Cognitive-Behavioral Treatments for School-Related Anxiety in Children and Adolescents

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Anxiety disorders are common in school-aged children with 7–20% of children in the general population and primary care settings reporting clinically significant anxiety (Chavira et al., 2004; Ghandour et al., 2019; Merikangas et al., 2010). School refusal, which can be related to anxiety, occurs in about 1–2% of youth (Egger et al., 2003). Additionally, 16.4% of youth report high test anxiety (Putwain & Daly, 2014). The risk for anxiety increases with age (Ghandour et al., 2019); approximately 11% of adolescents meet diagnostic criteria for social anxiety disorder and 9% for separation anxiety disorder (Merikangas et al., 2010). Panic attacks and panic disorder also become more common in teens (Beesdo et al., 2009). This chapter provides an overview of cognitive-behavioral treatments for youth anxiety in school settings, including specific discussions on test anxiety and school refusal due to their relevance in school settings.

Anxiety is, at times, a normative and developmentally appropriate response. Many youth, for example, experience anxiety on the first day of school or when performing in a school play or recital. Anxiety can also be highly adaptive, such as when nerves before a big test motivate a youth to study. However, when anxiety causes prolonged distress or interferes with functioning, treatment may be indicated. In elementary-aged children, anxiety may manifest in the school setting as difficulty separating from a caregiver at morning drop-off, frequent reassurance seeking from teachers about academic work quality, or extreme shyness. In older students, social evaluation and performance anxiety may be displayed, such as difficulty answering questions in class, reading aloud, or doing presentations. Students with generalized anxiety disorder (GAD) may exhibit perfectionism in their school

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work (e.g., erasing and rewriting multiple times) or excessive studying above and beyond what is needed and in great contrast to their peers.

Fortunately, when treatment is needed, there are evidence-based options for children and adolescents, including those that have been specifically developed for and evaluated in schools. The psychosocial intervention approaches with the most empirical support for youth with anxiety are grounded in principles of cognitive-behavioral therapy (CBT; Higa-McMillan et al., 2016). These include CBT protocols developed for specific populations, for example, youth with social anxiety disorder (Beidel et al., 2000) or panic disorder (Pincus et al., 2010), and those that have been designed and tested for youth with a range of anxiety disorders and presentations (Kendall & Hedtke, 2006a, b). Social anxiety disorder, GAD, and separation anxiety disorder are believed to share an underlying anxiety construct (Pine & Grun, 1998), are commonly researched collectively and treated similarly (Kendall et al., 2008; Walkup et al., 2008), and are highly comorbid (Hankin et al., 2016).

CBT for child anxiety is classified as a well-established treatment; it has been shown to be effective in reducing symptoms of anxiety and improving functional impairment and is recommended as a first-line treatment (Higa-McMillan et al., 2016). One of the more widely researched CBT protocols for youth anxiety is the *Coping Cat* program (Kendall & Hedtke, 2006a, b). *Coping Cat* was developed for youth ages 7–14; an adolescent version, the *CAT Project*, is also available (Kendall et al., 2002). *Coping Cat* has been translated in several languages and adapted for a variety of international contexts. Randomized controlled trials have shown *Coping Cat* is effective for youth with social anxiety, separation anxiety, and GAD (e.g., Kendall et al., 1997, 2008) and that treatment gains are maintained long term (e.g., Benjamin et al., 2013; Kendall et al., 2004). Between 50% and 72% of children with anxiety who receive CBT no longer meet criteria for their primary pre-treatment anxiety disorder following treatment (e.g., Barrett et al., 1996; Kendall et al., 2008). In the multi-site Child/Adolescent Anxiety Multimodal Study (CAMS; Walkup et al., 2008), 12 weeks of CBT (i.e., *Coping Cat*) was compared to medication (i.e., sertraline), their combination, or pill placebo. Both CBT and sertraline alone effectively reduced anxiety symptoms, and combination treatment was superior to either monotherapy (Piacentini et al., 2014; Walkup et al., 2008). A 12-session computer-assisted program based on *Coping Cat* (i.e., "Camp Cope-A-Lot"; Kendall & Khanna, 2008) has also been developed and shows promise (Khanna & Kendall, 2010).

CBT protocols for child and adolescent anxiety share a number of common intervention components (Gorman et al., 2002; March & Mulle, 1998; Velting et al., 2004). These include psychoeducation about anxiety and its treatment, self-monitoring anxiety symptoms and triggers, cognitive restructuring (identifying, challenging, and changing maladaptive thoughts and beliefs, also sometimes referred to as anxious self-talk; Kendall & Hedtke, 2006a), relaxation training (diaphragmatic breathing, progressive muscle relaxation), problem-solving, and exposure. Homework is also a routine part of CBT treatments for youth with anxiety, though clinicians may opt to call it by another name, such as take-home practice, to avoid associations with school homework.

There are several reasons why it makes sense to treat anxiety in schools and advantages to treating anxiety in this context (Beidas et al., 2012; Mychailyszyn et al., 2011). Children already spend much of their time in school, so the provision of mental health services in schools has the advantage of treating children where they already are. This can reduce burden on families, increase access to care, and reduce stigma. Additionally, school treatment enables good communication between mental health personnel and teachers, which can be a challenge in the outpatient context. It can also facilitate opportunities for exposure, because peers are readily available and opportunities to practice test-taking or public speaking, if those are anxiety-provoking for a given youth, are easy to arrange. In some countries, including the United States, more children receive their mental health care through schools than through other publicly funded systems (Farmer et al., 2003; President's New Freedom Commission on Mental Health, 2003) so it is critical for school mental health clinicians in these contexts to have training in effective interventions for anxiety.

School-Based Prevention and Intervention Services

When anxiety is exhibited in the school setting, teachers are often first to identify symptoms. They play a critical role in identifying and referring students with anxiety to school mental health professionals or counselors for additional support. Children with mild to moderate anxiety can often be treated in school if a trained school mental health clinician is available. In cases of more severe anxiety or when mental health services are not offered within the school, a referral to a community provider, ideally with a specialization in treating anxiety, may be warranted. Assessment and treatment planning is best engaged in as a collaborative process where parents, teachers, and the youth themselves provide their perspectives to the school mental health provider and work as a team to develop a treatment plan (Mychailyszyn et al., 2011).

Numerous evidence-based programs at different levels of service delivery exist within the school setting. These include universal prevention services provided to all students in a classroom, selective prevention provided only to students at risk for mental health problems according to a teacher referral or mental health screening, and targeted intervention for students identified as having clinically elevated anxiety.

School-Based Universal and Selective Prevention Programs

Universal and selective prevention programs play a critical role in expanding access to services. Research suggests that CBT-based prevention programs can be effective in reducing anxiety, at least in the short term (Johnstone et al., 2018; Werner-Seidler et al., 2017). Results from a recent meta-analysis reported no difference in

effectiveness between universal and selective prevention programs (Werner-Seidler et al., 2017). These programs are typically manualized with a group leader and child workbook and incorporate the common components of CBT (see Table 1). Prevention programs vary greatly in length, (2–40 sessions) with the majority containing 8–12 sessions, and are often conducted in a group format. Few programs include parent involvement, although there is some evidence to suggest parental involvement may support maintenance of program gains (Manassis et al., 2014).

One of the most well-studied and widely implemented school-based anxiety prevention programs is FRIENDS, a CBT-based program that has been designed as

Table 1 Top components of school-based CBT treatment for anxiety disorders

Component	Description
Exposure	Techniques or exercises that involve direct or imagined experience with a target stimulus, whether performed gradually or suddenly, and with or without the therapist's elaboration or intensification of the meaning of the stimulus
Cognitive restructuring	Any techniques designed to alter interpretation of events through examination of the youth's reported thoughts, typically through the generation and rehearsal of more realistic, alternative counter-statements. This may be accompanied by exercises designed to comparatively test the validity of the original thoughts and the alternative thoughts by gathering and reviewing real-life evidence
Relaxation	Techniques or exercises designed to induce physiological calming, including muscle relaxation, breathing exercises, imagery, meditation, and similar activities. Relaxation strategies, such as progressive muscle relaxation, can be applied class-wide. Audio scripts are widely available (e.g., https://www.anxietycanada.com)
Psychoeducation (child and caregiver)	The formal review of information with the child/caregiver about the development of a problem and its relation to a proposed intervention (e.g., how anxiety is maintained through avoidance). For example, information about the cycle of anxiety and the maintenance of anxiety through avoidance
Modeling	Demonstration to the youth of a desired behavior, typically performed by a therapist, peers, or other actors to promote the imitation and subsequent performance of that behavior in the youth
Social skills training	Providing constructive information, training, and feedback to improve interpersonal verbal or non-verbal functioning, which may include direct rehearsal of the skills. This can include group feedback, the use of audio or videotape, or feedback from a therapist or peer
Praise/rewards	The training of parents, teachers, or others involved in the administration of rewards to promote desired behaviors (e.g., specific praise statements, tangible rewards)
Maintenance/ relapse prevention	Exercises and training designed to consolidate skills already developed and to anticipate future challenges that might arise after termination or reduction of services, with the overall goal to minimize the chance that gains will be lost in the future

Sources: Elements are listed in order of most frequently present to least frequently present in school-based cognitive-behavioral interventions with good support or better (adapted from PracticeWise, 2021)

both a universal and a selective prevention program (Barrett et al., 2006). Three versions have been developed for school-aged youth, Fun FRIENDS for children 4–7 years old (Barrett, 2012), FRIENDS for Life for children 8–11 years old (Barrett, 2005), and My FRIENDS Youth for teenagers 12–15 years old (Barrett, 2010). FRIENDS is an acronym that describes the types of skills being taught: F, feelings (emotion identification), R, remember to relax (physiological responses, relaxation strategies, and mindfulness), I, I can try my best (inner helpful thoughts – cognitive coping), E, explore solutions and coping step plans (problem-solving, social skills, and social support), N, now reward yourself (teaching rewarding effort toward approach behavior), D, do it every day (encourage continued use of skills after program ends), and S, smile! stay calm, and talk to support teams (relapse prevention). FRIENDS is a manualized nine and ten session programs, with options to include booster sessions and parent psychoeducation. Caregiver sessions provide an overview of the program, rationale for CBT, and the skills that children learn in order to reinforce learning in the home environment.

School-Based Targeted Interventions

The majority of well-supported targeted intervention programs that have been specifically tested in schools are group-based; only about 37% contain an individual treatment component (PracticeWise, 2021). School-based interventions typically leverage the school setting to conduct externally valid, real-world exposures in the school setting and are similar in length to clinic-based CBT (e.g., 12–16 sessions). A recent meta-analysis demonstrated that session length for school-based interventions was not predictive of outcomes (Sanchez et al., 2018), suggesting that brief interventions can be effective while being less burdensome on school staff (e.g., Crawley et al., 2013). Some programs incorporate specific skills related to particular anxiety disorders (e.g., social skills development and assertiveness training for youth with social anxiety; Beidel et al., 2006; Masia Warner, 2016). Most CBT for anxiety protocols that have been tested in schools share a set of common components which are defined and listed in Table 1 and build on core strategies established in *Coping Cat* (Kendall & Hedtke, 2006a, b).

Modular CBT, in which the session order and number of sessions can be flexibly delivered and tailored, is particularly well suited for school settings. Modular CBT has demonstrated efficacy in outpatient settings and preliminary effectiveness in school settings (Chiu et al., 2013; Ginsburg et al., 2020; Kininger et al., 2018). We draw special attention to the most critical component of anxiety treatment: exposure (Abramowitz, 2013; Higa-McMillan et al., 2016). Figure 1 provides an example of a fear ladder, which is used to plan exposure sessions in a school setting. The fear ladder is collaboratively created by the clinician and client (often with parental input) to develop a hierarchy of situations, ordered from least to most feared. The child gradually practices the situations in order. Exposure helps the child learn that

Fear Ladder

Harder	Fear Rating	
	10	Answering questions about my presentation in front of the class.
	9	Presenting my work in front of the class.
	8	Being called on by the teacher to answer a question.
	7	Raising my hand in class.
	6	Reading aloud in front of the whole class.
	5	Practicing my presentation in front of a small group.
	5	Practicing my presentation in front of 1 person not in my family.
	4	Answering questions about my presentation in front of my family.
	3	Practicing my presentation in front of my mom.
	3	Answering a question that another student asks me individually.
	2	Watching my classmate present their work.
Easier	1	Sitting in the classroom with the whole class present.

Fig. 1 Example fear ladder in a school setting

the situation is not actually dangerous, that they are capable of coping, and that anxiety will often naturally dissipate with time (Kaplan & Tolin, 2011).

Test Anxiety

Test anxiety, also known as exam anxiety, exam stress, or test stress, is defined as the emotional, physiological, and behavioral responses related to perceived consequences of an exam (von de Embse et al., 2018). Test anxiety can be experienced prior to, during, and after an exam. Although text anxiety is not a diagnostic category listed in the DSM-5 or ICD-10, more than half of children with high test anxiety also meet criteria for another anxiety disorder, most often social anxiety and generalized anxiety disorder, and have elevated symptoms of depression (Beidel et al., 1994; King et al., 1995). Untreated test anxiety is associated with negative outcomes such as poor grades, reduced academic engagement, and increased risk for anxiety and depression (von der Embse, 2018). Because test anxiety is a significant concern of schools, we discuss specific CBT approaches to test anxiety (Neill et al., 2021).

Interventions for Test Anxiety

Experts recommend that school officials take a tiered approach to preventing and treating test anxiety in schools. A review on test anxiety interventions for K–12 students found that interventions using cognitive-behavioral strategies were among the most frequently tested, although results differed according to the strategies used and intervention level (von der Embse et al., 2013). Universal prevention strategies include class-wide interventions facilitated by a teacher or mental health staff. Effectiveness in decreasing test anxiety and improving grades for universal prevention strategies is varied. For example, Gregor (2005) found that following a cognitive-behavioral prevention program, performance improved only for mathematics, but not other subjects. On the other hand, Yeo et al. (2016) found reductions in self-reported test anxiety for a four-session prevention program for fourth graders in Singapore. Interestingly, they found that behavioral skills, such as study skills and relaxation training, contributed to the treatment effects, whereas cognitive skills, such as calming self-talk, did not (Yeo et al., 2016).

Targeted interventions for students who report high test anxiety include computer-facilitated, group-based, and multicomponent interventions. Testbusters, an 11-week group program on study skills and test-taking strategies developed for elementary and middle (primary) school students, found decreases in self-reported test anxiety and improvements in grade point average but found no improvements on self-reported cognitive, social, and physical competence (Beidel et al., 1999). Weems and colleagues (2015) developed and tested a group intervention delivered in public schools for students ages 8–17 with elevated test anxiety. It was delivered in five sessions over 4–6 weeks by advanced graduate students and was designed to promote positive emotional development by targeting test anxiety. Results indicated a decrease in test anxiety and reduction in related anxiety disorder symptoms and depression symptoms post-treatment and during subsequent follow-ups in the next year. Putwain and colleagues (2014, 2017) developed a six-session computerized intervention, STEPS, to reduce test anxiety in secondary (high school) students. STEPS consists of the following components: identifying signs and triggers of test anxiety, changing negative self-talk, relaxation, study and test-taking skills, and goal setting. They found a reduction in worry and tension scores, but not test-irrelevant thoughts or bodily symptoms. Furthermore, the authors found that the intervention may have specifically helped students reduce uncertain control. As a result, after the intervention, students believed that their actions are linked to their exam outcome. In sum, school-based cognitive-behavioral interventions focused on test anxiety show promising results for elementary through high school populations in improving grades along with other areas of well-being.

Anxiety and School Refusal Behavior

School refusal is defined as a child's refusal to attend part or all of the school day. Youth with anxiety-based school refusal experience high levels of emotional distress with the anticipation of attending school (Heyne et al., 2019), and it is not uncommon for them to have a comorbid diagnosable anxiety disorder (Kearney & Albano, 2004). They display a variety of behaviors related to absenteeism along a continuum from consistent pleas to parents to skip school to repeated tardiness, all the way to prolonged absence from school (Kearney, 2008). Consequently, it is important for school officials and parents to be aware of the early signs of school refusal. Untreated children with school refusal behavior have prolonged problems with school attendance and are at risk for later mental health problems, low educational achievement, and social difficulties (Maynard et al., 2018; Egger et al., 2003). School refusal may be distinguished from truancy in that children with school refusal have an absence of severe antisocial behavior and do not conceal their efforts to stay at home during school hours from parents (Heyne et al., 2019). Understanding the primary reason behind a youth's school refusal behavior provides a greater understanding of the problem and improves treatment planning (Kearney & Silverman, 1999).

School procedures to regularly review patterns of student attendance and tardiness fit well within a tiered approach to prevention and treatment of school refusal behavior (Ingul et al., 2019). The National Dropout Prevention Center (2021) highlights effective universal strategies such as improving family engagement, providing educator professional development on working with at-risk youth, and developing school community collaborations. Targeted (tier 2) interventions may be appropriate for students who are under the legal allowable limit for absences but show a concerning pattern of absences (Kearney & Graczyk, 2014). Targeted interventions begin with creating a collaborative plan with school staff, the student, and family to improve regular student attendance and providing frequent communication and support for the family. Examples of tier 2 interventions may also include providing referrals for mental health services, tutoring, or community supports (Kearney & Graczyk, 2014).

In addition to planned reviews of attendance, students at risk for school refusal may need more frequent and nuanced assessment. The SRAS-R (School Refusal Assessment Scale-Revised; Kearney, 2006) is 24-item self-report measure available in child and parent versions that differentiates profiles of children who refuse school. Kearney (2006) describes the four profiles included on the SRAS-R to differentiate students who (a) avoid school-related stimuli that provoke negative affectivity (i.e., anxiety and depression symptoms), (b) escape school-related aversive social and/or evaluative situations, (c) gain attention from significant others (e.g., parents), and/or (d) pursue tangible reinforcement outside of school (e.g., shopping, playing with friends, or drug use). After determining the primary profile of the student, it is recommended to follow up with additional evidence-based assessments related to the profile. For example, a student whose primary motivation is to avoid school-related

stimuli that provoke negative affectivity, it is recommended to follow up with assessments for anxiety and depression symptoms (Kearney & Albano, 2004). In addition, a biopsychosocial approach to understand other problems that relate to absenteeism should be assessed and incorporated into the treatment plan, such as chronic medical conditions, family functioning, family adversity (e.g., homelessness, transportation concerns), social concerns, and academic difficulties.

Treatment for school refusal behavior is more likely to be successful when a treatment plan is developed based on the profile ascertained from the SRAS-R (Kearney & Silverman, 1999). For example, a student whose primary motivation is to pursue tangible reinforcement outside of school, treatment may need to include family coordination to increase supervision and behavioral contracts to ensure that reinforcers are earned when the child attends school. Common components of intervention for school refusal include cognitive-behavioral strategies (e.g., listed in Table 1) along with other components such as contingency management or communication skills training (Kearney & Albano, 2018). Generally, greater treatment success is found with younger students and prior to the development of severe and chronic attendance problems (Strömbeck et al., 2021). Consequently, a key component in treatment includes a focus on increasing the student's return to school early in treatment (Maynard et al., 2018).

Cognitive-behavioral interventions for school refusal behavior have resulted in positive effects such as improved attendance and decreased symptoms, especially when related to anxiety (Pina et al., 2009). Furthermore, these interventions have been tested with a wide range of students from elementary to high school (Kearney & Graczyk, 2014). A rigorous meta-analysis on eight studies of psychosocial treatments for school refusal found a positive effect for attendance but found varied effects for anxiety depending on the study (Maynard et al., 2018). Additional studies on the effect of treatment long term and on other pertinent variables (e.g., self-esteem, social adjustment; Heyne et al., 2020) will enhance the field.

Culturally Responsive Prevention and Intervention for Anxiety

Despite evidence that school mental health services can increase access to care, research continues to point to disparities in the receipt of anxiety treatment for culturally diverse youth (Gudiño et al., 2009). The majority of anxiety prevention and intervention programs are conducted with primarily White non-Hispanic students and implementers (Huey & Polo, 2008) and do not consider the unique needs and strengths of culturally diverse youth that may affect their mental health and treatment experience. Youth from intersecting marginalized identities (e.g., race/ethnicity, gender, lower socioeconomic status, immigration status) are particularly likely to experience stressors related to racism, discrimination, acculturation, and housing or food insecurity that contribute to experiences of anxiety (Anderson et al., 2018).

In these cases, it is important that school-based prevention and intervention services acknowledge and incorporate this context into program development (Graham et al., 2013). For example, rather than challenging irrational thoughts, strategies could focus on addressing internalization and negative self-focused thoughts due to experiences of marginalization. Additionally, incorporating a focus on cultural strengths and identity development (e.g., racial/ethnic identity, cultural pride, values, heritage) has been shown to be an important aspect of treatment effectiveness for culturally diverse youth (Anderson et al., 2018; Morris et al., 2021; Yoon et al., 2013). Researchers continue to explore ways that salient cultural and contextual factors can be intentionally incorporated into the development and delivery of school-based mental health programs (Castro-Olivo, 2017; Owens et al., 2013).

Implementation Challenges in a School Setting

While providing services in the school setting can reduce stigma and increase access to needed services, there are several challenges that must be acknowledged. First, conducting services in the school setting means youth are likely receiving services with peers and teachers/staff that they will interact with in other settings, making confidentiality and privacy more complicated. Moreover, if students are receiving targeted interventions, it may be more likely for them to be singled out or for other students to be aware of their participation in services. To minimize these issues, it is important that rules around confidentiality are laid out clearly among students and staff from the onset of service provision.

Second, many school-based programs do not focus on parental involvement and those that do often have poor attendance, which is typically a result of competing demands from parent work schedules. Lack of intentional and successful parental engagement may explain less than ideal long-term prevention and treatment gains (Lee et al., 2016), as studies have suggested that including caregivers in child anxiety treatment can improve treatment outcomes and maintain gains (Manassis et al., 2014). Therefore, it is imperative that mental health programs in schools promote school-home communication. Providing childcare and meals and holding sessions in the evenings are some ways that schools can support caregiver participation.

Third, sufficient staffing and resources remain a problem for sustainability of mental health programing. While over half of prevention and intervention programs tested in rigorous trials are delivered by external personnel (e.g., researchers, graduate students, external clinicians), CBT delivered by school providers in school settings can also be effective (e.g., Ginsburg et al., 2020; Masia Warner et al., 2016). It is important to consider whether the format and intensity of a manualized CBT program are feasible when considering competing demands, priorities, and resources of school-based providers (LoCurto et al., 2020). These challenges lead us to suggest that effective school supports require collaborative partnerships with community-based organizations; a focus on low-burden, brief interventions; and additional funding for hiring of staff in order to focus attention on mental health services.

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