ANXIETY INTERVENTIONS IN SCHOOLS: A SURVEY OF SCHOOL

PSYCHOLOGISTS

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ANXIETY INTERVENTIONS IN SCHOOLS: A SURVEY OF SCHOOL PSYCHOLOGISTS

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ABSTRACT

ANXIETY INTERVENTIONS IN SCHOOLS: A SURVEY OF SCHOOL PSYCHOLOGISTS

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Anxiety disorders are among the most common psychiatric conditions that children and adolescents suffer from. With the negative impact anxiety disorders can have on childhood development, academic performance, and later adult life functioning, it is imperative that prevention and early intervention services are provided. Given the availability of evidenced-based interventions, their documented transportability to the school setting, and school psychology graduate training, school psychologists are in a unique position to provide these services. The present study surveyed (N=111) practicing school psychologists in Ohio to determine their current use of evidenced-based interventions (EBIs) for the prevention and treatment of anxious youth in the school setting and the barriers they perceive to implementing these services. Results indicated
that while 84.1% of participants report the use of evidenced-based programs to be “very
important,” 44.6% of those same participants report that they do not currently implement
any evidenced-based intervention programs for anxious youth. Potential barriers to
implementing these services most frequently reported included: available time, available
resources, feasibility of training teachers and staff for delivering treatment, and other job
responsibilities taking precedence. Implications for providing mental health
prevention/intervention programming in the schools and methods for conquering
potential barriers to delivering services are discussed.
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CHAPTER I
INTRODUCTION

Anxiety is defined as an overwhelming sense of fear elicited by an anticipatory event (Huberty, 2008). While anxiety is a naturally occurring mental state, it can become extreme and uncontrollable, leading to debilitating symptoms, both mental and physical. Anxiety disorders are the most common psychiatric conditions that afflict children and adolescents (Ginsburg & Kingery, 2007). Despite high prevalence rates, the majority of students with mental health issues, such as anxiety, do not receive services (Allen, 2011). Untreated anxiety disorders can cause a variety of impairments ranging from poor academic performance to deficits in social skills. These impairments can cause lifelong difficulties, influencing one’s academic, social, and emotional development (Ginsburg & Kingery, 2007).

Given the negative consequences associated with untreated anxiety, it is imperative that children and adolescents with anxiety receive prevention and early intervention services. With the early onset of anxiety symptoms, the school setting is an ideal location for school-based mental health professionals to deliver preventative interventions (Tomb & Hunter, 2004). Research suggests that more than 80% of community-based treatment options for children with anxiety are not empirically
 supported (Herzig-Anderson, Colognori, Fox, Stewart, & Warner, 2012). It is therefore critical that school-based mental health professionals, such as school psychologists, use evidence-based interventions (EBIs) for treating anxious youth in the school setting.

Research supports cognitive-behavioral therapy (CBT) to be the most effective psychosocial treatment evaluated for childhood anxiety (Ginsburg & Kingery, 2007). Despite the benefits of using EBIs, research has shown difficulties associated with transporting EBIs from the clinical setting to the school setting (Ginsburg, Becker, Drazdowski, & Tein, 2012; Ginsburg, Becker, Newman Kingery, & Nichols, 2008; McLoone, Hudson, & Rapee, 2006; Schaeffer et al., 2005). With proper training, sustained involvement, the use of standardized intervention protocols, and the support of key stakeholders, EBIs can be effectively integrated into a school system (Schaeffer et al., 2005). For example, a recent study by Miller et al. (2011) examined the school-based implementation of the Skills for Academic and Social Success (SASS) program, an early intervention program aimed at reducing anxiety, behavioral avoidance, and depression symptoms. Results of this study were positive, demonstrating a reduction of symptoms in students within a secondary school setting. Given the availability of EBIs for treating anxiety and their demonstrated effectiveness in the school setting, it is important to determine if these prevention and intervention services are actually provided by school-based practitioners. The purpose of the present study is to identify what types of prevention and intervention services are currently implemented by school psychologists to treat anxiety in the school setting.
CHAPTER II
LITERATURE REVIEW

Significant research has led to a foundational understanding of the phenomenology, prevalence, and comorbidity of anxiety disorders (Costello, Egger, & Angold, 2005). Excessive anxiety in school-aged youth can cause a variety of impairments, ranging from poor academic performance to deficits in social skills. These impairments can cause lifelong issues, influencing an individual’s academic, social, and emotional development (Ginsburg & Kingery, 2007). Research has shown that prevention and early interventions are essential for treating anxiety symptoms and disorders in school-aged youth (Tomb & Hunter, 2004). The literature has identified the importance of using evidenced-based interventions (EBIs), specifically, cognitive behavioral therapy (CBT) for treating anxiety in the school setting (Ginsburg & Kingery, 2007).

The following literature review provides an overview of anxiety, discussing symptoms, prevalence, comorbidity, and the overall impact of anxiety symptoms and disorders when left untreated. Also included in the review of the literature is a summary of evidenced-based prevention and intervention services and programs for treating anxiety in schools, as well an analysis of the variables associated with transporting these evidenced-based practices into the school setting. Finally, the review provides an
overview of the role of school psychologists in implementing evidenced-based prevention and intervention services for treating anxiety in the school setting.

**Anxiety**

When defined, anxiety is described as an overwhelming sense of fear, stimulated by an anticipatory event, which may produce an adverse outcome (Huberty, 2008). Though it is a naturally occurring mental state, anxiety can become severe and uncontrollable, which can lead to the development of a clinical disorder or psychopathology. The disturbances caused by anxiety can trigger a variety of symptoms, both mental and physical. House (2002) states that physical symptoms of anxiety may include: muscle tremors, increased heart rate, increased blood pressure, increased perspiration, and muscle tension. According to the American Psychiatric Association (2000), other symptoms of anxiety may include, but are not limited to: difficulty falling asleep or staying asleep, irritability, difficulty concentrating, hypervigilance, exaggerated startle response, and motor restlessness. It is important that mental health professionals are familiar with early signs and symptoms in order to be able to identify, treat, and prevent anxiety disorders.

**Prevalence.** Anxiety disorders are among the most common mental health illnesses worldwide (Demyttenaere, et al., 2004; Wittchen & Jacobi, 2005). In a National Comorbidity Survey Replication, approximately 29% of the respondents met the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, (DSM-IV) criteria for an anxiety disorder at some point in their lifetime (Kessler et al., 2005). With a median onset age of 11 years (Kessler et al., 2005), anxiety disorders are grouped as some of the earliest developing psychopathologies (Fox et al., 2012).
Anxiety disorders are considered to be among the most common psychiatric conditions in children and adolescents (Ginsburg & Kingery, 2007). Research has shown childhood anxiety prevalence rates as high as 20% (Costello, Egger, & Agnold, 2004), and overall lifetime prevalence rates averaging between 8% and 27% (Costello et al., 2005). Subclinical symptoms refer to early stage symptoms that are not at a detectable or clinical level (Merriam-Webster, 2013). When including children and adolescents with subclinical anxiety symptoms, previous research has estimated prevalence rates to be between 18-21% (Kashani & Orvaschel, 1990).

**Comorbidity.** Anxiety disorders are rarely observed in isolation, and most often, they are found in conjunction with another type of anxiety (Wenar & Kerig, 2006). It is not uncommon for children to meet the diagnosis criteria for more than one anxiety disorder. Depression is the next most commonly comorbid condition with anxiety, followed by externalizing disorders (i.e., ADHD) (Wenar & Kerig, 2006). Lifetime comorbidity rates occur in more than 80% of individuals with anxiety disorders (Brown, Campbell, Lehman, Grisham, & Mancill, 2001). Given the high comorbidity rates of anxiety disorders, it is important to consider other prevalent conditions when determining appropriate interventions and treatment plans.

**Impact**

Despite high prevalence rates, most youth with mental health issues (92-94.5%) do not receive any type of mental health service (Allen, 2011; Kataoka, Zhang, & Wells, 2002). When left untreated, anxiety disorders can become chronic disturbances that can negatively impact life outcomes and adult functioning (Ollendick & King, 1994; Keller et al., 1992). Anxiety disorders are internalizing conditions that often go unrecognized and
untreated, partially due to the difficulty surrounding their identification (Moldovan, 2011). Children with anxiety display symptoms in a covert manner, as compared to children with behavioral disorders (Herzig-Anderson, Colognori, Fox, Stewart, & Warner, 2012). In the school setting, children with anxiety are likely to be compliant, obey school rules, and avoid attention-seeking behaviors (Herzig-Anderson et al., 2012).

A recent study has shown that over 80% of children suffering from anxiety disorders do not receive mental health services (Merikangas et al., 2011). Childhood anxiety disorders often go unnoticed, as internal symptoms are difficult to recognize for an untrained professional (Essau, Conradt, Sasagawa, & Ollendick, 2012). Research has shown that 75% of the children who do receive mental health supports are provided these services through their educational setting, with many individuals reporting the school services to be their only source of treatment (Egger & Burns, 2004). It is widely accepted that schools are at the forefront of assessing and treating mental health difficulties in the United States. The school system has been identified as the ideal environment to prevent and treat anxiety disorders (Masia-Welmer, Nangle, & Hansen, 2006), as schools have the unique opportunity to provide treatment to students as part of their everyday routine (Elkins, McHugh, Santucci, & Barlow, 2011). It is therefore important for school-based mental health care providers to be trained to use EBIs for identifying, assessing, and treating anxiety disorders in the school setting.

**Short-term effects.** Anxiety disorders can cause individuals a great deal of functional impairment and personal distress in their daily lives (Ginsberg & Kingery, 2007). Even short-term effects of anxiety can have a negative impact on a person’s overall development. Children and adolescents with anxiety have reported experiencing
distorted patterns of thinking, low levels of self-esteem, and negative physical symptoms (Alfano, Beidel, & Turner, 2006; Ginsburg, Riddle, & Davies, 2006). In terms of social interactions, children and adolescents with anxiety disorders tend to lack social skills and avoid social situations (Albano, Chorpita, & Barlow, 2003). Research has also shown that children with anxiety, when compared to children without, are observed to be less popular and less likeable (Nelson, Rubin, & Fox, 2005).

**School-related implications.** Anxiety disorders can prevent children and adolescents from achieving their maximum academic potential. The school setting can create an environment that is highly stressful and emotionally provoking for anxious youth (Mychailyszyn, Mendez, & Kendall, 2010). Anxiety can influence all aspects of school functioning, including: academic performance, social interactions, behavior in the classroom, and emotional development. An analysis of the data from Mychailyszyn et al. (2010) indicates that children with no diagnoses of anxiety have a significantly higher level of school functioning than those with a principal diagnosis of certain anxiety disorders (i.e., separation anxiety disorder, generalized anxiety disorder, or social phobia).

Children and adolescents with anxiety disorders may struggle academically, which can impact their opportunity to reach their maximum academic potential. A study by Van Ameringen, Mancini, and Farvolden (2003) showed anxiety disorders to be associated with premature withdrawal from school. In their study of individuals who met the DSM-IV criteria for a primary anxiety disorder, 49% of participants reported leaving school early, and 24% of those individuals listed anxiety as their main reason for withdrawal (Van Ameringen et al., 2003). With anxious youth at-risk for academic
difficulties and premature withdrawal from school, it is important for schools to adopt prevention and early intervention programs to meet the needs of these students.

**Long-term effects.** Left untreated, the long-term effects of anxiety can have a negative impact on childhood development and later adult life functioning. Long-term effects of untreated anxiety can include: adult anxiety disorders, mood disorders, and substance abuse concerns (Kendall, Safford, Flannery-Schroeder, & Webb, 2004). Many adults with anxiety disorders report that during their childhood, they experienced strong anxiety symptoms that went unrecognized and untreated (Pollack, Otto, Sabatino, & Majcher, 1996). Given the research, it is clear that childhood anxiety symptoms require psychological treatment and support to reduce symptoms, treat comorbidity, and reduce lasting effects.

Due to the prevalence and chronic state of anxiety disorders, there is a high cost burden to society (Greensberg et al., 1999). In the study by Greensberg et al., (1999), it was estimated that in 1990 in the United States, the annual cost of anxiety disorders was $43.2 billion. The costs in this study were calculated to include: non-psychiatric medical treatments, psychiatric treatments, indirect workplace costs (i.e., lost productivity), mortality costs, and pharmaceutical prescriptions. Given the psychological and monetary consequences of untreated anxiety, it is important that evidenced-based prevention measures are put into place. Such services ensure that anxious, at-risk, and identified individuals receive support and early intervention treatments.

**Prevention**

Preventative interventions are aimed at reducing risk factors that may later develop into a disorder (Tomb & Hunter, 2004). Findings suggest that the developmental
trajectory of anxiety disorders revolves around genetics, child temperament, psychosocial factors, and parental influences (Huberty, 2008). Risk factors increase the likelihood of developing anxiety symptoms. For children, these risk factors are reported to include: emotional difficulties, parental anxiety, family conditions, interpersonal issues, traumatic and stressful life events, and difficulties in school (Greenberg, Domitrovich, & Bumbarger, 2001). While risk factors increase the likelihood of developing symptoms, protective factors, such as strong coping skills, may prevent a child from developing anxiety-related symptoms (Tomb & Hunter, 2004).

Given the chronic state and overall burden of anxiety disorders, research supports the implementation of preventative measures at an early age (Bienvenu & Ginsberg, 2007). Some research suggests that preventive interventions are most successful during high-risk transitions, such as those that take place during the move from elementary to middle school (Bienvenu & Ginsberg, 2007). Other research has found that preventative interventions should be implemented at an even earlier age, such as parent-child preventative interventions for anxious preschool aged children (Fox et al., 2012). Including parents in early anxiety interventions for preschoolers is helpful in decreasing maladaptive parental attitudes and behaviors that are associated with an increased risk for childhood anxiety (Hirshfeld-Becker & Biederman, 2002). Younger children are also ideal for early intervention because their neurodevelopment and behaviors are more plastic and easily adaptable (Hirshfeld-Becker & Biederman, 2002). Given that their anxious tendencies are less ingrained, their behaviors are more easily modified, and young children can be taught anxiety management skills to use on a daily basis (Hirshfeld-Becker & Biederman, 2002). Regardless of the exact age group, researchers
agree that early prevention and intervention measures are necessary for combating childhood and adolescent anxiety. It is important for school-based mental health professionals to utilize preventative interventions for reducing anxiety symptoms in anxious youth.

**The school setting.** With the high prevalence rate and early onset of anxiety symptoms, the school setting is an ideal location to deliver evidenced-based preventative interventions (Tomb & Hunter, 2004). By targeting anxiety symptoms in the school setting, mental health professionals can reduce the likelihood of the development of anxiety disorders, as well as promote healthy developmental strategies (Greenberg et al., 2001). School-based mental health professionals can use preventative interventions to reduce anxiety across the school setting, including areas of academics, peer interactions, and social-emotional development (Tomb & Hunter, 2004). By providing preventative interventions, schools can normalize mental health care and increase the likelihood of children and adolescents receiving treatment (Herzig-Anderson et al., 2012). Schools are an ideal venue to identify anxiety symptoms at an early age, provide support and treatment, and help children confront many of the anxiety-provoking situations that occur within the school environment (Herzig-Anderson et al., 2012).

**Three-tiered model.** The three-tiered model of prevention is aimed at providing a whole-school approach for identifying, treating, and reducing anxiety symptoms and disorders in school-aged youth (Tomb & Hunter, 2004). This model includes three levels: universal, selected, and targeted prevention. The universal level of prevention targets the entire student population of those who have not yet been identified to be at-risk (Tomb & Hunter, 2004). An example of a universal prevention program is

The second prevention level of the three-tiered model is labeled “selective,” and targets individuals who are at a greater risk for developing a mental health disorder, based on known risk-factors, and those who do not respond to universal prevention methods (Tomb & Hunter, 2004). In a review of the literature completed by Bienvenu and Ginsberg (2007), selective prevention studies were reviewed, and results indicated that working with individuals considered at “high-risk” for anxiety disorders significantly reduces the number of anxiety disorder diagnoses. “Ready….Set….R.E.L.A.X.” (Allen & Klein, 1996) can also be implemented at a selective level in classrooms or with small groups of students. By modifying the delivery of this intervention, school based mental health professionals can train teachers to work with an identified group of students to teach them effective strategies and coping methods (Tomb & Hunter, 2004).

The last prevention level of the three-tiered model is labeled “targeted” prevention, and is also referred to in the literature as “indicated” prevention. This level of prevention involves working with students who display early signs and symptoms of mental health disorders, but who have not yet been identified or diagnosed (Tomb & Hunter, 2004; Bienvenu & Ginsberg, 2007). An example of an individual prevention program would be “Coping Cat” (Kendall & Hedtke, 2006). This type of intervention uses a cognitive-behavioral intervention manual with 16-sessions for treating anxiety disorders (Tomb & Hunter, 2004). Implementation of a three-tiered model with evidenced-based programs ensures that schools can prevent, identify, and treat anxiety
within the scope of the school setting.

**Intervention**

**Evidenced-based interventions.** When providing mental health services, it is imperative that professionals implement evidenced-based practices (EBPs). EBP has been defined by Hoagwood (2003-04) as scientific knowledge about treatments, intervention/prevention approaches, and service practices that have structured clinical research to support their effectiveness. By selecting evidenced-based interventions (EBIs), professionals are providing individuals with researched-based treatment options that have demonstrated their effectiveness for working with targeted populations (i.e., cognitive-behavioral therapy (CBT) for treating anxiety disorders). Despite the benefits of using EBIs, research has shown many difficulties associated with transporting EBIs from the clinical setting to the school setting. Challenges to implementing EBIs in the school setting include: the support of school personnel and administration, limited funding for materials (i.e., protocols), lack of knowledge for selecting and implementing an EBI, clinician reluctance to use EBIs, and resistance from school staff and students (Schaeffer et al., 2005). With proper training, sustained involvement, the use of standardized intervention protocols, and the support of key stakeholders, EBIs can be effectively integrated into the daily functioning of a school system (Schaeffer et al., 2005).

**Treating anxiety.** Research has demonstrated the negative consequences associated with neglecting the early signs and symptoms of childhood anxiety disorders (Moldovan, 2011). It is therefore important to screen school-aged children to identify those who are at-risk and start early interventions for those who have demonstrated signs
and symptoms. Children with anxiety disorders are the least likely among youth with psychiatric conditions to receive treatment (Merikangas et al., 2011). Schools are in a unique position to provide these services, with unexampled access to identify and treat students displaying anxiety symptoms and disorders (Chatterji, Caffray, Crowe, Freeman, & Jensen, 2004). Research suggests that more than 80% of community-based treatment options for children with anxiety are not empirically supported (Herzig-Anderson et al., 2012). It is therefore critical for school-based mental health professionals, such as school psychologists, to advocate for the use of EBIs that can effectively treat anxious youth.

A review of the treatment literature designates Cognitive-Behavioral Therapy (CBT) to be the most effective psychosocial treatment evaluated for childhood anxiety, with the majority of youth even benefiting from short-term CBT course work (Ginsburg & Kingery, 2007). A meta-analysis of current research indicates that there is sufficient evidence to support CBT as an effective intervention in preventing anxiety disorders in school-aged children (Gallegos, Beretvas, Benavides, & Linan-Thompson, 2012). Results from this study also suggest CBT is an effective, long-term treatment for children at-risk for developing an anxiety disorder (Gallegos et al., 2012). The research on using CBT for treating anxiety is copious, supporting it as an evidenced-based and empirically supported intervention. Given the availability, it is important for schools to consider the logistics and necessary modifications for delivering EBIs for treating anxiety in the school setting.

**School-Based Interventions**

The anxiety-provoking dynamics of the school environment can contribute to the need for school-based mental health services for anxious youth. Several school factors,
such as teacher demands, peer interactions, academic performance pressures, and school violence add to, and can maintain, anxiety related symptoms (Ginsburg, Becker, Newman Kingery, & Nichols, 2008). By providing mental health services in the school setting, school-based mental health professionals, such as school psychologists, can utilize the “least restrictive environment” (Doll, 2008) to promote positive mental health programs. By integrating evidenced-based CBT programs into the school system, trained personnel can help identify and treat anxious children who may have otherwise gone unrecognized and untreated (Weist & Evans, 2005).

The service delivery model and the support of key stakeholders (i.e., teachers and school personnel) are important factors in any implemented program or systems-level change within the school environment. As defined by Sheridan and Kratochwill (1992), Conjoint Behavioral Consultation (CBC) is a collaborative method of school-based consultation that involves communication with both parents and teachers. In a review of the literature by Auster, Feeney-Kettler, & Kratochwill (2006), it was concluded that CBC provides a positive service delivery model that fosters successful treatment outcomes for EBIs. When treating anxiety disorders in the school setting, communication among teachers, parents, and mental health professionals (i.e., school psychologists, school counselors, social workers) must be constant and explicated. Both teachers and parents play important roles as intervention agents in the treatment of anxiety disorders (Auster et al., 2006). By being involved in CBC and the treatment process, parents and teachers (consultees) can learn how to recognize the signs and symptoms of anxiety, and learn the necessary skills for treatment of presenting anxiety in the future (Auster et al., 2006).
Using the school setting to implement services and interventions aimed at treating anxiety has both advantages and limitations. By providing treatment options for anxious youth, schools can reduce referral difficulties and eliminate barriers associated with cost and transportation for outside services (McLoone, Hudson, & Rapee, 2006). By utilizing trained teachers and mental health professionals, schools can look for and treat early signs and symptoms of anxiety, with the ultimate goal of reducing formal diagnoses and long-term consequences (McLoone et al., 2006). School-based mental health services are also advantageous because they provide students with opportunities to practice confronting their anxiety with real-life, anxiety-provoking scenarios (Herzig-Anderson et al., 2012). Treatment in the school setting is unique in that it provides trained clinicians the opportunity to give immediate corrective feedback and intervene in ways that cannot occur when treatment is through outpatient clinicians (Ginsburg et al., 2008). Additionally, by treating anxiety in the school setting, a supportive environment is created where peers can talk about anxiety, share experiences, normalize their fears, and gain a sense of belonging (Miller, Short, Garland, & Clark, 2010).

While the school setting is an ideal venue for working with anxious children, nothing is without limitations. A variety of challenges arise in transporting anxiety interventions to the school setting, and in order for schools to effectively provide mental health services, logistics must be considered. Most effective studies conducted on school-based anxiety treatments have used expert cognitive behavioral therapy (CBT) therapists (Ginsburg, Becker, Drazdowski, & Tein, 2012), which are difficult to find, and are “cost-prohibitive,” especially in urban school districts (Ginsburg et al., 2008). Results from Ginsberg et al. (2012) indicate that novice CBT clinicians can be trained to
successfully implement school-based interventions and significantly reduce anxiety symptoms in school-aged youth.

Another challenge with transporting anxiety interventions into the school setting involves the support of key stakeholders. It may be difficult to obtain initial buy-in for treating anxiety in the school setting, as studies have shown that staff members (including some school clinicians) are skeptical that anxious children are even present in their setting with the need for treatment (Ginsburg et al., 2008). There are also issues surrounding the cost of services and the feasibility of training teachers and staff for delivering treatment (McLoone et al., 2006). Parental consent and support is also a concern, as some parents do not see a need for the services, and others are concerned by the negative stigma associated with receiving mental health services (McLoone et al., 2006).

**Cognitive-Behavioral Therapy**

Cognitive-Behavioral Therapy (CBT) can help individuals learn how to acknowledge anxious behaviors and correct dysfunctional cognitions. While there are a variety of approaches associated with CBT, when working with anxious children, key CBT strategies include: psychoeducation, exposure therapy, contingency management, affective education, relaxation training, cognitive restructuring, and efficient problem solving (Ginsberg & Kingery, 2007). Using CBT for treating anxiety is aimed at reducing excessive worry and teaching effective coping skills so that children can manage their anxiety across settings (Ginsberg & Kingery, 2007).

With limited time available to work with children and make a difference, it is imperative that evidenced-based treatment models, in conjunction with best practices, are
used for treating psychopathology in the school setting (Davis, Kruczek, & McIntosh, 2006). Years of research and randomized clinical trials have confirmed the efficacy of CBT for treating youth with anxiety disorders (Mychailyzyn et al., 2011). Research has also suggested that CBT has effective, long-term benefits for children at-risk for developing an anxiety disorder (Gallegos et al., 2012). Given the importance of treating anxiety with EBIs, it is necessary to explore the documented successfulness of transporting effective clinical treatments, such as CBT, to the school setting.

In terms of generalization, studies have shown promising results for the transportability of CBT to the school setting (Mychailyzyn et al., 2011). While more research is necessary, several studies have shown it is possible to implement CBT in the schools with positive results (Mychailyzyn et al., 2011). In a recent school-based study by Essau et al. (2012), children in the cognitive behavioral prevention program “FRIENDS” displayed significantly fewer anxiety and depression symptoms than those in the control group. Results from a study by Fox et al. (2012) indicate that a parent-child cognitive behavioral preventative intervention may be beneficial for reducing anxiety symptoms in preschool aged children. Bernstein, Layne, Egan, and Tennison (2005) conducted a study to compare the effectiveness of different school-based interventions for children with anxiety. Results indicate that the effectiveness of group CBT is significantly greater than that of no treatment at all, and that parent training combined with group CBT shows significantly greater improvement in anxiety symptoms over group CBT only (Bernstein et al., 2005).

Coping Cat and FRIENDS are manual-based treatments that utilize CBT components. Both of these frequently used protocols have been found to be effective for
treating children with anxiety (Moldovan, 2011). When implemented with integrity, these interventions have been found to be effective for treating anxious children in the school setting (Schoenfeld, College, & Janney, 2008). The following is a brief summary of these two interventions, with research to support their efficacy when delivered in the school setting.

**Coping Cat.** *Coping Cat* is a 16-session manualized CBT program that can be used to treat Generalized Anxiety Disorder, Social Phobia, and Separation Anxiety Disorder in children ages 7-13 (Kendall & Hedtke, 2006). The sessions in this program are divided in half, with the first eight sessions covering psychoeducation, and the second eight revolving around exposure to anxiety-provoking situations. During psychoeducation, children are taught the “FEAR” plan for managing anxiety, which is an acronym that stands for “**F**eeling frightened?; **E**xpect bad things to happen?; **A**ttitudes and actions that can help; **R**esults and rewards” (Kendall & Hedtke, 2006). In summarizing this plan, youth are taught: (1) to recognize somatic reactions to anxiety and strategies for reducing these symptoms, (2) to identify negative cognitive processes and initiate “coping” thoughts, (3) to problem-solve for alternate ways for handling situations, and (4) to evaluate their progress and reward themselves for using coping strategies (Mychailyszyn et al., 2011). During the last eight sessions of *Coping Cat*, children establish a “fear hierarchy” and slowly challenge themselves by facing their fears, while utilizing their newfound skills from the FEAR plan. Several studies and randomized controlled trials (RCTs) (i.e., Kendall, 1994) have shown the efficacy of this intervention for reducing anxiety symptoms in school-aged youth, with follow-up studies reporting lasting effects.
**FRIENDS.** FRIENDS is a 12-session, CBT-based prevention and intervention program that teaches coping strategies to children with anxiety and depression (Barrett, Lowry-Webster, & Turner, 2000). Similar to the FEAR plan for the previously described program *Coping Cat*, FRIENDS is an acronym used to help children remember the steps for managing their anxiety. FRIENDS stands for “Feeling worried?; Relax and feel good; Inner thoughts; Explore plans; Nice work, reward yourself; Don’t forget to practice; Stay calm” (Barrett et al., 2000). There have been several studies demonstrating the efficacy of this intervention for reducing childhood anxiety. A recent study by Essau et al., (2012) provides empirical evidence to support the FRIENDS program as an effective preventative program for reducing anxiety symptoms in youth. Other studies have found that using the FRIENDS program to treat anxiety in the school setting has also led to a reduction in behavioral issues and an increase in academic achievement, with lasting effects over time (i.e., Schoenfeld & Mathur, 2009).

**The School Psychologists’ Role**

As previously stated, research has shown that approximately 70-80% of youth that receive treatment for mental health services receive it in the school setting (Hoagwood, 2001; Rones & Hoagwood, 2002); however, it has also been shown that schools habitually do not implement EBIs when providing mental health services (Hoagwood, 2001; Rones & Hoagwood, 2002). Schools have the opportunity to provide economically viable early prevention and intervention services, with the hope of teaching children positive coping skills to reduce and treat anxiety symptoms (Anticich, Barrett, Gillies, & Silverman, 2012). Given the availability of EBIs to treat anxiety, it is imperative that mental health professionals, such as school psychologists, act as change-agents in the
School psychologists can best support students who struggle with anxiety symptoms and disorders by encouraging the use of EBIs. With a high percentage of children in schools who experience mental health issues, it is important for school psychologists to collaborate with other school-based mental health professionals (i.e., school counselors and school social workers) to step into the role of mental health service providers (Perfect & Morris, 2011).

The NASP Model for Comprehensive and Integrated School Psychology Services designates which services school psychologists are responsible for providing across the 10 domains of practice (NASP, 2010). In terms of mental health services, Domain 4 (Interventions and Mental Health Services to Develop Social and Life Skills) states “School psychologists have knowledge of biological, cultural, developmental, and social influences on behavior and mental health, behavioral and emotional impacts on learning and life skills, and evidence-based strategies to promote social–emotional functioning and mental health” (NASP, 2010). Domain 6 (Preventive and Responsive Services) states that “School psychologists have knowledge of principles and research related to resilience and risk factors in learning and mental health, services in schools and communities to support multitiered prevention, and evidence-based strategies for effective crisis response” (NASP, 2010). In accordance with the previously stated NASP Practice Model, school psychologists should be trained to provide and support mental health prevention and intervention services. School psychologists can help transform the availability of mental health services in the school setting by engaging in professional development opportunities to increase their knowledge and expertise in EBIs, and by collaborating with teachers, building and district administrators, and other service
providers (i.e., social workers, school counselors, outside community providers) to deliver effective and comprehensive mental health care services (Eklund, Vaillancourt, & Pedley, 2013). By collectively working with school personnel and other mental health professionals, school psychologists can advocate for and help facilitate the use of EBIs and programs that promote prevention, early identification, and treatment of anxiety symptoms and diagnosed anxiety disorders.

In accordance with best practices, NASP (2006) advocates for school psychologists to support a continuum of mental health services, with a goal of helping students increase their academic achievement and overall well-being. In a recent study by Suldo, Friedrich, & Michalowski (2010), results indicate that school psychologists are currently providing a wide range of school-based mental health services, with emphasis on group counseling, crisis intervention, and individual counseling. With anxiety disorders being rated among the most common psychiatric conditions from which children and adolescents suffer (Ginsburg & Kingery, 2007), it is important to narrow the research to determine how anxiety is currently being identified and treated in the school setting. Further research is necessary to determine if schools are currently providing evidenced-based prevention and intervention services for reducing anxiety.

The Present Research Study

Given the high prevalence rates and detrimental consequences associated with untreated anxiety, it is important that schools utilize the educational setting for prevention and intervention services. With known and available evidenced-based treatment programs, school psychologists should be advocating for the use of these services. By promoting early identification and treatment of anxiety related symptoms, schools can
reduce the likelihood of the development of anxiety disorders, as well as promote healthy developmental strategies (Greenberg et al., 2001). Numerous studies have examined the effectiveness of EBIs in the school setting, in addition to research examining and surveying the potential barriers to school-based mental health services. While research exists to support other school-based mental health professional’s (i.e., school counselors) influence on treating mental health disorders, the current literature lacks research on what school psychologists are currently implementing to prevent and treat anxiety in the school setting. The purpose of the present study was to identify what prevention, intervention, and/or treatment methods are currently utilized by practicing school psychologists to treat anxiety in the school setting. Specifically, this study surveyed school psychologists in Ohio on their use of EBIs in school-based mental health services for treating anxiety. In addition, school psychologists were surveyed regarding potential barriers to treating anxiety in the school setting.
CHAPTER III

METHOD

Research Questions and Hypotheses

Research question 1. What percentage of currently practicing school psychologists are using known evidenced-based prevention and/or intervention methods for treating anxiety in the school setting?

It is hypothesized that surveyed school psychologists will report limited use of evidenced-based prevention and intervention services for treating anxiety. This hypothesis is based on research which suggests that potential barriers, such as the cost of services, the feasibility of training teachers and staff for delivering treatment, and parental consent, may prevent the delivery of EBIs for treating anxiety in the school setting (McLoone et al., 2006).

Research question 2. What potential barriers for treating anxiety in the school setting do school psychologists most frequently report?

It is hypothesized that school psychologists will report a perceived importance of evidenced-based treatment programs, but report an overall lack of funding, resources, and available time to implement these services. This hypothesis is based on research that suggests the implementation of anxiety programs in the school setting is often viewed as
infeasible due to financial costs, training requirements, and competing demands (McLoone et al., 2006).

**Research Design**

The present study utilized a survey design and produced quantitative data. A sequential mixed-mode strategy was used for the data collection. The purpose of using multi-modes for data collection was to gain access to a larger sample and increase response rates. Results were compared across participants.

**Participants**

Probability sampling was used to gather a homogeneous sample of participants. Participants who completed the survey (\(N=111\)) included licensed, practicing school psychologists in the state of Ohio who are members of the Ohio School Psychologists Association (OSPA) listserv, or who attended the OSPA spring (2013) conference. See Table 1 for information regarding participants’ demographics. In terms of highest educational degree, 87.3% of the participants had a pre-doctoral degree (which includes participants with Masters degrees and Educational Specialist degrees), and 12.7% of participants had a Doctorate. The participants’ median number of years of experience practicing as a school psychologist was between six and ten years.
### Table 1

**Participant Demographics**

<table>
<thead>
<tr>
<th>School Psychologists</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22-29 years</td>
<td>26</td>
<td>22%</td>
</tr>
<tr>
<td>30-39 years</td>
<td>33</td>
<td>28%</td>
</tr>
<tr>
<td>40-49 years</td>
<td>18</td>
<td>15%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>25</td>
<td>21%</td>
</tr>
<tr>
<td>60+ years</td>
<td>17</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s</td>
<td>52</td>
<td>44%</td>
</tr>
<tr>
<td>Education Specialist</td>
<td>51</td>
<td>43%</td>
</tr>
<tr>
<td>Doctorate</td>
<td>15</td>
<td>13%</td>
</tr>
<tr>
<td><strong>School District</strong>³</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charter</td>
<td>9</td>
<td>5%</td>
</tr>
<tr>
<td>Private</td>
<td>14</td>
<td>7%</td>
</tr>
<tr>
<td>Public</td>
<td>92</td>
<td>47%</td>
</tr>
<tr>
<td>Rural</td>
<td>29</td>
<td>15%</td>
</tr>
<tr>
<td>Suburban</td>
<td>29</td>
<td>15%</td>
</tr>
<tr>
<td>Urban</td>
<td>22</td>
<td>11%</td>
</tr>
</tbody>
</table>

Note: The number of participants who completed this survey was 111. The variables Age (N=119) and Education (N=118) include individuals who started the survey but did not complete the entire measure.

³ In regard to school district, participants were encouraged to select all answers that applied, giving a total of 195 responses to this question.
Materials

A quantitative survey (see Appendix B) was created and hosted on www.qualtrics.com. A total of eight questions were utilized to assess participants’ personal and district involvement in the prevention and treatment of anxiety in the school setting. The topical areas covered on the survey included: (a) district involvement in implementing anxiety prevention and intervention services, (b) level of graduate training for implementing Cognitive Behavioral Therapy (CBT) to prevent and treat anxiety, (c) current mental health services offered in the school setting, (d) importance of using evidenced-based interventions (EBIs), (e) current use of evidenced-based programs for treating anxiety, and (f) potential barriers to implementing anxiety prevention and intervention services.

The researcher and a co-researcher, who is examining assessment practices for anxiety, collaboratively designed the questions on the survey. In order to test the reliability and validity of the designed survey, the survey was piloted on a group of school psychology interns (N= 10) to refine the wording and content of questions. Several changes were made to the layout and content of the survey based on qualitative feedback. Changes to the survey included: moving the demographic and background information to the beginning of the survey, rewording several questions for clarity purposes, inserting additional response choices for specific questions, and finally, all qualitative questions were removed in an attempt to shorten the overall length of the survey.
Procedures

Approval for the research study was obtained through the Institutional Review Board (IRB) at the University of Dayton. Data collection occurred through two methods: (1) a web-based survey, and (2) face-to-face recruitment. In both methods, participants took the survey electronically through the same online distributor: Qualtrics. Consent was voluntary, and participants agreed to informed consent by clicking through the survey. No information collected in the survey was connected back to the identity of a participant. All data were reported in the aggregate, thus participants’ names were not connected with their responses in any published use of the data.

Members of the Ohio School Psychologists Association (OSPA) listserv were emailed the web-based survey through the OSPA listserv on March 19, 2013. A follow-up contact was sent out to non-respondents on April 8, 2013, approximately three-weeks after the initial email. A face-to-face approach was then used at the OSPA spring conference on April 18-19, 2013, to recruit OSPA members and conference attendees to take part in the survey. The researchers used a recruitment poster to advertise the survey at a conference table. Consenting participants took the survey electronically at one of the six available computer or iPad stations. Precautions were taken to ensure confidentiality, as participants were appropriately spaced across the conference table, and were also provided the opportunity to move the electronic device (i.e., computer or iPad) to another specified location (a lounge area) to complete the survey. A disclaimer was placed in the follow-up email, as well as on the recruitment poster, requesting that individuals who had already participated in the study not take the survey again. Given that the individuals on the listserv and the individuals attending the conference were not mutually exclusive
populations, a response rate is difficult to estimate. This is also due to the fact that the survey was available for listserv members to take online during the conference; therefore, the researchers are unable to differentiate between responses recorded from participants at the conference, and responses recorded online through email recruitment.

An incentive was offered to all individuals who participated in the study to increase the sample size. The advertised incentive offered all participants (both email and face-to-face respondents) the chance to win one of four $25 Amazon gift cards for completing the survey. At the end of the survey, participants who chose to enter the drawing emailed the identified survey code “ANXIETYSURVEY” to the following email address: anxietysurvey.ud@gmail.com. At the conclusion of the data collection, participants’ email addresses were entered into a raffle drawing, and four individuals were randomly selected as recipients of the gift cards. The raffle winners were contacted via email with an electronic gift card.
CHAPTER IV

RESULTS

The information gathered from the survey produced quantitative data, which was analyzed using descriptive and correlational statistics. Nominal data were collected for: (1) identifying responsibility for implementing anxiety prevention and intervention services in the school setting, (2) identifying additional types of training completed for providing anxiety prevention and intervention services, (3) identifying current use of anxiety prevention and intervention services in the school setting, and (4) identifying current use of evidenced-based anxiety intervention programs and strategies in the school setting. Ordinal data were collected for: (1) perceived preparation from graduate training to provide anxiety prevention/intervention services, (2) perceived preparation from graduate training to implement Cognitive-Behavioral Therapy (CBT) to prevent and treat anxiety, (3) the perceived importance of using evidenced-based programs when treating anxiety in the schools, and (4) identifying the strongest barriers to implementing anxiety prevention and intervention services in the school setting. Nominal data were collected for remaining background and demographic information. Median scores were reported
for participant years of experience, as well as for participants’ reported number of anxiety referrals per year. Percentages were used to summarize remaining nominal background and demographic data, including: age, educational attainment, and type of school district.

**Research Question 1.** Descriptive statistics were used to analyze the percentage of currently practicing school psychologists who are currently using evidenced-based prevention and/or intervention methods for treating anxiety in the school setting.

**Research Question 2.** Descriptive statistics were used to report the perceived importance of implementing evidence-based treatment programs, and to analyze the frequency of reported potential barriers for treating anxiety in the school setting.

**Descriptive Statistics**

**Role responsibility and referrals.** Descriptive statistics were gathered to identify persons primarily responsible for implementing anxiety prevention and intervention services. Of the surveyed individuals, 55% of participants reported that school counselors are the person responsible for this role in their school setting, and 33% of participants indicated this to be the school psychologists’ role. Eight percent of participants indicated that their schools (or districts) do not provide any interventions for students with anxiety (See Table 2). Descriptive statistics were also gathered to identify the number of referrals for anxiety. Participants’ median number of referrals per school year for students presenting with anxiety symptoms was between five and ten students, with a participant mode response of less than five students.
Table 2  

Reported Role Responsibility for Providing Anxiety Services

<table>
<thead>
<tr>
<th>Providers</th>
<th>Frequency</th>
<th>Percent of n&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention Specialists</td>
<td>20</td>
<td>18%</td>
</tr>
<tr>
<td>Outside Mental Health Care Providers in the School Setting</td>
<td>26</td>
<td>23%</td>
</tr>
<tr>
<td>School Counselors</td>
<td>62</td>
<td>55%</td>
</tr>
<tr>
<td>School Psychologists</td>
<td>37</td>
<td>33%</td>
</tr>
<tr>
<td>Social Workers</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td>General Education Teachers</td>
<td>8</td>
<td>7%</td>
</tr>
<tr>
<td>No Interventions are Currently Provided for Students With Anxiety</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>10%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Participants were able to select more than one answer choice; therefore, the total number of responses is greater than the number of participants (N=111). The statistic “Percent of n” represents the percent of individuals that selected a particular answer choice. These percentages are not mutually exclusive of one another.

Training perceptions. Data were collected on participants’ perceptions of the graduate training they received to provide prevention/intervention services for students with anxiety in the school setting. Descriptive statistics were gathered on participants’ perceptions of their preparation to implement Cognitive-Behavioral Therapy (CBT) to prevent and treat anxious youth in the school setting. Participants rated the training that
they had received on a Likert scale ranging from one to five: 1 = not at all, 2 = very little, 3 = somewhat, 4 = adequately, and 5 = very much. Percentages are reported to indicate the participants’ perceptions.

Based on gathered information, 7% of participants reported feeling “very much” prepared to provide prevention/intervention services for anxiety in the school; 22% of participants reported feeling “adequately” prepared; 38% of participants reported feeling “somewhat” prepared; 30% of participants reported feeling “very little” prepared, and 3% of participants reported feeling “not at all” prepared (See Table 3).

In terms of CBT training, participants most frequently reported that their graduate training prepared them “very little” to implement Cognitive-Behavioral Therapy (CBT) to prevent and treat anxiety in the school setting. Specifically, 4% of participants reported feeling “very much” prepared, 14% of participants reported feeling “adequately” prepared, 24% of participants reported feeling “somewhat” prepared, 41% of participants reported feeling “very little” prepared, and 17% of participants reported feeling “not at all” prepared (See Table 3).

**Additional types of training.** Data were gathered to identify additional types of training participants had completed on providing anxiety prevention/intervention services. Participants were encouraged to select all response choices that apply. Information gathered indicates that 40% of participants completed courses for CEU’s, which was the most frequently reported response, 36% of participants completed state association conference workshops, and 31% of participants completed regional association conference workshops (See Table 4).
Table 3

*Participants’ Perceptions of Preparedness Post-Graduate Training*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Not At All</th>
<th>Very Little</th>
<th>Somewhat</th>
<th>Adequately</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants’ Level of Preparedness to provide Anxiety Prevention and Intervention</td>
<td>3%</td>
<td>30%</td>
<td>38%</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td>Participants’ Level of Preparedness to Provide Cognitive Behavioral Therapy (CB)</td>
<td>17%</td>
<td>41%</td>
<td>24%</td>
<td>14%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Table 4

*Additional Types of Training for Providing Anxiety Prevention/Intervention Services*

<table>
<thead>
<tr>
<th>Training</th>
<th>Frequency</th>
<th>Percent of n&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courses Taken for CEU’s</td>
<td>46</td>
<td>40%</td>
</tr>
<tr>
<td>Topically Related University Courses for Credit</td>
<td>20</td>
<td>17%</td>
</tr>
<tr>
<td>District-level Professional Development</td>
<td>21</td>
<td>18%</td>
</tr>
<tr>
<td>Regional Association Conference Workshops</td>
<td>36</td>
<td>31%</td>
</tr>
<tr>
<td>State Association Conference Workshops</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td>NASP Conference Paid Workshops</td>
<td>16</td>
<td>14%</td>
</tr>
<tr>
<td>NASP Conference Mini Skills Workshops or Paper Presentations</td>
<td>24</td>
<td>21%</td>
</tr>
<tr>
<td>Webinars/Online Training</td>
<td>20</td>
<td>17%</td>
</tr>
<tr>
<td>I Have Not Had Any Additional Training</td>
<td>16</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>21%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Participants were able to select more than one answer choice; therefore the total number of responses is greater than the number of participants (N=111). The statistic “Percent of n” represents the percent of individuals that selected a particular answer choice. These percentages are not mutually exclusive of one another.
Types of services provided. Data were gathered to determine what types of prevention/intervention services are currently being implemented in the school setting. Participants were encouraged to select all response choices that apply. Results show that 74% of respondents’ schools refer students to outside agencies, 70% provide individual counseling, 52% complete an individualized social-emotional behavioral assessment, and 40% conduct small group counseling (See Table 5).
Table 5

Types of Anxiety Prevention/Intervention Services Provided

<table>
<thead>
<tr>
<th>Services</th>
<th>Frequency</th>
<th>Percent of n&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small group Counseling</td>
<td>46</td>
<td>40%</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>80</td>
<td>70%</td>
</tr>
<tr>
<td>Parent Support Groups</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Referral to Outside Agencies</td>
<td>84</td>
<td>74%</td>
</tr>
<tr>
<td>School or Class-wide Anxiety Screening</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Individualized Social Emotional-Behavioral Assessment</td>
<td>59</td>
<td>52%</td>
</tr>
<tr>
<td>Universal Interventions or Programming</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>No Interventions are Currently Provided for Students With Anxiety</td>
<td>11</td>
<td>10%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Participants were able to select more than one answer choice; therefore the total number of responses is greater than the number of participants (N=111). The statistic “Percent of n” represents the percent of individuals that selected a particular answer choice. These percentages are not mutually exclusive of one another.
Research Question 1

To analyze research question one, data were collapsed into three categories: yes, no, and unsure. Respondents who reported using one or more evidenced-based interventions were recorded as “yes,” and respondents who selected “We currently do not implement any evidenced-based interventions” were recorded as “no.” Respondents who selected “other,” and reported unfamiliarity with intervention services, were placed in the “unsure” category. Data indicates that 49.1% of surveyed school psychologists are using known evidenced-based prevention and/or intervention methods for treating anxiety in the school setting. Furthermore, the evidenced-based programs/strategies most frequently used include: Relaxation Training (37% of participants), Coping Cat (16% of participants), Ready….Set…R.E.L.A.X. (5% of participants), Skills for Social and Academic Success (SSAS) (3% of participants), Cognitive Behavioral Interventions for Trauma in Schools (CBITS) (2% of participants), and The C.A.T. Project (2% of participants). The data indicated that 45.4% of participants do not implement any evidenced-based intervention programs for treating anxious youth (See Table 6).

Table 6

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49.1%</td>
</tr>
<tr>
<td>No</td>
<td>45.4%</td>
</tr>
<tr>
<td>Unsure</td>
<td>5.6%</td>
</tr>
</tbody>
</table>
Research Question 2

**Importance of evidenced-based programs.** Participants rated their perceived level of importance for implementing programs that are evidenced-based when treating anxiety in the school setting based on a Likert scale ranging from zero to five: 0 = not at all important, 1 = very unimportant, 2 = somewhat unimportant, 3 = somewhat important, 4 = very important, and 5= extremely important. For data analysis, the six categories were collapsed into four categories. The categories “not at all important” and “very unimportant” were collapsed to create a single category: “very unimportant.” The categories “very important” and “extremely important” were collapsed to create a single category: “very important.” Results indicated that 84.1% of participants view the use of evidenced-based programs to be “very important” (See Figure 1).

**Potential barriers.** Participants were asked to rank their top three potential barriers to implementing anxiety prevention and intervention services. Available time (37%), available resources (25%), and feasibility of training teachers and staff for delivering treatment (19%) were cited as the three strongest, and most frequently reported barriers. Other job responsibilities taking precedence (18%) was also frequently reported, and was therefore highlighted as a potential barrier (See Table 7).
Figure 1

**Participants’ Perceived Level of Importance for Implementing Evidenced-Based Programs**

- Very Unimportant
- Somewhat Unimportant
- Somewhat Important
- Very Important
<table>
<thead>
<tr>
<th>Barriers</th>
<th>Frequency of 1</th>
<th>Frequency of 2</th>
<th>Frequency of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Time</td>
<td>40(^a)</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>Available Resources</td>
<td>19</td>
<td>26(^a)</td>
<td>15</td>
</tr>
<tr>
<td>Cost of Services</td>
<td>5</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Difficulties Implementing</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Exposure Activities as Part of CBT</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Feasibility of Training Teachers and Staff for</td>
<td>6</td>
<td>11</td>
<td>20(^a)</td>
</tr>
<tr>
<td>Delivering Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of Training and/or Professional Development</td>
<td>5</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Limited Familiarity with Anxiety Intervention</td>
<td>1</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Other Job Responsibilities Taking Precedence</td>
<td>20(^a)</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Parental Consent</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Support of Key-Stakeholders</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Willingness of Child to Participate</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Currently Do Not See Any Barriers</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

\(^a\) Highlighted as the strongest, and most frequently reported barriers.
Correlational Statistics

There was a non-statistically significant positive correlation between educational attainment and the use of evidenced-based programs ($r = .123$, $p = .208$). There was also a non-statistically significant weak positive correlation between perceived level of importance of implementing evidenced-based programs and the use of evidenced-based programs ($r = .077$, $p = .428$).
CHAPTER V
DISCUSSION

Review of Purpose

Previous research has highlighted the importance of prevention and early intervention services for treating anxiety in school-aged youth (Bienvenu & Ginsberg, 2007; Fox et al., 2012; Hirshfeld-Becker & Biederman, 2002; Tomb & Hunter, 2004). When providing mental health services, it is imperative that professionals utilize evidenced-based interventions (EBIs), which are researched-based treatment options that have previously demonstrated their effectiveness. Despite the availability and known benefits of using EBIs for treating anxiety, research has highlighted difficulties associated with transporting EBIs from the clinical setting to the schools (Ginsburg, Becker, Drazdowski, & Tein, 2012; Ginsburg, Becker, Newman Kingery, & Nichols, 2008; McLoone, Hudson, & Rapee, 2006; Schaeffer et al., 2005). Previous studies have identified challenges to implementing EBIs in the school setting, including: lack of support for school personnel and administration, limited funding for materials (i.e., protocols), lack of knowledge for selecting and implementing an EBI, clinician reluctance to use EBIs, and resistance from school staff and students (Schaeffer et al., 2005). The purpose of the present study was to identify what prevention, intervention, and/or treatment methods school psychologists are currently implementing
for anxiety in the school setting. Furthermore, the present study aimed to identify what EBIs are being utilized for anxiety prevention and intervention, in addition to perceived potential barriers for providing these services.

**Interpretation of Major Findings**

According to the NASP Model for Comprehensive and Integrated School Psychology Services, school psychologists should be trained to provide and support mental health prevention and intervention services. Based on gathered information in this study, the majority of school psychologists feel “somewhat” prepared to provide prevention and intervention services for anxious youth in the school setting. Research supports cognitive-behavioral therapy (CBT) to be the most effective psychosocial treatment evaluated for childhood anxiety (Ginsburg & Kingery, 2007). Findings indicate that the majority (41%) of participants’ graduate training prepared them “very little” to implement Cognitive-Behavioral Therapy (CBT) to prevent and treat anxiety in the school setting. Thus, while graduate training programs are required, under the NASP domains, to prepare school psychologists to provided mental health services, the majority of participants feel inadequately prepared to provide these services to anxious youth.

Findings indicate that school psychologists are implementing evidenced-based prevention and intervention services for treating anxiety more than predicted. The present study found that 49.1% of school psychologists are using known evidenced-based prevention and/or intervention methods for treating anxiety in the school setting. Evidenced-based programs/strategies most frequently used by participants include: relaxation training, Coping Cat, and Ready….Set…R.E.L.A.X.. With approximately half of the respondents implementing one or more EBIs for treating anxiety, these results
suggest that school psychologists and their districts are more involved with anxiety prevention and intervention than predicted. However, with 45.4% of participants reporting they do not currently implement any evidenced-based intervention programs for treating anxious youth, there is clearly room for professional development and service delivery improvement.

The present study found that available time, available resources, feasibility of training teachers and staff, and other job responsibilities taking precedence were the most frequently reported and highest ranked barriers to implementing prevention and intervention services. These findings are consistent with McLoone et al., (2006), who found that potential barriers, such as the cost of services, the feasibility of training teachers and staff for delivering treatment, parental consent, and competing demands, may prevent the delivery of EBIs for treating anxiety in the school setting.

School Psychologists’ perceived importance of implementing evidenced-based programs was not correlated with their actual implementation of evidenced-based programs. While 84.1% of participants reported the use of evidenced-based programs to be “very important,” 44.6% of those same participants reported that they do not currently implement any evidenced-based intervention programs for anxious youth. Additionally, while current White House initiatives support the increased delivery of mental health services in the school setting (White House, 2013), findings from this study indicate that 74% of respondents refer anxious youth to outside agencies as part of their provided services. Thus, there is a gap in the service delivery model between what research and current White House initiatives support, verses what participants reported as current practice in the school setting.
Findings Relative to Hypotheses

Practicing school psychologists are implementing more evidenced-based prevention and intervention services for treating anxiety than predicted. Hypothesis 1 stated that school psychologists would report limited use of evidenced-based prevention and intervention services for treating anxiety. Findings indicate that 49.1% of participants are using known evidenced-based prevention and/or intervention methods. Thus, hypothesis 1 was not supported.

It was predicted that school psychologists would report a perceived importance of evidenced-based treatment programs, but report an overall lack of funding, resources, and available time to implement these services. As predicted, the majority, 84.1%, of participants view the use of evidenced-based programs to be “very important.” Participants most frequently reported the following potential barriers for treating anxiety in the school setting: available time, available resources, feasibility of training teachers and staff, and other job responsibilities taking precedence. These findings support the predictions, thus hypothesis 2 was supported.

Limitations

The current study had several limitations that likely impacted the results. First, the sample is limited to school psychologists practicing in Ohio, thus the results may only reflect current practices in Ohio. The sample was further limited to Ohio school psychologists who are OSPA listserv members or OSPA spring conference attendees, limiting the generalizability of the results to practicing school psychologists in the state of Ohio. School psychologists who are members of a professional organization, such as OSPA, or those who attend professional conferences, may be more interested and
involved in professional development, and updated in best practices such as promoting positive social-emotional health. It is therefore important to recognize that the sample may not represent an accurate picture of anxiety prevention and intervention services being provided across the state.

It should also be noted that this study faces the risk of having a biased sample due to the social-emotional topic that was featured at the OSPA spring conference (interventions for students with Attention Deficit Hyperactivity Disorder). Participants attending the conference may have been more interested in mental health services, therefore influencing the results of the survey. Also to be considered is response bias, which can be defined as conditions or circumstances that influence the way responses are provided to survey questions, therefore leading to an underestimation or overestimation of the true population parameter (Lavrakas, 2008). For example, participants may recognize that providing evidenced-based interventions is best practice, and therefore report providing these types services to treat anxious youth, regardless of whether they are actually implemented. As with every study, it is possible that respondents may have misinterpreted a survey question(s), which would likely impact the results of the study. Lastly, it should be noted that while a disclaimer was placed in the recruitment follow-up email and recruitment poster, it is possible that certain participants may have taken the survey twice (either twice online, or once online and once at the OSPA conference), which may ultimately skew the data.

**Implications for Practice and Future Research**

The current research has implications for practice, graduate training, and future research. In terms of training, additional research should be conducted to determine what
types of training methods graduate programs are providing to prepare professionals to prevent and treat mental health issues such as anxiety in the schools. Future studies could utilize a survey design to gather information from school psychology program directors to determine how much emphasis is placed on evidenced-based practice for treating mental health issues. Specifically, future research could explore if school psychology graduate programs are training their students in these evidenced-based interventions, such as CBT for treating anxiety in the school setting. If training is not occurring, a program evaluation may be necessary to review and eventually modify existing curriculum to include training in evidenced-based prevention and intervention for mental health issues. Future research could also explore prevention and intervention methods for treating anxiety in the schools across the nation. This data would add to the reliability, validity, and generalizability of this study.

Results of the current study have many practical implications as well. With approximately half of surveyed school psychologists reporting that they do not currently implement any evidenced-based interventions, future research could examine feasible ways to eliminate or reduce potential barriers for delivering anxiety prevention and intervention services. Future research should more fully examine the school psychologists’ role in delivering mental health based services in the school setting. Future studies could compare the training and active role in providing these services of school psychologists verses school counselors. Finally, future research could examine the collaborative relationship among school-based mental health professionals (i.e., school psychologists, school counselors, social workers, etc.) in providing mental health services in the school setting.
Conclusion

Though anxiety is a naturally occurring mental state, it can become intense and uncontainable, leading to the development of a clinical disorder or psychopathology. Anxiety disorders are rated to be among the most common mental health conditions that children and adolescents suffer from. Given the negative impact anxiety disorders have on childhood development and academic functioning, it is imperative that efforts are taken to provide prevention and early intervention services. There are many identified evidence-based interventions for treating anxiety that have demonstrated effectiveness in the school setting. However, previous research has also shown the existence of many barriers to implementing these services in the school setting. School psychologists are in an ideal position to advocate for and provide these research-based treatment options. According to the *NASP Model for Comprehensive and Integrated School Psychology Services*, school psychologists should be trained to provide and support mental health prevention and intervention services. The current study found that school psychologists feel inadequately prepared to provided prevention and intervention services for anxious youth in the school setting. While the majority of participants perceive the use of evidenced-based interventions to be very important, only approximately half of those participants are actually using EBIs to treat anxiety in the school setting. Participants most frequently reported the following potential barriers for treating anxiety in the school setting: available time, available resources, feasibility of training teachers and staff, and other job responsibilities taking precedence. These results suggest future research should examine the training methods that graduate programs are providing to prepare professionals to prevent and treat mental health issues in the schools. Additionally,
future research could explore methods for reducing difficulties associated with delivering mental health services in the school setting. By increasing the training and delivery of evidenced-based interventions for treating anxious youth, school psychologists can collaborate with other school-based mental health professionals to meet the needs of anxious students.
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Dear Participant,

This letter is a request for you to take part in a research project entitled: *Current Assessments and Interventions to Identify and Treat Anxiety in the School Setting: A Survey of School Psychologists*. This project is being conducted by Dr. Elana Bernstein, a clinical faculty member in the Department of Counselor Education and Human Services at the University of Dayton along with graduate students, Brad Fletcher, MS and Brooke Gosser, MS. Your participation in this project is voluntary and greatly appreciated. Participation in the survey will take approximately 10 minutes.

Your involvement in this project is completely confidential. No information collected in the survey will be connected back to your identity as a participant. All data will be reported in the aggregate, thus your name will not be connected with your responses in any published use of the data. You must be 18 years of age or older to participate. Your participation is completely voluntary. By clicking through the attached link to the survey you are providing your consent to participate. You may skip any question that you do not wish to answer and you may discontinue your participation at any time. The University of Dayton’s Institutional Review Board acknowledgement of this research project is on file.

At the end of the survey you will be provided with the opportunity to enter to win one of four $25 Amazon gift cards. Participants who wish to enter the drawing may email the identified survey code to the following email address: anxietysurvey.ud@gmail.com. You will be notified in May via the e-mail address you send the code from if your e-mail address is selected in the drawing. Your mailing address will be requested at that time so you can receive your gift card.
We hope that you will participate in this research project, as it may be beneficial in understanding various barriers associated with delivering evidenced-based assessments and interventions for identifying and treating anxiety in the school setting. Thank you for your time. Should you have any questions about this letter, the survey, or the research project, please feel free to contact Dr. Elana Bernstein at (937) 229-3624 or by e-mail at ebernstein1@udayton.edu.

Thank you for your time and help with this important project.

Sincerely,

Elana R. Bernstein, PhD
Clinical Faculty

Brad Fletcher, MS
Graduate Researcher

Brooke Gosser, MS
Graduate Researcher
APPENDIX B

Current Assessments and Interventions to Identify and Treat Anxiety in the School Setting: A Survey of School Psychologists

Directions: Please answer the following brief questions regarding your knowledge and current practice of assessing and treating anxiety in your school setting. Please answer all questions to the best of your ability. It is estimated that this survey will take approximately 10 minutes to complete. Thank you in advance for your time and help.

Preliminary Questions:

Are you currently employed in a school as a school psychologist? Yes  
No

If your answer was No to the above question, have you worked in a school as a school psychologist in the past three years? Yes  
No

*If you are not currently employed in a school as a school psychologist and have not been employed in a school as a school psychologist at some point in the past three years, thank you for your time, but you are not eligible to participate. Please discontinue this survey at this time.
Demographic and Background Information:

What is your age?  
- 22-29 years
- 30-39 years
- 40-49 years
- 50-59 years
- 60+ years

Please mark your highest educational degree.  
- Masters Degree
- Educational Specialist
- Doctorate

Please mark the number of years of experience you have practicing as a school psychologist.  
- Intern
- < 2 years
- 3 to 5 years
- 6 to 10 years
- 11 to 15 years
- 16 to 20 years
- 21 or more years

Please select all that apply in describing the type of school district you currently work in.  
- Charter
- Private
- Public
Rural
Suburban
Urban

Approximately how many referrals a year do you receive for students who present with symptoms of anxiety?

- < 5 students
- 5-10
- 11-20
- 21-30
- > 30

I have worked < 1 yr

Other (specify): __________

Assessment of Anxiety Disorders in the Schools:

When identifying students with anxiety in your school, which of the following assessment methods do you and/or your district implement?

Please select all that apply:

- Interviews
- Child Self-Report Measures
- Parent Rating Scales (PRS)
- Teacher Rating Scales (TRS)
- Behavioral Observations
- Other (Please list) ________________________________________________

________________________________________________
Please rank the following assessment methods from 1 (most important) to 5 (least important) based on their importance in the process of assessing anxiety in your school:

____ Interviews
____ Child Self-Report Measures
____ Parent Rating Scales (PRS)
____ Teacher Rating Scales (TRS)
____ Behavioral Observations

Which of the following evidenced-based assessment measures do you and/or your district implement when assessing students for anxiety? Please select all that apply:

____ Anxiety Disorders Interview Schedule for Children (AIDIS)
____ Spence Children’s Anxiety Scale (SCAS)
____ Multidimensional Anxiety Scale for Children (MASC)
____ Revised Children’s Manifest Anxiety Scale (RCMAS-2)
____ Child Anxiety Impact Scale
____ Behavior Assessment Scale for Children-2nd edition (BASC-2)
____ Teacher Report Form (TRF)
____ Screen for Child Anxiety Related Disorders (SCARED)
____ Other (Please list) ________________________________________________

Indicate potential barriers to assessing anxiety in your school setting:

Please select and rank your top three, with 1 being the strongest barrier:

____ Available Time
____ Available Resources
Cost of assessments  
Feasibility of training teachers and staff for assessment  
Parental Cooperation  
I currently do not see any barriers to conducting anxiety assessment in my school district.  
Other (Please list) 

Do you or your school district currently conduct social-emotional screenings of which anxiety is a component?  
Yes  No

Interventions for Anxiety Disorders in the Schools:

In your school setting, who is primarily responsible for implementing anxiety prevention and intervention services?  
Intervention Specialists  
Outside mental health care providers working in the school setting  
School Counselors  
School Psychologists  
Social Workers  
General Education Teachers  
We do not currently provide interventions for students with anxiety.

Other (Please list) 

The following two questions will be answered on a scale from 1 to 6, with 1 being not at all, and 6 being very much.
Do you feel that your graduate training adequately prepared you to provide prevention/intervention services for anxiety in the school setting?

1 – 2 – 3 – 4 – 5 – 6

More specifically, do you feel that your graduate training adequately prepared you to implement Cognitive-Behavioral Therapy (CBT) to prevent and treat anxiety in the school setting?

1 – 2 – 3 – 4 – 5 – 6

When providing interventions for students with anxiety in your school, which of the following prevention and intervention services do you and/or your district implement? Please select all that apply:

_____ Small group counseling
_____ Individual counseling
_____ Parent support groups
_____ Referral to outside agencies
_____ School or class-wide anxiety screening
_____ Individualized social–emotional–behavioral assessment
_____ Universal (school-wide or class-wide) interventions or programming for anxiety/stress reduction

_____ We currently do not provide prevention and intervention services for treating anxiety.

The following question will be answered on a scale from 1 to 6, with 1 being not very important and 6 being very important.

How important do you feel it is to use programs that are evidenced-based interventions when treating anxiety in the schools?

1 – 2 – 3 – 4 – 5 – 6
When providing interventions for anxiety in your school, which of the following evidenced-based intervention programs/strategies do you and/or your district implement (if, and when, you receive an anxiety referral) for prevention and intervention services? Please select all that apply:

_____ Camp Cope-a-Lot (Computer based Coping Cat)
_____ The C.A.T. Project
_____ Cognitive Behavioral Interventions for Trauma in Schools (CBITS)
_____ Coping Cat
_____ Cool Kids Child and Adolescent Anxiety Program: School Version
_____ FRIENDS for Life
_____ Modular Cognitive-Behavioral Therapy for Childhood Anxiety Disorders (Chorpita)
_____ Ready....Set....R.E.L.A.X.
_____ Relaxation Training
_____ Skills for Social and Academic Success (SSAS)
_____ Social Effectiveness Therapy for Children (SET-C)
_____ Strong Start, Kids, or Teens Program
_____ Transfer of Control Approach
_____ Queensland Early Intervention and Prevention of Anxiety Project

_____ We currently do not implement any evidenced-based treatment programs for treating anxiety.

_____ Other (Please list) ________________________________________________
When considering potential barriers to implementing anxiety prevention and intervention services in your school setting, please select and rank your top 3, with 1 being the strongest barrier:

___ Available time
___ Available resources
___ Cost of services
___ Difficulties implementing exposure activities as part of CBT
___ Feasibility of training teachers and staff for delivering treatment
___ Lack of training and/or professional development
___ Limited familiarity with anxiety intervention
___ Other job responsibilities taking precedence
___ Parental consent
___ Support of key-stakeholders
___ Willingness of child to participate
___ I currently do not see any barriers to implementing anxiety prevention and intervention services in my school district.

___ Other (Please list) ______________________________________________

________________________________________________

Thank you for participating in this survey!

If you are interested in being entered to win one of four $25 Amazon gift cards, please send the code ANXIETYSURVEY to anxietysurvey.ud@gmail.com. You will be notified in May via the e-mail address you send the code from if your e-mail address is selected in the drawing and your mailing address will be requested at that time so you can receive your gift card.