EVALUATION OF A TRAINING ON TEACHERS’ IDENTIFICATION
OF ANXIETY IN STUDENTS

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EVALUATION OF A TRAINING ON TEACHERS’ IDENTIFICATION
OF ANXIETY IN STUDENTS

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ABSTRACT

EVALUATION OF A TRAINING ON TEACHERS’ IDENTIFICATION OF ANXIETY IN STUDENTS

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Students living with anxiety symptoms, without the proper identification or assistance, may experience adverse short- and long-term effects. Given the high prevalence rate and negative consequences associated with anxiety, it is important to continually increase awareness and training in identification and assistance of students experiencing anxiety symptoms. The present study employed a small-scale randomized experimental design evaluating the effect of a training program entitled Training Teachers to Identify Children with Anxiety Problems (T-TICAP) on teacher’s ability to identify students with heightened anxiety and on teachers’ gained knowledge about anxiety. Ten teachers were selected through convenience sampling and were randomly assigned to either a no-training (control) or training group; five teachers were placed in each group. Next, students (n = 92) in the teacher’s classrooms were assessed with the Multidimensional Anxiety Scale for Children, Self-Report, 2nd Edition (MASC 2-SR) after consent was
received from their parents. Teachers in the training group assessed students’ anxiety levels using the *Anxiety Nomination Rubric* after training with the *T-TICAP*. Teachers in the no-training group assessed students’ level of anxiety using the *Anxiety Nomination Rubric* before the *T-TICAP* training. Results indicated no statistical difference between teachers in the training versus no training groups with regard to accurate identification of student anxiety. Teachers’ overall knowledge of anxiety symptoms significantly increased between the *T-TICAP* pre-test and post-test. Suggestions are made for future research to improve practices in early identification of childhood anxiety in a school setting.
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CHAPTER I
INTRODUCTION

Students spend a great deal of their time in school, second only to time spent at home (Clauss-Ehlers, Serpell, & Weist, 2013). Students derive their context, direction, and support for academic, social, and emotional learning from their school day (Clauss-Ehlers et al., 2013). However, the sense of secrecy and shame associated with mental health difficulties in students’ peer groups, the school system, and society prevents a number of people from seeking help or identifying students in need of assistance (The White House, 2013). Between 10-21% of children and adolescents struggle with some type of anxiety disorder and approximately 15-30% of children have struggled with subclinical (undiagnosed) levels of anxiety (Costello, Egger, & Angold, 2005; Reivich, Gillham, Chaplin, & Seligman, 2005).

Anxiety can be defined as the anticipation of a future threat with symptoms including muscle tension, avoidance, and cautious behaviors (American Psychiatric Association, 2013). These responses to future threat can lead to avoidance behaviors, limiting one’s independent options in relation to the anxious situation socially and/or situationally (Cross & Cross, 2015). Miller et al. (2011) found that unidentified students had a higher risk of developing severe secondary disorders. The lack of diagnosis or identification increases the students’ risk for psychiatric disorders later in life (Legerstee et al., 2013). Easy accessibility to students in the school systems poses a perfect place to
identify anxiety symptoms early and increase awareness of anxiety disorders.

The current study evaluated a training program for increasing teachers’ awareness of anxiety disorders, as well as their ability to accurately identify anxiety problems in their students. Previous studies indicated that the knowledge teachers gained from the training program improved their ability to accurately identify students with anxiety in the classroom.
CHAPTER II
LITERATURE REVIEW

This literature review will examine the lack of identification of mental health problems in school-age youth, research on screening methods, the importance of teacher professional development in the schools, and the teacher’s role in identifying students with mental health risk indicators. It will conclude with a specific focus on studies involving anxiety related problems.

Mental Health in the Schools

The United States Department of Health and Human Services (USDHHS, 2000) defines mental health in childhood and adolescence as the attainment of developmental milestones involving cognitive, social, and emotional capabilities. Beyond developmental milestones, individuals attain mental health by maintaining secure attachments, satisfying social relationships, and effective coping skills. The years of early childhood (3 years to 8 years), late childhood (9 years to 12 years), and adolescence (13 years to 18 years) span nearly two decades of time during which children gain wisdom about the world around them. When consulting Erik Erikson’s *Psychosocial Stages of Development*, the third, fourth, and fifth stages include a wide variation of growth adaptability: Initiative vs. Guilt (3 years to 5 years), Industry vs. Inferiority (5 years to 12 years), and Ego Identity vs. Role Confusion (12 years to 18 years). When
mental health issues arise during these stages in a child’s life, they can become a roadblock for a child’s academic and social success (Hussein & Vostanis, 2013).

Among children and adults with identifiable mental health difficulties, less than half receive the treatment that they require (The White House, 2013). Gleason et al. (2012) noted that attitudes toward mental health problems are poor due to a lack of general knowledge in the area. Training in mental health can positively increase perceived knowledge and attitudes about mental health in the schools (Gleason et al., 2012). Perhaps now is the time to redefine mental illness, create awareness, and train individuals to help identify and refer those in need of assistance. The need for early identification of students with mental health issues is important because symptoms can worsen over time, requiring more intensive treatment (The White House, 2013).

Second only to the base of knowledge that children learn at home, they learn their context, direction, and support for academic, social, and emotional learning at school (Clauss-Ehlers et al., 2013). When teachers and other school staff possess an awareness and knowledge of mental health problems in children and adolescents, they can play an important role in helping to identify students with these difficulties in the schools (Johnson, Eva, Johnson, & Walker, 2011). The more knowledge teachers and other school faculty have, the more equipped they will be to identify mental health needs of students and, in turn, improve student functioning and achievement (Blank & Alas, 2010).

**Anxiety**

Anxiety is the anticipation of a future threat with symptoms including muscle tension, avoidance, and cautious behaviors (American Psychiatric Association, 2013).
These responses to future threat can lead to avoidance behaviors, limiting one’s independent options in relation to the anxious situation socially and/or situationally (Cross & Cross, 2015).

**Prevalence.** The overall lifetime prevalence rate of anxiety disorders in school-aged children is between 10-21% and approximately 15-30% of children have struggled with subclinical (undiagnosed) levels of anxiety (Costello et al., 2005; Reivich et al., 2005). This high prevalence makes anxiety related disorders the most commonly found diagnosis in schools today, with social anxiety at the top (Sportel, Hullu, Jong, & Nauta, 2013). The median age of onset for anxiety disorders is 11 years old and they tend to be chronic throughout adulthood. Anxiety often presents with other diagnoses (e.g. ADHD, depression, etc.) across the lifespan (Costello et al., 2005).

**Long-term consequences.** Simon, Bogels, and Voncken (2011) found that untreated anxiety symptoms in students may lead to high levels of anxiety in the years to follow. Coplan, Findlay, and Schneider (2010) also found that children rated as highly anxious by their parents were rated as significantly more anxious by their teachers two years later. Anxiety in adolescence is associated with interpreting neutral stimuli as potentially threatening. This can lead to maladaptive cognitive styles, such as lower perceived control of situations and increased avoidance of anxiety related symptoms (Erozkan, 2012). Students with untreated anxiety are at a higher risk for developing more severe anxiety and other related problems in the future. These problems may include co-morbid diagnoses, school drop-out, academic difficulties, school avoidance, social difficulties, peer rejection, social incompetence, emotional difficulties, low self-worth, and depression (Copeland, Angold, Shanahan, & Costello, 2014; Grills-Taquechel,
Norton, & Ollendick, 2010). Other long-term consequences may include, but are not limited to: suicide, marital discord/divorce, premature death, impaired family cohesion, and the increased probability of psychiatric disorders (Legerstee et al., 2013; Miller et al., 2011).

**Impact on school functioning.** A study by Jarrett, Black, Rapport, Grills-Taquechel, & Ollendick (2015) compared the school functioning of younger and older children who were diagnosed with Generalized Anxiety Disorder. Data found that parents reported greater school competence issues for older children and greater amounts of perfectionism in younger children. Teachers reported more learning problems and less happiness in older children.

A study by Mychailyszyn, Mendez, and Kendall (2010) compared the school functioning of several groups of students diagnosed with different anxiety disorders. The authors compared a group of undiagnosed students with a group of diagnosed students. Diagnoses included separation anxiety disorder, social phobia, and generalized anxiety disorder. Students were diagnosed based on parent and teacher reports of school functioning. These parent and teacher reports assessed academics, determination in academics, appropriate behaviors, happiness levels, and possible internalizing behaviors. The researchers found that the students with no anxiety diagnoses displayed significantly higher levels of school functioning than students with separation anxiety disorder, social phobia, and generalized anxiety disorder. Their findings indicate that identification of anxiety in the school systems is beneficial for improving students’ school functioning.

**School-based services for anxiety.** Approximately 36.2% of adolescents who have a mental health disorder receive services (Merikangas et al., 2011). Anxiety
treatment in school-aged children is very effective in both the short and the long term, whether using individual- or small-group approaches. These results are found in the school, clinic, or private locations (Erford, Kress, Giguere, Cieri, & Erford, 2015). However, Masia-Warner, Nangle, and Hansen (2006) found that schools are the best place to reach children and adolescents in need of support. In fact, 70–80% of students who receive mental health services receive them in a school setting (Allen, 2011). Positive aspects of children and adolescents receiving community mental health services at school are cost reduction and ease of transportation (Masia-Warner et al., 2006). Failure to provide treatment to youth presents a major concern (Mychailyszyn et al., 2011). Using the school systems and its employees can be an effective way to solve this crisis.

**Prevention of Anxiety**

With the high prevalence of mental health disorders among students, evaluating the efficacy of different levels of interventions is important in preventing and decreasing mental health disorders in the school system (Crawford et al., 2015). Prevention of anxiety disorders involves implementation of an intervention developed to assuage or reduce the symptoms/characteristics of elevated anxiety levels or diagnosed anxiety disorders. Literature suggests that prevention programs may significantly improve children’s anxious behaviors and cognitive processes (Anticich, Barrett, Gillies, & Silverman, 2012). There are three types of prevention programs: Universal (Tier 1) programs are provided to all students, regardless of symptoms, and designed to build resiliency or enhance general mental health of the whole population. Selective (Tier 2) programs target students who are at risk of developing a disorder. Indicated (Tier 3)
programs target students who exhibit early or mild symptoms of the disorder (Neil & Christensen, 2009). Neil and Christensen (2009) reviewed 20 early intervention programs for anxiety, most of which targeted school-aged students. They found that the majority of school-based universal, selected, and indicated prevention programs successfully reduced students’ anxiety symptoms.

Most of these programs (78%) included cognitive behavioral therapy (CBT). CBT is highly effective in reducing anxiety symptoms and preventing onset of anxiety disorders (Sportel et al., 2013). According to Gallegos, Linan-Thompson, Stark, and Ruvalcaba (2013), anxious children who received early intervention displayed increased practical coping skills and decreased depressive symptoms and risk for depression. This suggests that early intervention/prevention techniques for anxiety management may significantly reduce or prevent symptoms and characteristics associated with anxiety, and thus the overall prevalence of the problem.

Universal programs (i.e., providing school-wide relaxation training in the classroom) offer prevention for students showing clinical level symptoms, subclinical level symptoms, and no symptoms at all. When working with students ranging from subclinical level symptoms to no symptoms, these programs can promote resiliency and prevent symptoms that may result in a diagnosis (Neil & Christensen, 2009). Reivich et al. (2005) suggest symptoms of anxiety can be reduced and prevented by promoting appropriate cognitive styles, problem-solving skills, and encouraging family interactions through early intervention programs.

Essau, Conradt, Sasagawa, and Ollendick (2012) found supportive relationships between parents and their children were the most important aspect of anxiety prevention.
They suggested that schools should use positive parent and child relationships to increase the efficiency in anxiety prevention interventions. Given that mental health services are difficult to access because of potential barriers for children and families, early school-based prevention may be an economically feasible and efficient method for providing treatment (Anticich et al., 2012). Such school-based prevention services help parents and children increase their knowledge of positive coping skills and reduce anxiety symptoms (Anticich et al., 2012).

**Early identification.** An important component of prevention is early identification. Early identification of a mental health problem increases the possibility that parents and children will seek help for the identified problem (Cauce et al., 2009). Sherbourne et al. (2009) found that early identification and treatment of anxiety may result in more favorable treatment responses from the child/adolescent. Recognition and identification of the problem signify the first step in seeking help for a student with an anxiety disorder. A deeper understanding of anxiety and its effects on youth is crucial to understanding the importance of the decision to seek help (Cauce et al., 2009).

**School-based identification.** Teachers’ daily extended contact with children puts them in a perfect position to distinguish early warning signs of a child’s academic, social, emotional or behavioral functioning (Feeney-Kettler, Kratochwill, Kaiser, Hemmeter, & Kettler, 2010). Lane and Menzies (2003) found that in the school setting academic failure and future life difficulties may decrease when students receive early prevention and intervention strategies. When appropriate screening and early identification procedures are unavailable, children’s mental health problems are often left untreated, leading to the aforementioned long-term consequences (Dvorsky, Girio-Herrera, &
Universal screening. Universal screening is conducted with all students in a given classroom, school, or district to identify students at risk of behavioral or academic difficulties (Eklund et al., 2009). It consists of brief assessments that are highly predictive of future outcomes (Jenkins, 2003). Universal screening is effective for identifying students in need of prevention and intervention programs for mental health problems. While schools provide academic screening and supports for students in the general and special education setting, early identification tools such as universal screening for behavior/social-emotional functioning can increase the likelihood that students are healthier and moving toward improved functioning (Eklund et al., 2009). Evidence suggests that universal screening and interventions enhance not only mental health and resilience, but also promote pro-social behavior, pupil engagement, and academic learning (Roffey, 2015). Universal screening can help to identify and alleviate some of the symptoms of mental health disorders, reducing the likelihood of a future diagnosis (Feeney-Kettler et al., 2010). Essex et al. (2009) found that school entry screening, a universal screening tactic used when a student enters the education system, can efficiently identify students with co-morbid recurrent symptomatology and provide a base for developing intervention programs targeting students’ specific issues.

Internalizing problems such as anxiety and depression often go unnoticed due to their covert and subjective symptoms. These symptoms are best identified through self-report or individual interviews and generally include emotional problems that originate internally (Watkins, 2007). According to Dwyer, Nicholson, and Battistutta (2006), parent- and teacher-based screenings are more effective at identifying externalizing
behaviors (e.g. ADHD/Conduct issues) than internalizing behaviors (e.g. depression/anxiety). They found that teachers and parents correctly identified 30-46% of students with internalizing problems and 68-78% of students without internalizing behaviors without any prior training. Given that parents and teachers were not as effective at identifying internalizing behaviors than externalizing behaviors in this study, Dwyer et al. (2006) inquired about the extent of training previously received by parents and teachers, as this may be helpful in increasing their ability to identify internalizing problems in their students.

There are limited cost-effective and time-efficient universal screening measures available for screening students (Feeney-Kettler et al., 2010). With limited funding in most school districts, Eklund et al. (2009) found it more acceptable to incorporate screening of behavioral and emotional problems into school districts already utilizing Response to Intervention (RTI) models and universal academic screeners in reading and math (e.g., DIBELS or AIMSweb). Some examples of universal screening for behavior include the Behavior Assessment System for Children (BASC-2), Behavioral and Emotional Screening System (BESS), Ages and Stages Questionnaires-Social Emotional (ASQ-SE), and Systematic Screening for Behavior Disorders (SSBD; Coffee, Ray-Submaranian, Schanding, & Feeney-Kettler, 2013). Eklund et al. (2009) noted that given the lack of access and funds to screen every child in the school system, teaching teachers to properly identify students with mental health problems can be beneficial to the students. Although research has demonstrated the reliability and validity of several screening tools, very few studies have provided information about the feasibility and acceptability of universal screening procedures for students with academic, behavioral, or
emotional difficulties (Glover & Albers, 2007). Successful referrals after the screening process critically depend upon the school’s mental health services, the staff’s ability to identify, and the school’s identification efforts (Lynch et al., 2015).

**Training Teachers to Identify Mental Health Problems**

While mental health professionals are trained to identify mental health problems, data shows that most teachers are not. Furthermore, teachers are generally the first trusted person in whom a struggling student will confide (Cornett, 2015). School teachers often have contact with students for an extended amount of time each school day. Through this job, they are in a position to recognize early warning signs in a student’s academic, social, emotional or behavioral functioning (Feeney-Kettler et al. 2010). Kourkoutas and Giovazolias (2015) found that teachers can effectively assist students who are at-risk or showing mental health difficulties when they are effectively directed and supported by well-trained mental health personnel. Froelich, Breuer, Doepfner, and Amonn (2012) worked with teachers for a 12 week period, giving them intensive information regarding attention deficit hyperactivity disorder (ADHD) and oppositional defiance disorder (ODD). They suggest increased professional development for teachers on early identification of ADHD and ODD can improve teachers’ skills in addressing attentional and disruptive behavioral problems in the classroom. In a study by Loades and Mastroyannopoulou (2010), teachers were asked to recognize the existence of students’ mental health problems in their classroom and rate its severity. The teachers were significantly more concerned with students with symptoms of a behavioral disorder than of an emotional disorder. However, they found that teachers’ awareness of mental health problems are relatively unexplored (Loades and Mastroyannopoulou, 2010). Rothi,
Leavey, and Best (2008) found that teachers were concerned with their lack of training in the mental health field, and because of this, they felt incapable of properly identifying mental health problems in their students. Seeking help for a child with a mental health disability often depends on the teacher’s attentiveness to detail regarding the problems (Sayal, 2006). If teachers lack training in how to identify students with mental health disabilities, their attentiveness to detail may decrease.

**Teacher professional development.** Professional development in education is the most effective approach for sustaining, extending, and refining skills in novice to experienced teachers. This development helps increase teachers’ knowledge, skills, outlook, and best practices throughout their career paths as educators (Jaquith, Mindich, Wei, & Darling-Hammond, 2010). A study by White et al. (2011) found through a two-week teacher training program on obsessive-compulsive disorder (OCD) and ADHD that the workshop showed improvement in knowledge of OCD and ADHD for all of the teachers. Even greater improvement was found for teachers who scored below the mean on the pre-test, before the training session (White et al., 2011). Reinke, Stormont, Herman, Puri, and Goel (2011) found that teachers reported a lack of experience and training in supporting children with mental health needs in their classroom. Tilly (2008) found in the RTI three-tiered model that teachers are expected to identify when students fall far enough behind to warrant a referral for assessment. The limitations in this system are that most teachers may lack training in mental health problems. Hussein and Vostanis (2013) created a teacher training program targeting the early identification of child mental health problems in Pakistan. Their research demonstrated that after a two-day workshop promoting teachers’ knowledge and awareness of mental health disorders
(including emotional and behavioral), teachers improved their knowledge and awareness of signs and symptoms of mental health disorders. Hussein and Vostanis (2013) noted that the highest improvement was seen on a section regarding strategies to manage difficult behaviors. In order for teachers to be able to more adequately identify students with emotional and behavioral disabilities; specific training in how to identify and when to refer is necessary.

**Training teachers to identify anxiety.** There is a significant lack of research on the effectiveness of teacher training on anxiety disorder identification in children and adolescents. Trudgen and Lawn (2011) interviewed teachers regarding their training in recognizing anxiety and depression in secondary school students. Out of 20 teachers in their study, six attended formal training in a broad area of mental health and one received specific training on anxiety. This one teacher obtained anxiety training based on the specific needs of the school he was working with at the time. Even with the professional training these teachers received, most had no training in the recognition of anxiety in students (Trudgen & Lawn, 2011).

Auster (2006) created, implemented, and evaluated a teacher training program on the identification of childhood anxiety disorders in a classroom setting. Her study meant to expand upon the limited research of training teachers to identify anxiety problems in students. The *Teacher Training to Identify Children with Anxiety Problems* (*T-TICAP*; Feeney-Kettler, Auster, & Kratochwill, 2005) training program and the *Anxiety Nomination Rubric* were both developed for the purpose of her study. This training entailed a pre-knowledge assessment, training needs assessment, post-knowledge assessment, and lessons to train teachers about anxiety. The average completion time for
the entire training was 50 minutes. Results of her study indicated that the training was effective in increasing teachers’ knowledge of identifying students with anxiety.

**Measures Involving Teachers in Anxiety Identification**

The present study is a replication of the unpublished master’s thesis by Auster (2006), previously discussed.

The *Anxiety Nomination Rubric* is based on the *Systematic Screening for Behavior Disorders (SSBD)* created by Walker and Severson (1990) and the *Training Teachers to Identify Program (TTIP)* created by Tomb and Hunter (2003). The *SSBD* is a multiple-gate screening system for identifying at-risk elementary school (K – 6) students. The *SSBD* consists of three stages (“gates”), including: (1) teacher ranking of students, (2) teacher completion of behavior rating scales, and (3) playground and classroom observations (Walker & Severson, 1992). Stage One includes identification guidelines and a class roster. The teachers are asked to identify twenty students from their classrooms, ten students who display internalizing behaviors and ten students who display externalizing behaviors (Walker & Severson, 1992). In Stage Two, the teachers are asked to rank the ten internalizing students from the most internalizing to the least internalizing and asked to rank the ten externalizing students from the most externalizing to the least externalizing. In Stage Three, trained professionals are brought in to observe the students who were previously identified in Stages two and three (Walker & Severson, 1992).

Tomb and Hunter (2003) found the *SSBD* to be time-consuming and limited to only elementary students. To address these limitations, they created the *TTIP*. The *TTIP* provides teachers with the appropriate tools to identify and recognize internalizing or
externalizing behaviors in students grades K-12. Using the TTIP, Tomb and Hunter (2003) found that of the students identified with internalizing and externalizing behaviors, 59.3% needed referral for further evaluation by a school-based intervention team for a potential disorder. Auster (2006) created the Anxiety Nomination Rubric for her study based on Walker and Severson’s SSBD and Tomb and Hunter’s TTIP. She created the Anxiety Nomination Rubric to screen for anxiety in children and adolescents.

Auster (2006) found that the teachers’ knowledge of anxiety identification increased as a result of the T-TICAP training program. Since Auster’s study, little research in this area has been conducted. The purpose of the present study is to replicate her study and add to the limited research base.

The Present Study

The proposed research study examined identification of anxiety disorders in the school systems through training teachers to appropriately identify anxious students. The study involved comparing teacher judgments of students’ levels of anxiety to students’ responses on a questionnaire about their thoughts, feelings, and behaviors. The study compared the responses of teachers and students, with half of the teachers participating in a training program on anxiety, and half of the teachers not participating in training.
CHAPTER III
METHOD

Research Questions and Predictions

The following research questions were examined in the present study:

**Research question 1.** Will teachers who receive the *T-TICAP* program more accurately identify students with anxiety problems measured by the *Multidimensional Anxiety Scale for Children 2, Self-Report* (MASC 2-SR; March, 2013) and the *Anxiety Nomination Rubric* (Auster, 2006) compared to the teachers who do not receive the *T-TICAP* training program?

**Prediction 1.** It was predicted that teachers who received the *T-TICAP* program would be better able to identify students with anxiety problems measured by the *MASC 2-SR* and the *Anxiety Nomination Rubric* compared to the teachers who do not receive the *T-TICAP* training program. This prediction is based on Walker and Severson’s (1992) research indicating that training teachers is beneficial in improving their awareness of mental health in children and their ability to identify it.

**Research question 2.** Will the Training Teachers to Identify Children with Anxiety Problems (*T-TICAP; Feeney-Kettler, Auster, & Kratochwill, 2005*) program increase teachers knowledge of child and adolescent anxiety problems by indicating a higher percentage correct on the Anxiety Symptoms Knowledge Assessment post-test
than on the Anxiety Symptoms Knowledge Assessment pre-test?

**Prediction 2.** It was predicted that teachers who received the T-TICAP program would increase their knowledge of child and adolescent anxiety problems as demonstrated on the *Anxiety Symptoms Knowledge Assessment*. Jaquith et al. (2010) found that professional development is the best approach for gaining knowledge, skills, and best practice throughout teachers’ career paths. This prediction is also based on a study by White et al. (2011) that found a brief teacher training program on OCD and ADHD significantly improved teacher’s knowledge of the disorders.

**Research Design**

The present study employed a small-scale randomized experimental design. The measures in this study produced quantitative data to analyze the accuracy of teacher ratings in identifying anxiety symptoms in students. Teachers were selected through convenience sampling and were randomly assigned to either a training or no-training group. This design was selected based on the positive outcomes that Auster (2006) demonstrated in her study as well as the limited opportunity to conduct a large-scale experiment. The independent variable in this study was participation in either the training group or the no-training group. The dependent variables in this study included: 1) teachers’ knowledge gains on the *Anxiety Symptoms Knowledge Assessment* and 2) the accuracy in identification of student anxiety based on the correlation between the *Anxiety Nomination Rubric* and the *MASC 2-SR*.

**Participants and setting.** Participants in the current study included (n = 10) general education teachers (5 teachers in the control [no-training] group and 5 teachers in the training group), and (n = 92) students from a rural school district in the Midwestern
region of the United States. Teachers were recruited from the school district in which the researcher was completing a school psychology internship.

Students in this study ranged from 8 years of age (3rd grade) to 12 years of age (6th grade). Student demographics included 38 males (41.3%) and 54 females (58.6%). Out of the males: 15 were 3rd grade, 8 were 5th grade, and 15 were 6th grade. Out of the females, 12 were 3rd grade, 15 were 5th grade, and 27 were 6th grade. Out of 92 students in the study, 50 students were rated by teachers in the training condition and 42 students were rated by teachers in the no-training condition. There were an uneven number of students rated by each teacher due to issues with obtaining parental consent. Frequency counts of students per teacher can be found in Table 1. The sampling strategy used for recruiting teachers was convenience sampling. Convenience sampling is used when participants are chosen because they are available (Mertens, 2015). The student age range of 8 years of age (3rd grade) to 12 years of age (6th grade) was selected due to the normative sample used in the development of the MASC 2-SR (March, 2013). The normative sample included 1800 self-report ratings from youths aged 8 to 19 years-old. The choice to include students in 6th grade or younger was due to the emphasis on early identification and prevention of anxiety in the literature.
Table 1

Teacher Demographic Information

<table>
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<th>Teacher Identification Number</th>
<th>Teacher Gender</th>
<th>Grade Level</th>
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<td>4</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>6</td>
<td>Training</td>
<td>8</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>5</td>
<td>No-training</td>
<td>10</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>6</td>
<td>Training</td>
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<td>9</td>
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<td>5</td>
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<td>3</td>
<td>No-training</td>
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<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
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<td>No-training</td>
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<td>2</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>Male</td>
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<td>Training</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>5</td>
<td>No-training</td>
<td>13</td>
<td>5</td>
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</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>3</td>
<td>No-training</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>Female</td>
<td>6</td>
<td>Training</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

Measures

Anxiety Nomination Rubric. The Anxiety Nomination Rubric (see Appendix B) is based on the Systematic Screening for Behavior Disorders (SSBD) assessment created by Walker and Severson (1990). Created by Auster (2006), the Anxiety Nomination Rubric was developed specifically for her study and administered to teachers as the second to last section of the Teacher Training to Identify Children with Anxiety Problems (T-TICAP; Feeney-Kettler, Auster, & Kratochwill, 2005) program for teachers in the training condition and independently for teachers in the control (no-training) condition.
Participating students (with signed consent forms on file) were compiled into a list for each participating teacher’s classroom (i.e., teachers completed the rubric only for students in their classroom whose parents consented to their participation). Based on their ongoing observations in the classroom (and knowledge gained via the training for teachers in the training condition), teachers rated each student on an Anxiety Nomination Rubric Likert scale from 1 to 5: 1 = Never Anxious, 2 = Rarely Anxious, 3 = Sometimes Anxious, 4 = Often Anxious, and 5 = Always Anxious. This scale is based on the premise that anxiety symptoms exist on a continuum.

**Anxiety Symptoms Knowledge Assessment.** The Anxiety Symptoms Knowledge Assessment (see Appendix B) was completed as a pre-post test to the T-TICAP program (Feeney-Kettler, Auster, & Kratochwill, 2005). The goal of the Anxiety Symptoms Knowledge Assessment was to assess teachers’ knowledge of anxiety before and after the training program occurred.

The pre-test contained 10 questions, including true/false (1 question), multiple choice (4 questions), short answer/fill in the blank (3 questions), and long answer/fill in the blank (2 questions) questions. The questions focused on general anxiety knowledge, including: anxiety prevalence, symptomology, consequences if untreated, differences between anxiety and other disorders, teacher action strategies, prevention, and risk factors. The pre-test was scored based on the percentage correct out of 25 points. Several questions on the pre-test were worth multiple points. The Anxiety Symptoms Knowledge Assessment pre-test can be found in Appendix B.

The post-test (see Appendix B) contained 20 questions that included a mixture of true/false (5 questions), multiple choice (11 questions), and short answer/fill in the blank
(4 questions) items. Questions focused on identification of anxiety symptoms in children and adolescents in the school setting, including: anxiety prevalence, symptoms, consequences if untreated, risk factors, treatment, teacher action strategies, and prevention. The post-test was scored based on the percentage correct out of 32 points. Several questions on the post-test were worth multiple points. The content on the post-test was covered throughout the training program.

Multidimensional Anxiety Scale for Children 2nd edition, Self-Report. The online version of the Multidimensional Anxiety Scale for Children 2nd ed. Self-Report (MASC 2-SR; March, 2013) is a narrowband measure of anxiety appropriate for children and adolescents ranging in age from 8 to 19 years. It consists of 50 Likert scale questions rated on a scale from 0 to 3 where 0 = Never, 1 = Rarely, 2 = Sometimes, and 3 = Often. This scale is designed to assess a broad range of emotional, physical, cognitive, and behavioral symptoms in order to cover the representation of childhood anxiety symptoms (March, 2013). Participating students whose parents provided consent completed the MASC 2-SR in order to measure their current level of anxiety. The MASC 2-SR online assessment was administered in a computer lab in small groups of approximately 5 to 6 students; each group took approximately 15-20 minutes. Each student had his or her own computer and was read the directions as a group before taking the assessment. This time included reading the assent form, instructions, and completing the measure. The assent form, instructions, and all items in the measure were read out loud to the students. It is important to note that students with emotional or behavioral disorders may require more time because of problems concerning concentration, decision making, or needed instruction repetition (March, 2013). If necessary, these students completed the form
with the researcher in a one-on-one setting. Students’ online assessments were scored automatically and sent to the researchers account.

The *MASC 2-SR* contains four main subscales: 1) physical symptoms, 2) harm avoidance, 3) social anxiety, and 4) separation/panic. There is also a Total Anxiety Scale Score that measures symptoms across all four main subscales. The *MASC 2-SR* results in standardized *T*-scores that have a mean of 50 and standard deviation of 10. High *T*-scores on the *MASC-2* generally indicate high levels of anxiety-related symptoms. A *T*-score of < 40 is Low (fewer concerns than are typically reported), 40-54 is Average (Typical levels of concern), 55-59 is High Average (Borderline levels of concern), 60-64 is Slightly Elevated (Slightly more concerns than are typically reported), 65-69 is Elevated (More concerns than are typically reported), and 70 + is Very Elevated (Many more concerns than are typically reported).

The *MASC 2-SR* has strong psychometric properties. The coefficient alpha reliability of the *MASC 2-SR* Total Score is .92 in the overall *MASC 2-SR* normative sample; test-retest reliability ranged from .80 to .94, all *p*<.001. The internal consistency of the *MASC 2-SR* was .92 in the normative sample and a .79 median alpha value for the scales and subscales. The normative sample for the *MASC 2-SR* included 1800 self-report ratings from youths aged 8 to 19 years-old. This information demonstrates that the users of the *MASC 2-SR* can be confident the scores generated using this measure will be consistent and reliable (March, 2013). The validity measures for the *MASC 2-SR* found that it is highly acceptable in discriminating between relevant groups, correlating meaningfully with scores from other measures of anxiety, and generalizing across rater type and racial/ethnic groups (March, 2013).
**Evaluation survey for the T-TICAP.** Teachers were asked to complete an evaluation survey for the *T-TICAP* program adapted from the evaluation survey created by Auster (2006). This evaluation contained 13 questions that involved a mixture of Likert scale (10 questions) and qualitative/fill in the blank (4 questions) items. The Likert scale questions were rated on a scale from 1 to 5 where 1 = Very Ineffective, 2 = Somewhat Ineffective, 3 = Not Sure, 4 = Somewhat Effective, and 5 = Very Effective. This evaluation was utilized to assess the perception of the usefulness of the training program by the teachers who completed it. The evaluation survey for the *T-TICAP* can be found in Appendix B.

**Training Materials**

**Training Teachers to Identify Children with Anxiety Problems (T-TICAP) Program.** For research question 1, teachers in the training group took part in the *T-TICAP* training program. For research question 2, all teachers whom had not previously been given the training was given the *T-TICAP* training program. This was due to a high interest in the training. The *T-TICAP* is designed to train teachers to appropriately identify anxiety in children. Components of the *T-TICAP* program are described in Table 2.
Table 2

*Components of the T-TICAP Program*

<table>
<thead>
<tr>
<th>Component</th>
<th>Topic</th>
<th>Objectives</th>
<th>Time for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1</strong></td>
<td>a) What do you know about childhood anxiety disorders?</td>
<td>Determine teachers’ current understanding of childhood anxiety.</td>
<td>7 minutes</td>
</tr>
<tr>
<td></td>
<td>b) What are my training needs regarding child and adolescent anxiety?</td>
<td>Determine what areas teachers are in need of training on the topic.</td>
<td>3 minutes</td>
</tr>
<tr>
<td><strong>Part 2</strong></td>
<td>Why is it important to identify children and adolescents with anxiety?</td>
<td>Present teachers with information on the prevalence and long-term consequences of anxiety as well as the importance of early intervention.</td>
<td>5 minutes</td>
</tr>
<tr>
<td><strong>Part 3</strong></td>
<td>What places someone at-risk for anxiety?</td>
<td>Present teachers with information about the risk and protective factors for anxiety.</td>
<td>2 minutes</td>
</tr>
<tr>
<td><strong>Part 4</strong></td>
<td>What are the symptoms of anxiety?</td>
<td>Present the common symptoms of anxiety across four main types (physical, emotional, academic, &amp; social). Also present the Anxiety Symptom Spectrum to discuss how symptoms can vary in intensity.</td>
<td>10 minutes</td>
</tr>
<tr>
<td><strong>Part 5</strong></td>
<td>What does a child with anxiety look like?</td>
<td>Discuss with teachers how symptoms of anxiety might be observed in a classroom.</td>
<td>3 minutes</td>
</tr>
<tr>
<td><strong>Part 6</strong></td>
<td>What role can you (the teacher) play?</td>
<td>Re-visit the importance of early identification and prevention and present teachers with things they can</td>
<td>2 minutes</td>
</tr>
</tbody>
</table>
Part 7  Can you identify varying levels of anxiety?  Teachers will read and provide ratings (based on level of anxiety) of students described in a series of case examples.  5 minutes

Part 8  Can you identify varying levels of anxiety in your students?  Teachers will consider the students in their own classroom and provide ratings (based on level of anxiety) of their students.  7 minutes

Part 9  Evaluation Survey and time for questions  Obtain information on teachers’ perceived effectiveness and utility of the program. Allow teachers to ask questions.  6 minutes

Part 10  Knowledge Assessment  Determine if teachers’ knowledge on the subject increased.  10 minutes

TOTAL TIME FOR IMPLEMENTATION  60 minutes


Procedures

Phase I: Institutional Review Board (IRB) approval. Approval to conduct this research study was obtained through the IRB at the University of Dayton and the district school board prior to recruitment and data collection.

Phase II: Recruitment and parental consent. Recruitment of teachers occurred through word of mouth, emails, and telephone calls in the school district in which the researcher was completing a school psychology internship. Once teacher participants were recruited, they were randomly assigned to either the training or no-training
condition. Students in the teachers’ classrooms were then recruited by sending parental consent forms home. Students who brought back the consent forms signed by their parent(s) then completed the MASC 2-SR and were included on the list of students that teachers rated with the Anxiety Nomination Rubric.

Phase III: Anxiety Symptoms Knowledge Assessment. The Anxiety Symptoms Knowledge pre-test was administered to all teachers in the training and no-training group.

Phase IV: T-TICAP with all training group teachers. The T-TICAP training program was delivered by the researcher to teachers in the training condition.

Phase V: MASC 2-SR with all participating students. All participating students were read the assent form and asked to sign. The researcher read the instructions for the MASC 2-SR and asked if there were any questions. Students completed the MASC 2-SR online as the researcher read each item out loud. Students received a small incentive (a prize from a small treasure box) for their participation in the study. Students’ online assessments were scores automatically and results were sent to the researcher’s password protected account.

Phase VI: Anxiety Nomination Rubric with all training group and no-training group teachers. All participating teachers were given the Anxiety Nomination Rubric to assess their participating students’ anxiety levels based on knowledge gained (for training group teachers), observation, and daily interactions in the classroom.

Phase VII: Evaluation Survey for the T-TICAP with all training group teachers. All participating training group teachers completed the evaluation survey of the T-TICAP program in order to assess the perception of the usefulness of the training program.
Phase VIII. Anxiety Symptoms Knowledge Assessment post-test with all training group and no-training group teachers. The Anxiety Symptoms Knowledge Assessment post-test was given to all training and no-training group teachers. This assessment was given to teachers in both conditions in order to compare the two groups appropriately. Teachers in both conditions were given a twenty dollar gas gift card at the completion of the study for their participation. At the conclusion of this study, all teachers in the no-training group were given the option to participate in the T-TICAP and given the materials that were provided to the training group teachers. All no-training group teachers chose to participate in the T-TICAP program.
CHAPTER IV
RESULTS

The primary purpose of the current study was to examine the effectiveness of the teacher training program entitled *Teacher Training to Identify Children with Anxiety Problems (T-TICAP;* Feeney-Kettler, Auster, & Kratochwill, 2005). The effectiveness of the training was measured by the teachers’ ability to accurately identify anxiety problems in their students as well as by the knowledge gained by teachers, as measured on a pre/post knowledge assessment.

**Research Question 1**

*Will the teachers who receive the T-TICAP program identify more students with anxiety problems measured by the MASC 2-SR (March, 2013) and the Anxiety Nomination Rubric (Auster, 2006) when compared to the teachers who did not receive the T-TICAP training program?*

It was predicted that teachers who received the *T-TICAP* program would more accurately identify students with anxiety problems measured by the *MASC 2-SR* and the *Anxiety Nomination Rubric* compared to the teachers who did not receive the *T-TICAP* training program.

This prediction was evaluated by comparing teacher ratings of students’ anxiety levels on the *Anxiety Nomination Rubric* to the student *MASC 2-SR T*-scores. The
training group teachers’ ratings of students’ anxiety levels on the *Anxiety Nomination Rubric* were compared with the no-training group ratings of students’ anxiety levels on the *Anxiety Nomination Rubric*. The scores on the *MASC 2-SR* were transformed from an interval variable to an ordinal variable, creating five levels (equivalent to the number of levels on the *Anxiety Nomination Rubric*). A *T*-score of < 40 is Low (fewer concerns than are typically reported), 40-54 is Average (Typical levels of concern), 55-59 is High Average (Borderline levels of concern), 60-64 is Slightly Elevated (Slightly more concerns than are typically reported), 65-69 is Elevated (More concerns than are typically reported), and 70 + is Very Elevated (Many more concerns than are typically reported). Figure 1 displays the distribution of *T*-scores on the *MASC 2-SR*.

It is important to note that, out of 92 students assessed, 13 students had a heightened inconsistency index on the *MASC 2-SR*. The *MASC 2-SR* specifies that the inconsistency index score indicates responses on similar items showed high levels of inconsistency. Scores may not accurately reflect the individual’s anxiety levels due to careless or unusual responses to some items. These results should be interpreted with caution. A score of 9 to 24 is considered to be a high level of inconsistency and a score 8 or lower is considered to be a low level of inconsistency. Data revealed that out of 13 students with heightened inconsistency indexes: 8 were third graders, 3 were fifth graders, and 2 were sixth graders. Though the *MASC 2-SR* is normed for children ages 8 to 19 years old, it was found that 8 and 9 year old students had a higher likelihood of demonstrating inconsistency on the measure compared to other ages and grades. Because a large number of third grade students showed heightened inconsistency index scores and the norms found that 8 and 9 year old students had a higher likelihood of demonstrating
inconsistency, the researcher removed all third graders from the study. This resulted in the final study including 79 students total: 40 students rated by teachers in the training condition and 39 students rated by teachers in the no-training condition. Figure 1 displays the MASC-2-SR scores for these remaining 79 students. The resulting distribution of students’ Total Anxiety Scale t-scores resulted in 5 students scoring in the Low range, 28 students scoring in the Average range, 10 students scoring in the High Average range, 10 students scoring in the Slightly Elevated range, 10 students scoring in the Elevated range, and 16 students scoring in the Very Elevated range.

Figure 1

_Distribution of Students’ Total Anxiety Scale T-scores on the MASC 2-SR_

Participating students (with signed consent forms on file) were compiled into a list for each participating teacher’s classroom. Based on observation and daily
interactions (plus knowledge gained from the training for teachers in the training condition), the teachers rated each child on an Anxiety Nomination Rubric Likert scale from 1 to 5; 1 = Never Anxious, 2 = Rarely Anxious, 3 = Sometimes Anxious, 4 = Often Anxious, and 5 = Always Anxious. The distribution of teacher-rated levels of student anxiety on the Anxiety Nomination Rubric can be found in Figure 2. Out of 79 students, teachers rated 16 as Never Anxious, 20 as Rarely Anxious, 24 as Sometimes Anxious, 15 as Often Anxious, and 4 as Always Anxious.

Figure 2

*Distribution of Teacher Rated Levels of Student Anxiety on the Anxiety Nomination Rubric*

To compare student scores on the MASC 2-SR and teacher ratings on the Anxiety Nomination Rubric, a sensitivity-specificity analysis was conducted. A simple
correlation could not be conducted because of the uneven distribution of students per teacher, the lack of variability among teachers’ ratings, and non-independent nature of the two scores (MASC 2-SR and ANR). Instead, a sensitivity and specificity analysis was conducted to measure the accuracy of the Anxiety Nomination Rubric. A sensitivity and specificity analysis is a statistical measure classification function, also known as a binary classification test. This data analysis can be found in Table 3 and an expanded version of the data can be found in Table 5. This analysis revealed that the T-TICAP had no statistical significance in increasing teachers’ ability to identify students. Across conditions, teachers misidentified 19 students with anxiety symptoms. Specifically, teachers in the training group misidentified 9 (22.5%) students with anxiety symptoms and teachers in the no-training group misidentified 10 (25.6%) students with anxiety symptoms.
Table 3

*Sensitivity and Specificity Analysis by Condition*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Sensitivity (True Positive)</th>
<th>Misidentified Rate (False Positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student self-reported elevated symptoms of anxiety (MASC-2 Total Anxiety Score ≥ 65)</td>
<td>Total n^a = 7 (8.8%)</td>
<td>Total n^a = 12 (15.2%)</td>
</tr>
<tr>
<td>Teacher reported elevated level of anxiety for the student (ANR rating of 4-5)</td>
<td>Training Teachers n^b = 2 (5%)</td>
<td>Training Teachers n^b = 6 (15%)</td>
</tr>
<tr>
<td>No-Training Teachers n^c = 5 (12.8%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Miss Rate (False Negative)</th>
<th>Specificity (True Negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student did not self-report elevated symptoms of anxiety (MASC-2 Total Anxiety Score &lt; 65)</td>
<td>Total n^a = 19 (24%)</td>
<td>Total n^a = 41 (51.8%)</td>
</tr>
<tr>
<td>Teacher did not report elevated level of anxiety for the student (ANR rating of 1-3)</td>
<td>Training Teachers n^b = 9 (22.5%)</td>
<td>Training Teachers n^b = 23 (57.5%)</td>
</tr>
<tr>
<td>No-Training Teachers n^c = 10 (25.6%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Table adapted from Green & Zar, 1989

- ^a^ Number of students rated out of total number of students (in grades 4-6) across both conditions (n = 79)
- ^b^ Number of students rated in *training* condition out of total number of students (n = 40)
- ^c^ Number of students rated in *no training* condition out of total number of students (n = 39)

Classification of teachers’ accuracy in identifying students with anxiety symptoms was created for this study to further represent teachers’ accuracy of identification. This classification chart can be found in Table 4.
Table 4

*Classification of Teachers Accuracy Percentage in Correctly Identifying Students with Anxiety*

<table>
<thead>
<tr>
<th>Correct Identifications (in percentages)</th>
<th>Classification Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>81-100%</td>
<td>High Accuracy</td>
</tr>
<tr>
<td>61-80%</td>
<td>Moderate Accuracy</td>
</tr>
<tr>
<td>41-60%</td>
<td>Slight Accuracy</td>
</tr>
<tr>
<td>21-40%</td>
<td>Poor Accuracy</td>
</tr>
<tr>
<td>1-20%</td>
<td>Very Poor Accuracy</td>
</tr>
</tbody>
</table>
Table 5

*Sensitivity and Specificity Analysis by Teacher and Condition*

<table>
<thead>
<tr>
<th>Teacher Identification Number</th>
<th>Training/No-Training Group</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Misidentified Rate</th>
<th>Miss Rate</th>
<th>Accuracy</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Training</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>56%</td>
<td>Slight Accuracy</td>
</tr>
<tr>
<td>2</td>
<td>Training</td>
<td>0</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>88%</td>
<td>High Accuracy</td>
</tr>
<tr>
<td>3</td>
<td>No-training</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>63%</td>
<td>Moderate Accuracy</td>
</tr>
<tr>
<td>4</td>
<td>Training</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>60%</td>
<td>Slight Accuracy</td>
</tr>
<tr>
<td>5</td>
<td>No-training</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>63%</td>
<td>Moderate Accuracy</td>
</tr>
<tr>
<td>6</td>
<td>No-training</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>80%</td>
<td>Moderate Accuracy</td>
</tr>
<tr>
<td>7</td>
<td>Training</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>75%</td>
<td>Moderate Accuracy</td>
</tr>
<tr>
<td>8</td>
<td>No-training</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>58%</td>
<td>Slight Accuracy</td>
</tr>
<tr>
<td>9</td>
<td>No-training</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>33%</td>
<td>Poor Accuracy</td>
</tr>
<tr>
<td>10</td>
<td>Training</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>44%</td>
<td>Slight Accuracy</td>
</tr>
<tr>
<td>Combined Training Group</td>
<td></td>
<td>2</td>
<td>23</td>
<td>6</td>
<td>9</td>
<td>64.6%</td>
<td>Moderate Accuracy</td>
</tr>
</tbody>
</table>

36
<table>
<thead>
<tr>
<th></th>
<th>5</th>
<th>18</th>
<th>6</th>
<th>10</th>
<th>59.4%</th>
<th>Slight Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined No-Training Group</td>
<td>5</td>
<td>18</td>
<td>6</td>
<td>10</td>
<td>59.4%</td>
<td>Slight Accuracy</td>
</tr>
<tr>
<td>Combined Overall</td>
<td>7</td>
<td>41</td>
<td>12</td>
<td>19</td>
<td>62%</td>
<td>Moderate Accuracy</td>
</tr>
</tbody>
</table>
Research Question 2

Will the Training Teachers to Identify Children with Anxiety Problems (T-TICAP; Feeney-Kettler, Auster, & Kratochwill, 2005) program increase teachers knowledge of child and adolescent anxiety problems by indicating a higher percentage correct on the Anxiety Symptoms Knowledge Assessment post-test than on the Anxiety Symptoms Knowledge Assessment pre-test?

It was predicted that teachers who received the T-TICAP program would increase their knowledge of child and adolescent anxiety problems as demonstrated on the Anxiety Symptoms Knowledge Assessment. Jaquith et al. (2010) found that professional development is the best approach for gaining knowledge, skills, and best practice throughout teachers’ career paths. This prediction was also based on a study by White et al. (2011) that found a brief teacher training program on OCD and ADHD significantly improved teacher’s knowledge of the disorders.

This prediction was evaluated by comparing teachers’ scores on the Anxiety Symptoms Knowledge Assessment pre-test and the Anxiety Symptoms Knowledge Assessment post-test. After data collection, all teachers in the no-training group chose to participate in the T-TICAP training. Because the Anxiety Symptoms Knowledge Assessment post-test was given to teachers in both conditions after the training, an independent samples t-test could not be conducted to compare the knowledge gained between the training and no-training groups. Instead, a Wilcoxon Signed-Rank Test was completed for all participants comparing the knowledge gained from pre-test to post-test for the group as a whole. The nonparametric Wilcoxon Signed-Rank Test was chosen (as opposed to a one sample t-test) because of the small sample size ($n = 10$). The results of
the Wilcoxon Signed-Rank Test showed gains in knowledge from pre-test (median = 62% of items correct) to post-test (median = 93.75% of items correct) that was statistically significant \( z = -2.803; \) Asymp. Sig 2-tailed = .005; effect size = .88). This indicates the likelihood that the results were not random. Knowledge gained was calculated for each teacher in the study. The percent of questions answered correctly was calculated for the pre- and post-test. The difference between the two tests was calculated as a percentage because the pre- and post-knowledge assessments contained different numbers of items. Pre- and post-test score data can be found in Table 6.

Table 6

*Comparison of Mean Scores on the Pre- and Post-Test of Knowledge*

<table>
<thead>
<tr>
<th>N</th>
<th>Mean Pre-Test Score (out of 25)</th>
<th>Median Pre-Test Score (out of 25)</th>
<th>Mean Post-Test Score (out of 32)</th>
<th>Median Post-Test Score (out of 32)</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>16 (64%)</td>
<td>15.5 (62%)</td>
<td>29.7 (92.8%)</td>
<td>30 (93.7%)</td>
<td>9.68</td>
</tr>
</tbody>
</table>

**Evaluation of the T-TICAP.** In order to determine if teachers found the *T-TICAP* program useful, teachers’ answers to the *T-TICAP* evaluation survey were examined using descriptive statistics. These evaluations contained nine Likert scale questions and four qualitative/fill in the blank questions. The Likert scale questions were rated on a scale from 1 to 5 where 1 = Very Ineffective, 2 = Somewhat Ineffective, 3 = Not Sure, 4 = Somewhat Effective, and 5 = Very Effective. Mean responses for each Likert scale question are provided in Table 7. The overall mean value for the nine Likert scale questions was 4.71 (SD = 0.45). This score indicates that teachers reported the *T-*
TICAP program to be effective in increasing their knowledge of childhood anxiety as well as their ability to accurately identify students with anxiety in their classroom.

Responses to the qualitative/fill-in-the-blank questions were evaluated as well. The first question asked: “What is the most important thing that you learned in this training program?” Teachers’ responses included the following: (a) anxiety characteristics, (b) how to better identify different levels of anxiety in students, (c) many symptoms and comparisons to other disorders, (d) symptoms of anxiety, (e) symptoms and the rubric to determine the severity of anxiety, (f) there were many different types of symptoms of anxiety that I hadn't thought about, (g) signs of anxiety, (h) The signs of anxiety that could have otherwise been attributed to other diagnoses, (i) all the signs a student with anxiety could have, and (j) symptoms/warning signs of anxiety in students.

The second qualitative question on the evaluation survey asked: “What is the least important thing that you learned in this program?” Three teachers stated that it was all important; one teacher stated that the information regarding how anxiety affects school performance was not as important because they knew it previously, and six teachers indicated that the question was not applicable.

The final qualitative question asked: “What else would you have liked to learn about anxiety problems that were not provided in this training program?” Teachers’ responses included the following: (a) more with gifted students, (b) more strategies to help students with anxiety issues, (c) examples of modifications in the classroom, (d) who to refer students to for anxiety, (e) more information on how to help with anxiety within the classroom, (f) specific coping strategies for children, (g) how to address students directly while they are experiencing anxiety symptoms, (h) more ways to handle
anxiety in the classroom, (i) more ways of helping students treat or cope with their symptoms, and one teacher stated that they felt all important topics were covered.

Qualitative responses from teachers on the evaluation survey were very positive; indicating that teachers felt the T-TICAP program was helpful and useful. This prediction was supported based on the descriptive statistics provided above through the T-TICAP questionnaire.

To further evaluate the acceptability of the training program, the total completion time was collected from each of the teachers in the training condition. The average completion time across conditions was 50 minutes. The anticipated total time for completion predicted by the researcher was 60 minutes, and was maintained during the actual implementation of the program.
### Table 7

*Mean Ratings on the T-TICAP Evaluation Survey*

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4.70</td>
<td>0.48</td>
</tr>
<tr>
<td>2</td>
<td>4.90</td>
<td>0.31</td>
</tr>
<tr>
<td>3</td>
<td>4.90</td>
<td>0.31</td>
</tr>
<tr>
<td>4</td>
<td>4.50</td>
<td>0.52</td>
</tr>
<tr>
<td>5</td>
<td>4.50</td>
<td>0.70</td>
</tr>
<tr>
<td>6</td>
<td>4.80</td>
<td>0.42</td>
</tr>
<tr>
<td>7</td>
<td>4.80</td>
<td>0.42</td>
</tr>
<tr>
<td>Overall Rating of the T-TICAP</td>
<td>4.60</td>
<td>0.51</td>
</tr>
<tr>
<td>Overall Rating of the Facilitator</td>
<td>4.80</td>
<td>0.42</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>4.71</td>
<td>0.45</td>
</tr>
<tr>
<td>Completion Time for the Training</td>
<td>50(^a)</td>
<td>9.42</td>
</tr>
</tbody>
</table>

\(^a\) Reported in minutes

### Supplementary Results

As part of the *T-TICAP* program, all 10 teachers completed a measure indicating their training needs with regards to anxiety symptoms identification. The measure asked teachers to respond on a five-point likert scale (1 = Strongly Agree; 2 = Agree Somewhat; 3 = Not Sure; 4 = Disagree Somewhat; 5 = Strongly Disagree).
The total mean of all items was 2.89 (SD = 0.23). When asked if they have had adequate training in identifying students with anxiety disorders, teachers answered with an average of 1.50 (SD = 0.70). This indicates that teachers somewhat to strongly disagreed. When asked if they were familiar with the symptoms of anxiety disorders in children and adolescents, knew who to refer a student with heightened anxiety to, how anxiety affects a student’s school performance, if they have had experience teaching students with anxiety, and if they knew how to modify a curriculum for a student with anxiety, most teachers answered in the “somewhat not knowing” to “not sure” categories. This questionnaire indicated that although teachers have some understanding of anxiety symptoms in their students, they have not previously received training on how to identify anxiety symptoms in their students. Results from the seven items on the training needs measure are provided in Table 8.
Table 8

Mean Ratings on the T-TICAP Training Needs Measure

<table>
<thead>
<tr>
<th>Training Needs Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.50</td>
<td>0.70</td>
</tr>
<tr>
<td>2</td>
<td>2.60</td>
<td>1.26</td>
</tr>
<tr>
<td>3</td>
<td>3.50</td>
<td>1.26</td>
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<tr>
<td>4</td>
<td>3.65</td>
<td>1.33</td>
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<td>5</td>
<td>2.60</td>
<td>1.42</td>
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<tr>
<td>6</td>
<td>3.55</td>
<td>1.16</td>
</tr>
<tr>
<td>7</td>
<td>2.85</td>
<td>1.15</td>
</tr>
<tr>
<td><strong>Total Mean</strong></td>
<td>2.89</td>
<td>0.23</td>
</tr>
</tbody>
</table>
CHAPTER V
DISCUSSION

Review of Purpose and Major Findings

The purpose of the present study was to expand the research on training teachers to identify anxiety in their students and replicate a previous study completed by Auster (2008). Specifically, the purpose was to determine teachers’ abilities to accurately identify anxiety in their students following participation in an anxiety training program. The results provide implications for future research in the area.

The research study initially included 10 teachers and 92 students, in grades three through six. The third graders were removed from the study because of a heightened inconsistency index seen across the third grade students. This left 79 students in the present study. Further, all ten teachers were eventually given the training program because of a high interest in increasing their knowledge of child and adolescent anxiety problems. Therefore, the no-training teachers were given the Anxiety Nomination Rubric before the training (in order to compare accuracy across conditions); however, training data involving the pre-test and post-test were compiled for both training and no-training participants because the no-training participants completed the post-training questionnaire after completing the training. The following conclusions can be drawn from the results: (1) teachers who received the Training Teachers to Identify Children
with Anxiety Problems (T-TICAP; Feeney-Kettler, Auster, & Kratochwill, 2005) program increased their knowledge of child and adolescent anxiety problems demonstrated by a higher percentage on the Anxiety Symptoms Knowledge Assessment post-test than on the Anxiety Symptoms Knowledge Assessment pre-test, and (2) the T-TICAP program had no statistical significance in improving teachers’ accuracy in the identification of students with anxiety problems measured by the MASC 2-SR (March, 2013) and the Anxiety Nomination Rubric (Auster, 2005). Although the teachers overall demonstrated slight accuracy (accurately identifying 60.6% of students in the study) in their identification of students with anxiety, no statistically significant differences were found across conditions.

**Interpretation of Findings Relative to Predictions**

**Research Question 1.** It was predicted that the teachers who received the T-TICAP program would more accurately identify students with anxiety problems compared to teachers who did not receive the T-TICAP program. Data analyses did not support this hypothesis. The training program had no statistically significant effect on teachers’ ability to identify students in their classrooms with anxiety problems. Teachers in the training group accurately identified 2 (5%) students with anxiety symptoms, while teachers in the no-training group accurately identified 5 (12.8%) students with anxiety symptoms. Conversely, teachers in the training group correctly perceived 23 (57.5%) non-anxious students, while teachers in the no-training group correctly perceived 18 (46.2%) non-anxious students. In a study by Cunningham and Suldo (2014), teachers accurately identified approximately 40% of students who had heightened anxiety. This study did not include a training program. Figueroa (2013) found that teachers’ level of
awareness was more consistent in identifying students with externalizing behavioral issues than students with internalizing mental health issues. The awareness levels of teachers were inconsistent for students who had anxiety issues. Furthermore, Figueroa (2013) found that teachers' training, backgrounds, acquired degrees, and years of teaching experience did not positively correlate with accurate identification of students with anxiety symptoms. Data collected from this study did not support the predicted hypothesis for research question two.

There are several possible reasons why the training program was not effective. One possible reason is that, after the training, teachers were unable to return to their classroom to observe their students before ranking the students anxiety levels. Another reason is that anxiety is internal and therefore not visible unless students are showing external symptoms. Finally, teachers were unable to give more time than one planning period for the training. Therefore, the training was reduced to fit within their planning period and may have produced a “rushed” training resulting in less effective training results.

**Research Question 2.** It was predicted that teachers who received the *T-TICAP* program would increase their knowledge of child and adolescent anxiety problems by scoring a higher percentage on the post-test than the pre-test. This hypothesis was accepted. In the study, an average score of 16 out of 25 points possible, 64%, was tabulated for the pre-test. An average score of 29.7 out of 32 points possible, or 92%, was tabulated for the post-test. Average knowledge gained from pre- to post-test was 28%. The knowledge of child and adolescent anxiety problems gained by teachers in the training program was statistically significant. Teachers in the no-training condition were
offered the opportunity to receive the training program after data was collected for research question two (completion of the ANR). Therefore, data comparing the pre-test and post-test for the training included all ten teachers in the study, and could not be compared across conditions.

The results of the Wilcoxon Signed-Rank Test showed that the knowledge gained from pre- to post-test was statistically significant. This indicates the likelihood that the results were not random. Jaquith, Mindich, Wei, and Darling-Hammond (2010) suggest that professional development in education is the most effective approach for sustaining, extending, and refining skills in novice to experienced teachers. This development helps to increase teachers’ knowledge, skills, outlook, and best practices throughout their career paths as educators. Data collected from this study supported the predicted hypothesis for research question one.

**Follow-up**

After the *MASC 2-SR* scores were tabulated, parents of all 92 students were called by the evaluator to discuss a summary of their students’ anxiety levels. It was found that all students except for two (with scores in the average range) were found to have similar anxiety levels at home reported by parents compared to what was observed on the *MASC 2-SR*. The parents of these two students (with scores in the average range) expressed concerns about the anxiety symptoms they were seeing in their students at home. The evaluator consulted with each parent regarding their concerns and sent home an anxiety fact sheet that included the definition, incidence and prevalence, symptoms of anxiety, interventions, and types of media that may be beneficial. This factsheet was created by the evaluator to help parents to understand the anxiety they may be seeing and to provide
suggestions for how to work with their child. All parents whose children’s scores fell in the Elevated or Very Elevated range received the anxiety fact sheet as well. Further, parents who expressed additional concerns about their child were provided the option of having their students attend an anxiety group counseling session with the school counselor and the researcher.

**Limitations**

There are several limitations to consider when interpreting the findings of this study. First, students were assessed using the *Multidimensional Anxiety Scale for Children – Second Edition (MASC 2-SR)* once during this study. The potentiality of an overly sensitive measure being used once may have contributed to measurement error. Test-retest reliability for the *MASC 2-SR* states that students can be re-assessed after four weeks. Assessing the students twice and averaging their scores together might ensure a more valid *T*-score for each student on the *MASC 2-SR*. Next, the number of students participating in this study was not evenly distributed across the 10 teachers. For example, one teacher provided ratings for four students while another teacher provided ratings for thirteen students. This uneven distribution across classrooms could be attributed to parents not returning the consent letters/declining participation or students forgetting to return the permission slip to school. This uneven distribution of students participating in several classrooms limited the potential statistical analyses that could have been used as well as the interpretation of the results.

Another known limitation of the current study is that teachers were selected on a voluntary basis. This introduced selection bias into the study because of possible prior interest in the area of anxiety among participating teachers. Additionally, 13 students out
of the total 92 were removed from the study because of a heightened inconsistency index score on the MASC 2-SR, eight of whom were third graders. It was found that third graders did not generally understand the MASC 2-SR questions or had a lack of self-awareness that is necessary in completing a self-report questionnaire. The final limitation to this study was that the researcher also doubled as the trainer.

Implications for Future Research

The present study suggests important implications for future research. First, a large portion of third graders (compared to other grades) were removed from the study because of heightened inconsistency index scores. After further research, Stone et al. (2013) suggests that when using self-report assessments, it is better to assess young children in an interview format instead of a questionnaire. This may ensure more reliable answers because younger children are often incapable of self-perception without help through an interview format. Stone et al. (2013) cautions that young children are sensitive to suggestion; therefore, it is important that the evaluator has interviewing skills to ensure an increased validity in responses. This study also found that student’s anxiety rates slowly increased with each given year. It would be helpful for future research studies to identify the approximate amount of anxiety students in the third grade or below have through the use of an interview format. It would also be helpful for future researchers to assess the anxiety levels of students above the sixth grade to find if the rate of anxiety steadily increases to the senior year of high school or if the steady increase of anxiety levels is based on life transitions throughout the school years.

Second, this research study found that teachers’ accurate identification of students with anxiety was lower than what the researcher had anticipated, even for teachers who
received the T-TICAP training. This is a serious concern. When teachers are not identifying students with heightened anxiety, it implies an increased risk for the student. It would be helpful for future researchers to investigate how to help teachers to increase their identification rate of anxious students in their classrooms. Anxiety is a difficult trait for informants (i.e., parents, teachers, etc.) to rate, and refined measurement is an important goal for future studies. This could be through refining the T-TICAP, completing follow-up trainings, having the teachers go back to their classrooms after the T-TICAP and observe their students before rating which students have heightened anxiety, and/or allowing more time for the training. It would also be helpful for future researchers to investigate why teachers gave higher ratings to some students that did not accurately indicate highly anxious symptoms.

Finally, recent research has found that using parent rating scales as a first gate in the multi-gate system is premature and may create un-due stress on parents because of false-positive rates (i.e., inaccurately telling parents that their kindergarten child is at risk; Owens et al., 2015). Teachers have been found to be an excellent first gate in a multi-gate system (i.e., the SSBD; Walker & Severson, 1990) of identifying students with heightened anxiety. Future research could investigate how to improve collaboration of all school personnel involved in the multi-gate system to increase the percentage of students who are given the assistance they need.

Conclusion

With an average of 10-21% of students nationally who struggle with anxiety disorders, not including the 15-30% of undiagnosed students who struggle with subclinical anxiety symptoms, anxiety disorder holds the title of the most common
disorder in school age students (Costello, Egger, & Angold, 2005; Reivich, Gillham, Chaplin, & Seligman, 2005). This high prevalence, coupled with the negative consequences associated with anxiety, indicates a need for our schools to increase awareness, knowledge, and training in the identification of anxiety in their students.

The school system provides easy accessibility to students who may benefit from the identification and increased awareness of anxiety symptoms because of the amount of time students spend at school each day (Clauss-Ehlers, Serpell, & Weist, 2013). However, in order for teachers and other school professionals to properly assist students with heightened anxiety, staff members need to be adequately trained in the identification of anxiety in their students. School psychologists and other school professionals can assist in the increased awareness of anxiety symptoms in their school system and assist in the implementation of interventions to reduce possible negative consequences and lessen the impact that increased anxiety can have on the students’ social/emotional and academic progress.
REFERENCES


health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70*(1), 44-55. doi: 10.1037/0022-006x.70.1.44


http://dx.doi.org/10.1111/j.1469-7610.2005.01543.x


http://dx.doi.org/10.1080/15374416.2011.546039


The White House. (2013). *Now is the Time: The president’s plan to protect our children and our communities by reducing gun violence.*

http://dx.doi.org/10.1037/e521652013-001


REFERENCES FOR APPENDIX B


APPENDIX A

IRB MATERIALS AND CONSENT/ASSENT LETTERS

UNIVERSITY OF DAYTON - CONSENT TO PARTICIPATE IN RESEARCH

TITLE of STUDY:

EVALUATION OF A TRAINING PROGRAM TO INCREASE TEACHERS’ ACCURATE IDENTIFICATION OF ANXIETY SYMPTOMS IN STUDENTS.

Dear Teacher,

You are asked to participate in a research study conducted by School Psychology Intern Sharon K. Deacon from the School Psychology Program at the University of Dayton. Participation in this study is voluntary. Read the information below, and ask questions about anything you do not understand, before deciding whether or not to participate.

PURPOSE OF THE STUDY

This project examines the effect of teacher training on identifying children and adolescents with anxiety. If teachers can identify students with anxiety problems, these children can be referred for prevention/intervention services. The study involves comparing teacher judgments of students’ levels of anxiety to students’ responses on a questionnaire about their thoughts, feelings, and behaviors. I will compare the responses of teachers and students, with half of the teachers participating in a training program on anxiety, and half of the teachers not participating in training.

PROCEDURES

If you agree to participate in the project, you will be randomly assigned to one of two conditions: training or no-training. If you are assigned to the training condition, I will ask to schedule a 2.5 hour time block, at your convenience, for you to participate in a training program, developed for the present study, and complete: (a) an initial knowledge test on child and adolescent anxiety (b) a rubric about each of your students’ level of anxiety, (c) a post knowledge test on the identification of child and adolescent anxiety, and (d) an evaluation of the training program. The training program called, Teacher Training to Identify Children with Anxiety Problems (T-TICAP) will be administered in a group format. If you are assigned to
the no-training condition, I schedule a 1 hour time block, at your convenience, for you to complete: (a) an initial knowledge test on child and adolescent anxiety, (b) a rubric about each of your students’ level of anxiety, and (c) a post knowledge test on the identification of child and adolescent anxiety. The rubric will ask you to rate each of your students based on their level of anxiety. You will only be asked to complete the rubric for those students who have parental consent.

The second part of the project involves your students’ completion of a questionnaire about their thoughts, feelings, and behavior. In the days following your completion of the things described above, I will ask to schedule a 30 minute time block with you to administer a questionnaire called the Multidimensional Anxiety Scale for Children 2nd edition, Self-Report (MASC 2-SR; March, 2013) to the students in your classroom. I will ask students to complete the questionnaires by circling yes or no on various descriptions of their thoughts, feelings, and behavior. Only students who have parental consent and have also signed an assent form agreeing to participate will be asked to complete the questionnaires. The questionnaire will be administered in groups of 5 or 6 children; however, each child will work individually on it. The questionnaire will be administered in a quiet location outside of the classroom so it will not disturb instruction. Children who do not wish to participate or who do not have parental consent will continue doing their schoolwork in the classroom. I will have the school psychologist and/or guidance counselor contact parents of students who receive an average score of 75 or greater on the questionnaire because a score of 75 or greater may indicate a high level of anxiety.

WHAT IF I WISH TO WITHDRAW OR NOT PARTICIPATE IN THE STUDY?

Your participation is completely voluntary. If you agree to participate, you are free to stop participating at any time, without penalty. You are also free to choose not to answer any question that you are uncomfortable with, without penalty.

POTENTIAL RISKS AND DISCOMFORTS

There may be three risks associated with participation in my research project. First, parents and students may experience some psychological stress if students’ scores on any of the questionnaires fall in the high-end range and require a follow-up phone call. If students require further testing by a psychologist or psychiatrist regarding an anxiety or other social/emotional concern, they may experience some psychological stress as a result. In addition, there may be a financial expenditure required for further evaluation. Finally, providing ratings of your students’ anxiety symptoms may not match exactly the students’ true behaviors; therefore, it is possible that ratings of some students may not be a valid representation of their true classroom behavior.

ANTICIPATED BENEFITS TO PARTICIPANTS

There are also a number of benefits associated with participation in this project. Benefits may include: (a) contribution to the development of a training program to teach teachers how to
identify childhood anxiety problems, (b) gain in knowledge regarding child and adolescent anxiety, specifically in identifying it and working with students with anxiety in your classroom, and (c) the early identification of students in your classroom who may need further assistance for an anxiety problem, before the problem worsens.

**PAYMENT FOR PARTICIPATION**

To express my appreciation for your assistance in completing my research project, I will provide a $20 gift card for your participation and completion of the study.

**IN CASE OF RESEARCH RELATED ADVERSE EFFECTS**

If you are experiencing any kind of discomfort as a result of your participation in this study, you may contact the principal investigator Sharon K. Deacon at (740)-222-5082 and the projects advisory committee chair Dr. Elana Bernstein at (937)-229-3644.

**CONFIDENTIALITY**

All of your responses on the questionnaires will be kept confidential, with the exception of the evaluation survey of the training program for teachers in the training condition. Some responses on this questionnaire may be used in future publications describing the training program, but no personally identifying information will be used. All other responses will be kept under lock and key in a file cabinet at Valley View school district. The questionnaires will only be available to my advisor (Dr. Elana R. Bernstein) and me, unless I was concerned about the safety of a student or someone who the student knows. Your name as well as students’ names will be coded as numbers and will not appear in any data sets or publications.

**PARTICIPATION AND WITHDRAWAL**

Your participation in this research is voluntary. If you choose not to participate, that will not affect your relationship with the University of Dayton or other services to which you are otherwise entitled. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without prejudice or penalty. The investigator may withdraw you from participating in this research if circumstances arise which warrant doing so.

**NEW FINDINGS**

During the course of the study, you will be informed of any significant new findings (either good or bad), such as changes in the risks or benefits resulting from participation in the research or new alternatives to participation, that might cause you to change your mind about continuing in the study. If new information is provided to you, your consent to continue participating in this study will be re-obtained.

**IDENTIFICATION OF INVESTIGATORS**
If you have any questions about this research, please contact one of the investigators listed below:

Sharon K. Deacon, Principal Investigator, University of Dayton, School Psychology Graduate Student, (740) 222-5082, deacons1@udayton.edu

Elana R. Bernstein, Advisory Committee Chair, University of Dayton, Department of Counselor Education School & Human Services, School Psychology Program, (937) 229-3644, ebernstein1@udayton.edu

**RIGHTS OF RESEARCH PARTICIPANTS**

If you have questions regarding your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB) at the University of Dayton: Dr. Mary Connolly, (937) 229-3493, Mary.Connolly@notes.udayton.edu.

**THANK YOU**

Thank you for considering participating in this project. If you agree to participate, I will contact you by phone to answer any questions and to arrange times for you and your students to complete the questionnaires and, if necessary, the training program. Please feel free to contact me with any questions or concerns by phone at (740) 222-5082 or by email at deacons1@udayton.edu. If you have any questions regarding your rights as a research participant, please contact the School of Education’s Human Subjects Committee office at (937) 229-3493 or via email at IRB@udayton.edu.

**SIGNATURE OF RESEARCH PARTICIPANT (or legal guardian)**

I have read the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form. **I certify that I am at least 18 years of age.**

Name of Participant (please print) _____________________________________________

Address _____________________________________________________________________

Signature of Participant __________________________________________ Date___________

**SIGNATURE OF WITNESS**

My signature as witness certifies that the Participant signed this consent form in my presence.

Name of Witness (please print) ________________________________________________

Signature of Witness __________________________________________ Date___________
UNIVERSITY OF DAYTON - CONSENT TO PARTICIPATE IN RESEARCH

TITLE of STUDY:

EVALUATION OF A TRAINING PROGRAM TO INCREASE TEACHERS’ ACCURATE IDENTIFICATION OF ANXIETY SYMPTOMS IN STUDENTS.

Dear Parent,

Your child is asked to participate in a research study conducted by School Psychology Intern Sharon K. Deacon from the School Psychology Program at the University of Dayton. Participation in this study is voluntary. Read the information below, and ask questions about anything you do not understand, before deciding whether or not to participate.

PURPOSE OF THE STUDY

This project examines the effect of teacher training on identifying children and adolescents with anxiety. If teachers can identify students with anxiety problems, these children can be referred for prevention/ intervention services. The study involves comparing teacher judgments of students’ levels of anxiety to students’ responses on a questionnaire about their thoughts, feelings, and behaviors. I will compare the responses of teachers and students, with half of the teachers participating in a training program on anxiety, and half of the teachers not participating in training.

PROCEDURES

If you agree to let your child participate in my project, their teacher will first be randomly assigned to one of two conditions: training or no-training. If they are assigned to the training condition, they will participate in a training program, designed for the present study, called Teacher Training to Identify Children with Anxiety Problems (T-TICAP), which will be administered in a group format. All of the teachers, regardless of the condition to which they are assigned, will complete a rubric that will ask them to rate each of their students based on the child’s current level of anxiety. Teachers in the training condition will complete several other measures evaluating the training program. They will only be asked to complete the rubric for those students who have parental consent.

In the days following teacher completion of the things described above, I will ask your child to complete a 39-item questionnaire called the Multidimensional Anxiety Scale for Children 2nd edition, Self-Report (MASC 2-SR; March, 2013). The questionnaire will ask your child to answer yes or no to questions about his/her thoughts, feelings, and behavior. Before completing the questionnaire, I will describe the questionnaire to your child to ensure that he/she would like to participate. He/she will then sign an assent form if they choose to participate. The questionnaire will take approximately 30 minutes to complete and will be
administered in groups of 5 or 6 children; however, each child will work individually on the questionnaire. The questionnaire will be administered in a quiet location outside of the classroom so it will not disturb instruction. All questionnaires will be administered by Sharon Deacon, a school psychology graduate student trained in administering social-emotional assessments to school-age youth. Children who do not wish to participate or who do not have parental consent will be able to continue doing their schoolwork in the classroom. If your child’s score on the questionnaire is above average or their teacher indicates that they may be experiencing anxiety, I will work with the school psychologist at your child’s school, who will contact you directly, because above average scores or a high rating by your child’s teacher may indicate a high level of anxiety. If your child’s school does not have a school psychologist, I will work with the school counselor and/or social worker, who will contact you directly. The school psychologist/counselor may recommend further assessment be conducted and will provide you with appropriate referral information, if necessary. If you would like, you can preview the items on the questionnaire prior to the administration before agreeing/ not agreeing to allow your child to participate in my project. You can do so by contacting Sharon Deacon via email or phone at the email address/phone number provided below.

WHAT IF I WISH TO WITHDRAW OR NOT PARTICIPATE IN THE STUDY?

Participation is completely voluntary. If you and your child agree to participate, you and your child are free to stop participating at any time, without penalty. Your child is also free to choose not to answer any questions that he/she is not comfortable with, without penalty. If you choose, you can inspect the questionnaire before agreeing/not agreeing to allow your child to participate in my project.

POTENTIAL RISKS AND DISCOMFORTS

There may be three risks associated with participation in my research project. First, you and your child may experience some psychological stress if his/her scores on any of the questionnaires fall in the high-end range and require a follow-up phone call. If your child requires further testing by a psychologist or psychiatrist regarding an anxiety or other social/emotional concern, you and/or he/she may experience some psychological stress as a result. In addition, there may be a financial expenditure required for further evaluation. Finally, teachers’ ratings of their students’ anxiety symptoms may not match exactly the students’ true behaviors; therefore, it is possible that ratings of some students may not be a valid representation of their true classroom behavior.

ANTICIPATED BENEFITS TO PARTICIPANTS

There are also a number of benefits associated with participation in my project. Benefits may include: (a) contribution to the development of a training program to teach teachers how to identify childhood anxiety problems, (b) teachers’ gain of knowledge regarding child and adolescent anxiety, specifically in identifying it and working with students with anxiety in their classroom, (c) the early identification of your child if he/she needs further assistance for
an anxiety problem, before the problem worsens, and (d) assistance in the completion of my thesis project.

PAYMENT FOR PARTICIPATION

To express my appreciation for your child’s assistance in completing my research project, I will provide a small toy incentive for your child’s participation and completion of the study.

IN CASE OF RESEARCH RELATED ADVERSE EFFECTS

If you are experiencing any kind of discomfort as a result of your participation in this study, you may contact the principal investigator Sharon K. Deacon at (740)-222-5082 and the projects advisory committee chair Dr. Elana Bernstein at (937)-229-3644.

CONFIDENTIALITY

All of the teachers’ responses on the questionnaires and you child’s responses to their questionnaire will be kept confidential, with the exception of the evaluation survey of the training program for teachers in the training condition. Some responses on this questionnaire may be used in future publications describing the training program, but no personally identifying information will be used. All other responses will be kept under lock and key in a file cabinet at Valley View school district. The questionnaires will only be available to my advisor (Dr. Elana R. Bernstein) and me, unless I was concerned about the safety your child or someone your child knows. Teachers’ names as well as students’ names will be coded as numbers and will not appear in any data sets or publications.

PARTICIPATION AND WITHDRAWAL

Participation is completely voluntary. If you and your child agree to participate, you and your child are free to stop participating at any time, without penalty. Your child is also free to choose not to answer any questions that he/she is not comfortable with, without penalty. If you choose, you can inspect the questionnaire before agreeing/not agreeing to allow your child to participate in my project.

NEW FINDINGS

During the course of the study, you will be informed of any significant new findings (either good or bad), such as changes in the risks or benefits resulting from participation in the research or new alternatives to participation, that might cause you to change your mind about your child continuing in the study. If new information is provided to you, your consent to allow your child to continue participating in this study will be re-obtained.

IDENTIFICATION OF INVESTIGATORS

If you have any questions about this research, please contact one of the investigators listed below:
Sharon K. Deacon, Principal Investigator, University of Dayton, School Psychology Graduate Student, (740) 222-5082, deacons1@udayton.edu

Elana R. Bernstein, Advisory Committee Chair, University of Dayton, Department of Counselor Education School & Human Services, School Psychology Program, (937) 229-3644, ebernstein1@udayton.edu

RIGHTS OF RESEARCH PARTICIPANTS

If you have questions regarding your rights as a research participant, you may contact the Chair of the Institutional Review Board (IRB) at the University of Dayton: Dr. Mary Connolly, (937) 229-3493, Mary.Connolly@notes.udayton.edu.

THANK YOU

Thank you for considering participating in my thesis project. Please return the attached consent form to your child’s classroom teacher, indicating whether or not you agree to allow your child to participate in my thesis project. Please feel free to contact me with any questions or concerns by phone at (740) 222-5082 or by email at deacons1@udayton.edu. If you have any questions regarding your rights as a research participant, please contact the School of Education’s Human Subjects Committee office at (937) 229-3493 or via email at IRB@udayton.edu.

SIGNATURE OF RESEARCH PARTICIPANT (or legal guardian)

I have read the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form. I certify that I am at least 18 years of age.

Name of Participant (please print) _____________________________________________

Address _____________________________________________________________________

Signature of Participant ______________________________________________________ Date___________

SIGNATURE OF WITNESS

My signature as witness certifies that the Participant signed this consent form in my presence.

Name of Witness (please print) ________________________________________________

Signature of Witness ______________________________________________________ Date___________

(Must be same as participant signature date)
UNIVERSITY OF DAYTON - CONSENT TO PARTICIPATE IN RESEARCH

TITLE of STUDY:

EVALUATION OF A TRAINING PROGRAM TO INCREASE TEACHERS’ ACCURATE IDENTIFICATION OF ANXIETY SYMPTOMS IN STUDENTS.

Dear Student,

You are asked to participate in a research study conducted by School Psychology Intern Sharon K. Deacon from the School Psychology Program at the University of Dayton. Participation in this study is voluntary. Read the information below, and ask questions about anything you do not understand, before deciding whether or not to participate.

PURPOSE OF THE STUDY

My name is Sharon K. Deacon, and I am a graduate student in the School Psychology Program at the University of Dayton. I am writing to invite you and your teacher to participate in my school research project. Many kids and teenagers worry about things. Sometimes, kids may worry about tests and homework assignments, and sometimes kids worry that bad things might happen to them. Unfortunately, sometimes adults do not always know that kids worry, so they cannot help them with their worries. I want to learn how to help teachers find out if their students are worrying a lot about different things, so that an adult can help kids to not worry as much. To learn more about this, I am going to teach your teacher about what kids might be like if they worry a lot. I want to find out if this will help your teacher notice if kids are worrying.

PROCEDURES

If you agree to participate in the project, I will ask you to answer some questions by circling yes or no. The questions will ask you about things you do, feel, and think. You will fill out the questionnaire on your own; however, I will read the questions out loud to several students at the same time. The questions will take about 30 minutes to answer.

WHAT IF I WISH TO WITHDRAW OR NOT PARTICIPATE IN THE STUDY?

You don’t have to participate in my school project if you do not want to. You can tell your teacher, parent, or me at any time if you do not want to participate anymore. It is also okay to not answer any questions that you do not want to answer. If you do not want to participate, you can continue doing your schoolwork in your classroom instead.

POTENTIAL RISKS AND DISCOMFORTS
There may be some risks to participating in the project. You and your parents might be concerned if your answers told me that you worried a lot. Your parents might want to take you to the doctor to find out more about what you are worried about.

**ANTICIPATED BENEFITS TO PARTICIPANTS**

There are also some benefits to participating in my school research project. First, you will be helping me to find out if teaching your teacher about kids who worry will help them be able to know if their students are worrying a lot. Second, if you do worry a lot, I can tell your parents and give them some information to help you not worry as much.

**PAYMENT FOR PARTICIPATION**

For participating in my school research project, you will receive a small toy after you complete all questions.

**IN CASE OF RESEARCH RELATED ADVERSE EFFECTS**

If you are uncomfortable during or after answering the questions in my school research project, you may contact me, Sharon K. Deacon, at (740)-222-5082 and my advisor, Dr. Elana Bernstein, at (937)-229-3644.

**CONFIDENTIALITY**

All of your answers to the questionnaire will be kept confidential. This means that no one will know your answers except for my teacher (Dr. Elana Bernstein) and me. They will be kept locked in a file cabinet at the Valley View school district. If your answers tell me that you are worrying a lot, I will call your parents so they can help you to not worry as much. I would also need to let your parents know if you told me that you were hurting yourself or someone else, or if someone else was hurting you. I will code your name as a number, and your name will not be used in any reports that I write for school or publish in journals.

**PARTICIPATION AND WITHDRAWAL**

You don’t have to participate in my school project if you do not want to. You can tell your teacher, parent, or me at any time if you do not want to participate anymore. It is also okay to not answer any questions that you do not want to answer. If you do not want to participate, you can continue doing your schoolwork in your classroom instead.

**NEW FINDINGS**

During my school research project, you will be told of anything new (either good or bad), such as changes in the risks or benefits of your participation in my school research project. If I give you new information, you will be asked if you want to continue participating in my school research project again.
IDENTIFICATION OF INVESTIGATORS

If you have any questions about this research, please contact one of the investigators listed below:

Sharon K. Deacon, Principal Investigator, University of Dayton, School Psychology Graduate Student, (740) 222-5082, deacons1@udayton.edu

Elana R. Bernstein, Advisory Committee Chair, University of Dayton, Department of Counselor Education School & Human Services, School Psychology Program, (937) 229-3644, ebernstein1@udayton.edu

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SIGNATURE OF RESEARCH PARTICIPANT (or legal guardian)

I have read the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form. I certify that I am at least 18 years of age.

Name of Participant (please print) _____________________________________________

Address ___________________________________________________________________

Signature of Participant __________________________________________ Date ________

SIGNATURE OF WITNESS

My signature as witness certifies that the Participant signed this consent form in my presence.

Name of Witness (please print) ________________________________________________

Signature of Witness __________________________________________ Date ________

(Must be same as participant signature date)
APPENDIX B

TEACHER TRAINING TO IDENTIFY CHILDREN WITH ANXIETY PROBLEMS
(T-TICAP)

TRAINING PROGRAM


The following website contains information on ordering the *MASC 2-SR* questionnaire:

http://www.mhs.com/
Teacher Training to Identify Children with Anxiety Problems

(T•TICAP) ©

Elana R. Bernstein, PhD
University of Dayton

Contributors:
Sharon K. Deacon, M.S., University of Dayton
Kelly A. Feeney-Kettler, PhD, Rutgers University
Thomas R. Kratochwill, PhD, University of Wisconsin-Madison
Training Teachers to Identify Children with Anxiety Problems

TEACHER MANUAL

Elana R. Bernstein • Kelly Feeney-Kettler • Thomas R. Kratochwill • Sharon Deacon
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Program Purpose

The purpose of the *T-TICAP* program is to provide teachers with information on childhood anxiety disorders that will help them to accurately identify students who may be experiencing anxiety in their classroom. By accurately identifying students with anxiety problems, teachers can make appropriate referrals to their school mental health professionals, and children can receive services to help reduce their anxiety and the long-term consequences associated with it.
PART 1a: What Do You Know About Childhood Anxiety Disorders?

We would like to learn more about your knowledge of childhood anxiety disorders.

DIRECTIONS: Please circle or write in what you think is the best response(s) to each question below.

1. What percentage of children and adolescents in the general population has anxiety disorders?
   (a) 1-2 %  
   (b) 10-21%  
   (c) 40-50%  
   (d) 80%

2. For which population(s) is anxiety disorders most prevalent?
   (a) Females  
   (b) Males  
   (c) Adolescents (12-17)  
   (d) Young children (3-6)

3. What are the potential consequences of untreated anxiety disorders?
   (a) Future/Other mental health problems (e.g., drug use, depression, suicide)  
   (b) Risk for the development of future mental health problems  
   (c) Impairments in social relationships  
   (d) Lower levels of overall academic achievement  
   (e) All of the above

4. Alex is a student with an anxiety disorder. What symptoms of anxiety might he/she display in your classroom?
   ___________________  ___________________  ___________________
   ___________________  ___________________  ___________________
   ___________________  ___________________  ___________________

5. Which of the following statements is true regarding the differences between depression and anxiety in children and adolescents?
(a) Both anxiety and depression can be characterized by social withdrawal. With depression students often display a loss of interest in activities that they formerly enjoyed, while with anxiety, students often display a fear of or inability to participate in activities.
(b) Only students with depression commit suicide.
(c) Both depression & anxiety may result in irritability and difficulty sleeping.
(d) One of the symptoms of depression is weight loss or weight gain whereas these are not often characteristics of anxiety disorders.

6. If you thought that a student might have an anxiety disorder, what would be the best course of action to take?
___________________________________________________________________________

7. How can teachers prevent the development and/or consequences of anxiety disorders in their students?
___________________________________________________________________________

8. Fill in the blank. Three factors that may place a child at risk for the development of an anxiety problem are ____________, ____________, and ____________.

9. Circle either true or false. If a child has a risk factor for the development of an anxiety problem, he/she will develop an anxiety disorder.

   TRUE       or       FALSE

10. Fill in the blank. Three factors that may protect a child from developing an anxiety problem are ____________, ____________, and ____________.
**PART 1b: What Are Your Training Needs Regarding Child and Adolescent Anxiety?**

This survey is designed to help identify your training needs regarding the early identification of students with anxiety disorders.

**DIRECTIONS:** Please respond to the following statements regarding your current educational needs using the five-point scale below:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree Somewhat</td>
<td>Not Sure</td>
<td>Agree Somewhat</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

1) I have had adequate training in identifying students with anxiety disorders.

2) I am familiar with the symptoms of anxiety disorders in children and adolescents.

3) If I thought that a student in my class was experiencing anxiety, I would know who to refer him/her to first.

4) I understand how anxiety may affect a student’s performance in school.

5) I know how to modify my curriculum to accommodate students with anxiety problems.

6) I have had experience teaching students with anxiety in the past.

7) I understand the difference between the symptoms of anxiety and depression.
PART 2: Why is it Important to Identify Children and Adolescents with Anxiety?

Prevalence & Consequences

Prevalence:
- Anxiety disorders are the most common disorders among children and adolescents [1].
- Nationally, between 10% to 21% of all children and adolescents suffer from some form of an anxiety disorder [2], but this only includes those who have been identified and diagnosed.
- Anxiety disorders are under-identified and under-diagnosed because symptoms of anxiety are internal (directed inwardly, towards the self) and therefore are not always observable.
- Anxiety disorders may be more common among females than males, [3] but this can be dependent upon the type of anxiety disorder (e.g., Obsessive Compulsive Disorder is equally prevalent in both genders at adolescence [1]).
- Anxiety disorders vary with a student’s age and developmental level
  - Young children typically have higher rates of separation anxiety disorder [4].
  - Adolescents have higher rates of social phobia & panic disorder [4].

Consequences:
- When anxiety symptoms are left unidentified and untreated, they often worsen over time [5].
- In fact, adults with anxiety disorders often report that they experienced intense anxiety as children and was left untreated [6].
- Untreated anxiety disorders and anxiety symptoms can negatively impact children’s social, emotional, and academic development.
- Untreated anxiety disorders place individuals at risk for:
  - Future mental health problems, including other anxiety disorders, depression, and substance abuse disorders [5]
  - Academic underachievement [7]
  - Maladaptive cognitive styles [8]
- Peer rejection [7]
- Social difficulties [7]

**Why Identify Children with Anxiety?**

- There are many children and adolescents who have symptoms of anxiety, but do not yet have diagnosable anxiety disorders. Even without anxiety disorder diagnoses, these youth still require treatment to alleviate their problems. Even “sub-clinical” symptoms of anxiety disorders can cause emotional distress for these youth and their families.
- The United States spends 42 billion dollars per year on medical related treatment for anxiety (physician and ER visits) [10]. This statistic does not include the cost of mental health treatment (therapy) or of emotional suffering by those who experience anxiety problems.
- It is more desirable and cost-effective to prevent problems than to treat them. Treatment is not always effective, nor can it always erase the negative impact from the problem’s previous effects.
- Because of the high prevalence and negative consequences associated with anxiety disorders, coupled with the high cost, we need to focus our efforts on preventing the development of anxiety disorders in children and adolescents.
- The best way to get children and adolescents with anxiety problems help is to identify these youth before their anxiety worsens and negatively impacts their development. Teachers are in the perfect position to do this, given that children spend the majority of their week in school.
- In addition, teachers are in a unique position to (a) observe children in situations that parents may not see at home (e.g., interactions with peers, engaging in challenging academic tasks, etc.) and (b) compare children’s behavior to that of other children their age and grade level.
PART 3: What Places Someone At-Risk for Developing an Anxiety Disorder?

Researchers are still trying to determine what actually causes anxiety disorders. Whether someone develops an anxiety disorder is believed to be a combination of a number of factors, but no one knows the answer for sure.

*Risk factors are things that make someone vulnerable to developing a problem. Possible risk factors for developing anxiety disorders include [1,9,11]:*

- Genetics (predisposition for anxiety based on genes)
- Family history (e.g., parent or other family member with mental health problems)
- Over-protective, over-critical, and anxious parenting styles
- Shy temperament
- Traumatic life events (e.g., divorce, death in the family, witness to violence)
- Life transitions (e.g., moving, school transitions)
- Early anxiety symptoms (i.e., trouble separating from primary caregivers at a young age)
- Insecure attachment style
- Previous anxiety disorder
- Poor emotion regulation
- Alcohol and drug use
- Cognitive biases (i.e., a distorted perception of how the world really is)
Like risk factors for anxiety disorder development, researchers are still trying to determine what specifically protects people from developing anxiety problems.

*Protective factors are things that protect someone from developing a problem. Possible protective factors against developing anxiety disorders include [1,9,11]:*

- Emotion management skills
- Positive prior learning experiences
- Teaching children coping skills and relaxation techniques
- Problem-focused coping (e.g. actively taking steps to solve a problem)
- Secure attachment
- Social support
PART 4: What are the Symptoms of Anxiety Problems?

There are many types of anxiety disorders; however, for the purpose of this training, it is not important to learn how to distinguish between or diagnose the different disorders, but rather learn to recognize symptoms of anxiety so that children can be identified and referred for evaluation and prevention services.

Here are some symptoms of anxiety disorders in children and adolescents [12, 13]:

<table>
<thead>
<tr>
<th>CATEGORIES OF ANXIETY SYMPTOMS</th>
<th>Physical (r/o medical cause)</th>
<th>Emotional</th>
<th>Academic</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased perspiration (palms, armpits, forehead)</td>
<td>Irrational fears (dying, losing control, illness, spiders, dogs, failure, performing, social situations)</td>
<td>Perfectionism (taking a long time to complete work; frequent erasing, redoing assignments; tries to do everything right)</td>
<td>Decreased grades</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>Trembling or shaking (hands, neck)</td>
<td>Obsessions (repeated, intrusive, or persistent thoughts; superstitions)</td>
<td>Compulsions (repetitive behaviors that one feels driven to do in response to an obsession; handwashing, counting)</td>
<td>Peer rejection</td>
<td></td>
</tr>
<tr>
<td>Complaints of shortness of breath</td>
<td>Persistent worrying and need for reassurance</td>
<td>Lack of concentration or inability to pay attention; appears to have difficulty listening</td>
<td>Lack of friends</td>
<td></td>
</tr>
<tr>
<td>Nausea and stomach discomfort; feelings of &quot;butterflies&quot; in stomach</td>
<td>Mind going blank</td>
<td>Avoidance of specific situations (performance, school) or people</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Complaints of chest pain or heart racing</th>
<th>Irrational thoughts (e.g., I will fail; Something bad will happen)</th>
<th>Avoiding specific tasks or activities (e.g., gym, recess, math)</th>
<th>Reluctance or refusal to speak</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness, faintness, lightheadedness</td>
<td>Nightmares, Insomnia, or Hypervigilence (constantly on-guard, “jumpy”)</td>
<td>Low frustration tolerance</td>
<td>Easily embarrassed</td>
</tr>
<tr>
<td>Numbness or tingling in extremities</td>
<td>Hypervigilence (constantly on-guard, “jumpy”)</td>
<td>Giving up easily or unwillingness to try</td>
<td>Feelings of shame and inadequacy</td>
</tr>
<tr>
<td>Feelings of disconnection from the self</td>
<td>Irritability</td>
<td>Fear of making mistakes; punishing self for making mistakes</td>
<td>Reluctance to be separated from primary caregivers</td>
</tr>
<tr>
<td>Extreme changes in temperature</td>
<td>Inappropriate display of emotions in response to feared objects or situations (tantrums when parent leaves)</td>
<td>Seeking frequent reassurance (Is this right? Will I be OK?)</td>
<td>Failure to initiate social interactions</td>
</tr>
<tr>
<td>Flushed face</td>
<td>Continuous avoidance of specific objects or situations</td>
<td>Failure to turn in assignments</td>
<td></td>
</tr>
<tr>
<td>Tense or tight muscles</td>
<td>Clinging (follows mother/father everywhere to avoid being alone)</td>
<td>Obedient</td>
<td></td>
</tr>
<tr>
<td>Fidgeting (plays with hair, hands) or picks at skin/nails</td>
<td>Strange eating habits (not wanting to eat at school due to fear of contamination)</td>
<td>Avoids being called on in class; avoids raising hand</td>
<td></td>
</tr>
<tr>
<td>Tics (involuntary movements – neck twitching)</td>
<td>Negative self-talk (I can't do this; I'm stupid)</td>
<td>Tries hard to please others</td>
<td></td>
</tr>
<tr>
<td>Restlessness</td>
<td>Continuously examining surroundings for danger (e.g., double checking things for safety)</td>
<td>Worries about what other people think or about things before they happen</td>
<td></td>
</tr>
<tr>
<td>Feeling “frozen” out of fear as if unable to move or speak</td>
<td>Behaving younger than their actual age (e.g., baby talk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abrupt intense emotional reactions</td>
<td>Low self-esteem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Symptoms of anxiety can vary among individuals, with age, as well as in intensity. Thus, the focus of a student’s anxiety may change with development. For example, a preschooler who fears the dark or separation from parents is exhibiting developmentally appropriate behaviors. If a 10-year-old displayed these same fears, this may indicate an anxiety problem. In addition, many anxiety symptoms are setting specific. For example, a student may display extreme bedtime fears at home, but display no symptoms of anxiety at school. Anxiety symptoms can also occur at school, but not at home.

*Anxiety symptoms can exist on a continuum. How do you think a student would look in your classroom if s/he was?*

**Anxiety Symptom Continuum**

<table>
<thead>
<tr>
<th>Never Anxious</th>
<th>Rarely Anxious</th>
<th>Sometimes Anxious</th>
<th>Often Anxious</th>
<th>Always Anxious</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For example, a student who is:

<table>
<thead>
<tr>
<th>Never Anxious</th>
<th>Rarely Anxious</th>
<th>Sometimes Anxious</th>
<th>Often Anxious</th>
<th>Always Anxious</th>
</tr>
</thead>
</table>

- **Never Anxious** – does not usually experience anxiety symptoms
- **Rarely Anxious** – experiences anxiety symptoms once and a while in commonly feared situations such as before performing in front of the class or taking a big exam; the anxiety does not interfere with the student’s ability to function.
- **Sometimes Anxious** – experiences anxiety some of the time in both commonly feared situations, such as those above, and other less commonly feared situations, such as fear of failure on math assignments or worries about having a friend to sit next to at lunch; the student’s fears or worries are not intense and only slightly interfere with the student’s ability to function in some situations.
- **Often Anxious** – experiences anxiety frequently in commonly feared situations, but also in many less commonly and some uncommonly feared situations, such as fear of dying, resulting in an increased need to ask others for reassurance of safety; student also experiences more intense recurrent and irrational thoughts, resulting in the avoidance of some situations and objects; the anxiety symptoms interfere with the student’s ability to function in many situations.
- **Always Anxious** – experiences anxiety most of the time in both commonly feared, less commonly feared, and many uncommonly feared situations; the fears are intense, resulting in many symptoms of anxiety; student also displays extreme avoidant behaviors of specific situations and objects; student functioning is greatly impaired in most situations.

*We want to pay special attention to the children and adolescents who display symptoms of anxiety often, and always.*
Symptoms of childhood anxiety problems can appear similar to symptoms of other childhood problems. In fact, some childhood problems, like anxiety and depression, share some of the same symptoms and may even co-occur. Regardless of the problem a child has, if any, all concerning symptoms should be discussed with your school’s mental health professionals and the child’s parents.

Here are some of the overlapping symptoms associated with problems that may co-occur with anxiety [12, 13]:

### Depression

- ✔ Irritability
- ✔ Sleep difficulties
- ✔ Negative self-talk
- ✔ Relationship difficulties
- ✔ Decreased grades
- ✔ Physical complaints
- ✔ Low frustration tolerance
- ✔ Poor concentration

*Depression and anxiety differ because depression is characterized more by symptoms of sadness, hopelessness, boredom, and decreased or complete loss of interest in previously enjoyed activities. Anxiety is characterized more by fears and worries that result in an avoidance of activities, objects, and situations.*

### Attention Deficit Hyperactivity Disorder (ADHD)

- ✔ Difficulty concentrating
- ✔ Inattention
- ✔ Fidgeting
- ✔ Trouble listening
- ✔ Failure to turn in assignments
- ✔ Decreased grades

*ADHD and anxiety differ because ADHD is characterized by an inability to attend whereas anxious children have difficulty paying attention because they are often overly focused on anxious thoughts/fears.*
PART 5: What Would an Anxious Child Look Like in the Classroom?

Anxiety Symptom Continuum

Brayden, a student in your classroom, may exhibit the following symptoms of anxiety at varying levels:

<table>
<thead>
<tr>
<th>Never Anxious</th>
<th>Rarely Anxious</th>
<th>Sometimes Anxious</th>
<th>Often Anxious</th>
<th>Always Anxious</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Participates in all classroom activities without hesitation.</td>
<td>✓ Participates in most classroom activities without hesitation.</td>
<td>✓ Sometimes procrastinates during math tasks.</td>
<td>✓ Tries hard to please you and peers.</td>
<td>✓ Displays many physical symptoms described above; makes frequent trips to the nurse’s office.</td>
</tr>
<tr>
<td>✓ Usually picked by his peers for group activities.</td>
<td>✓ Face becomes flushed before giving class presentation.</td>
<td>✓ Frustrated with self if makes mistakes.</td>
<td>✓ Wants to be near you.</td>
<td>✓ Asks a lot of questions.</td>
</tr>
<tr>
<td>✓ Initiates games with peers during recess.</td>
<td>✓ Has many close friends.</td>
<td>✓ Asks a peer to sit next to him at lunch every day.</td>
<td>✓ Repeatedly asks you if his work is correct.</td>
<td>✓ Low self-esteem.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Has many close friends.</td>
<td>✓ Overly concerned about things that will happen in the future.</td>
<td>✓ Avoids class activities or appears distracted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>✓ Takes a long time to complete assignments.</td>
<td>✓ Doesn’t try new things.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>✓ Struggles to maintain close friendships.</td>
<td>✓ Has few friends.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>✓ Requires a lot of teacher attention.</td>
</tr>
</tbody>
</table>
PART 6: What Role Can You Play in the Identification of Childhood Anxiety?

Specific ways teachers like you can help in the early identification of child and adolescent anxiety problems include the following:

- Observe student behavior in both academic and social situations.
- Take note of students who are socially isolated and who display symptoms of anxiety.
- Don’t be afraid to discuss your concerns with parents. Always keep lines of communication open.
- Consult your school mental health professionals with any concerns you may have about specific students.
- Encourage evaluation of students who display symptoms of anxiety “often” and “always.”
- Participate in evaluation process by providing your observations of student behavior.
- Your referral may be extremely important in getting children and adolescents with anxiety symptoms the prevention services they need.

Specific ways you can help students with anxiety problems in your classroom include the following:

- Collaborate with parents, outside mental health providers, school mental health professionals, and other teachers to support students.
- Monitor student progress and communicate with treatment team.
- Provide classroom modifications as determined by treatment team.
- Foster a positive and supportive relationship with students and their parents.
PART 7: Can You Identify Varying Levels of Anxiety?

Anxiety Symptom Continuum

<table>
<thead>
<tr>
<th>Never Anxious</th>
<th>Rarely Anxious</th>
<th>Sometimes Anxious</th>
<th>Often Anxious</th>
<th>Always Anxious</th>
</tr>
</thead>
</table>

Ellen turns in her assignments, but is constantly asking if they are correct, neat enough, or if she should re-do them. She often wants to call her mother to ensure her safety, always appears “on guard,” and often asks you to reassure her about future events (i.e., the bus not breaking down on the upcoming field trip). Most days, she complains of headaches and fatigue. She often is in the nurse’s office during gym class.

Scott has many friends in his 4th grade classroom. He is a good student, is compliant, and turns in his homework regularly. His favorite subjects are gym and history. When required to give a presentation in front of the class, he appears flushed, jittery, sweaty, and “freezes” for several seconds before beginning to speak. He tells you that he sometimes gets nervous when giving presentations in front of the class, and always requests to present last.

Rachel loves to attend school. She is very popular and has many friends. Rachel loves to be the center of attention. Sometimes she appears inattentive during math lessons and is easily distracted by her peers. She participates in many extracurricular activities, including performing in the annual school play. Rachel has a habit of chewing on her pencil during academic subjects, but gets her work done most of the time.

Jose inconsistently completes his work. He always appears distracted and preoccupied, and has difficulty following directions. He frequently bites his nails and asks you if you think he is a good student. Some of his behaviors appear repetitive, causing his peers to avoid him. He does not like to eat in school and seems very shy. He complains of not being able to breathe well and a racing heart, which results in frequent visits to the nurse’s office.

Brady typically turns in his assignments later than other students. He participates in some classroom discussions and activities, and has one or two close friends. He enjoys spending most of his time outside of school playing videogames with his younger brother. He occasionally asks to stay inside during recess, especially when his close friends are absent. On some days, he seems tired, distracted, and complains of stomach aches.
Anxiety Symptom Continuum

<table>
<thead>
<tr>
<th></th>
<th>Never Anxious</th>
<th>Rarely Anxious</th>
<th>Sometimes Anxious</th>
<th>Often Anxious</th>
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</tr>
</thead>
</table>

Using the Anxiety Symptom Continuum above, please provide a rating for each of the case examples on the Anxiety Nomination Rubric below.

Anxiety Nomination Rubric

<table>
<thead>
<tr>
<th>STUDENT</th>
<th>LEVEL OF ANXIETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ellen</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2. Scott</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3. Rachel</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. Jose</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5. Brady</td>
<td>1 2 3 4 5</td>
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</tbody>
</table>
PART 8: Can You Identify Varying Levels of Anxiety in Your Classroom Students?

Using the Anxiety Symptom Continuum below, please provide a rating for each of your classroom students (with parent permission) on the Anxiety Nomination Rubric.

## Anxiety Symptom Continuum

<table>
<thead>
<tr>
<th></th>
<th>Never Anxious 1</th>
<th>Rarely Anxious 2</th>
<th>Sometimes Anxious 3</th>
<th>Often Anxious 4</th>
<th>Always Anxious 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not usually experience anxiety symptoms</td>
<td>Experiences anxiety symptoms once and a while in commonly feared situations such as before performing in front of the class or taking a big exam; the anxiety does not interfere with the student’s ability to function.</td>
<td>Experiences anxiety some of the time in both commonly feared situations, such as those above, and other less commonly feared situations, such as fear of failure on math assignments or worries about having a friend to sit next to at lunch; the student’s fears or worries are not intense and only slightly interfere with the student’s ability to function in some situations.</td>
<td>Experiences anxiety frequently in commonly feared situations, but also in many less commonly and some uncommonly feared situations, such as fear of dying, resulting in an increased need to ask others for reassurance of safety; student also experiences more intense recurrent and irrational thoughts, resulting in the avoidance of some situations and objects; the anxiety symptoms interfere with the student’s ability to function in many situations.</td>
<td>Experiences anxiety all of the time in both commonly feared, less commonly feared, and many uncommonly feared situations; the fears are intense, resulting in many symptoms of anxiety; student also displays extreme avoidant behaviors of specific situations and objects; student functioning is greatly impaired in most situations.</td>
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</table>
# Anxiety Nomination Rubric

<table>
<thead>
<tr>
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<tbody>
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<tr>
<td>17.</td>
<td>1 2 3 4 5</td>
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</tbody>
</table>

101
T-TICAP Evaluation Survey

We want to ensure that the time you spent with us today was a valuable experience. Therefore, we welcome your feedback about our program, and ask that you take a few minutes to complete an evaluation of the training program. Your feedback will be used to improve future training sessions.

**DIRECTIONS:** *Please answer each question using the following 5-point scale:*

<table>
<thead>
<tr>
<th>Very Ineffective</th>
<th>Somewhat Ineffective</th>
<th>Not Sure</th>
<th>Somewhat Effective</th>
<th>Very Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. How effective was this training program in helping you understand the importance of the early identification and prevention of anxiety disorders?

1 2 3 4 5

2. How effective was this training program in helping you understand the role that teachers can play in the early identification and prevention of anxiety problems in children and adolescents?

1 2 3 4 5

3. How effective was this workshop in improving your knowledge of the symptoms of anxiety problems?

1 2 3 4 5
4. How effective was this workshop in improving your knowledge of what to do when you suspect that a student may have an anxiety problem?  

1  2  3  4  5

5. How effective was this workshop in providing you with an opportunity to practice your anxiety problem identification skills?  

1  2  3  4  5

6. How effective do you think the materials provided will be in reinforcing the information you have learned in the T-TICAP?  

1  2  3  4  5

7. How effective was the group facilitator in providing the training program?  

1  2  3  4  5

**Additional Questions:**

What is the most important thing that you learned in this training program?

What is the least important thing that you learned in this training program?

How long did it take you to complete this training program?

What else would you have liked to learn about anxiety problems that were not provided in this training program?
Additional Comments:

<table>
<thead>
<tr>
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<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

My overall rating of the T-TICAP

1 2 3 4 5

My overall rating of the facilitator(s)

1 2 3 4 5

Thank you for taking the time to complete this evaluation survey!
Anxiety Symptoms Knowledge Assessment

We would like to find out what you have learned from the T-TICAP.

DIRECTIONS: Please circle what you think is the best response to each question below without referring to the training manual.

1. What percentage of children and adolescents in the general population has anxiety disorders?
   (a) 1-2%
   (b) 10-21%
   (c) 40-50%
   (d) 80%

2. List 4 physical symptoms of an anxiety problem.
   1._____________________  2._______________________
   3._____________________  4._______________________

3. Anxiety disorders are more prevalent in males. True or false?
   TRUE      or      FALSE

4. What are the potential consequences of an untreated anxiety disorder?
   (a) Future/Other mental health problems (e.g., drug use, depression, suicide)
   (b) Conduct disorder
   (c) Low IQ
   (d) Poor athletic performance

5. What are the categories of anxiety symptoms?
   (a) Physical and Neurological
   (b) Physical, Emotional, Academic, and Social
   (c) Neurological and Emotional
   (d) Academic and Social

1. _______________  2. _______________
3. _______________  4. _______________

7. What are some of the symptoms of anxiety that a student may display in the classroom?
   (a) Being overly confident about work products
   (b) Being very disruptive and not following directions
   (c) Appearing lost in their own thoughts and asks for reassurance
   (d) Appearing sad & lonely; fails to participate in formerly enjoyable activities

8. What are some of the risk factors for developing anxiety disorders?
   (a) Fair skin and blonde hair
   (b) A sibling with autism
   (c) Parent mental illness or shy temperament
   (d) Learning disability

9. Which of the following is an emotional symptom of anxiety?
   (a) Socially withdrawn
   (b) Obedient
   (c) Fidgets and appears restless
   (d) Appears to be “always on guard”

10. True or False: Even without an anxiety disorder diagnosis, children with symptoms of anxiety problems still require treatment to alleviate their symptoms.
    
    TRUE or FALSE

11. On the Anxiety Symptom Spectrum, what levels of symptoms may be a cause for concern?
    (a) Symptoms classified as sometimes, often, and always
    (b) Only symptoms classified as physical and emotional
    (c) Symptoms classified as often and always
    (d) Symptoms that lead to impairments in functioning
12. An example of a protective factor against the development of an anxiety problem is having a secure attachment to a caregiver. True or False?

TRUE or FALSE

13. If Renee, a student in your classroom, was often anxious on the Anxiety Symptom Spectrum, she may:
   (a) Repeatedly ask you if her work is correct
   (b) Be overly concerned about things that may happen in the future
   (c) Have many close friends
   (d) Both A and B

14. Why do we need to identify anxiety problems early?
   (a) To have the child evaluated for a learning disability
   (b) Problems may worsen over time and negatively affect development
   (c) To make sure that the child does not require a change in classroom placement
   (d) It is not necessary to identify anxiety problems early

15. List 4 academic symptoms of an anxiety problem.

1. ________________ 2. ________________
3. ________________ 4. ________________

16. Students who are classified as always anxious on the Anxiety Symptom Spectrum may avoid many classroom activities, appear distracted, and make many trips to the nurse’s office. True or False?

TRUE or FALSE

17. Jax, a student in your classroom, appears nervous before the weekly spelling tests but does not appear to have other symptoms of anxiety. Jax would be classified on the Anxiety Symptom Spectrum as:
(a) Often Anxious
(b) Sometimes Anxious
(c) Never Anxious
(d) Rarely Anxious

18. Obsessions are an emotional symptom of anxiety in which a child has repeated, intrusive, or persistent anxious thoughts, similar to superstitions. True or False?

TRUE      or      FALSE


1._____________________ 2._____________________
3._____________________ 4._____________________

20. Which of the following symptoms of an anxiety problem may also be a symptom of depression?
(a) Irritability
(b) Physical Complaints
(c) Poor Concentration
(d) All of the above

Thank you very much for participating in the T-TICAP!
Contact Information:

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Thank you to Lesley Burdiss for her assistance in compiling this document.