

Transporting CBT for Childhood Anxiety Disorders into Inner-City School-Based Mental Health Clinics

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The systematic expansion of evidence-based cognitive behavioral (CBT) protocols into the schools provides an opportunity for training front-line service providers in the early identification of anxious children and in the delivery of evidence-based treatments to children who might otherwise go without such treatment [Weist, M. D., & Evans, S. W. (2005). Expanded school mental health: Challenges and opportunities in an emerging field. Journal of Youth and Adolescence, 3, 3–6]. In this article, we discuss the progress of our ongoing study aimed at transporting manualized CBT for anxious youth into inner-city school-based clinics. In this context, we outline the rationale for the study and specific adaptations and obstacles encountered to date.

PSYCHOLOGICAL SCIENCE has enhanced clinical practice through the development, identification, and utilization of treatments supported by research (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Recent studies with children and adolescents document the efficacy of treatments for childhood psychiatric disorders, including the use of cognitive behavioral therapy (CBT) for children with anxiety disorders (e.g., Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Kendall et al., 1997; Silverman, Kurtines, Ginsburg, Weems, Lumpkin, et al., 1999; Silverman, Kurtines, Ginsburg, Weems, Rabian, et al., 1999). The challenges that continue to confront psychology, however, are the dissemination of empirically supported assessment and treatment strategies to children's community mental health treatment settings and the evaluation of treatment effectiveness with youth from diverse racial and ethnic backgrounds (Barlow, 2000; Weisz, Donenberg, Han, & Weiss, 1995).

The systematic expansion of evidence-based CBT protocols into inner-city schools provides an opportunity to address these gaps in services and research by training school-based clinicians in the early detection of anxious children and in the delivery of treatment to children who might otherwise go without treatment (Weist & Evans 2005). However, this task is fraught with challenges and requires numerous adaptations to both the intervention

and evaluation process. The Baltimore Child Anxiety Treatment Study in the Schools (BCATSS) was designed to address these issues.

BCATSS: Study Description

The primary aim of BCATSS is to determine the feasibility and effectiveness of a school-based CBT, delivered by school-based clinicians, in reducing levels of anxiety symptoms among inner-city (predominantly African American) boys and girls (ages 7 to 12). More specifically, the study takes place in five public elementary schools in inner-city Baltimore, a low-income, high-crime, and predominantly African American community. The study is comprised of several stages. Stage 1 focuses on engaging community stakeholders, refining the intervention and research methods (e.g., assessments) to ensure their cultural relevance, and training school-based clinicians. Stage 2 involves an open trial during which clinicians and researchers identify an anxious child in each school and pilot the study and intervention procedures. The study will culminate in Stage 3, a randomized controlled trial (RCT). Specifically, within each of four elementary/middle schools, 10 children with a primary diagnosis of generalized anxiety disorder (GAD), social phobia (SOP), separation anxiety (SAD), and/or specific phobia (SP) as determined by Anxiety Disorders Interview Schedule for DSM-IV–Child version (ADIS-IV-C; Silverman & Albano, 1996) will be randomly assigned to either a 12-week individual CBT for anxiety intervention or treatment-as-usual (TAU) delivered by school-based clinicians. Independent evaluators (IE) will conduct assessments of outcomes (along with child, parent, and teacher reports). Intervention adherence and quality

assurance will be assessed via structured manuals, audio-taped sessions reviewed by study staff, and ongoing weekly supervision provided by the BCATSS staff.

Youth are recruited via existing referral processes to the school-based clinic, including referrals made by school personnel (e.g., teacher, nurse) and parents. As part of routine care, youth complete a psychiatric evaluation and a self-report anxiety screen (i.e., Screen for Child Anxiety and Related Emotional Disorders [SCARED]; Birmaher et al., 1999). Youth who receive a preliminary diagnosis of an anxiety disorder by a psychiatrist and/or score in the clinical range on the SCARED are invited to participate in the BCATSS assessment to determine whether they meet the study's inclusion criteria (i.e., a diagnosis of GAD, SOP, SP, SAD). This approach to recruitment was selected in consultation with school clinicians over a school-wide screening approach because it is more naturalistic and generalizable to the current functioning of the participating schools.

In the sections that follow, we explain the rationale for this study, review the current state of the literature on the feasibility and effectiveness of school-based CBT for anxiety disorders, and share our progress to date by discussing details of the study along with the challenges and adaptations needed when transporting CBT for anxiety into inner city school-based clinics.

Rationale for the Current Study

Rationale for Transporting CBT for Anxiety Disorders Into Schools

Several features unique to the school setting highlight the value of conducting treatment for anxious children in their schools. The school context is a primary setting in which anxiety-related problems occur. This is partly because school factors, such as teachers, peers, academic performance requirements, and school violence, contribute to and/or maintain anxiety symptoms. As a result, anxious youth may experience declines in their academic performance (Ialongo, Edelsohn, Werthamer-Larsson, Crockett, & Kellam, 1995). School-based anxiety interventions also enhance the generalizability of treatment because participants can practice their new skills in real-world situations at school and with peers (Masia, Klein, Storch, & Corda, 2001). In addition, when treatment is delivered at school, clinicians are on-site and can intervene in ways that are not available to outpatient clinic-based therapists (e.g., providing corrective feedback in real time). On a practical level, school-based interventions are more accessible and affordable than traditional community or hospital-based services. Specifically, transportation and scheduling are easier to arrange for in-school programs than in outpatient clinics. Also, utilization rates in school-based programs are higher than community outpatient clinics because of the familiarity

and nonthreatening nature of the setting (Weist & Evans, 2005).

A review of the literature yields a number of studies involving successful school-based delivery of CBT to anxious youth (e.g., Dadds, Spence, Holland, Barrett, & Laurens, 1997; March, Amaya-Jackson, Murray, & Schulte, 1998; Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001). In Australia, Mifsud and Rapee (2005) selected 91 children between the ages of 8 and 11 from economically disadvantaged families (race unspecified) to participate in a CBT study based on their scores at or above the 75th percentile on the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). Nine schools were randomly assigned to either an 8-session school-based group CBT intervention delivered by school counselor and mental health worker pairs or wait-list control (approximately 6 months) (Mifsud & Rapee, 2005). Youth receiving the group CBT intervention reported significantly greater reductions in anxiety symptoms and cognitive biases following the intervention and at a 4-month follow-up than did youth in the control group.

In a separate school-based study in Australia, 61 youth (97% Caucasian, primarily middle-class) with anxiety disorders (i.e., SOP, GAD, or SAD) were assigned to one of three groups: (1) group CBT, (2) group CBT plus parent training, or (3) no-treatment control (Bernstein, Layne, Egan, & Tennison, 2005). The CBT intervention involved 9 weekly sessions and was delivered by experienced CBT therapists assisted by graduate psychology students. Results demonstrated the superiority of the CBT interventions compared to the control condition in the reduction of anxiety symptoms as indicated by child, parent, and clinician reports and provided preliminary data to support the added benefit of parent training over group CBT alone.

In New York City, Masia and colleagues (2001) conducted an open trial of CBT for 6 middle-class Caucasian adolescents with a diagnosis of SOP (based on the ADIS-IV-C). A CBT-trained clinical psychologist and an advanced doctoral student in clinical psychology led a 14-session school-based CBT group treatment program. At posttreatment, half of the participants no longer met criteria for a diagnosis of SOP. In a larger replication trial, Masia-Warner and colleagues (2005) then used a randomized wait-list control design to evaluate the same school-based CBT program. Thirty-five youth ages 13 to 17 (83% Caucasian) with a primary diagnosis of SOP were randomly assigned to CBT or a wait-list control. At posttreatment, 67% of adolescents in the treatment group, but only 6% of participants in the wait-list control group, no longer met criteria for SOP. In a more stringent test of treatment efficacy, Masia-Warner and colleagues compared CBT (delivered by a Ph.D. clinical psychologist and a clinical psychology graduate student) to an attention

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