Parents' Perception of Students Mental Health and Resiliency: Effects of COVID-19 Distancing Stipulations Among High School Students

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Jamie Brenae Snow

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Correspondence concerning this thesis should be addressed to Jamie Snow,

JamieSnow3@purdueglobal.edu.

Abstract

Symptoms of depression and anxiety often begin to develop during adolescence due to the developmental stage of identity versus role confusion. Sustaining meaningful relationships among peers is vital in this stage. In March 2020, the World Health Organization declared COVID-19 an emergency, causing schools nationwide to shut down. Social distancing forced adolescents away from their peers, which led to various studies on the implications of isolation amongst children. Researchers are discovering a significant correlation between social distancing and depression in adolescents. The current study (*N*=52) examined participants that were parents of a high school student. The intent was to gain knowledge on parental perspectives on how their child has dealt with social distancing and if they believed their student would benefit from resilience training in the school curriculum. Respondents answered questions from SCARED, UCLA Loneliness Scale, and the CES-D, NIMH measurements with a follow-up question about their child's school curriculum. Depression and anxiety were positively correlated with social distancing on all respondents' surveys.

Keywords: adolescence, COVID-19, depression, isolation, anxiety.

Table of Contents

Parents' Perception of Students' Mental Health and Resiliency: Effects of COVID-19

Distancing Stipulations Among High School Students'

According to psychosocial theory, adolescence is a critical time for youth to strive for identity, typically through peer relationships (Rageliené, 2016). Former research has established adolescence as a time when mental well-being decreases and symptoms of depression and anxiety begin to manifest (Kapetanovic & Boson, 2020). The Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-5) identifies depression as a period of sadness where one may feel empty or irritable, usually associated with changes in cognitive function (American Psychological Association, 2013). Some depressive disorders lead to anxiety or suicidal ideation, such as Major Depressive Disorder (MDD), and often originate in adolescence. There is a lower tendency for adolescents to experience negative feelings, such as depression and anxiety when maintaining meaningful relationships among peers (Rageliené, 2016). Negative emotions are typically associated with loneliness and isolation.

In March 2020, the World Health Organization (WHO) declared an emergency due to an unfamiliar disease that causes infirmity and occasional death, known as COVID-19 (Laing et al., 2020). Isolation and social distancing are specifications during COVID-19 to help control the virus (Centers for Disease Control and Prevention, 2019). However, isolation is often a contributing factor among adolescents' psychological disturbances, such as depression and anxiety (Lin et al., 2018). Predictors of mental well-being in adolescents may rely heavily on parent and adolescent correspondence (De Looze et al., 2020). The more extended adolescents are isolated, the more distant they become from society (Fegert et al., 2020). The scarcity of adolescent disclosure to parents is a probable antecedent in mental health concerns. Findings by Lee et al. (2017) show adolescents have less knowledge of psychological resilience than adults.

The researchers define resilience as one's ability to respond to extrinsic variables healthily despite severe threats in the individual's maturation and adjustment. The inability to be resilient provokes isolation during mandated distancing stipulations, such as COVID-19 directives. Isolation correlates with negative feelings leading to loneliness and low psychological contentment (Rageliené, 2016).

In March 2020, nearly 6M students across America began distance learning as COVID-19 progressed through the country (Freedberg, 2020). As of March 2020, school dances, sporting events, and graduation ceremonies have been temporarily suspended. Social distancing policies mean students spend more time at home with immediate family members and less time socializing with friends (Fegert et al., 2020). Consequently, this also allowed more time for technology devices and less time being social and active. Depression, loneliness, and stress correspond with increased technology time (Ellis et al., 2020). Fegert et al. (2020) suspect a surge in adolescent mental health issues and increased suicidal behavior due to new normalcy following COVID-19.

Greek philosopher, Aristotle, believed that humans are naturally sociable creatures (Melchior, 2020). Melchior thought isolation is typically a sign of developmental complications. However, these complications can sometimes be misrepresented when social isolation is mandated to help contain the spread of a virus (Kapetanovic & Boson, 2016). The purpose of this study was to assess symptoms of loneliness, depression, and anxiety in adolescents through a parents' perspective during COVID-19 social distancing. The intent was to examine the need for resilience training in the educational system to recognize signs and symptoms of psychological distress and understand how to overcome such feelings.

Literature Review

Kapetanovic and Boson (2016) conducted a longitudinal study on how parent and adolescent interrelations correspond with adolescent psychological dilemmas. The researchers intended to highlight the discrepancies in adolescent and parental views on parenting and how such distinctions affect the adolescents' behavior and, ultimately, their mental well-being. The study's focus was psychological growth, adolescent-to-parent disclosure, parental awareness, incitement, and behavioral containment. According to Kapetanovic and Boson, poor relationships among parents and adolescents can lead to misinterpretations of behavior. There were four precincts in Sweden that incorporated adolescents from the general population ranging from 12 to 18. There was an even distribution of male and female participants. Questionnaires assessed the discrepancies among parent and adolescent perceptions. The researchers collected data from waves, T1 and T2. There were 550 parental and 1,378 adolescent reports collected in T1 and 1,324 in

Parents answered questions about communication with their adolescent, knowledge of whereabouts, and attempts to solicit generalized information about their child's interests (Kapetanovic & Boson, 2016). Adolescents answered a modified question on their perception of parental communication. The adolescent context had calculated self-reports on internal and external problems. A validated instrument, The Swedish version of the Strength and Difficulty Questionnaire (SDQ-S), helped target behavioral issues. The SDQ-S incorporates four subscales: hyperactivity and inattention, emotional expression, problems in conduct, and peers' issues. A Likert scale used a three-point measurement from zero to two. A two-factor model scored the internalizing and externalizing factors. The researcher utilized paired and independent sample *t*-tests for statistical evidence. The statistical package for the social sciences, version 25 (SPSS-

25), displayed independent sample *t*-tests. The researcher paired the responses from the adolescents' questionnaires with parents' answers. Results showed significantly higher parental reports on behavioral oversight, adolescent divulgence, and solicitation than reports from adolescents. Females indicated a higher level of internal problems, whereas males revealed higher external issues in both waves. Internal problems such as depression and anxiety and external problems are explained as conduct difficulties. The correlation summary demonstrated parent and adolescent inconsistencies corresponding with adolescent psychological health.

Adolescence is a vulnerable stage in the development process where mental illness often begins, such as depression (Ellis et al., 2020). Kapetanovic and Boson (2016) found that teenage girls are typically the most affected by depression, corroborating Ellis et al.'s (2020) findings on female adolescents. MDD is a depressive disorder that typically originates in adolescence, usually around puberty, with females being more likely to be diagnosed than males (American Psychological Association, 2013). The higher rates are possibly due to females communicating more of their internal issues than males (Kapetanovic & Boson, 2016). Being socially isolated from their peers brings a higher probability of depression among adolescents. The stipulations on social distancing due to COVID-19 have had a detrimental effect on adolescent mental health (Ellis et al., 2020). Adolescents socially connect through social media sites; however, previous research has found that increased screen time has the potential to increase depressive symptoms (Bhardwaj, 2018). Contrasting research revealed screen time, especially social media, helps combat stress and endorses one's well-being (Ellis et al., 2020). Other studies believe some adolescents who experience symptoms fail to seek help, typically male adolescents (Kapetanovic & Boson, 2016; Fegert et al., 2020). When there is a substantial relationship between the parent and adolescent, the adolescent is more likely to solicit help when feelings of depression develop

(Kapetanovic & Boson, 2016). Parental knowledge of adolescent behavior is essential during COVID-19 stipulations on social distancing as they can provide coping strategies when symptoms emerge. The Kapetanovic and Boson study is relevant to the current research as a parent's perspective is vital in adolescents' psychological well-being. The discrepancies in the previous research indicate a skewed perception of parental knowledge on adolescent behavior. The researchers believe a laissez-faire form of parenting may cause the parent to miss complications in their adolescents' development. Therefore, lack of parental knowledge appears to have a direct response to poor psychological aftereffects.

Depression, Loneliness, and Stress

Ellis et al. (2020) surveyed 1,316 Canadian high school students on COVID-19 related stress, emphasizing depression and solitude feelings. Two hundred sixty-two participants incorrectly filled out the survey, leaving a sample size of 1,054. The researchers measured the relationship between adolescents' daily conduct and the amount of time spent on schoolwork, physical exertion, and time spent on virtual stimulation. The target age range was 14 to 18 years, with a mean of 16. Roughly 66% of the participants claimed to be White of European descent. The researchers recruited participants through an advertisement posted on social media. Incentives included entry into one of 20 $50.00 drawings or a set of air pods.

There were eight items measured on a four-point scale, calculating adolescent fear of contracting COVID-19 and concern about social distancing (Ellis et al., 2020). Items included concern for the school year and impact of family finances, connection to friends and maintaining one's reputation, contracting or knowing someone who may contract the virus, severity of illness if infected, and overall concern. Results showed 71% of adolescents were very much concerned

with COVID-19 impacting their school year. Less than 5% were worried that someone they know would contract the virus, with nearly 79% being concerned about being infected themselves. Roughly 58% were worried about their family's finances. Approximately 32% were apprehensive that they would become infected, with around 64% being somewhat concerned they would become severely indisposed. Less than 4% were not worried about their friends' connection, and almost 61% were slightly worried that COVID-19 isolation would impact their reputation. Relatively 43% reported being very concerned about the crisis, with less than 3% not being concerned at all. There was a correlation among all eight variables involving adolescents' feelings of solitude. The researchers used the Brief Symptom Inventory (BSI) and found a significant correlation with all eight variables-concerning depression.

The Ellis et al. (2020) study took place within the first month of school closures. Social media (virtual stimulation) usage was measured by the number of hours spent during the past six months before COVID-19 and again at the three-week mark amidst the pandemic. The researchers gave eight possible options, with the least amount being two to three hours and the most being more than ten daily. Adolescents' were also asked a series of questions on their daily amount of virtual stimulation, such as texting and video chatting. There were seven options available, with one hour being the least and more than six being the most. Results show an approximate 4% increase in virtual stimulation since COVID-19.

The Godin-Shephard Leisure Time Exercise Questionnaire (GSLTPAQ) measured activeness, with variables including the moderation of exercise (Ellis et al., 2020). The GSLTPAQ has a high test and retest accuracy, making it a valid questionnaire when assessing physical assertion. Questions pertained to the description of activity and levels being strenuous, mild, or moderate. A self-report indicated the participants' level of activity over seven days. The

number of times noted was multiplied by moderate levels of nine, five, or three, with the final

score being the sum of all variables. The average calculations for challenging levels of activity

were less than two times over the past seven days. Moderate levels were roughly three times,

where mild was just over three.

A multivariate analysis of variance found no significant disparities among grade levels

but did on gender (Ellis et al., 2020). Kaptetanovic and Boson (2016) found that females

collectively reported a higher level of depression and lonesomeness, higher social media use, and

more significant stress due to COVID-19. However, studies have shown that females tend to

disclose more mental health issues than males, typically internal dilemmas (Ellis et al., 2020).

An independent *t-test* found less reported depression and anxiety among the adolescents

proclaiming to be physically active. A slope analysis indicated a significant result among gender

but not on age. Data showed a higher level of stress due to COVID-19 with the adolescents who

spent more time on social media. The researchers found a significant correlation between stress

and exercise. Stress corresponded with inadequate adjustment following COVID-19 stipulations

on social distancing and online classes. The correlations among stress, anxiety, and depression

express the need for a form of training. There has been minimal research on adolescent

resiliency. Therefore, this study was essential as it indicates parental views concerning a likely

need for resiliency training in the public-school systems. Evidence shows higher depression,

loneliness, and stress among adolescents during COVID-19 in both Ellis et al. (2020) and

Kapetanovic and Boson (2016) studies.

Kılınçel et al. (2020) performed a cross-sectional study on adolescents ages ranging from

12 to 18 in Turkey and Sakarya. There were 745 participants recruited from social media sites

and free online surveys, such as Google forms. The purpose of the study was to indicate how

COVID-19 has impacted youth throughout the two provinces. Questionnaires were sent to 13

schools with the help of teachers and clinics that specialized in child psychiatry. The first

parameters measured were the participant's gender, age, education level, previous psychological

impairment, chronic illness, and remote learning attendance. The researchers identified socio-

demographics for possible correspondence between higher and lower anxiety among adolescents.

The state and trait anxiety scales were used to assess students' generalized feelings and those

within a set condition, COVID-19 social distancing. The UCLA loneliness scale assessed

participants' feelings of solitude. A four-point Likert scale identified the individuals who felt

most alone amid the pandemic. Statistical Package for the Social Sciences, version 22 (SPSS-

22), programmed data analysis with a significant level set at .05. Histograms and graphs

displayed correlations among variables.

Adolescents answered a series of questions on their knowledge of the pandemic and how

they received this information; television, social media, associates, or internet sites (Kılınçel et

al., 2020). Roughly 90% claimed to have some knowledge through the media, with less than 2%

stating they had no experience. Other questions addressed were anxiety levels pre and post

COVID, health concerns, school concerns, apprehension about their social life, and regard for

family finances. Nearly 55% claimed to have no change in anxiety level. However, roughly 58%

showed concern over health conditions. Only 15% seemed to be very concerned about the school

year. A noticeable 51% decrease compared to the study conducted by Ellis et al. (2020) amongst

Canadian adolescents. Nearly 15% were very concerned about their social life and roughly 15%

of the condition of the family's finances. There was a positive correlation between the state

anxiety scale and the trait anxiety scale and loneliness. The predictive analysis was statistically

significant among pre-COVID-19 concern for health and having someone positively result in their environment.

Kılınçel et al. (2020) confirmed an increase in anxiety among adolescents who got COVID-19 related information through television. Furthermore, an estimated 5% higher rate of stress amongst adolescents with a previous psychological illness. However, a valid limitation was the self-reports on previous referrals for psychiatric issues. It is unknown to the researchers if the self-reports were an actual clinical diagnosis or a perceived illness. Children are sometimes most vulnerable when the parents are in a lower socioeconomic status (SES). Kılınçel et al. (2020) neglected to incorporate the parents' socioeconomic status (SES), which often leaves children vulnerable, especially during a crisis. The current study will incorporate SES into the variables. The researchers also failed to suggest future study implications.

Resiliency

Lee et al. (2017) studied resiliency in adolescents by examining coping strategies in 1,446 middle and high school students in South Korea. Participants were voluntary students in the general population. There were no incentives to participate. Ages ranged from 13 to 18, with an even distribution of male and female participants. The researchers categorized adolescents into four groups on knowledge and the ability to be resilient. Adolescents were either resilient, struggling, competent, or vulnerable. Coping variables consisted of problem or emotion-focused or avoidance strategies. The intent was to identify rare coping methods used by adolescents who fell into the resilient category compared to those in the opposing groups. The researchers utilized a self-report survey containing 50 elements measured on a four-point scale.

Eight experts in counseling established risks that were either controllable or uncontrollable (Lee et al., 2017). The controllable category consisted of 22 variables, while the uncontrollable held 28. Some items identified as being uncontrollable were separation among parents and mental illness. Those that were considered controllable were grade point average (GPA) and use of stimulants, among others. Adolescents rated items on the questionnaire as having no resiliency experience (0) to highly experienced (3). Risk assessment examined the previous two years on the adolescents' uncontrollable and controllable experiences. The researchers estimated item classifications by tallying risk levels into a single sum. A five-point Likert measurement from zero to five consisted of strongly disagreeing to strongly agreeing. The measurement assessed the adolescents' academic adjustment. The Coping Inventory determined coping strategies for Stress Situations (CISS). The researcher computed emotion, problem, and avoidance focused strategies through a five-point Likert scale where one meant not at all, to five being very much. Problem-focused entailed the adolescent's ability to problem solve strategically. Techniques involving emotions entailed self-blame and ponderance. Avoidance strategies used distractions, such as television, to avoid the situation.

Version 21 of the Statistical Package for the Social Sciences (SPSS) analyzed the data (Lee et al., 2017). The researcher placed participants into high and low-risk categories through risk (M = 18.06) and again for adaptation. Pearson's correlation helped to establish any relationship among variables. There was a significant correlation between school pliancy and problem-focused strategies and avoidance strategies. However, adapting to school was not significantly correlated with emotion-focused strategies. The researchers identified significant correlations among all three coping scales. Coping strategies were highest among students within the resilient category. The researcher observed lower scores among students in the struggling

class in both emotional and problem-focused strategies. Those in the competent and vulnerable groups scored low on emotion, problem, and avoidance focused strategies. However, the competent group scored higher on problem and avoidance strategies than the second category, the struggling group. Furthermore, the vulnerable group scored low on all three types but scored higher than the competent group in emotion-focused coping skills.

The researchers placed roughly 15% of adolescents in the resilient category (Lee et al., 2017). Approximately 25% were identified as being competent in resiliency, and another 25% as struggling. A majority of the students, over 26%, were placed in the vulnerable category. Results support the researchers' claim that adolescents are less knowledgeable than adults in resiliency. This study is crucial as it reflects adolescents' ability to deal with difficult situations healthily. The current study found nearly 16% of adolescents, through the social challenge part of the questionnaire, reported drinking alcohol. Isolation is a precursor of adolescent substance use (Butler et al., 2016). Therefore, the need for a form of resiliency training is vital in maintaining healthy behavior among adolescents.

Liang et al. (2020) completed a cross-sectional study on 610 participants in China, ranging in age from 14 to 35. The final sample size was 584, as 26 participants failed to fill out the questionnaire correctly. A five-point scale measured each participant's knowledge of COVID-19. Specified chemical agents thought to kill the virus were addressed as not having full knowledge (0) to being all knowledgeable (5). The General Health Questionnaire, version 12 (GHQ-12), and the Civilian Version of PTSD Checklist measured post-traumatic stress symptoms and any self-reports of psychological disturbances. A coping style questionnaire used two subscales, active and negative, measuring participants' ability to cope. The negative ability

included eight sub-items while the active held 12. Participants who scored high showed more negative coping strategies utilized compared to the active coping method.

Data were analyzed using SPSS-24 with a significance level set at .05 (Liang et al., 2020). A least significant difference (LSD) post hoc and one way ANOVA test compared GHQ-12 results, post-traumatic stress symptoms, and coping scores. The variance analysis found a significant difference among gender in all three measurement scales but no difference in age. The researchers found a powerful analogy in education and higher scores among post-traumatic stress symptoms and negative coping. There was an established correlation between coping methods, signs of trauma, and potentially long-term psychological issues. Adolescents seemed to be at a higher risk for developing PTSD following COVID-19 than other older participants due to their inability to cope. Students in junior high school were most vulnerable to long-term psychological issues than the older groups of participants. The researchers believed participants in the older groups were more knowledgeable of pandemics and how they work; therefore, their coping abilities were much more robust. Evidence from the study seemed to support such claims.

Liang et al. (2020) believed a limitation to their study was due to the cross-sectional study sample size as the research took place two weeks following the World Health Organization declaring COVID-19 a pandemic. The researchers suggested a longitudinal study of similar variables for future research. Another limitation, identical to the previous five studies, was the self-report measures, which may question the reliability. Furthermore, the study compared COVID-19 to the 2003 respiratory syndrome (SARS) and the 2009 H1N1 contagion. Prior research on the SARS pandemic found an increase in post-traumatic stress among isolated adolescents. Such findings were conclusive with the results found by Liang et al. (2020). According to current and prior studies, psychological distress seems similar to previous

pandemics and COVID-19 (Tzeng et al., 2020). The research on SARS, N1H1, and COVID-19 epidemics displays a higher quota of PTSD symptoms in adolescents as they have statistically been found less resilient than adults (Liang et al., 2020).

The high scores on negative coping skills amongst adolescents indicate the need for resilience training. Liang et al. 's (2020) study supports the current research on adolescent mental health issues amid COVID-19 stipulations. In the present study, parents were asked if they believe adding resilience training to the educational system's curriculum would be beneficial. Parental perspective is imperative in understanding their adolescent's mental health and ability to be resilient, as shown by Kapetanovic and Boson (2016). Previous research brings relevance for the parental perspective on the need for resilience training in the educational setting. More research on student's mental health and their ability to cope is vital in maintaining psychological well-being.

Fegert et al. (2020) completed a systematic review of the phases associated with COVID-19, focusing on child and adolescent psychiatry (CAP). Their research explored treatment and communication among CAP experts throughout Europe. Facets of the epidemiology were: preparation, punctum maximum, and back to normality. In the first or acute phase, services became limited. There were probable adverse outcomes suggested, such as loss of education, daily structure, and developing mental illness, essentially depression and anxiety. The severe challenges associated with COVID-19 are especially vital for adolescents with preexisting mental health conditions. According to Fegert et al. (2020), telepsychiatry has been available; however, adolescents may not be taking advantage of the service due to a lack of privacy or fear of safety. The researchers anticipate a rise in child abuse cases to increase in phase two due to the lack of visits from protection services extending from isolation. Therefore, CAP

professionals should concentrate on preexisting conditions, such as severe autism, and focus on developing disorders. Helplines are a suggested tool to screen patients experiencing a decrease in their mental well-being. Phase three is where society focuses on the new normal. It is imperative that CAP vastly revamps and restores any treatment lost in the final stage. Addressing new patients while maintaining treatment for current patients is an essential strategy. Fegert et al. (2020) expect a surge in mental health issues during phase three, as there will be immense pressure to catch up on lost time. The more extended adolescents are isolated, the more distant they become from real life.

Fegert et al. (2020) suspect a rise in teenage suicidal behavior due to the uncertainty of normalcy and believe it should be an area for future studies. The researchers also discuss probable research into political limitations on mental well-being. There is a strong need for adolescent coping strategies as well as stress regulation. Further studies should also incorporate the resilience and risk variables using a mixed-method design. One limitation was the restrictions on research studies during COVID-19 distancing stipulations. The systematic review is vital for the current research as Fegert and associates discuss the need for children, adolescents, and parents to be well versed in coping abilities. Therefore, resilience training to prepare for future prospective pandemics is imperative.

Internet Addiction

Puri and Sharma (2016) researched the correlation between internet addiction, social isolation, depression, and loneliness, with adolescents in India. The purpose was to disprove previous studies indicating a significant correlation among the four measures. They hypothesized that there would be no significant relationship among the variables. There were 100 volunteers

chosen, 50 females and 50 males, ages 16 to 18. The adolescents were from various schools

throughout South Delhi. Teachers assisted the researchers in administering the questionnaires,

which consisted of four previous measures. Students were asked demographic information for

corresponding socioeconomic status (SES) factors on internet addiction. Instruments included

were the Internet Addiction Test (IAT), Beck's Depression Inventory, Loneliness Scale by

UCLA, and the Social Isolation Test. All instruments were self-reported and measured on a

Likert Scale. The process took roughly 50 minutes to complete.

The Statistical Package for Social Sciences, version 21 (SPSS-21), was used to analyze

quantitative data (Puri & Sharma, 2016). Results were dependent upon the correlation coefficient

and t-test measures. Cronbach's Alpha calculated the internal consistency of IAT at .90. Alpha,

p-value, was set to .05 with a significance level of confidence being .01. The descriptive

statistics results indicated a significant correlation among all four variables, conclusive with

previous research by Ellis et al. (2020). Puri and Sharma (2016) characterized internet addiction

by the American Society of Addiction Medicines (ASAM) definition, which states addiction is

behavioral or chemical (American Society of Addiction Medicines, 2019). The Internet

Addiction Test (IAT) measured the magnitude of issues associated with addiction in each

participant. Addiction to the internet was positively correlated with lonesomeness, while

depression and isolation displayed a significant correlation. According to the standard deviation

of 14 in the IAT, nearly 80% of adolescents had internet addiction. Numerical data indicated a

link between internet addiction and depression among adolescents. The researchers believe there

is a bidirectional contingency between depression and isolation. Results showed adolescents who

spend more time on the internet are more likely to develop depression. There is a perceived level

of isolation among adolescents with internet addiction.

Currently, the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-5) only recognizes gambling addiction as a mental disorder (American Psychiatric Association, 2013). However, internet gaming is a proposed mental disorder. Various research found links between internet addiction, depression, isolation, and loneliness (Puri & Sharma, 2016). Adolescents are more likely to spend a significant amount of time on the internet during COVID-19 restrictions than ever before. Previous research indicated higher internet use levels among adolescents following COVID-19 regulations on social distancing (Ellis et al., 2020). Puri and Sharma's (2016) study was roughly four years before COVID, but the results remained conclusive. Results support the researcher's hypothesis that participants who spend more time on the internet have a higher tendency to develop depressive symptoms. Furthermore, those who were addicted to the internet had a propensity to self-isolate. According to the study by Puri and Sharma, Isolation and depression seemed to be bidirectional. Those socially isolated may become depressed, while those depressed may self isolate. Interactions tend to decrease with adolescents who develop internet addiction. However, social interactions are severely limited, leaving adolescents vulnerable to depression, isolation, loneliness, even addiction. The results are significant to the present study as adolescents are currently socially isolated with a vast amount of time spent on the internet.

Bhardwaj (2018) studied the effects of internet addiction among 200 adolescents in India, ranging in age from 15 to 18. Bhardwaj believed adolescents are among the most vulnerable individuals that would develop an internet addiction due to their developmental stage. The study aimed to prove a significant correlation between the internet, stress, depression, and anxiety. The IAT and the Beck Depression Inventory (BDI) assessed participants' usage by hours and the state of their current mental health. There were 20 questions on the IAT while the BDI held 21.

Scores for addiction were from 0 to 100, with measurements ranging from normal to severe. Beck's scales ranged from 0 to 63, with measurements being low depression to severe. The higher the score in both addiction and depression, the more severe the symptoms were.

Bhardwaj (2018) found a significant correlation between higher internet use, depression, and age with a significance level of .01. Adolescents in higher SES reported higher levels of both internet usage and depressive levels. Moreover, those who had dual working parents displayed a higher probability of becoming dependent on the internet. Internet addiction seemed more prevalent in adolescents, typically around age 17. The study found a relationship between internet addiction, stress, anxiety, and depression. The researcher believed those addicted to the internet might also experience physical distress such as sleep deprivation. Internet dependency can also have a dramatic effect on academic achievement. Bhardwaj found adolescents who reported a higher level of internet use typically held lower grade point averages.

Internet addiction is much like any other addiction, as it often manifests through stressful circumstances or events, leaving the individual feeling psychologically incapable of escaping (Bhardwaj, 2018). People often develop a virtual world to help deal with uncertainties of stressful situations like pandemics. The World Health Organization declared COVID-19 as an international emergency in January 2020 (Liang et al., 2020). Schools began shutting down worldwide, forcing children to learn remotely. Social media became the children's primary way to stay connected as the stipulations mandated a social distancing policy to help contain the virus's spread. Programs meant to keep communication can often lead to addiction, which correlates with stress, depression, and anxiety (Bhardwaj, 2018). The researcher believed future studies should focus more on the link between depression and internet addiction. Bhardwaj's investigation relates to the current research as children have been socially isolated for most of

2020. There is a higher probability of depressive and anxiety symptoms; the more extended

adolescents stay connected to the internet. A significant variable being the current stage of

development among adolescents.

Summary and Research Question

Stipulations following the COVID-19 pandemic have socially isolated adolescents from

their peers while participating in remote learning from home. However, some studies have found

an improvement in students' mental health (Ellis et al., 2020). Ellis and researchers reported

high internet use levels significantly correlating with anxiety, depression, and loneliness among

1,054 adolescents amid COVID-19 distancing. The researchers also found adolescents who

moderately used the internet, such as social media, reported feeling less lonely as they could

connect with their peers. The relationship among stress, depression, anxiety, and internet

addiction was researched by Bhardwaj (2018) on 200 adolescents establishing that higher

internet use correlates with a greater risk for developing depressive symptoms and isolation

behavior. A small sample size of 100 participants by Puri and Sharma (2016) found internet

addiction to be significantly correlated with depression among adolescents and believe a

bidirectional contingency exists between depression and isolation. Additionally, the researchers

feel some use of social media can aid in overall well-being. A cross-sectional study on 745

participants by Kılınçel et al. (2020) demonstrates how COVID-19 stipulations can have a drastic

effect on adolescents' mental health by worrying about family finances and social life, remote

learning, time spent on the internet, and concern for overall health. The researchers believe in-

person school routines are essential for children's positive mental health, conclusive with N. V.

et al. 's (2020) editorial on schools being anchor points that give children stability by having a

routine.

A critical study by Lee et al. (2017) found that youth are significantly less resilient to natural and economic disasters than adults, leading to self-destructive behavior as a coping strategy. A similar study by Liang et al. (2020) identified a relationship between coping abilities and post-traumatic stress in a cross-sectional survey of 584 participants. COVID-19 phases were systematically reviewed by Fegert et al. (2020) with a focus on child and adolescent psychiatry as the researchers believe there will be a rise in suicidal behavior among children during the third phase of back to normal due to the uncertainties and limited knowledge on coping methods. Kapetanovic and Boson (2016) found discrepancies in perceived mental wellness among parents and adolescents through self-reports, suggesting that psychological health complications during stressful events may be missed or misinterpreted.

The timeframe was a significant limitation in the studies conducted by Ellis et al. (2020) and Liang et al. (2020), as both were within the first month of school closures. Established routines were yet identified (Ellis et al., 2020). Longitudinal studies may have been more appropriate due to the lack of causality in cross-sectional designs (Liang et al., 2020). Many researchers used self-report questionnaires, such as the Beck's Depression Inventory and the UCLA Loneliness Scale. There can be a question of reliability, especially when addressing previous psychological issues (Kılınçel et al., 2020). Some studies failed to incorporate demographics and SES, which play a significant role in adolescent physical and mental well-being (Addae, 2020).

The previous studies have some strengths. Kapetanovic and Boson (2016) found discrepancies between parent and adolescent perceived well-being. Puri and Sharma (2016) and Bhardwaj (2018) discovered a link between internet addiction, isolation, and depression. However, Bhardwaj believes cellphones may be beneficial as adolescents can send photos, text,

and call friends during isolation. The researcher recommends parents be cautious about the time spent on cell phones as adolescents could become addicted. Lee et al. (2017) and Liang et al. (2020) found adolescents' were less resilient in natural and economic disasters than adults. However, Lee (2017) discovered resilient students used both problem and emotion-focused strategies to cope during stressful situations. Ellis et al. (2020) found communication with friends through social media seemingly led to fewer solitude feelings.

Furthermore, the study found adolescents who had isolated themselves with family had a higher psychological well-being level. Puri and Sharma (2016) and Bhardwaj (2018) suggest that social media can help combat adolescent stress as they can socialize, even in isolation. This thesis proposed the following research questions due to the limited studies on the effects of COVID-19 policies on adolescents. Has the forced separation among social relationships caused an increase in depression and anxiety symptoms in high school students? Will the parents find resiliency training in the school system useful in helping students overcome psychological controversy during stressful situations?

Method

The purpose of this study was to gauge parents' views on their child's ability to cope during COVID-19. The survey measurements helped determine if students have experienced a higher level of depression since the distancing stipulations. A quantitative approach was used to measure depression and anxiety. The hypothesis was parents would perceive that their children have experienced an increase in depressive behavior following distancing procedures. The second hypothesis was that participating parents would agree that adding resiliency training to school curriculums would help students' coping ability. The following paragraphs include how the study was announced, the intended population, informed consent, and how anonymity was

ensured of the participants. The measurements that were used in the survey are included in this

methods section.

The Research Announcement was posted on the Facebook pages of several open-access

groups frequented by parents of high school students or dedicated to research announcements.

Facebook's terms of service permit such research postings; see www.facebook.com/terms. The

Research Announcement remained on the social media sites for four weeks. The announcement

was reposted repeatedly to keep the announcement appearing in the news feed for the selected

groups. Some Facebook groups have moderators; others do not. Some groups include language

in their terms, disallowing posting on their pages for research and data collection. The Research

Announcement was only posted on Facebook pages whose terms allow postings for research or

data collection purposes. If this was unclear from the terms, the group moderators were contacted

and permission was requested to post the Research Announcement. One school district agreed to

participate following review of the proposal. The superintendent contacted the Executive

Director in the Exceptional Children's Department. She agreed to send out the research

announcement to all high school principals to disement to the parents. The Institutional Review

Board (IRB) accepted my proposal with proper documentation and therefore was permitted to

send out the survey.

The Research Announcement included a link to the anonymous survey, accessible via

SurveyMonkey. The link took the subject to SurveyMonkey, where the subject first saw and

agreed to the Informed Consent; see Appendix B for the text of Informed Consent. If participants

agreed to the Informed Consent, they automatically received access to the survey to complete

online. The participants that did not agree to the Informed Consent proceeded to a thank you

page, and participation was terminated at that point. Participants were given the Emotional

Distress Hotline, a national mental health hotline, available 24/7 for free at 1-800-LIFENETA in

case they experienced any emotional discomfort from completing the study. Although it is

unlikely, should participants experience any emotional discomfort resulting from completing the

survey, they could use the Emotional Distress Hotline, a national mental health hotline, available

24/7 for free at 1-800-LIFENETA. After several weeks, I closed the SurveyMonkey survey and

analyzed the data.

Participants

Participants were recruited through Facebook organizations frequented by parents of high

school students. Participants were also recruited through a school district with help from the

Executive director, Superintendent, and principles. The announcement was sent out through a

newsletter. The research announcement specified the survey was only to be completed by

parents. The general population of parents and guardians in school districts throughout the

United States were surveyed. The sample size was 80. With this sample size, the confidence

level was 95%, with a margin of error of 14%.

The research announcement, which included the URL for the survey, was posted to

participating FaceBook sites. The link took the participants to an anonymous survey accessible

through SurveyMonkey. The parent or guardian completed one survey per high school student

within their household. Screening questions followed the agreement of consent. Disqualifying

variables included students who do not attend high school and parents who do not read English

fluently.

Measures

There were five measures administered to participants of this study. Participants first

completed a demographic questionnaire, which also included screening questions. Following the

demographic questionnaire, participants completed the Screen for Childhood Anxiety Related

Disorders, Parent Version (SCARED) (Behrens et al., 2019), the UCLA Loneliness Scale -

Version 3 (Russell, 1996), Center for Epidemiologic Studies Depression Scale (CES-D)

(Radloff, 1977), and the Purpose in Life Test (PIL) (Crumbaugh & Maholick, 1964).

Demographic Questionnaire

The survey consisted of screening and demographic questions. Parents/guardians

answered three questions that ensured they could participate. Participants were asked if the

student is currently in high school, the student's age, and if the individual completing the

questionnaire could read English fluently. Demographic questions followed the screening

questions. The participating parent was asked a series of six questions about themselves,

assessing their age, gender, race and ethnicity, highest education level completed, marital status,

and the number of dependents under 18 living in the household. The survey included options for

not answering demographic questions and writing in "other" responses when applicable (see

table 1).

Screen for Child Anxiety Related Disorders (Parent Version)

Participants completed the SCARED parent version assessment to measure adolescents'

anxiety over the past three months. The SCARED is a 41-question self-report measure (Behrens

et al., 2019). However, I removed six questions as they do not pertain to the current research.

Questions removed reference physically attending school, having sleepovers, and going to

parties. Therefore, parents answered a series of 35 questions. A three-point Likert scale

measured responses with 0 (not true or hardly ever true) to 2 (very true or often true) (see

Appendix C).

Validation studies involving roughly 1090 child and parent dyads showed high test-retest reliability for the SCARED (Behrens et al., 2019). Approximately 450 of the participating youth had been previously diagnosed with an anxiety disorder, with the remaining participants identified as being healthy. Physical symptoms, avoidance of school, total score, and social and separation anxieties were generalized. A score of 25 or higher indicated clinical symptoms of anxiety. Child and parent scores were calculated separately utilizing z-scores. A linear mixed methods design measured reliability and a linear regression assessed external validity using Pearson's correlations. All regressions indicated a positive correlation with both child and parent mean scores. Results showed healthy children over-reported, parents reported less than children, and the previously diagnosed children matched parent SCARED scores. There was significant statistical evidence in the dyads with test-retest reliability shown through similar measurements (Behrens et al., 2019).

The multitrait-multimethod (MTMM) demonstrates good internal consistency and test-retest reliability (Behrens et al., 2019). Validity was confirmed by a convergence and divergence test among and between measures; Child Behavior Checklist (CBCL) and the State-Trait Anxiety Inventory for Children (STAIC). SCARED demonstrated discriminative validity by identifying previously diagnosed anxiety separately from previously diagnosed depression or conduct disorders in the participants. The test-retest and internal consistency levels were rated good, making SCARED a reliable assessment to identify anxious behavior in children (Behrens et al., 2019).

UCLA Loneliness Scale-Version 3

In 1978, Russell, Peplau, and Cutrona (1980) created the UCLA Loneliness Scale, a 20 question self-report survey measuring loneliness. It was revised in 1980 and again in 1996.

Russell (1996) changed the UCLA Loneliness scale to version 3, so those with a lower literacy

could comprehend it. The measurement is a four-point Likert scale with responses ranging from

1 (never) to 4 (always) (Kılınçel et al., 2020; Russell et al., 1980). There is a reversed scoring

system for questions that are contrary to the existing measure (Stanford University, n.d.). The

higher the value indicates a higher level of loneliness. The participants answered questions on

their perceived view of their child's social isolation and loneliness over the last month. See

Appendix D for the UCLA Loneliness Scale.

Psychometric data proves the UCLA Loneliness Scale, version 3, to have a high test-

retest and internal consistency (Russell, 1996). Validation studies show a strong correlation

among college students' loneliness scales negatively associated with the social support scales,

supporting discriminant, and construct validity. Although not significant, there seemed to be a

slight relationship between loneliness and mood. Teachers and nurses had exact correspondence

between burnout and loneliness, verifying the validity. There was a significant correlation

between loneliness and well-being in the elderly. The test-retest correlates .73 with an internal

consistency range of .89 to .94, making the scale a reliable way to detect loneliness. Construct

and convergent validity was significantly associated with various measures of loneliness. Results

from multiple populations support the reliability and validity of the UCLA Loneliness Scale,

Version 3.

Center for Epidemiologic Studies Depression Scale (CES-D)

Parents assessed their children's depression over the past week using a modified version

of the Center for Epidemiologic Studies Depression Scale (CES-D). Radloff designed the CES-D

to assess the degree of depression and potentially identify at-risk individuals (Jiang et al., 2019).

The CES-D is a self-report measurement consisting of 20 questions (American Psychological

Association, 2020). Four Likert-type responses range from 0 (rarely or none of the time) to 3 (most or all of the time). Scores range from 0 to 60, with higher scores indicative of depressive symptoms (Jiang et al., 2019). The questions were modified so the questions reflected a parent's perspective of their child while keeping the initial measurement's integrity (see Appendix E).

Researchers tested reliability and validity on roughly 1,900 university students in Guangzhou, China (Jiang et al., 2019). The large sample size helped to reduce sampling error. The initial CES-D has a cutoff score of 16. However, the researchers used a cutoff score of 20 as they excluded some of the initial questions that demonstrated potential bias. There were good reliability and validity shown over various constructs, including diabetic patients, the elderly, those who have attempted suicide, and patients in primary care. The scale demonstrates good internal consistency, with a Cronbach's alpha coefficient of .94 and .85 within those who attempted suicide and the primary care patients.

Participants were in two sectors, with results showing no difference in the independent sample *t*-tests. Convergent validity was assessed by examining correlations among Beck's Depression Inventory-II (BDI-II) and the Positive and Negative Affect Schedule (PANAS) (Jiang et al., 2019). The BDI-II demonstrates good validity with a Cronbach's alpha of .85. The PANAS also has a Cronbach's alpha of .85. There was a significant correlation between the scores on CES-D and BDI-II. The CES-D proved to be a reliable and valid measure to assess individuals who may be at risk for depression.

Purpose in Life Test (PIL)

Participants completed a 20 item self-report on their perceptions of their children's overall sense of purpose. Participants responded to the PIL using its seven point scale, and the responses to the items were aggregated according to the scoring protocol (Crumbaugh &

Maholick, 1964). The lowest score an individual can receive on the PIL is 20, with 140 being the highest. Higher numbers on the aggregate level indicate a more heightened sense of purpose in life. The range of answers includes 1 (bored) to 5 (enthusiastic) (item deleted).

Crumbaugh and Maholick created the PIL to assess an individual's mood, goals, and general purpose or meaning of life (Davies et al., 1970). Internal consistency was measured using a split-half method by dividing the test and comparing individual scores (Crumbaugh & Maholick, 1962). The researchers assessed reliability and validity by developing the Seeking of Noetic Goals (SONG) and the PIL. A correlation matrix measured the validity by identifying coefficients, mainly present and future life, and discrepancies among the two (Reker & Cousins, 1979). An internal consistency displays a coefficient of nearly .80. Coefficients were stable over 1, 6, and 12-week test-retest reliability checks. Psychometric data has proven the PIL to be a valid and reliable instrument for detecting general populations' feelings of life satisfaction.

Procedures

Participants received the research announcement through FaceBook organizations. Those who were willing to participate logged into the URL included in the announcement and sent it to the SurveyMonkey site. The URL immediately went to the consent form where the participant either clicked "yes" they agree, or "no," they do not agree to participate. If they agreed to participate, they proceeded to the screening questions. If they did not agree to participate, they were directed out of the study (i.e., to a "thank-you" page). Once participation was validated, the individuals then took the demographic questionnaire. Only one parent per household was permitted to participate in lessening overrepresentation. The parents completed one survey for each high school student within their home.

The first survey the participants took, immediately following the demographic questionnaire, was the parent version of the SCARED. Here the participating parent answered a set of 35 questions that pertained to their child's perceived feelings of anxiety over the past three months since COVID-19 stipulations were mandated. There was an option for 0 to 3 where the parent chose either not true or hardly ever true, somewhat true or sometimes true, or very true or often true. The next series of questions were from the UCLA Loneliness Scale. There were a total of 20 questions referencing their child's perceived loneliness over the last month. Each item was rated as never (1), rarely (2), sometimes (3), or often (4). The CES-D followed the UCLA Loneliness Scale with a set of 20 questions relating to the parents' view on their child's depression over the past week. The participant chose one of four options from 0 to 3. Rarely or none of the time, some or a little of the time, occasionally or moderate amount of the time, most or all of the time. Lastly, the participants answered a set of 20 questions from the PIL gauging their child's mood, goals, and perception of how their child currently views the meaning of their life. The participant was automatically closed out of the URL following a thank you message from the researcher.

Data Management

To ensure the anonymity of the survey participants, in using SurveyMonkey, IP addresses were not collected. For this study, the data was transferred from SurveyMonkey into an SPSS database for analysis. The results were presented in aggregate form to protect participants' identities. The researcher had access to the data only in the form of virtually completed surveys maintained in SurveyMonkey. My thesis advisor and I were the only parties with access to the strong password that protects the SPSS dataset. The dataset did not contain coded identifiers and, as such, was completely anonymous.

All electronic data was stored on an encrypted flash drive and not on any computer hard

drive. T will be retained and related files for a minimum of five years after the study completion

in case questions arise about the analyses. After five years, I will destroy the data using the

current Department of Defense data destruction standards. I will likely choose an affordable

technique, such as encryption, pending technology at the time.

Statistical Analysis

Results from SurveyMonkey were transferred into the Statistical Package of Social

Sciences, version 27 (SPSS-27). Once the survey was closed, the results were analyzed and

transferred to the dataset to verify the descriptive statistics. Along with the advisor, the

researcher was the only one who had the secure password that held the data transferred into

SPSS.

Participant Characteristics

The announcement was delivered through participating school district newsletters and

posted on various FaceBook sites. It is unknown how much of the population saw the

announcement. Therefore the response rate cannot be calculated. Participants were parents who

currently have children who attend high school. The participant was required to read English

fluently to eliminate outliers. The number of participants was 95, with 15 surveys deleted due to

page logic formalities. The 15 deleted had not completed any portion of the survey other than the

consent to participate. Of the remaining 80, two were disqualified for not reading English

fluently, with another eight disqualified for not having a high school student. Another 15 were

deleted for not completing the survey. The final sample size was 52.

Participants were asked a series of demographic questions. The individual completing the

survey's age and gender with options for prefer not to answer or other. Participants' mean age

was between 45 and 54 years of age, with most respondents being White or Caucasian female. A

total of 20% of participants reported having a Bachelor's degree for the level of education

completed, with another 17.5% having a Master's degree or higher. A majority of participants

(60%) reported their marital status as married. For a complete list of demographics, see

Appendix D, Table D1.

ANXIETY

Participants completed the Screen for Child Anxiety Related Disorders, Parent Version

(SCARED). The parent version was the only variant used in this study as the research was

targeted at parents' perspectives. There were six of the original 41 questions removed as they did

not apply to the current research. There were 27 participants deleted as they had partial answers,

which left a total of 52 (N=52) calculated scores. Participants answered a

series of 35 questions measured on a three-point Likert scale.

Responses were "never or hardly ever true," "somewhat or sometimes

true," and "very or often true." A score of ≥ 25 shows a probability

for anxiety disorder (Birmaher et al., 1999). Participant scores were

aggregated and had a possible range of 0 - 105. Participants' actual

scores ranged from 35 to 104 (M = 55.23, SD =14.87).

A frequency table was computed to show participants' perception of their child's stress

and anxiety levels during COVID-19 distancing stipulations. A total of 21% of participants

reported "very true or often true" for their child being worried about other people liking them.

Another 35% believed this to be "somewhat or sometimes true," while 8% did not believe their

child had concerns with others liking them. Then, 40 % reported "somewhat or sometimes true"

about their child being nervous. Finally, 35 % of participants responded with "somewhat or

sometimes true" if their child worries about being as good as other kids. Nearly half (48.8%)

reported "not true or hardly ever true" that their child experiences nightmares about something

terrible happening to the parents. A total of 38% of respondents believe that it is "very true" their

child worries about how he or she does things. Additionally, 22.5% reported "very true" that

their child worries about things that have already happened. Likewise, 27.5% selected "very

true" that their child worries about what will happen in the future. No participant chose "not true

or hardly ever true," but 25% chose somewhat or sometimes true for the same variable. The

SCARED scale demonstrated high internal consistency, with a Cronbach's alpha = .961. Table

D2 in Appendix D summarizes participants' scores on the SCARED.

Loneliness

Participants completed a 20 item measurement on feelings of isolation and loneliness.

Items were scored on a four-point Likert scale with nine questions reverse scored. Respondents

chose from never, rarely, sometimes, or often. Participant scores were aggregated and had a

possible range of 0 - 80. Participants' actual scores ranged from 24 to 68 ($M = 50.48$ $SD = 12.62$).

There was a collective response of "sometimes" ratings from all 52 respondents on all 20

items. Participants reported whether their children feel "in tune" with people around them, and

59.6% of parents reported this is the case "sometimes," whereas 34.6% reported that their

children "never" feel in tune with those around them. Additionally, 44.2% report sometimes

lacking the feeling of companionship, with 38.5% sometimes feeling there is no one they can

turn to. Likewise, 48.1% "sometimes" feel alone, with 13.5% "often" feeling alone. Over half the

participants reported their child "sometimes" feels like they are part of a group, with 38.5%

"never" feeling part of a group. Only 32.7% reported they believe their child no longer felt close

to someone, with over 15% reporting they often feel no longer close to someone. Over 50%

"sometimes" feels left out, and 50% feels no one knows them well. Roughly 60% "sometimes" feel their child can find companionship, with another 26.9% "never" feeling they can find companionship. Approximately 20% "often" believe their child feels there are people around them, but not with them, and 40% "never" feeling like there is someone they can turn to. Another 28.8% believe their child feels there are "never" people they can talk to. Only 50% reported their child "sometimes" feels isolated from others. The UCLA Loneliness scale demonstrated high internal consistency, with a Cronbach's alpha = .947. Table 2 summarizes participants' scores on UCLA Loneliness Scale.

Depression

The CES-D, NIMH is a self-report 20 item instrument used to measure how often an individual felt symptoms of depression over the previous week (Jiang et al., 2019). A total of 31 participants were removed for disqualifying or incomplete answers, leaving a sample size of 49 (N=49). The CES-D, NIMH is scored with 0 for answers in the first column, 1 for answers in the second column, 2 for answers in the third column, 3 for answers in the fourth column. The scoring of positive items is reversed. Items were scored on a four-point Likert scale with answers ranging from rarely, some, occasionally, or most of the time. Participant scores were aggregated and had a possible range of 0 to 60. Participants' actual scores ranged from 24 to 60 ($M = 40$ SD =8.9). Higher scores mean there is a higher indication for the individuals to show a presence of more symptomatology (Radloff, 1977). See table 2 for summarization of participants' scores.

Participants reported 40% of their children were bothered by things over the past week that typically do not bother them at least three days, while 30% said a minimum of five days or almost all of the time. Over 52% believed most of the time their child had difficulty keeping their mind on what they were doing. Respondents believed 38% of their children had been depressed

most or all of the time, five to seven days. Additionally, another 32% felt their child was depressed a moderate amount of time, with 28% reporting some or few days their child seemed depressed. Roughly 42% reported most days, five to seven, everything their child had done over the past week seemed like an effort. Another 40% of the participants said their child seemed sad for a moderate amount of time, three to four days.

The CES-D, NIMH results from 49 respondents were contradictory to my hypothesis that children were experiencing higher levels of depression following COVID-19. Over 65% reported their child was happy most or all of the time. Likewise, 63% enjoyed life most days, while another 59% felt hopeful about the future most or all of the time. One to two days of the week, 59% of respondents believed their child thought their life had been a failure compared to the 14% who reported their child feels this way most of the days. The CES-D, NIMH scale demonstrated moderately high internal consistency, with a Cronbach's alpha = .749.

Purpose in Life

The purpose in life test was designed in 1964 to help identify and indicate an existential void in one's life (Crumbaugh & Maholick, 1964). Participant scores were aggregated and had a possible range of 20 - 100. The PIL results were eliminated from the study as nearly 95% of the participants failed to respond to most of the questions. The range of scores would have been inapplicable to the justification of this study.

Ethical Considerations

Some studies have shown contradictory results concerning parent and child views on well-being (Behrens et al., 2019; Kapetanovic & Boson, 2020). Results suggest there may be over, under, or misrepresentation of a behavior. The present study asked questions that may have been uncomfortable for parents to answer, which may cause error variance. The researcher's

priority was to ensure no harm came to the participants and that all aspects of the study and its

participants remained anonymous. The Facebook groups have an administrator which the

announcement had to go through before being posted. Although each assessment has proven

reliable and valid, parents must understand it is not a diagnosis.

Discussion

This study was intended to gauge parents' views on how social distancing has

affected their high school students. Previous research has indicated a dramatic increase in

depression and anxiety in adolescents since COVID-19 social distancing policies were

mandated (Centers for Disease Control and Prevention, 2019). However, most studies were

done within the first few weeks to months of school closure, and this study took place a year

after COVID-19 was deemed an emergency by the WHO. The hypothesis being that parents

would report their child had experienced an increase in depression and anxiety symptoms

from being socially distant from their peers. The final hypothesis was that parents would find

resiliency training beneficial within the schools' curriculum to aid in better mental

preparation for the students during the next pandemic. Results are inconclusive as a good

portion of the data had to be discarded for being incomplete. The theorem was that parents

would think adding resilience training to the school system would be beneficial. However,

there was a split decision, with 42.86% of respondents being "unsure" and 42.86% reporting

"yes." There were only 14.29% of participants that responded "no."

This study was formulated around social isolation and a parent's perspective on how

it has affected their high school student. An unexpected result was the insufficient number of

respondents on the UCLA Loneliness scale that said their child often felt isolated from

others, 13.5%. However, over 50% sometimes felt isolated, while 21.2% rarely felt isolated

and 9.6% never felt isolated. From previous studies, the assumption would be that this

number would be more significant. Over 65% reported their child rarely feels outgoing or

friendly, while another 59% rarely feels close to people. Another unexpected result was the

split decision on parents' views on adding resilience training to a school's curriculum.

Similarities and Differences

Many instruments have been used to evaluate depression, anxiety, and loneliness in

adolescents since COVID-19. The BDI and UCLA Loneliness scale were the two most

commonly used in previous studies. The UCLA Loneliness Scale was used in the current

study, but also incorporated were the CES-D, NIMH, and SCARED (parent version). The

UCLA Loneliness Scale scores in the present study were not as significant as previous

studies due to the low sample size. However, there were indications of depression and

anxiety in the present study that was conclusive to prior measures.

Participants in the present study reported 59% of their students no longer feel in tune

with those around them. Similarly, Ellis et al. (2020) found over 40% of participants were

very worried COVID-19 would impact their connections with their friends. Respondents

reported most days, five to seven, had difficulty staying concentrated on current tasks. More

than 26% had difficulty for four to five days. The rates were relatively low for those who

reported depressive feelings, with only 21% claiming they occasionally feel depressed.

Limitations

This study has several limitations. The survey began 11 months after social

distancing policies caused school closures nationwide and commenced remote learning.

However, schools began to reopen while data was still being collected. This could cause an

error variance as the measurements took place in the past three months to two weeks from

the survey date. The limitation changes could have influenced the parents' perception. Many

children began in-person school and were no longer socially distant, as the beginning of the

study suggested.

The response rate is unknown due to not knowing the number of individuals who saw

the announcement. The sample size was a significant limitation. There were initially 80

participants; however, 27 had to be deleted for disqualifying factors or not completing the

survey. Therefore, the sample size was 52 for all measurements and 49 for the CES-D,

NIMH. The coefficient levels were not significant enough to be valid nor reliable. Another

study should be conducted, which includes the student's perception as well as the parents.

The PIL was not the most appropriate questionnaire to give parents their perception of their

students. The inconclusive data on the PIL was justification for deleting the instrument from

the research. The PIL should be incorporated into a study where the student answers such

questions.

The length could have been an issue and caused individuals to lose interest in the

survey. The survey had 107 questions which have been a contributing factor to the number of

incomplete cases. Some questions may have been difficult for the parent to answer about

their child, while other questions may have led to bias answers. A limitation was also present

in Kapetanovic and Boson's (2020) study, where the researchers surveyed parents'

perspectives on their child's well-being. Results were skewed due to potential bias and

misinterpretation of mood. There has been little research done on parents' views concerning

their child's mental health during social distancing limitations during COVID-19. Likewise,

minimal research has been done on adolescent resiliency with little known studies on parents'
views.

Conclusions

Parental knowledge is indispensable when it comes to being an advocate for their
child's mental health. Kapetanovic and Boson (2017) found significant oversights in parent
and child perceptions of mental health, a key variable in the present study. Liang et al. (2020)
discovered a lack of coping abilities in adolescents correlating with Lee et al. (2017) study
on adolescent resiliency. Adolescents are less knowledgeable in dealing with stressors which
justifies the research question on parents' views of adding resiliency training to the school's
curriculum. However, the split decision among present participants suggests further research
on adolescent resiliency is needed.

Studies have been conducted worldwide on how COVID-19 has affected children.
Adolescence is a challenging part of the developmental stage where children begin to
understand themselves and develop their personalities. Adolescence is also the stage in
development where feelings of anxiety and depression manifest (Kapetanovic & Boson,
2020). Having forced distancing regulations among teenagers and their peers could
potentially make the transition from school age to adolescence more difficult. Puri and
Sharma (2016) results give the impression that there is a bidirectional contingency between
depression and isolation. Children who were depressed were often self-isolated, whereas
those who were self-isolated showed signs of depression.

COVID-19 caused a nationwide pandemic making social distancing a mandate in
which students could no longer attend school or sports. The students were not permitted to

spend time with their peers for fear of spreading the virus. Many adolescents employed a form of social media to stay in contact with others. Some studies suggest social media could cause depressive symptoms, while others believe that social media can be a helpful tool for one's mental health (Bhardwaj, 2018).

There is enough concern for adolescents' mental well-being, even with the low sample size, that should justify further research. Future studies should incorporate the adolescents' responses to correlate with their parents' views on social distancing. It may be beneficial to add an even distribution of mother and father surveys to distinguish if there is a difference in the findings. Bhardwaj (2018) postulates that cell phones could help combat depression in adolescents in moderation. Future research should incorporate if the student has a cell phone and how often it is used, the type of phone, and if the phone is used for any social media sites. Any previously diagnosed conditions should be factored into future studies to account for extraneous variables. Due to the low numbers on the UCLA Loneliness score, future studies should incorporate a question if the child is more of an introvert or extravert. This could be a factor in the low numbers of those who felt isolated compared to those who did not.

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Appendix A

Research Announcement

My name is *Jamie Snow.*

I am conducting research through Purdue University Global to obtain a Master's Degree in

Psychology.

The purpose of the research is to get parents' perception of their students' mental health and how

COVID-19 distancing stipulations have affected their high school child or children.

If you are interested in taking the survey, please click here for more information: URL:

 The survey will take about 20 to 30 minutes of your time.

This study will be anonymous, so no one will know that you were a participant, and no one will

ever be able to connect your answers to your identity.

Click here to participate!

https://www.surveymonkey.com/r/JGNFD2F

Appendix B

Purdue University Global
Consent for Participation in Research
"Parents Perception of Students Mental Health and Resiliency: Effects of COVID-19 Distancing
Stipulations Among High School Students"

CONCISE SUMMARY
This study will assess parents' views on their students' mental health and ability to cope
during stressful situations, such as the COVID-19 pandemic. Significant evidence has
shown a lack of resilience and coping strategies among previous adolescents in prior
research. Results will be used to indicate if there is a need for resilience training in schools.
The survey will take approximately 20 to 30 minutes to complete.

<u>Why am I being asked?</u>
You are being asked to be a participant in a research study about parents' perception of students'
mental well-being and the effects of COVID-19 distancing stipulations on your child or children.
This study is intended to get parents' perspective on their adolescents' mental well-being since
COVID-19 stipulations and whether the parent or guardian will find adding resilience training in
schools beneficial.

This research study is being conducted by Jamie Snow, a Master's of Science in Psychology student at Purdue University Global. You have been asked to participate in the research because you have a child or children who are high school students and may be eligible to participate. We ask that you read this form and ask any questions you may have before agreeing to be in the research.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Purdue University Global. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

What is the purpose of this research?

The purpose of this research is to help to determine if the forced separation among social relationships caused an increase in depression and anxiety symptoms in high school students. The researcher is also attempting to gauge parents' views on adding resiliency training to the school systems curriculum.

What procedures are involved?

If you agree to be in this research, we would ask you to do the following things: Read and ask any questions prior to clicking you agree on the consent form. The researcher's phone number, along with the advisor's email, is listed above. The researcher then asks that you continue on to the consent screen. The consent is an agree or disagree button when you enter the URL included in the research announcement. If you agree, you will proceed to screening questions ensuring you are eligible to participate. The survey will take roughly 20 to 30 minutes to complete once you have finished the screening questions. Approximately 350 parents of students may participate in this research at Purdue University Global.

What are the potential risks and discomforts?

The research may bring discomfort. A prior study found discrepancies in parent and adolescent views on their child's well-being. Therefore this research may bring discomfort as depressive or anxiety symptoms may have been missed or misrepresented in your adolescent.

Are there benefits to taking part in the research?

Benefits may include: There are no direct benefits to the participants. However, participants may gain a better insight into children's mental well-being. The research results will also be shared with participating organizations. Results could lead to a more informed decision on adding resiliency training to the curriculum in the participating districts.

What about privacy and confidentiality?

No one will know that you are a research subject because this research is totally anonymous. No information about you, or provided by you during the research, can ever be disclosed to others

because no information that can possibly identify you as an individual will be collected. When the results of the research are published or discussed in conferences, no information will be included that could ever reveal your identity. The researcher will close out the survey following an approximate two-week data collection.

The researcher will not collect IP addresses. Data will be directly transferred from SurveyMonkey into the Statistical Package for Social Sciences (SPSS). The researcher and advisor will be the only ones with access to the password. There will be no code identifiers ensuring anonymity.

Will I be reimbursed for any of my expenses or paid for my participation in this research?
At this time, no reimbursement is available for participation in this research.

Can I withdraw from the study?
You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study.

Whom should I contact if I have questions?

The researcher conducting this study is Jamie Snow. You may ask any questions you have now. If you have questions later, you may contact the researchers at: Phone: 907-342-7847. You may also contact the researcher's thesis adviser, Dr. Gabrielle Blackman PhD, at gblackman@purdueglobal.edu.

What are my rights as a research subject?
If you feel you have not been treated according to the descriptions in this form, or you have any questions about your rights as a research subject, you may contact the Institutional Review Board (IRB) at Purdue University Global through the following representative:

Susan Pettine, IRB Chair
Email: spettine@purdueglobal.edu

Remember: Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Purdue University Global. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

You may keep a copy of this form for your information and your records.

<u>Signature of Subject</u>

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I have been given a copy of this form.

_____   _____
Signature   Date

_____
Printed Name

_____   _____
Signature of Researcher   Date (must be same as subject's)

Appendix C

Screen for Child Anxiety Related Disorders 'Parent Version'
SCARED

Instructions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, check √ the box that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child. This assessment is to be filled out by the guardian.

1. When my child is frightened, it is hard for him/her to breathe

2. My child doesn't like to be with people he/she doesn't know

3. My child worries about other people liking him/her

4. When my child gets frightened, he/she feels like passing out

5. My child is nervous

6. My child follows me wherever I go

7. People tell me that my child looks nervous

8. My child feels nervous with people he/she doesn't know well

9. When my child gets frightened, he/she feels like he/she is going crazy

10. My child worries about sleeping alone

11. My child worries about being as good as other kids

12. When he/she gets frightened, he/she feels like things are not real

13. My child has nightmares about something bad happening to his/her parents

14. When my child gets frightened, his/her heart beats fast

15. He/she gets shaky

16. My child has nightmares about something bad happening to him/her

17. My child worries about things working out for him/her

18. When my child gets frightened, he/she sweats a lot

19. My child is a worrier

20. My child gets really frightened for no reason at all

21. My child is afraid to be alone in the house

22. It is hard for my child to talk with people he/she doesnt know well

23. When my child gets frightened, he/she feels like he/she is choking

24. People tell me that my child worries too much

25. My child doesn't like to be away from his/her family

26. My child is afraid of anxiety (panic) attacks

27. My child worries that something bad might happen to his/her parents

28. My child feels shy with people he/she doesnt know well

29. My child worries about what is going to happen in the future

30. When my child gets frightened, he/she feels like throwing up

31. My child worries about how well he/she does things

32. My child worries about things that have already happened

33. When my child gets frightened, he/she feels dizzy

34. My child feels nervous when he/she is with other

   children or adults and he/she has to do something while they watch him/her

   (example: read aloud, speak, play a game, play a sport)

35. My child is shy

Scoring: A total score of ≥ 25 may indicate the presence of an

Anxiety Disorder. Scores higher than 30 are more specific.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed.,
David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic,
University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Appendix D
UCLA Loneliness Score (Version 3)

Instructions: Indicate how often each of the statements below is descriptive of your child over the past month. Answer questions as best as you can with the perception of how your child feels, without asking the child. Answers are either never, rarely, sometimes, or often.

1. How often do you feel you are 'in tune' with the people around you? *
2. How often do you feel that you lack companionship?
3. How often do you feel that there is no one you can turn to?
4. How often do you feel alone?
5. How often do you feel part of a group of friends *
6. How often do you feel that you have a lot in common with the people around you?*
7. How often do you feel that you are no longer close to anyone?
8. How often do you feel that your interests and ideas are not shared by those around you?
9. How often do you feel outgoing and friendly? *
10. How often do you feel close to people? *
11. How often do you feel left out?
12. How often do you feel that your relationships with others are not meaningful?
13. How often do you feel that no one really knows you well?
14. How often do you feel isolated from others?
15. How often do you feel you can find companionship when you want it?*
16. How often do you feel that there are people who really understand you? *
17. How often do you feel shy?
18. How often do you feel that people are around you but not with you?
19. How often do you feel that there are people you can talk to? *
20. How often do you feel that there are people you can turn to? *

Scoring; The items with an asterisk are reverse scored. Keep scoring on a continuous

basis. This scale is only for researchers. Russell, 1996

Appendix E

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Instructions: Please tell me how you believe your child has felt over the past week. Answers will be rarely or none of the time (less than one day) some or a little of the time (1-2 days) occasionally or moderate amount of time (3-4 days) most or all of the time (5-7 days).

1. I was bothered by things that usually don't bother me
2. I did not feel like eating; my appetite was poor
3. I felt that I could not shake off the blues even with the help from my family or friends
4. I felt I was just as good as other people
5. I had trouble keeping my mind on what I was doing
6. I felt depressed
7. I felt that everything I did was an effort
8. I felt hopeful about the future
9. I thought my life had been a failure
10. I felt fearful
11. My sleep was restless
12. I was happy
13. I talked less than usual
14. I felt lonely
15. People were unfriendly
16. I enjoyed life
17. I had crying spells
18. I felt sad
19. I felt like people dislike me
20. I could not 'get going'

Scoring: zero for answers in the first column, 1 for answers in the second column, 2 for answers in the third column, 3 for answers in the fourth column. The scoring of positive items is reversed. Possible range of scores is zero to 60, with the higher scores indicating

the presence of more symptomatology. Radloff, L. S. (1977).

Table 1

Respondents' Sociodemographic Characteristics (N=52)

Measure	All Subjects
Age	
25-34	3.8%
35-44	27.5%
45-54	40%
55-64	3.8%
Did not answer	25%
Gender	
Male	6.3%
Female	66.3%
Prefer not to say	2.5%
Marital Status	
Single/Never Married	1.3%
Married or Domestic Relationship	60%
Divorced	10%
Widowed	1.3%
Seperated	2.5%

Race and Ethnicity	
Asian	
	2.5%
Black or African-American	
	6.3%
Hispanic or Latino	
	3.8%
Native Hawaiian or Pacific Islander	
	2.5%
White or Caucasian	
	56.3%
Prefer not to say	
	2.5%
Highest level of education completed	
High school graduate	3.8%
Some college/no degree	16.3%
Associates degree	17.5%
Bachelor's degree	20%
Masters degree or higher	17.5%
How many dependents under the age of 18 in household	
0	1.3%
1	28.7%
2	20%
3	16.3%
4	2.5%
5	3.8%

Table 2

Responses on the SCARED Survey (N=52)

Items	Mean	SD
1. When my child is frightened, it is hard for him/her to breathe	1.5	.610
2. My child doesn't like to be with people he/she doesn't know	2.10	.748
3. My child worries about other people liking him or her	2.19	.658
4. When my child gets frightened he/she feels like passing out	1.23	.581
5. My child is nervous	1.96	.625
6. My child follows me wherever I go	1.37	.595
7. People tell me that my child looks nervous	1.23	.546
8. My child feels nervous with people he/she doesn't know well	1.92	.682
9. When my child gets frightened he/she feels like he/she is going crazy	1.31	.612
10. My child worries about sleeping alone	1.23	.581
11. My child worries about being as good as other kids	1.77	.645
12. When he/she gets frightened, he/she feels things are not real	1.19	.487
13. My child has nightmares about something bad happening to his/her parents	1.33	.617
14. When my child gets frightened, his/her heart beats fast	1.92	.682
15. He/she gets shaky	1.40	.664

16. My child has nightmares about something bad happening to him/her	1.42	.637
17. My child worries about things working out for him/her	1.94	.752
18. When my child gets frightened, he/she sweats a lot	1.52	.779
19. My child is a worrier	1.92	.682
20. My child gets really frightened for no reason at all	1.21	.498
21. My child is afraid to be alone in the house	1.27	.630
22. It is hard for my child to talk with people he/she doesn't know well	1.88	.704
23. When my child gets frightened he/she feels like he/she is choking	1.13	.444
24. People tell me that my child worries too much	1.27	.598
25. My child doesn't like to be away from his/her family	1.37	.595
26. My child is afraid of panic/anxiety attacks	1.52	.727
27. My child worries that something bad is going to happen to his/her parents	1.46	.641
28. My child feels shy with people he/she doesn't know well	1.85	.668
29. My child worries about what is going to happen in the future	1.81	.742
30. When my child gets frightened he/she feels like throwing up	1.35	.683
31. My child worries about how well he/she does things	2.17	.617
32. My child worries about things that have already happened	1.62	.718
33. When my child gets frightened he/she feels dizzy	1.31	.643

34. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (example: read aloud, speak, play a game, play a sport)	1.77	.757
35. My child is shy	1.79	.667
Total (remove of n/a)		

Table 2

Responses on the UCLA Loneliness Scale Survey (N=52)

Items (include each question/item below)	Mean	SD
1. How often do you feel 'in tune' with those around you?	2.73	.97
2. How often do you feel you lack companionship?	2.67	.89
3. How often do you feel that there is no one you can turn to?	2.43	.91
4. How often do you feel alone?	2.65	.90
5. How often do you feel a part of a group of friends?	2.82	.99
How often do you feel that you have a lot in common with the people around you?	2.41	.81
7. How often do you feel that you are no longer close to anyone?	2.51	.96
8. How often do you feel that your interests and ideas are not shared by those around you?	2.63	.80
9. How often do you feel outgoing and friendly?	2.49	.93
10. How often do you feel close to people?		
11. How often do you feel left out?	2.67	.98
12. How often do you feel that your relationships with	2.65	.80
others are not meaningful?	2.47	.76
13. How often do you feel that no one really knows you well?	2.82	.83
14. How often do you feel isolated from others?	2.71	.84
15. How often do you feel companionship when you want it?	2.53	.96

16. How often do you feel that there are people who really understand you?	2.47	.89
17. How often do you feel shy?	2.78	.71
18. How often do you feel that people are around you but not with you?	2.76	.90
19. How often do you feel that there are people you can talk to?	2.61	.93
20. How often do you feel that there are people you can turn to?	2.86	1.0

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Table 2

Responses on the CES-D, NIMH (N=49)

Items (include each question/item below)	Mean	SD
1. I was bothered by things that don't usually bother me	2.08	.88

2. I did not feel like eating; my appetite was poor	2.02	1.0
3. I felt that I could not shake off the blues even with the help from my family or friends	1.98	.98
4. I felt I was just as good as other people	1.65	1.5
5. I had trouble keeping my mind on what I was doing	2.51	1.13
6. I felt depressed	2.27	1.0
7. I felt that everything I did was an effort	2.41	1.0
8. I felt hopeful about the future	1.59	1.5
9. I thought my life had been a failure	1.57	.79
10. I felt fearful	1.57	.81
11. My sleep was restless	2.24	1.1
12. I was happy	1.53	1.6
13. I talked less than usual	1.90	.79
14. I felt lonely	2.16	.98
15. People were unfriendly	1.69	.79
16. I enjoyed life	1.59	1.6
17. I had crying spells	1.55	.81
18. I felt sad	1.94	.92
19. I felt like people dislike me	1.53	.73
20. I could not 'get going'	2.20	1.0
		.