, 24, 63-47.
3. Bell-Dolan, D. J. & Wessler, A. E. (1994). Attributional style of anxious children: Extensions from cognitive theory and research on adult anxiety. *Journal of Anxiety Disorders*, 8, 79-96.
4. Berenbaum, H., Raghavan, C., Le, H. N., Vernon, L. L., & Gomez, J. J. (2003). A taxonomy of emotional disturbances. *Clinical Psychology: Science and Practice*, 10, 206-226.
5. Besharat, M.A, Ofoghi, Z., Aghaei Sabet, S. Habibnezhad, M; Pournaghдали, A; Geranmayepour, R.(2013). The moderating role of cognitive emotion regulation strategies in connection with emotional repression and interpersonal problems. *New Cognitive Sciences*, 15, 45-31.
6. Campbell-Sills, L., & Barlow, D. H. (2007). Incorporating emotion regulation into conceptualizations and treatments of anxiety and mood disorders. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 542-559). New York: Guilford Press.
7. Costello, E. J., Angold, A. (1995). A test-retest reliability study of child-reported psychiatric symptoms and diagnoses using the child and adolescent psychiatric assessment. *Psychol Med*, 25, 755-762.
8. Costello, E. J., Mustillo, S., Erkanly, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *ARCH GEN PSYCHIATRY*, 60, 837-844.
9. Eisenberg, N., Fabes, R. A., Guthrie, I. K., & Reiser, M. (2000). Dispositional emotionality and regulation: Their role in predicting quality of social functioning. *Journal of Personality and Social Psychology*, 78, 136-157.
10. Eley, T. C., Bolton, D., Connor, T. G., Plomin, S. (2003). Twin study of anxiety-related behaviors in pre-school children. *J child psychol psychiat*, 44, 945-960.
11. Franic, S., Middeldrop, C. M., Dolan, C., Ligthart, L., & Boomsma, D. (2010). Childhood and Adolescent Anxiety and Depression: Beyond Heritability. *JOURNAL OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY*, 49, 820-829.
12. Ghamkharfard, Z; Amrolahinia, M., & Azadfar, P. (2012). Evaluating the predictors of anxiety in childhood based on maladaptive schemas of children and maternal parenting styles. *Behavioral Sciences*, 6, 262-253.
13. Granejski, N., Van denkommer, T., Kraaij, Y., Teerds, J., Legerstee, J., & Onstein, E. (2007). The relationship between cognitive emotion regulation strategies and emotional problems, comparison between a clinical and non-clinical sample. *European Journal of personality*, 16, 403-430.
14. Gratz, K.L. & Roemer, L. (2006). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation. *Journal of Personality and Social Psychology*, 98, 176-189.
15. Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, D.C.: APA.
16. Gregory, A. M., Caspi, A., Eley, T., Moffitt, T. E., Connor, T. G., et al. (2005). Prospective Longitudinal Associations between Persistent Sleep Problems in Childhood and Anxiety and Depression Disorders in Adulthood. *Journal of Abnormal Child Psychology*, 33, 157-163.
17. Gross, J. J. (2001). Emotion regulation in adulthood: timing is everything. *Curr Dir Psychol Sci*, 10: 214-219.
18. Gross, J. J., & John, O. P. (2003). Individual difference in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 85: 348- 362.
19. Gross, J. J., & Munoz, R. F. (1995). Emotion regulation and mental health. *Clinical Psychology: Science and Practice*, 2, 151-164.
20. Gross, J.J. (2002). Emotion regulation. In: L. Feldman- Barrett & P. Salovey (Eds.), *The wisdom in feeling*. New York: The Guilford Press, 297-318.
21. Gross, J.J., Thompson, R.A. (2007). Emotion regulation: conceptual foundations, In J.J. Gross (Ed), *Handbook of emotion regulation* (pp.3-24). New York: Guilford press.
22. Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press; 1993.
23. Lynch, T. R., Morse, J. Q., Mendel, T., & Robins, C. J. (2003). Dialectical behavior therapy for depressed older adults: A randomized pilot study. *Am J Geriatric Psychiatry*, 11: 33-45.
24. Mennin, D. S., & Farach, F. J. (2007). Emotion and evolving treatments for adult psychopathology. *Clinical Psychology: Science and Practice*, 14, 329-352.
25. Mennin, D. S., Holoway, R. M., Fresco, D. M., Moore, M. T., & Heimberg, R. G. (2007). Delineating components of emotion and its dysregulation in anxiety and mood psychopathology. *Behavior Therapy*, 38, 284-302.
26. Mohammad Ismael, E. (2001). Evaluating the reliability, validity and cutoff points in Children Symptom Inventory (CSI- 4). Tehran: Center for Exceptional Children.
27. Monga, S., Birmaher, B., Chiappetta, L., Brent, D., Kaufman., et al. (2000). Screen for child anxiety related emotional disorders: convergent and divergent validity. *Depress Anxiety*, 12, 85-91.

28. Najafi, M.; Fouladchang, M, Alizadeh, H. & Mohammadifar, M.A. (2009). The prevalence of attention-deficit disorder and hyperactivity, conduct disorder and oppositional defiant disorder in primary school children. *Research on Exceptional Children*, 9, 254-139.
29. Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking rumination. *Perspectives on Psychological Science*, 3, 400-424.
30. Rice, F., Harold, G. T., Thapar, A. (2002). Negative life events as an account of age-related differences in the genetic a etiology of depression in childhood and adolescence. *J child Psychol Psychiat*, 44, 977-987.
31. Salehi, A., Baghban, I., Bahrami, F, & Ahmadi, S.A. (2012). Effect of Emotion Regulation Training based on Gross's process model and dialectical behavior therapy on the symptoms of emotional problems. *University of Medical Sciences*, 14, 57-49.
32. Spinhoven, P, Bernet, M. E., Jacqueline, G. F. M., Roelofs, K., Zitman, F., et al. (2010). The specificity of childhood adversities and negative life events across the life span to anxiety and depressive disorders. *Journal of Affective Disorders*, 43, 62-78.
33. Vahedi, S., Hashemi, T., & Einipour, J. (2013). Investigating the relationship between cognitive emotion regulation and obsessive beliefs in high school female students in the city of Rasht. *New Discoveries in Cognitive Sciences*, 15, 84-71.
34. Watson, D. (2005). Rethinking the mood and anxiety disorders: A quantitative hierarchical model for DSM-V. *Journal of Abnormal Psychology*, 114, 522-536.
35. Webb, T., Miles, E., & Sheeran, P. (2012). Dealing With Feeling: A Meta-Analysis of the Effectiveness of Strategies Derived From the Process Model of Emotion Regulation. *Psychological Bulletin*, 138, 775-808.