



# School-Based Interventions for Child and Adolescent Anxiety

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Anxiety disorders are the most common mental health problem among young people, with a lifetime prevalence rate of 32% prior to age 18 years (Merikangas et al., 2010). Left untreated, childhood anxiety is associated with academic and social impairment (Swan & Kendall, 2016), a chronic course into adulthood (Costello et al., 2005), and significant costs to families and communities (Bodden et al., 2008; Pella et al., 2020). Yet, despite the clear importance of early and effective intervention for anxious youth, many remain unidentified, and more than 80% do not receive treatment (Merikangas et al., 2011). Even when anxious youth connect with various health service sectors, such as pediatrics and school mental health, they may not receive evidence-

based services. Primary care providers can facilitate children's access to mental health services but often have difficulty identifying anxiety (Aydin et al., 2020), can feel ill-equipped to manage and support child anxiety (O'Brien et al., 2017), and are less likely to refer anxious youth to mental health services than youth with externalizing problems (Wren et al., 2005). Similarly, students identified as anxious through school-wide screenings are less likely than students with other mental health problems to receive follow-up care from a provider (Husky et al., 2011). Logistical barriers, including long wait-lists and high costs, can also prevent families from accessing community mental health care. This failure to deliver adequate care, combined with the high rates, impairments, and costs of child and adolescent anxiety, underscores the critical need for alternate methods of providing anxious youth with effective services.

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## Rationale for School-Based Interventions

Schools can play an important role in addressing the unmet mental health needs of anxious youth by potentially increasing access to cost-effective services. Implementing evidence-based interventions in school settings offers a number of advantages over traditional mental health services. Because schools provide unparalleled access to

youth, school-based services can reduce logistical barriers, such as cost and transportation (Husky et al., 2011). Training school personnel to identify anxiety and implement school-wide screenings may also facilitate early detection and intervention efforts (Fox et al., 2008). In addition, as stigma is among the largest barriers to mental health care, youth and families might be more accepting of mental health services if offered among the many routine services provided by schools (Bowers et al., 2013).

Moreover, the school environment is an ecologically valid setting to implement evidence-based interventions for child and adolescent anxiety. Many common triggers of anxiety occur at school, such as giving presentations, approaching peers, being assertive, using public bathrooms, separating from caregivers, taking exams, and worrying excessively about grades. As a result, school-based anxiety interventions allow students to practice new skills and engage in exposure exercises in everyday situations, thereby increasing the likelihood of generalization. For instance, children can complete exposures in which they read in front of the class or initiate conversations with peers at a school club. Peers and teachers can also be enlisted to assist in exposure tasks (e.g., requesting a peer to start a conversation with the anxious student to ensure repeated practice), and school-based clinicians can join students to provide additional coaching and encouragement (Ryan et al., 2012). In this way, interventions delivered in school can reduce the divide between the clinical setting and the “real world.”

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## School-Based Intervention Outcome Research

Building on research that established the efficacy of cognitive-behavioral therapy (CBT) for child and adolescent anxiety in clinic and laboratory settings (e.g., Cartwright-Hatton et al., 2004; Higa-McMillan et al., 2016), the past 15–20 years have witnessed a substantial increase in studies of anxiety interventions in school settings. These studies initially focused on exploring the *trans-*

*portability* of CBT interventions in schools. In contrast to more controlled efficacy research, these studies examined whether researchers could implement these interventions feasibly and effectively in the real-world conditions of school settings and with more open inclusion criteria for participants. More recently, a growing area of research has investigated the *dissemination* of school-based anxiety interventions. These studies aim to evaluate whether these interventions can be delivered successfully by school personnel, including school-based clinicians (e.g., school psychologists) and less-specialized school professionals (e.g., teachers) with limited background in CBT. These studies are also critical for understanding factors such as training and supervision models, which may influence whether schools are able to sustain these interventions without significant researcher involvement.

This chapter will present four school-based intervention programs for child and adolescent anxiety. While there are other school-based anxiety interventions in the literature, these four programs were selected because their feasibility and transportability have been demonstrated in multiple randomized controlled trials, and there have been significant efforts to investigate whether they can be delivered effectively by school personnel. Following the overview of these programs, various issues, challenges, and future directions related to the implementation of school-based anxiety interventions will be discussed.

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## FRIENDS

### Program Description

The *FRIENDS* program is a school-based universal anxiety prevention program for school-aged youth (Barrett & Turner, 2001), adapted from the *Coping Koala* (Barrett et al., 1996), which was based on the *Coping Cat*, a cognitive-behavioral treatment for child anxiety (Kendall, 1994). *FRIENDS* is an acronym designed to help children remember the skills learned during the program, which include emotion recognition and

regulation, relaxation skills, cognitive awareness and restructuring, problem-solving, and in vivo exposure. The acronym is as follows: F = Feeling worried; R = Relax and feel good; I = Inner thoughts; E = Explore plans of action; N = Nice work, reward yourself; D = Don't forget to practice; S = Stay cool. *FRIENDS* consists of 10 weekly group sessions open to all children, with two booster sessions occurring 1 month and 3 months after the final group. In addition, four parent sessions are used to inform parents about the program skills and enhance parenting related to anxiety management.

Since the initial development of *FRIENDS* in 2001, a set of *FRIENDS* programs (Fun *FRIENDS*, *FRIENDS* for Life, My *FRIENDS* Youth and Adult Resilience) have been developed to target various age groups. For example, the *FRIENDS* for Life program targets children ages 7–11 (Barrett, 2012a), whereas the My *FRIENDS* Youth program is intended for adolescents ages 12–16 (Barrett, 2012b). The different *FRIENDS* programs overlap in content but differ in their use of developmentally appropriate methods for delivering the intervention skills. Specifically, while programs for younger children (e.g., Fun *FRIENDS*) focus more on play-based techniques, including puppets, stories, and coloring activities, My *FRIENDS* Youth utilizes role-plays, group discussions, and written activities.

## Outcome Studies

Two early studies (Barrett & Turner, 2001; Lowry-Webster et al., 2001) offered an initial evaluation of *FRIENDS* as a universal program in 10–13-year-olds in Brisbane, Australia. First, Barrett and Turner (2001) compared *FRIENDS* to usual instruction across ten schools randomly assigned to one of the three conditions: teacher-led intervention (TI;  $N = 253$ ), psychologist-led intervention (PI;  $N = 152$ ), or usual instruction (UI;  $N = 84$ ). Children in both intervention conditions, compared to children receiving UI, reported significantly decreased anxiety at post-intervention. Second, Lowry-Webster et al.

(2001) compared *FRIENDS* ( $N = 392$ ), delivered by trained classroom teachers, to a waiting list control ( $N = 139$ ) in seven schools. Self-reported anxiety significantly decreased from pre- to post-intervention in both conditions, but the magnitude of change was significantly greater for students who participated in *FRIENDS*. In addition, of those who were classified as “at-risk” for an anxiety disorder based on high-baseline anxiety ratings, only 25% of those in the *FRIENDS* condition remained at risk at posttreatment compared to 55% of the control group.

Consistent with these findings, Lock and Barrett (2003) found that, among 336 sixth (ages 9–10) and ninth graders (ages 14–16) from seven schools in Australia, students who received *FRIENDS*, delivered by psychologists and doctoral students, reported greater decreases of anxiety than those in the control group, a monitoring condition. Moreover, sixth graders reported greater reductions than ninth graders, suggesting that late childhood may be an optimal period to deliver *FRIENDS*. As suggested by the authors, adolescents may be more likely to have coping strategies sufficient for managing anxiety and, thus, benefit less from a prevention program. While limited to child self-report data, all three of these studies showed early promise for the effectiveness of *FRIENDS* as a universal school-based prevention program for anxiety.

Subsequent follow-up studies provided evidence for the long-term efficacy of *FRIENDS* in preventing and reducing anxiety in children and adolescents. For example, in a follow-up evaluation of the aforementioned study by Lowry-Webster and colleagues, differences in child-reported anxiety were maintained 1 year following intervention, and 85% of treated youth who had scored in the clinically elevated range on baseline anxiety or depression self-report measures were diagnosis-free at follow-up, compared to only 31% of the waiting list group (Lowry-Webster et al., 2003). In addition, a follow-up of the aforementioned study by Lock and Barrett (2003) indicated that anxiety reductions associated with *FRIENDS* were largely maintained at 24 and 36 months post-intervention (Barrett et al., 2006). At 36 months post-

intervention, only 12% of the *FRIENDS* group was deemed at “high risk” for anxiety disorder (i.e., scoring in the top 10% on an anxiety self-report measure), compared with 31% of the control group. Moreover, the age difference from the initial study persisted at these two follow-up time points, again suggesting that *FRIENDS* may be more beneficial for elementary school-age children compared to adolescents.

## Cultural Adaptations

In the 20 years since these initial studies in Australia, researchers have evaluated the *FRIENDS* programs all over the world, from schools in high-income countries, such as Great Britain (Stallard et al., 2007), Slovenia (Kozina, 2021), Sweden (Ahlen et al., 2012), and Japan (Kato & Shimizu, 2017; Matsumoto & Shimizu, 2016), to low- and middle-income countries, such as Brazil (Rivero et al., 2020), Mexico (Gallegos et al., 2012), Iran (Moharreri & Heydari Yazdi, 2017), and Lebanon (Maalouf et al., 2020). To date, findings have been somewhat mixed. For instance, in an open trial of *FRIENDS* delivered by school nurses in Great Britain, featuring 106 children between ages 9 and 10, decreases in self-reported anxiety and self-esteem were observed from pre- to post-intervention (Stallard et al., 2007) and were maintained 12 months later (Stallard et al., 2008). In contrast, a trial of the *Fun FRIENDS* program delivered by school nurses in Japan (Kato & Shimizu, 2017), with 74 children ages 8–9, found that parents of children receiving *FRIENDS* reported a modest decrease in child anxiety compared to those in the control group, whereas no differences were observed in child-reported anxiety or depressive symptoms. Similarly, Ahlen et al. (2018) found no effectiveness of *FRIENDS for Life*, as led by teachers and culturally adapted for a sample of 695 children (ages 8–11) recruited from 17 schools in Sweden. Although self-reported and parent-reported anxiety and depressive symptoms did not change overall from pre- to post-intervention, nor 3 years after the completion of the program (Ahlen et al., 2019),

Ahlen et al. (2018) did find an enhanced effect of the intervention in children with elevated depressive symptoms at baseline, suggesting the intervention could be meaningful for students most at risk.

Of note, Maalouf et al. (2020) recently conducted a school-based randomized controlled trial (RCT) that compared the *My FRIENDS Youth* program to a waiting list control group in 280 middle school students (ages 11–13) from ten schools in Beirut, Lebanon. The program was translated into Arabic, and the intervention workbook was adapted to incorporate more locally salient examples (e.g., surfing changed to playing basketball) and replace English names and role models with more culturally relevant and familiar Arabic names. Results showed that students in the *My FRIENDS Youth* program reported greater decreases in general emotional and depressive symptoms, compared to the control group. In addition, girls in the intervention group reported greater reductions in anxiety symptoms, a gender difference that is consistent with previous research showing that girls tend to respond better to *FRIENDS* (Barrett et al., 2006).

*FRIENDS* has also been adapted to increase its reach to children from low socioeconomic backgrounds. For example, Iizuka et al. (2015) adapted *FRIENDS* for ethnic minority and low socioeconomic status students in Australia by substituting creative tasks, music, and art activities for those requiring reading and writing. Results showed that the adapted intervention benefited participants who were at risk for mental health problems at baseline, with 30% of the students being no longer at risk after the intervention. Importantly, most students rated the culturally adapted intervention as being highly acceptable and useful. Similarly, Eiraldi et al. (2016) adapted *FRIENDS* to make it more feasible for implementation with low-income children from urban schools in the United States. In creating their *CBT for Anxiety Treatment in Schools* program, or *CATS*, changes were made to the language, cultural fit, methods, number of sessions, and activities in the intervention manual. Although findings have yet to be published, the authors expect that this adaptation will result in a

more engaging and culturally sensitive protocol, while still maintaining the essential ingredients of cognitive-behavioral interventions for anxiety.

## Implementation Strategies

Studies of *FRIENDS* have also examined whether the program can be delivered successfully by school personnel. However, findings in this area have been mixed. For example, while the original study by Barrett and Turner (2001) found that *FRIENDS* was similarly effective at preventing anxiety regardless of whether it was led by teachers or psychologists, other studies have found that *FRIENDS* was not effective when delivered by teachers (Ahlen et al., 2018) or school nurses (Kato & Shimizu, 2017). In a larger RCT ( $N = 1362$  students, from 40 schools), Skryabina et al. (2016) found that *FRIENDS* led by health-care staff external to the school was more effective in decreasing social anxiety and generalized anxiety as compared to *FRIENDS* led by trained school staff or usual instruction. Taken together, these findings suggest that we cannot assume anxiety prevention programs such as *FRIENDS* will be as effective when delivered by trained school staff. Further research will be helpful in identifying factors that may contribute to successful implementation of *FRIENDS* by school personnel. Interestingly, Ahlen et al. (2018) found that children whose teachers attended a larger number of supervision sessions reported greater decreases of anxiety compared to children whose teachers attended fewer sessions and children in the control group, suggesting that supervision might be an important target for enhancing the ability of school personnel to deliver *FRIENDS* effectively.

## Parent Training

Bernstein et al. (2005) evaluated a modified version of *FRIENDS* that incorporated weekly parent group training to address the impact of child anxiety on families, help parents understand how family relationships can maintain anxiety, teach

parents strategies to encourage their children to face their fears, and/or instruct parents how to manage their own anxiety to be a more effective coach and better model for their children. In this study, 61 elementary school children (ages 7–11), with features or diagnoses of separation, generalized, or social anxiety disorder and mild to moderate symptomatology, were randomized to *FRIENDS*, *FRIENDS* with enhanced parent training (both delivered by experienced CBT therapists), or a no-treatment control. Clinician-, child-, and parent-report anxiety measures demonstrated significant benefits of both active treatments compared to the no-treatment control. Results were mixed regarding the additional benefits for the inclusion of parent training, and findings were largely maintained 3, 12, 24, and 36 months after intervention (Bernstein et al., 2008).

## Summary

*FRIENDS* has been shown to be an effective universal prevention program in schools in Australia, where it was originally developed. Evidence appears more mixed when *FRIENDS* is evaluated in other countries and when it is implemented by trained school personnel, such as teachers and school nurses. *FRIENDS* may be more effective for children most at risk for anxiety disorders and for elementary school children, rather than adolescents. Overall, these studies suggest that *FRIENDS* has the potential to improve access to anxiety interventions across different cultures and in low-resource school settings.

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## Cool Kids

### Program Overview

Unlike *FRIENDS*, which is an adaptation of a treatment protocol, *Cool Kids* was designed to be an indicated intervention for children and adolescents at risk for anxiety disorders (Mifsud & Rapee, 2005). *Cool Kids* consists of eight sessions delivered to small groups of youth during



school hours by a trained mental health provider. Separate child and adolescent protocols are available, and the level of parental involvement varies with the age of participants. More specifically, parents may be provided with two information sessions to learn about, and engage them in, the intervention. Weekly content may also be provided to parents if additional parental involvement is needed. Early sessions focus on rationale for treatment, psychoeducation about anxiety, identifying and restructuring anxious cognitions, and promoting emotion identification and regulation. By session four, students are encouraged to begin engaging in graded exposures, which are emphasized through the remaining sessions, along with skills for problem-solving, social interaction, handling bullying or teasing, and increasing assertiveness.

## Outcome Studies

To date, *Cool Kids* has been evaluated in at least three school-based randomized controlled trials: one comparison with a waiting list control group (Mifsud & Rapee, 2005) and two comparisons with attention control groups (Haugland et al., 2020; McLoone & Rapee, 2012). Mifsud and Rapee (2005) completed the first school-based evaluation of *Cool Kids* in a sample of 91 children (ages 8–11) with notable anxiety symptoms from nine schools in a low socioeconomic area. Schools were randomly assigned to *Cool Kids* or a waiting list control group. Each intervention group was implemented by a school counselor in conjunction with a community-based mental health worker who had attended a 1-day training in the intervention. No ongoing supervision was provided by the trainers. Children who participated in the active intervention showed significant improvement in anxiety symptoms immediately after intervention and at a 4-month follow-up, based on child and teacher report.

McLoone and Rapee (2012) conducted a novel investigation of *Cool Kids* by comparing the implementation of the program in school and home settings. A total of 152 children (ages 7–12), who either had an elevated score on the

Spence Children's Anxiety Scale (SCAS) or were nominated by a teacher, were randomized to school-based *Cool Kids*, home-based *Cool Kids*, or a waiting list control group. The school-based *Cool Kids* was delivered by school counselors in a group format, consisting of ten 1-hour sessions and two parent sessions. The home-based *Cool Kids* was implemented individually with each child by the child's parent(s), who completed two training sessions. Results showed that children who participated in either version of *Cool Kids* experienced greater reductions in child anxiety and anxiety-related interference than the waiting list group, according to parent report but not report by children or teachers.

Most recently, Haugland et al. (2020) compared the effectiveness of *Cool Kids* to a brief CBT intervention and a waiting list control in a sample of 313 adolescents, between ages 12 and 16, who had an elevated score on the SCAS. The *Cool Kids* and brief CBT conditions were implemented in a group format by school personnel (e.g., school nurses) or community mental health workers. The *Cool Kids* intervention consisted of ten 90-minute sessions, held weekly. The brief CBT intervention (*Vaag*) included five 45–90-minute weekly sessions, with a 5-week break between the last two sessions, during which the students completed exposure tasks with minimal contact with the group leaders. Findings showed that students in *Cool Kids* and *Vaag* reported similar reductions in anxiety symptoms, depressive symptoms, and anxiety-related impairment at post-intervention, and that these reductions were greater compared to those reported by students in the waiting list condition. These decreases were maintained at a 1-year follow-up in both intervention groups.

## Summary

*Cool Kids* appears to contribute to reductions in anxiety symptoms and anxiety-related impairment in anxious children and adolescents. These findings are largely in line with a meta-analysis conducted by Mychailyszyn (2017), which demonstrated the efficacy of *Cool Kids* as an indi-

cated intervention for anxiety across investigations in research, community, school, and other settings. It will be important moving forward to examine *Cool Kids* in the context of larger attention control trials and implementation solely by school personnel. In addition, given findings by Haugland et al. (2020) showing similar outcomes from *Cool Kids* and a briefer group-based CBT intervention, further study should explore the utility and effectiveness of potentially delivering *Cool Kids* in a briefer, flexible, or modular format.

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## Skills for Academic and Social Success

### Program Overview

Skills for Academic and Social Success (SASS; Masia et al., 1999; Masia Warner et al., 2018) is a cognitive-behavioral group treatment for social anxiety disorder (SAD) in adolescents in the school setting. SASS is based on Social Effectiveness Therapy for Children (SET-C), an efficacious, clinic-based treatment for children with SAD that emphasizes exposure, social skills training, and peer generalization exercises (Beidel et al., 2000, 2005). SASS features significant modifications for an adolescent population (e.g., developmentally appropriate social skills, addition of training in realistic thinking) and the school environment (e.g., fewer and briefer sessions and incorporation of teachers, parents, and school peers). SASS consists of 12 group school sessions, two individual meetings, two parent meetings, two teacher meetings, four social events attended by group participants and outgoing school peers, and two booster meetings. The 12 school sessions include realistic thinking (cognitive restructuring), social skills training, and exposures that are integrated into the school environment and include the assistance of school personnel or school peers (e.g., ordering and returning food in the cafeteria, starting a conversation with a teacher). In addition, two individual meetings focus on setting goals and problem-solving treatment obstacles. Sessions occur dur-

ing the course of the school day, with sessions lasting 40 minutes to coincide with a single class period. The parent sessions address psychoeducation about social anxiety and ways to manage children's anxiety and facilitate improvement. Teacher meetings are designed to educate teachers about social anxiety, obtain information about which classroom behaviors to target, and enlist their assistance with classroom exposure exercises (e.g., reading aloud, answering questions in class). Finally, the four social events provide real-world exposures and opportunities for skills generalization. Group members practice social interactions with actual school peers in natural community "hang-outs" (e.g., bowling, school picnic).

### Outcome Studies

SASS has been evaluated in a small open trial (Masia et al., 2001), a wait-list control trial (Masia Warner et al., 2005), an attention control trial (Masia Warner et al., 2007), and a large effectiveness trial (Masia Warner et al., 2016). In the wait-list control trial, 35 adolescents with SAD, ages 14–16 years, from two urban parochial schools were randomized to either SASS or a waiting list. Treatment was conducted by a clinical psychologist and a psychology graduate student trained in the intervention. The SASS intervention was superior to the waiting list in reducing social anxiety and avoidance and enhancing functioning, as noted by blind evaluator, parent, and adolescent ratings. Of the SASS group, 94% were classified as responders, compared to only 12% of wait-list participants. In addition, 67% of SASS participants, versus 6% in the wait-list group, no longer met diagnostic criteria for SAD at post-assessment.

The second investigation compared SASS to a credible attention control in 36 adolescents, ages 14–16, with SAD (Masia Warner et al., 2007). The attention control omitted therapeutic elements specific to reversing social anxiety but was matched on other relevant therapy variables. It was designed to match SASS in structure with the inclusion of the four social events conducted

without the outgoing school peers. The content consisted of psychoeducation about social anxiety, relaxation techniques, and support. At post-treatment, SASS was superior to the attention control in reducing social anxiety and improving overall functioning. Only 7% in the attention control, versus 82% in SASS, were treatment responders. In addition, 59% of the SASS group no longer qualified for a diagnosis of social phobia, versus 0% of the attention control. SASS was also superior to the attention control 6 months beyond the cessation of treatment.

To examine whether SASS could be implemented effectively by school counselors without specialized training in CBT, Masia Warner et al. (2016) conducted an RCT with 138 ninth through 11th graders from three public high schools. Students were randomized to one of three conditions: SASS as delivered by school counselors (C-SASS), SASS as delivered by clinical psychologists with experience in CBT for youth anxiety (P-SASS), and Skills for Living (SFL), a non-specific, manualized school counseling group program. School counselors completed a 5-hour training workshop and co-led a 12-week SASS training group with a clinical postdoctoral fellow. Following this, school counselors received weekly consultation during independent SASS implementation. Both immediately posttreatment and at a 5-month follow-up, treatment response was significantly greater in C-SASS (65% and 85%) and P-SASS (66% and 72%) than in SFL (18.6% and 25.6%). In addition, C-SASS and P-SASS participants had lower severity of SAD at both time points than students who completed SFL. Diagnostic remission was also higher for C-SASS (22% and 39%) and P-SASS (28% and 28%) than SFL (7% and 12%) at posttreatment and follow-up. No differences between C-SASS and P-SASS were observed on the main clinical outcomes.

## Summary

Masia Warner and colleagues have demonstrated the specific benefits of treating SAD in the school setting. School counselors were able to implement the SASS program with positive student

outcomes comparable to clinical psychologists when provided with training and supervision. These findings point to a model for promoting access to services by preparing frontline school professionals to deliver evidence-based care for underserved youth with SAD, which may extend to other anxiety disorders.

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## School-Based Treatment for Anxiety Research Study

### Program Overview

The School-Based Treatment for Anxiety Research Study (*STARS*; Ginsburg et al., 2020), as well as the related Baltimore Child Anxiety Treatment Study in the Schools (*BCATSS*; Ginsburg et al., 2008, 2012), were conducted to evaluate a treatment program for child anxiety disorders that was delivered in school districts by school-based clinicians. The *BCATSS* was initially adapted for, and conducted in, an inner-city environment that is typically underserved. However, the initial evaluation of the CBT treatment used in the *BCATSS* has evolved into a broader examination of the use of CBT in school-based anxiety treatment that can be used in different socioeconomic school settings. In contrast to most other school interventions, the treatment (henceforth known as the *STARS* program) is delivered in an individual rather than group format. *STARS* consists of 12 sessions conducted during regular school hours. Sessions are approximately 30–45 minutes in length in order to coincide with a single class period. The program was designed for delivery by school counselors, social workers, and psychologists following a brief training on the manual. A unique feature of the *STARS* program is that, while the protocol is manualized, it employs a modular approach that allows the therapist to decide which of the core cognitive-behavioral strategies should be addressed in any given session. The treatment modules include psychoeducation, contingency management, relaxation, exposure, cognitive restructuring, problem-solving, and relapse prevention.



## Outcome Studies

In a small open pilot study of nine African American adolescents with generalized anxiety disorder (GAD), social anxiety disorder (SAD), or specific phobia, Ginsburg and Drake (2002) compared their school-based cognitive-behavioral treatment to an attention control group. Three out of four treatment completers (75%) no longer met criteria for an anxiety disorder at the end of treatment, while only one of five youth (20%) in the attention control group remitted to nonclinical status. Results supported the feasibility and possible benefits of this approach.

To evaluate the effectiveness of the *STARS* program further, Ginsburg and colleagues conducted two attention-control trials with a larger number of participants in which they compared *STARS* to usual care provided by schools. Ginsburg et al. (2012) randomly assigned 32 students (ages 7–17) from the Baltimore City public school system to *STARS* or a treatment as usual (TAU) group that did not involve CBT strategies. Students were primarily African American, and all had a primary diagnosis of GAD, SAD, separation anxiety disorder, or specific phobia. A total of 11 social workers and counselors were also randomly assigned to serve as an implementer of one of the two treatment conditions. Both conditions were associated with reductions of anxiety symptoms, based on child and parent report, by posttreatment and a 1-month follow-up, and no differences were found between the conditions.

Ginsburg et al. (2020) conducted a randomized attention control trial that compared *STARS* to school-based TAU in 216 children (ages 6–18) throughout Connecticut and Maryland, along with 62 school psychologists and school social workers. All students had a primary anxiety disorder diagnosis. The sample was less diverse in race/ethnicity, with 62% of the students identified as Caucasian. Independent evaluators who observed the TAU condition found that very few sessions incorporated CBT skills and that the TAU providers were low in competence when providing CBT skills (Ginsburg et al., 2019a). Findings indicated that *STARS* and TAU were both effective in decreasing anxiety symptoms,

with 42% and 37% of students classified as responders, respectively. No differences were observed between the conditions when examining child-reported anxiety from pretreatment to posttreatment. However, *STARS* was shown to be more effective in reducing parent-reported child anxiety symptoms, as well as for students with a higher severity of anxiety symptoms (Ginsburg et al., 2020).

Ginsburg and colleagues have also explored the implementation of CBT in schools by school nurses. Recognizing that children and adolescents with anxiety frequently seek assistance from their school nurses, Ginsburg and colleagues sought to develop an intervention that could increase access to evidence-based care at school and allow school nurses to address factors contributing to student anxiety. The resulting 8-week intervention, the *Child Anxiety Learning Modules (CALM)*, focuses on the core components of CBT, such as psychoeducation, cognitive-restructuring, relaxation strategies, exposure, problem-solving, and relapse prevention. In order to provide flexibility for nurses and individualized treatment for students, *CALM* is a modular program and does not require a specific number of sessions. To date, *CALM* has been evaluated in an open trial (Muggeo et al., 2017) and an RCT (Ginsburg et al., 2021). The open trial (Muggeo et al., 2017) was composed of 11 children with GAD, separation anxiety disorder, or social phobia. There was a significant decrease in child-reported and parent-reported child anxiety from pre- to posttreatment, with 45% of children no longer meeting criteria for an anxiety disorder. Ginsburg et al. (2021) expanded on this initial trial by randomly assigning 54 children with elevated anxiety symptoms to *CALM* or a control condition, *CALM-R*, which focused on relaxation skills. Anxiety symptoms decreased across both groups from pre-intervention to post-intervention; however, no differences were observed when comparing *CALM* and *CALM-R*.

Looking ahead, Ginsburg and colleagues are in the process of examining whether teachers can successfully identify and address problematic anxiety in their students. Given that anxiety commonly manifests in the classroom, Ginsburg and

colleagues propose that teachers are well positioned for helping students with anxiety and have thus developed the *Teacher Anxiety Program for Elementary Students (TAPES)*, a school-based CBT intervention delivered to individual families by teachers. Over the course of 8 weeks, teachers conduct five 30-minute joint meetings with each student and their parent(s) to deliver each module of *TAPES*, which include relaxation skills, exposure, and cognitive restructuring. Teachers participate in an initial full-day in-person training in *TAPES*, as well as receive 30 minutes of weekly expert consultation while implementing the intervention. In an RCT funded by the US Department of Education, a racially, ethnically, and socioeconomically diverse sample of 60 elementary school students with elevated anxiety symptoms, along with 40 teachers, have been randomly assigned to the *TAPES* intervention or a control condition in which teachers attend 3 hours of a typical professional development seminar on student anxiety. The study is ongoing (see Ginsburg et al., 2019b for additional information).

## Summary

Studies by Ginsburg and colleagues show promise for increasing accessibility to individual CBT for anxiety disorders in urban and inner city schools through delivery by school personnel. However, their CBT programs yielded similar outcomes to TAU (Ginsburg et al., 2012, 2020) and a relaxation-based program (Ginsburg et al., 2021). School personnel may have found it challenging to deliver a modular individual treatment for multiple anxiety disorders. In contrast, a systematic manualized group treatment for a single disorder, such as the *SASS* treatment for SAD described previously, may be easier for school personnel to learn and implement with skill and fidelity. In addition, group treatments, which allow students to engage in social skills and exposure exercises with their peers, might be more beneficial for students with certain types of anxiety, such as social anxiety. Future research should explore the relative effectiveness and fidelity of individual and group CBT interven-

tions when implemented by trained school personnel.

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## Implementation Issues and Future Directions

Based on the promising findings described thus far, the delivery of evidence-based interventions in schools has potential to help remediate the high rates of child and adolescent anxiety. Moving forward, several issues and challenges will be important to address in order to advance the implementation of school-based mental health services.

## Multi-Tiered Systems of Support

Youth who experience anxiety are unfortunately not always eligible to receive interventions within the school context. For instance, even though the Individuals with Disabilities in Education Improvement Act (IDEIA, 2004) requires that students with severe anxiety are evaluated and provided with an Individualized Education Plan (IEP), these services are only provided if their anxiety significantly affects their educational performance. Students who demonstrate significant anxiety but not an educational deficit may be able to receive school-based accommodations and supports as part of a 504 plan (Conroy et al., 2021). However, IEP and 504 plans can be challenging for families to obtain and available only to students with severe anxiety (August et al., 2018). In addition, while IEPs and 504 plans offer supports, many of these supports for anxiety are not evidence-based and often include accommodations that do not address the root of the problem (e.g., exposure to anxiety-provoking situations) but instead inadvertently maintain student anxiety (e.g., accommodations that allow for continued avoidance of anxiety-provoking situations; Conroy et al., 2020; Harrison et al., 2013). For example, one recent survey of school mental health professionals found that most respondents reported using accommodations or supports that promote avoidance of anxiety-provoking

situations, such as letting youth sit in class but not participate (Conroy et al., 2020).

As concerns have been raised about limited access to evidence-based mental health services in schools, there has been increasing advocacy for schools to move away from a traditional medical model of school-based mental health treatment and toward a preventative model using a Multi-Tiered Systems of Support (MTSS) framework. An MTSS framework uses data to make informed decisions about students' levels of functioning and appropriately allocate resources and deliver interventions at varying levels of intensity (August et al., 2018). This approach allows for students who may have significant anxiety, but do not demonstrate the required educational impact for an IEP or 504 plan, to receive early interventions and supports that can prevent their anxiety from becoming severe enough to cause academic difficulties. MTSS typically includes three tiers: *Tier 1*, which involves universal prevention for all students; *Tier 2*, which focuses on small group interventions for those at risk for, or displaying signs of, anxiety; and *Tier 3*, which consists of individualized treatment for students who do not respond to previous interventions. While the school-based anxiety interventions described in this chapter are aligned with at least one tier, such as *FRIENDS* (a universal intervention) and *STARS* (an individualized treatment), further research is needed to evaluate a full MTSS three-tiered model for child and adolescent anxiety in schools. A research methodology developed by August et al. (2018), *Sequential Multiple Assignment Randomized Trials* (SMART), may be useful in this effort to evaluate the adaptive intervention strategies at the core of the MTSS model. If effective, this model would allow educators to select, adapt, and implement evidence-based interventions that are appropriately mapped to the needs of anxious students within a school.

### Identification of Anxious Youth

One challenge to effectively implementing an MTSS program for child and adolescent anxiety

is how to identify youth who require intervention. As anxiety disorders often go unnoticed and unidentified (Papandrea & Winefield, 2011), it is important that schools utilize a multi-method, comprehensive approach to understand the needs of students. A first step in this approach is typically to conduct universal screenings for anxiety and other related problems that involve administering evidence-based assessment tools to students, parents, and/or teachers. This universal screening process allows educators to make data-informed decisions about how to effectively allocate the limited resources available within a school, select appropriate interventions, and identify which students would benefit from interventions (Dowdy et al., 2015; Nickerson, 2019). Although universal screenings are commonly used by targeted prevention programs successful in promoting social and emotional well-being in youth (Durlak et al., 2011), and may be an affordable option for schools (Simon et al., 2013), questions do remain regarding their efficiency and cost-effectiveness. Future studies should explore the relative utility and affordability of other methods of identifying students, such as teacher referral, reviewing school records, and behavioral observations (Dowdy et al., 2015).

### Progress Monitoring

In addition to the initial assessment of anxiety to identify those who require additional supports, it is important that a progress-monitoring procedure be in place to evaluate progress and determine whether youth may require more intensive supports if they are not responding to evidence-based interventions provided through their MTSS system (Conroy et al., 2021). One tool that can be helpful to monitor progress is the use of Daily Behavior Report Cards (DBRC), which provide clear and explicit goals for students to meet each day and monitor students' progress toward those goals (Riley-Tillman et al., 2008). This can serve as a method to not only measure students' response to intervention but also provide feedback to students on their performance, celebrate their successes, and communicate progress to

caregivers to reinforce within the home setting. Other potential methods for monitoring clinically meaningful change may include student and parent ratings of clinical improvement, though there are concerns of reporting biases, such as social desirability (Fox et al., 2017). Therefore, further research should investigate strategies that facilitate honest and accurate reports of progress in the context of school-based anxiety interventions.

## School Culture and Climate

Successful entry of novel mental health programs into the school system requires an awareness of the school climate and the attitudes of key stakeholders. Federal and state initiatives have emphasized the importance of positive and supportive school climates as a necessary ingredient for effective schools, and many states have implemented social-emotional learning standards to ensure that social and emotional skills are prioritized (Zins & Elias, 2007). Despite such initiatives, school culture and climate can pose significant barriers to implementing school-based interventions for anxiety disorders. For example, as academic instruction is the primary mission of schools, school administrators and parents may question the value of programs that do not directly advance these goals. Therefore, it is important that interventions avoid interfering with class instruction. Sessions for group interventions can be rotated weekly to ensure that students do not miss the same class repeatedly, and conducting interventions individually can provide flexibility to schedule sessions during non-academic periods.

## Service Providers

Another important consideration in the effective implementation of school-based mental health services is identifying a skilled and interested provider within the school. As highlighted in this chapter, an increasing number of school-based anxiety intervention studies have utilized trained school personnel as service providers, with several showing that school personnel can implement

these interventions effectively. However, school personnel in these studies were provided with training, ongoing supervision, and other support from researchers. It remains uncertain whether school personnel can continue these services successfully without researcher involvement and/or financial support and resources from school leadership. School-based clinicians, such as school counselors, school psychologists, and school social workers, often have highly demanding caseloads and may lack sufficient time and funding to offer additional mental health services. Indeed, limited time and financial resources, along with the overall shortage of trained mental health professionals within schools, have been identified by school personnel as among their main barriers to implementing mental health interventions in their schools (Wang et al., 2020). In addition, if school staff who provide services for anxious students are emotionally exhausted by their work, they may be more likely to utilize non-evidence-based intervention strategies (Conroy et al., 2020). Therefore, further research is needed to examine the sustainability of anxiety intervention programs delivered by school-based clinicians over time without the ongoing involvement of researchers.

## Family-School-Community Partnerships

Building capacity within the school setting to recognize and treat mental health challenges is critical to ensuring that MTSS programs can be effective in supporting anxious youth (Sanchez et al., 2018). Researchers have suggested that one method to achieve this is for schools to develop strong family-school-community partnerships. For example, mental health professionals outside of the school setting can help to support and address some of the challenges of implementing evidence-based interventions through consultation with school professionals (Conroy et al., 2021). Given that outside mental health professionals have expertise in evidence-based anxiety interventions, educators have expertise in implementing school-based services and the educational setting, and families have expertise on their

children, collaboration among school, family, and community is central to promoting student success. This consultative framework is in line with the National Association of School Psychologists professional standards that emphasize family–school–community partnerships as one of the main domain areas for professional practice (NASP, 2020), and further study is needed to explore its utility in the context of school-based interventions for child and adolescent anxiety.

### Cost-Effectiveness

Sustaining the delivery of school-based mental health services for youth anxiety will require such services to be cost-effective for schools. However, the cost-effectiveness of school-based interventions for anxiety remains unclear. To our knowledge, only one published study has examined this question, finding that the *FRIENDS* universal prevention program was not cost-effective when delivered to elementary school students in England (Stallard et al., 2015). Further research is thus needed to understand the relative cost-effectiveness of different models of intervention, such as a comparison of universal prevention programs with more targeted programs for youth with anxiety risk factors, symptoms, and/or diagnoses. For instance, universal prevention programs may be more efficient given costs associated with mental health screening; however, if programs have better clinical outcomes when providing services only to youth with anxiety, the benefits of more targeted prevention and treatment programs may outweigh the initial cost of detection.

### Innovative Formats

Further study is also needed to develop and evaluate approaches to delivering effective school-based interventions while limiting costs. For example, online programs for child and adolescent anxiety could be well suited for the school setting. Students could complete online sessions on their own during the school day and check in

with school-based clinicians for components that require support. This would ease the burden on school personnel while still ensuring that students receive adequate intervention. While computer-assisted CBT has been shown to be efficacious in treating youth anxiety in a clinical setting (Khanna & Kendall, 2010) and a community setting (Crawford et al., 2013), studies of online anxiety interventions in school settings, such as *e-Couch* (Calear et al., 2016) and *Positive Search Training* (Waters et al., 2019), have shown limited effectiveness thus far.

In addition to innovative technologies, other cost-effective strategies for schools, such as brief and modular interventions, should be explored. Brief interventions that require less time from school-based clinicians may hold promise, as evidenced by an initial trial of the *DISCOVER* program, a 1-day CBT workshop for stress, anxiety, and depression that was superior to a waiting list condition in a sample of adolescents from inner-city schools in the United Kingdom (Brown et al., 2019). Modular CBT designs, which allow clinicians to select strategies to meet children's individual needs, may also offer a more efficient means of treating anxious students than a full intervention program. Support for this approach comes from an RCT evaluating a modular version of the *Building Confidence* CBT program in a sample of children with anxiety disorders from two elementary schools in the United States. This modular program outperformed a wait-list condition on treatment response, diagnostic outcomes, and caregiver-reported anxiety after the intervention (Chiu et al., 2013) and 1 year later (Galla et al., 2012).

Given that youth often experience both anxiety and depression, it may be more efficient to offer CBT techniques in a transdiagnostic format (i.e., targeting both difficulties) as a way to increase the reach and impact of the intervention. One example of this approach, the *Emotion* universal prevention program, was associated with greater reductions of anxious and depressive symptoms compared to usual care in children from schools in Norway (Martinsen et al., 2019), though some outcomes were not maintained 1 year later (Loevaas et al., 2020). Therefore, fur-



ther study is needed to examine the utility and effectiveness of transdiagnostic interventions.

## Diversity and Social Justice

School-based interventions for anxiety are not a one-size-fits-all approach but must be sensitive to the unique characteristics of students within a school. Despite the high rates of anxiety disorders in students of color, mental health service utilization by this population is especially low (Gudiño et al., 2009). The benefits of school-based mental health services have been limited by racial and ethnic disparities in access and enrollment, particularly for internalizing conditions (Bear et al., 2014; Gudiño et al., 2009). Additionally, racially and ethnically minoritized youth may be presented with unique challenges, such as racism and discrimination, which can exacerbate anxiety symptoms and place them at higher risk for negative outcomes (Graham et al., 2016). The racialized stressors experienced by Black youth may also create anxiety symptoms that are not typically included in commonly used measures of anxiety (Anderson et al., 2019). As a result, it is important that school-based interventions for anxiety disorders are culturally sensitive and that screenings for anxiety address risk factors associated with racialized stressors (Conroy et al., 2021). Masia Warner and colleagues are currently working on developing culturally sensitive, feasible, and acceptable methods to identify impairing social anxiety among Black American high school students. They are also revising SASS to enhance its usability, acceptability, and cultural sensitivity for students of color in under-resourced schools. Additional research of this type will be necessary to engage historically marginalized students in school-based services.

## Conclusion

Research over the past 15–20 years has demonstrated that schools are a promising setting for reaching children and adolescents with anxiety who may be unable to access evidence-based care.

Studies indicate that training frontline school personnel, such as teachers and school counselors, to deliver cognitive-behavioral anxiety interventions may be feasible and effective. Several issues and challenges related to the implementation of school-based interventions for child and adolescent anxiety will be important to address in the future. These include the need to explore a Multi-Tiered System of Support involving evidence-based, cost-effective, and adaptive strategies for identifying and addressing anxiety in schools, a means of fostering family–school–community partnerships, and culturally sensitive services that engage historically marginalized youth. Continued research in these areas will be essential for developing a sustainable model for promoting effective care for anxiety in school settings.

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