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Addressing Anxiety in School Settings: Information for Counselors

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Abstract

Given the nature of a fast paced society and the ever increasing stressors affecting students today, the need for research into the prevention and reduction of anxiety within school aged populations also increases. This article highlights and provides information for professional school counselors regarding current research on the effects of anxiety on children, anxiety development, implementation of cognitive-behavioral anxiety interventions, and recent trends in anxiety reduction efforts in school-based settings. Based on this research, recommendations and implications for professional counselors conclude the article.

Keywords: anxiety, children, cognitive behavioral, classroom guidance

For the 8 to 12% of children identified through epidemiological studies who suffer from anxiety complaints severe enough to interfere with their daily functioning (Muris, Mayer, Bartelds, Tierney, & Bogie, 2001), advances in anxiety research could not be considered more necessary. Offering large numbers of participants and the opportunity to reduce stigma as well as increase peer support, schools serve as the popular place for evidence-based interventions to be tested (Miller, Laye-Gindhu, Liu, et al., 2011). With schools often serving as the first line of defense in addressing anxiety, it becomes imperative for professional school counselors to be aware of research on the effects of anxiety on children, anxiety development, assessment of anxiety, and effective interventions conducted in school-based settings. This paper serves to fill that need by offering support for counselor assessment of anxiety, as well as implementation of classroom guidance interventions as a means of early intervention and prevention of anxiety in school-aged children. Recent trends in anxiety management and prevention, and implications for professional school counselors will conclude the article.

Effects of Anxiety on Child Development and Behavior

A review of the literature discussing childhood anxiety supports Campbell's (1986) early assertion that "anxiety may interfere with cognitive development, achievement motivation, and social relationships through adolescence and in to early adulthood with profound implications for adaptation across the life span" (p. 50). In the first long-term study measuring effects of early cognitive behavioral therapy (CBT) intervention for anxiety, Benjamin, Harrison, Settapani, Brodman, and Kendall (2013) found that children who were less responsive to early intervention had higher rates of panic disorder, alcohol dependence, and drug abuse in adulthood. Additional research findings call attention to the negative effects of anxiety on children's cognitive functioning, academic achievement, and emotional and social functioning.

Cognitive Functioning

Identification of specific cognitive errors found in anxious children can assist practitioners in the development of treatment strategies tailored for use with anxious children. Weems, Berman, Silverman, and Saavedra (2001) broadened the understanding of negative cognitive errors and anxiety in youth when results indicated, "each of the measures of anxiety (i.e., trait anxiety, manifest anxiety, and anxiety sensitivity) was significantly related to each of the cognitive errors examined (i.e., catastrophizing, overgeneralization, personalizing, and selective abstraction)" (p. 559). A related example by McDonald (2001) contributed to the understanding of the impact of anxiety on a child's cognitive development:

The thoughts of an anxious child who expects to perform poorly on a test may be characterised by unfavourable comparisons with others (e.g., 'all my friends will do better than me on this test'), doubts about their ability (e.g., 'I can't do tests, so I'm going to do badly on this one') and negative beliefs about the consequences of poor test performance (e.g., 'if I do badly on this test my friends will think I'm stupid'). (p. 91)

Further exploring the complicated nature of cognitive variables related to anxiety, Mitchell, Newall, Broeren, and Hudson (2013) explored the impact of self-oriented perfectionism (SOP) and socially prescribed perfectionism (SPP) on CBT outcomes. The researchers concluded that "perfectionism alone is not sufficient for the occurrence of elevated anxiety... (but) the presence of SOP can worsen some childhood anxiety treatment outcomes" (p. 553).

Academic Achievement

Social anxiety disorder is characterized by a child's fear of dealing with peers and adults, avoidance of a social situation like recess at school, difficulty developing and maintaining friendships, and interference with school performance or attendance. Severe cases of social anxiety may result in school refusal behavior, described as difficulty for the child to attend school, or remain in school the entire day. Hibbett and Fogelman (as cited in Stickney & Miltenberger, 1998) explained that "students engaging in school refusal behavior are at risk for experiencing a number of difficulties including marital and work-related distress, depression, anxiety, alcoholism, and antisocial behavior" (p. 160)

as long term effects, in addition to a decrease in academic achievement as an immediate effect.

Further evaluating the relationship between anxiety and academic achievement, Hancock (2001) suggested “students who are characteristically test anxious are not more or less motivated to learn... However, students with high-test anxiety are significantly less motivated in classrooms perceived as highly evaluative” (p. 288). Identification and treatment of test anxiety and anxiety related to academic achievement at the elementary level is imperative, as “the emergence of achievement-based anxieties is likely to become more evident as the child moves from elementary to secondary school. The school environment becomes more impersonal, formal, evaluative, and competence activity becomes less supported by the teacher” (Costanzo, Miller-Johnson, & Wencel, 1995, p. 91). High stakes testing implemented throughout the nation have not been linked to higher rates of academic achievement, but rather, an increase in test anxiety as these measures are tied to academic advancement (Von der Embse & Hasson, 2012). High-stakes testing implemented in earlier grades will warrant increased attention on helping students manage test anxiety to mediate negative effects on grade promotion and achievement.

Social Relationships and Peer Support

Silverman, La Greca, and Wasserstein (1995) examined the nature of worry in elementary aged children and found the most common areas of worry involved school, health, and personal harm. Topics eliciting worry in children with the most frequency involved classmates, friends, and family. Silverman et al. (1995) specifically noted that “concerns about classmates largely focused on rejection, exclusion from social activities, or being ignored by others. This may be indicative of the major roles that peers play in children’s everyday lives” (p. 682). In a 14-year follow-up study, Roza, Hofstra, Van der Ende, and Verhulst (2003) predicted the onset of anxiety disorders based on parent-reported emotional and behavioral problems in childhood, specifically noting, “the downward spiral starting with poor social skills and difficulties in peer relationships, lead to low self-confidence, negative self-evaluation, and self-criticism, can result in specific anxiety symptoms as perceived danger and threat, uncertainty, and hypervigilance” (p. 2120).

Ginsburg, La Greca, and Silverman (1998) acknowledge “highly socially anxious children reported low levels of social acceptance and global self-esteem and more negative peer interactions. Impairments in peer relations during the elementary school years have been linked with poor adjustment outcomes during adolescence and early adulthood” (p. 175). Beidel, Turner, and Morris (1999) make the point that children who do not know how to or have the ability to make and maintain peer relationships increase their probability of remaining isolated from others. Similarly, Ginsburg et al. (1998) evaluated and found “linkages between social anxiety and facets of social and emotional functioning... (a) self-perceptions of social acceptance and global self-worth, (b) positive and negative peer interactions, and (c) social skills. Highly anxious children...are less well liked and more rejected by peers” (p. 177). Through a comprehensive review of psychology literature from developmental and clinical perspectives, Kingery, Erdley, Marshall, Whitaker, and Reuter (2010) reiterate the impact of anxiety on children, namely on acceptance, friendship, peer victimization, social skills, and social-cognitive processes. It is at this point that a brief review of cognitive theories of anxiety becomes

important, in order to highlight particular areas of focus to be addressed within classroom guidance interventions.

Cognitive Theories of Anxiety

A person's beliefs about themselves and the world influence how the person perceives the situation, and in turn, how they will respond. A person who is anxious will tend to selectively, and erroneously, perceive a situation to be perilous. As the basis of cognitive theory, Beck and Weishaar (2000) point out that response to life events includes a complex "combination of cognitive, affective, motivational, and behavioral responses. The cognitive system deals with the way that people perceive, interpret, and assign meanings to events...cognitive theory teaches people to use conscious control to recognize and override maladaptive responses" (p. 241-242).

Beck and Weishaar (2000) clarify "anxiety disorders are conceptualized as excessive functioning of normal survival mechanisms, namely physiological responses that prepare the body for escape or self-defense. The anxious person's perception of danger is either based on false assumptions or exaggerated" (p. 250). Researchers go on to note that people suffering with anxiety are often unable to realize that they in fact are not in any danger. Cognitive theory focuses on the identification of maladaptive thoughts causing impairment or disruption to the person's life, all of which have been referred to a number of different ways: "'internalized statements,' 'self-statements,' 'things you tell yourself,' 'self-talk,' and 'automatic thoughts'" (Beck, 1976, p. 237). Beck's previously noted "automatic thoughts" have come to be referred to as cognitive errors or cognitive distortions, including four types: magnification or minimization, tunnel vision, mind reading or catastrophizing, and oversimplification or absolute thinking.

Beck (as cited in Basco, Glickman, Weatherfor, & Ryser, 2000, p. A59) "hypothesized that in times of emotional distress and individual is prone to making information-processing errors that lead to inaccurate or incomplete assessments of stimulus events, usually viewing them as more negative than they might, in fact, be." Craighead, Craighead, Kazdin, and Mahoney (1994) note that a person's beliefs about themselves develop over time, and the main goal is to change the associations between the beliefs and distorted or dysfunctional assumptions associated with them by using the following cognitive procedures:

- (1) identification of dysfunctional and distorted cognitions and realization that they produce negative feelings and maladaptive behaviors; (2) self-monitoring of negative thoughts, or self-talk; (3) identification of the relationship of thoughts to underlying beliefs and to feelings; (4) identification of alternative (functional and nondistorted) thinking patterns; and (5) hypothesis testing regarding the validity of the person's basic assumptions about self, world, and future. (p. 43)

Cognitive distortions and upsetting thoughts continue and the symptoms of anxiety may proceed into a full-blown panic attack, which lead the patient to convince himself that something bad really is happening. Without learning to dispute these cognitive distortions and disturbing visual images, the cycle will continue, having possible detrimental effects on the person's ability to function effectively.

Cognitive-behavioral therapy seeks to explain and break the chain of events leading to the development and maintenance of anxiety. Basco et al. (2000) positively report on the success of CBT as a treatment modality for anxiety disorders, and note that methods “include strategies for achieving a more accurate cognitive appraisal of self, methods for reducing fear and anxiety such as relaxation training, skills for developing more adaptive behavioral responses to stress, and graded exposure to break the negative reinforcement paradigm” (p. A61).

Francis and Beidel (1995) clarify the similarity in cognitive-behavioral treatment strategies “is that they are based on models of learning. Principles of classical conditioning, operant conditioning, cognitive learning theory, and social learning theory are the underpinnings of cognitive-behavioral strategies used to treat childhood anxiety” (p. 322). Research has detailed extremely similar presenting symptoms of childhood and adult anxiety (Beidel, 1998) so it is not surprising that anxious children and adults have similar thoughts “concerning dangers and negative outcomes...These thoughts tend to focus on both negative social outcomes (‘I will fail,’ or ‘They will laugh at me’) and negative physical outcomes (‘I will get hurt,’ or ‘My parents will be killed’)” (Rapee, Wignall, Hudson, & Schniering, 2000, p. 34). Treatment approaches for cognitive restructuring with children are often similar to those for adults, and can be applied by children to everyday situations, providing “a lifelong skill that the child can draw upon to cope with various negative emotions over the years” (Rapee et al., 2000, p. 61).

Cognitive-Behavioral Treatment of Anxiety Disorders

Ollendick and King (1998) credit Kendall (1994) and his colleagues for the impetus of empirical support for the efficacy of cognitive-behavioral treatment of childhood anxiety disorders. Research over the last 10 years has grown such that reviewers of CBT have not only reviewed the efficacy of CBT (Axelson & Birmaher, 2001; Dadds & Barrett, 2001; Hirshfeld-Becker & Biederman, 2002; Miller Laye-Gindhu, Bennett, et al., 2011; Ollendick & King, 1998; Southam-Gerow & Kendall, 2000), but have also extended their research to review specific types of treatment administered: small group, individual (Albano & Kendall, 2002; Miller, Short, Garland, & Clark, 2010), or family (Ginsburg & Schlossberg, 2002; Northey, Wells, Silverman, & Bailey, 2003).

According to Barrett and Turner (2001), a focus has been placed on the prevention and incidence reduction of psychopathology through preventive treatment, including that which can be provided in school settings. Addressing the overlooked necessity of anxiety prevention intervention in schools, a small number of researchers in Australia have implemented comprehensive cognitive-behavioral program interventions in school settings, reporting significant results demonstrating that childhood anxiety disorders can be prevented when addressed through early intervention.

Dadds, Spence, Holland, Barrett, and Laurens (1997) published the first study of an anxiety prevention program involving students diagnosed with mild to moderate anxiety, recommended for participation by their teacher. In the controlled trial, 128 Australian participants (ages 7 to 14 years) were assigned to a monitored control group, or a 10-week cognitive-behavioral and family-based small group (5-12) treatment group, which met up to 2 hours weekly. Clinical psychologists conducted the treatment groups, assisted by one or two postgraduate students as co-therapists. Both groups showed

improvement immediately after intervention, but only the treatment group had lowered rates of anxiety disorders at 6-month follow-up. Dadds et al. continued to assess the treatment gains of this sample at 12 and 24 months, finding that treatment gains were equal again at 12 months, but then significantly higher for the reduction of existing anxiety disorders and the prevention of new anxiety disorders in the treatment group at 24 months.

In a study of preventive interventions, Barrett and Turner (2001) detailed the *Friends for Children* program and its effectiveness as the first universal school-based trial. *Friends for Children*, a cognitive-behavioral program, originated from the *Coping Koala* program (Barrett, Dadds, & Rapee, 1996), which was an Australian adaptation of Kendall's *Coping Cat* program (Kendall, 1994). In this first universal trial led by Australian researchers, all students (489 children, ages 10 to 12 years) were included in the study regardless of measured level of anxiety or risk of developing an anxiety disorder. Not only was prevention of anxiety symptoms measured in this study, but also delivery method, as three treatment conditions were used: delivery of small group treatment by trained psychologists, delivery of small group treatment by teachers, and a control group. As part of the treatment condition, two booster sessions were administered to students at 1 month and at 3 months after the last session, for a total of twelve 75-minute sessions. In addition, four evening psychoeducational sessions were conducted with parents of the participants. Barrett and Turner (2001) found a reduction in the reported internalizing symptoms of those students identified as "at risk" for an anxiety disorder prior to the intervention, and also found both the psychologist-led and teacher-led conditions resulted in lowered anxiety scores, but found no significant difference between the two treatment delivery methods.

Study of delivery methods and subject focus continues outside of the United States, as evidenced by a brief school-based program conducted in Spain (Balle & Tortella-Feliu, 2010), replication of *Friends for Life* in a Canadian elementary school (Rose, Miller, & Martinez, 2009), an anxiety prevention program focusing on children from disadvantaged schools in Australia (Roberts et al., 2010), a universal anxiety prevention school-based trial in Germany (Essau, Conradt, Sasagawa, & Ollendick, 2012), and a group CBT universal school-based program conducted in England (Challen, Machin, & Gillham, 2013). Auger (2013) supports the belief that professional school counselors are in a prime position to utilize classroom-based interventions as well as consultation with parents and teachers to address mental health needs of students in today's schools. Assessing students for anxiety disorders would be one way to assist the counselor in developing appropriate classroom interventions.

Counselor Assessment of Anxiety

Epkins (2002) asserts that "early recognition of and intervention with youth might prevent the development of other disorders, as well as the short- and long-term detrimental outcomes" (p. 69). Despite the fact that professional school counselors are not called upon to diagnose anxiety in students, knowledge of assessment measures and diagnostic criteria for anxiety disorders can assist counselors with their determination of which interventions to implement with students. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) now details anxiety disorders according to a developmental perspective, describing

anxiety disorders in order of age of onset: separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder, panic disorder, agoraphobia, and generalized anxiety disorder. “The anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognitive ideation” (p. 189). Diagnostic criteria and assessment measures can help counselors to assign the correct diagnosis of anxiety in school-aged children.

As would be expected, variance in presentation of diagnostic symptoms warrants flexibility in the diagnostic process, along with a mechanism to assess severity. Conveniently, severity measures according to each anxiety disorder are available for adults (parent/guardian) and children (online assessments located at psychiatry.org/dsm5) and can be used not only upon initial assessment, but also as a way to track the severity of anxiety over time. In a research review conducted by Thompson, Robertson, Curtis, and Frick (2013), a table of recommendations was provided, listing brief anxiety assessments that could easily be used by professional school counselors. Information regarding appropriateness of the assessment regarding age range, versions, and time needed to complete the measure are included, along with method of availability.

The need to continue to research all anxiety disorders manifesting in childhood is supported by a review of 25 years of research on childhood anxiety completed by Muris and Broeren (2009) in which they found research dominated by investigations of post-traumatic stress disorder and obsessive-compulsive disorder. Within the newest revision, the DSM-5 (2013) no longer classifies these two disorders as anxiety disorders. Muris and Broeren (2009) did in fact agree that childhood anxiety should be viewed from a developmental perspective, implying “that it is equally relevant to study clinical as well as non-clinical populations of youth” (p. 393). Hence, utilizing universal approaches to preventing and managing anxiety, such as in a school setting, would work to address this developmental perspective. Cultural-related diagnostic issues are also presented for each anxiety disorder within the DSM-5, reminding us of the importance to investigate the impact of culture on childhood anxiety.

Classroom Guidance as Early Intervention and Prevention

The ASCA National Model (2005) strongly emphasizes the inclusion of classroom guidance within a comprehensive developmental guidance program, particularly for elementary aged students. Many developmental guidance programs already target constructs such as problem solving, interpersonal, and coping skills, so additional program implementation to address anxiety may not be difficult. Classroom guidance provides students with the opportunity to learn new coping skills, receive support and input from peers, and “creates and nurtures a climate of mutual trust, caring, understanding, acceptance, and support that enables children to share their personal concerns with their peers and the counselor” (Orton, 1997, p.193). Discussing prevention programming in school counseling, Baker and Gerler (2004) note that “teaching children and adolescents how to cope successfully with life’s various stressors may prepare them for such events in advance of occurrences (primary prevention) or help them manage challenges that are already influencing their lives (secondary prevention)” (p. 107). Given the large number of anxious students who do not receive any help or treatment from mental health providers in the community, “classroom guidance lessons could be

designed to teach students coping skills for managing anxiety” (Curtis, Kimball, & Stroup, 2004).

Ybañez (2010) conducted one such study, examining the effects of an anxiety reduction classroom guidance intervention on third grade students’ level of anxiety and self-concept. A 10-week educational instruction and support unit was conducted with 170 students, resulting in a measurable reduction in anxiety on two anxiety scales: physical symptoms and separation/panic. At the conclusion of the study, post-intervention interviews with 28 randomly selected study participants were conducted. The recorded interviews yielded qualitative data regarding which parts of the intervention made the most impact on relationships at school and home. Many students reported remembering how to identify feelings and implement relaxation techniques when needed, with one student specifically noting, “I used (the lessons) at home because my brother was mad...he was sad and crying.” The student reported being able to use these indicators to help others identify and name feelings. Another participant noted how his identified support system (i.e., parents and brother) routinely reinforced one of the guidance lessons (problem solving) when helping him to reduce the anxiety he was experiencing with reading difficulties: “they said take a step at a time when you’re reading and that really helped me. When I heard you say take a step at a time, it reminded me of my parents.” Regarding cognitive restructuring skills introduced in the lessons, one participant responded she used this skill at home: “If I got grounded, I could tell myself it’s not going to be forever.” This use of cognitive restructuring assisted the student in not becoming highly emotional when faced with consequences, a problem she reported having before learning and practicing these skills.

Recognizing that there are many barriers faced by professional school counselors when considering implementation of new programs and interventions, Sulkowski, Joyce, and Storch (2012) provide support for service delivery of interventions that address anxiety across the school setting. Descriptions are provided of tiered services which aim to first help all students through assessment of anxiety, then services to at-risk students through a group setting, and ultimately individual services to students who lack response to the first two levels of care. This framework also addresses how interventions meet legal requirements for the Individuals with Disabilities Education Improvement Act, as well as Section 504 of the Rehabilitation Act.

Trends and Implications for Counselors

Parental Involvement

Auger (2013) notes that even when school counselors refer students for mental health treatment in the community, numerous barriers may prevent the student from receiving treatment, from a lack of resources, to parents not taking students to appointments. Ongoing trends focus on the opportunity for counselors to work directly with teachers and parents, oftentimes educating the adult on the mental health needs of the student. Including parents in the assessment of students’ anxiety can highlight differences in perception, as evidenced by findings of Jarrett, Black, Rapport, Grills-Taquechel, and Ollendick (2014), where parents rated younger children as having far greater school-related worries than the child did. The opportunity to increase family involvement in schools can be facilitated through regular consultation meetings with the school counselor regarding a child’s problems with anxiety. Counselors can educate

parents about the child's cognitive distortions that contribute to the anxiety response, helping parents to better understand the cognitive facet of anxiety. Dia (2001) noted the importance of assessing and addressing the levels of protectiveness, reassurance, and negative parent-child interactions when helping parents understand their impact on the anxiety of the child. Manassis (2000) points out that

Informing parents of the limited control their children have over these biases (attending to or remembering threatening stimuli) can be clinically useful. This information often alleviates parental frustration with a child who appears to dwell on the most upsetting aspects of events despite repeated reassurance. Reduced parental frustration in turn alleviates some of the child's anxiety. (p. 726)

With increased school counselor interaction, families may be encouraged to continue with treatment when they see that their child can learn to cope with anxiety and it is no longer leading to difficulties to the same extent in their daily life (Manassis, 2000).

Approaches to parental involvement vary from educational programs, to incorporating direct parental involvement in CBT protocols (Chiu et al., 2013; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Khanna & Kendall, 2009). Education programs for parents can be offered to the entire population, thereby normalizing the presence and mediation of anxiety in elementary aged children. School counselors, along with cooperation and support from administrative personnel and teachers, can best implement these recommendations utilizing a "whole-systems" approach, focusing on topics such as parental anxiety and parenting (Pereira, Barros, Mendonca, & Muris, 2014), and heritability, attachment, family environment, and family involvement in treatment (Drake & Ginsburg, 2012).

Computer Based Programs

Knowing that not all students will respond to treatment, computerized CBT (CCBT) interventions for anxiety have been implemented to help youth with anxiety who are not responsive to other school-based interventions. Thompson et al. (2013) provide a list of computerized cognitive behavioral interventions that can be utilized by school counselors to reach anxious youth who choose not to participate in group counseling, are not appropriate for group counseling, or simply need support. "CCBT programs are cost-effective, convenient, interactive, and accessible to youth who may not be willing or able to engage in face-to-face counseling" (p. 228). Reviewing the computerized CBT program, Camp Cope-A-Lot, Khanna and Kendall (2010) reported significant gains in reducing anxiety severity and global functioning in participants, with gains maintained at 3 month follow up.

Mindfulness and Emotional Regulation

Biegel, Brown, Shapiro, and Schubert (2009) implemented a manualized psychoeducational training program in mindfulness, called mindfulness-based stress reduction (MBSR), which reportedly has yielded favorable results with numerous adult and child populations. After participating in 8 weeks of mindfulness practice, adolescent participants in this study "self-reported reduced symptoms of anxiety, depression, and somatic distress, and increased self-esteem and sleep quality" (p. 855). Focus on emotion regulation in youth and its relationship to the development of anxiety led Esbjorn,

Bender, Reinholdt-Dunne, Munck, and Ollendick (2012) to study attachment and emotional regulation, finding that “an insecure attachment style, especially an insecure-ambivalent attachment style, was associated with the development of ineffective emotion regulation strategies and anxiety disorders” (p. 141). Exploring predictors of risk for suicidal ideation in youth diagnosed with anxiety, O’Neil Rodriguez and Kendall (2014) found that youth self-report of emotion dysregulation and distress intolerance predicted higher levels of suicidal ideation. “Youth who have greater difficulty modulating and tolerating negative emotions may be more likely to think about suicide as a method to escape or find relief from their distress” (p. 52). These studies lend credence to the implementation of mindfulness-based practices and instruction in emotional regulation strategies by professional school counselors with school-aged youth.

Cultural Considerations

With growing numbers of minority children in schools, researchers have recognized the dearth of literature examining the effect of culture on anxiety disorders. As proponents for providing mental health services for elementary aged children, Oppenheim and Evert (2002) warn, “only a small percentage of children with emotional problems actually receive the care they need. The numbers of untreated children may be even higher among minority populations” (p.40). Wood, Chiu, Hwang, Jacobs, and Ifekwunigwe (2008) adapted CBT for use with Mexican American students by ensuring cultural values and parental involvement were infused throughout the intervention. Additional adaptations included acculturative status, language proficiency and preference, orientation sessions to educate family, respecting family’s conceptualization of anxiety, and consulting with cultural experts. Similarly, while conducting a randomized trial with Hispanic/Latino youth, Pina, Zerr, Villalta and Gonzales (2012) concentrated on “degree of caregiver involvement and the role of ethnicity/language” (p. 940) and found that Hispanic/Latino subjects demonstrated similar improvements in anxiety, as did the Caucasian subjects. For a more in depth discussion of the influence of culture on anxiety in Latino youth, see Varela and Hensley-Maloney (2009).

Conclusion

Kurtzman, Maser, and Ingram (1998) challenge us to consider the fact that “anxiety disorders represent troubling emotional states that are heterogeneous in their expression, pervasive in their incidence, and frequently devastating in their effects on the lives of people” (p. 535). Utilizing increased involvement of school personnel, in addition to the school counselor, children dealing with anxiety can be helped to increase their level of functioning in schools. This improvement in condition can carry over into their home life, aiding them in developing coping skills and strategies that can last a lifetime. Limited research across diverse and underserved populations has been conducted, as a majority of sample subjects have been Caucasian. With continued research across culturally diverse populations, it is hoped that the development of anxiety reduction and prevention interventions will both increase and be routinely implemented to help a larger number of children in school settings, as well as outpatient settings.

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