Exploring Teachers’ Perspectives on Child Anxiety: Opportunities to Promote Anxiety Management Skills in the Classroom

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Abstract

The purpose of the current study was to examine how teachers identify and provide supports for students with anxiety as well as their perspectives on implementing strategies informed from cognitive behavioural therapy (CBT) in the classroom. Data was collected from 11 classroom teachers in London, Ontario through virtual focus group sessions and an online demographic questionnaire. Thematic analysis revealed three key themes: opportunities to implement CBT-informed strategies, barriers to implementing CBT-informed strategies, and current knowledge and resources. The findings revealed that teachers perceived that they are facing increased demands to support the mental health needs of students without appropriate resources and training. The findings also outlined potential opportunities and barriers that teachers identified with regards to implementing CBT-informed strategies in the classroom. These insights could be used to develop CBT-informed programs for teachers that are both practical and effective in the classroom setting. Providing teachers with the necessary knowledge and support is important to improve overall identification and intervention supports for children and youth with anxiety.

Keywords: anxiety, cognitive behavioural therapy (CBT), children, teachers, school psychology
Summary for Lay Audience

Due to increasing demands for mental health services in the community, schools play an important role in supporting the mental health needs of students. Specifically, classroom teachers spend the most amount of time with students. As a result, classroom teachers are often the first to identify when students are experiencing potential mental health concerns. This is important as mental illness tend to become more severe the longer that they are left untreated. Therefore, classroom teachers must be aware of the key signs and symptoms of common mental health problems and how to refer students to mental health professionals for support. This ensures that students with potential mental health concerns are identified and receive the appropriate treatment. Teachers also work together with mental health professionals to support strategies that promote mental health in the classroom. This is important as classroom teachers can reach a large number of students, and have an important role in tiered intervention supports for mental health difficulties. Anxiety disorders are one of the most common mental illnesses among children and youth. Fortunately, research consistently demonstrates that cognitive behavioural therapy (CBT) is an effective treatment for anxiety. CBT involves simple strategies that are used to challenge negative thinking, feeling and acting patterns. However, limited research has examined teachers’ perspectives about utilizing strategies from CBT in the classroom setting. The purpose of the current study was to examine how teachers identify and provide intervention for students with anxiety and their perspectives on implementing strategies from cognitive behavioural therapy (CBT) in the classroom. Virtual focus groups were conducted with 11 classroom teachers from London, Ontario. Focus groups are group discussions about a particular topic or issue. Thematic analysis was used to identify key themes and patterns that were discussed in the focus groups. Three key themes were discussed: opportunities to implement
CBT-informed strategies, barriers to implementing CBT-informed strategies, and current knowledge and resources. These findings could be used to develop CBT-informed resources for teachers that are practical and effective in the classroom. These steps are required to improve teachers’ ability to identify and support students with anxiety in the classroom.
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# Table of Contents

Abstract .......................................................................................................................... ii

Summary for Lay Audience ............................................................................................ iii

Acknowledgements ......................................................................................................... v

List of Tables .................................................................................................................. ix

List of Figures ................................................................................................................ x

List of Appendices .......................................................................................................... xi

Introduction .................................................................................................................... 1

Literature Review ............................................................................................................. 2
  Anxiety in Schools ........................................................................................................ 2
  School-Based Mental Health Services ........................................................................ 5
  Cognitive Behavioural Therapy ................................................................................... 11

The Current Study ......................................................................................................... 16

Method ............................................................................................................................ 18
  Research Design .......................................................................................................... 18
  Participants .................................................................................................................. 19
  Materials ..................................................................................................................... 20
  Procedure .................................................................................................................... 21
  Thematic Analysis ....................................................................................................... 22

Results ............................................................................................................................ 25
  Theme: Opportunities to Implement CBT-Informed Strategies ................................ 26
Subtheme: Connection to the Curriculum ................................................................. 26
Subtheme: Exposure and Scaffolding ................................................................. 28
Subtheme: Aligns with Existing Practices ............................................................. 29
Subtheme: Class-Wide Implementation ................................................................. 31

Theme: Barriers to Implementing CBT-Informed Strategies ........................................ 32
Subtheme: Time Constraints ................................................................................. 32
Subtheme: Lack of Education, Resources and Support ................................................ 33
Subtheme: Variability in Practice ............................................................................ 35
Subtheme: Complexity of Anxiety Presentation ......................................................... 37
Subtheme: Role Boundaries ....................................................................................... 38
Subtheme: Overburdened Mental Health System ....................................................... 39

Theme: Current Knowledge and Resources ............................................................ 41
Subtheme: Community Resources ............................................................................ 41
Subtheme: Collaboration with School Staff ............................................................... 42
Subtheme: Collaboration with Parents and Families .................................................... 44
Subtheme: Professional Development ......................................................................... 44
Subtheme: Anxiety Signs and Symptoms (Avoidance, Disengagement, Emotional
Dysregulation and Reassurance-Seeking) ................................................................. 46

Discussion ................................................................................................................. 49

Connection to Previous Research ............................................................................. 49
The Role of Teachers in Tiered Intervention ............................................................. 53
Limitations ................................................................................................................. 55
Implications and Future Directions ........................................................................... 56
Conclusion ........................................................................................................................................... 58
References .......................................................................................................................................... 60
Appendices .......................................................................................................................................... 71
Curriculum Vitae ................................................................................................................................. 112
List of Tables

Table 1: Phases of Thematic Analysis .................................................................................. 23
List of Figures

Figure 1: Thematic Map.................................................................................................................. 25
# List of Appendices

- **Appendix A: Resource Booklet** ................................................................. 71
- **Appendix B: Recruitment Email Script** ...................................................... 100
- **Appendix C: Information and Consent Form** ............................................. 101
- **Appendix D: Qualtrics Demographic Questionnaire** ................................... 105
- **Appendix E: Moderator Guide** ................................................................. 106
- **Appendix F: Non-Medical Research Ethics Board Approval** ...................... 108
- **Appendix G: Themes, Subthemes, Codes and Sample Extracts** .................. 109
Introduction

Approximately 1 in 5 children and youth currently face a mental health concern in Canada (Mental Health Commission of Canada, 2013; MHASEF Research Team, 2015). Specifically, anxiety disorders are the most common mental health disorder reported in this age group (Georgiades et al., 2019). Anxiety can be defined as “the tense, unsettling anticipation of a threatening but vague event” (Rachman, 2004, p. 14). Excessive levels of fear or anxiety may be considered an anxiety disorder when it is disproportionate, persists over time and interferes with daily functioning (American Psychiatric Association, 2013). For children and youth, common signs of an anxiety disorder may include excessive worrying, avoiding specific things or situations, becoming upset when separated from parents or caregivers, physical complaints, sleep difficulties and asking a number of “what if” questions (Canadian Mental Health Association, 2018). Furthermore, anxiety disorders can negatively impact the school success of children and youth, which poses significant costs to society (Kessler et al., 1995; Van Ameringen et al., 2003).

Despite the prevalence and impact of anxiety among children and youth, many face barriers to accessing mental health services in Ontario (Boak et al., 2018; Georgiades et al., 2019). School-based mental health services have the potential to improve service contact among children and youth with anxiety through school-wide and targeted prevention and intervention programs (Mental Health Commission of Canada, 2012; School Mental Health Ontario, 2019; Stewart & Toohey, under review). Teachers play an important role in identifying students with anxiety. However, research suggests that teachers tend to identify students with the most severe anxiety symptoms, which may limit identification and intervention among students with less severe anxiety symptoms (Headley & Campbell, 2011; Layne et al., 2006).
With regards to intervention, cognitive behavioural therapy (CBT) is an effective evidence-based treatment for anxiety disorders in children and youth with skills that can be applied in the school setting (Chorpita et al., 2011). Research suggests that teachers can effectively facilitate CBT-informed programs and yield similar results as mental health professionals (Neil & Christensen, 2009). However, research has yet to examine teachers’ perspectives on using CBT-informed strategies and if these strategies are being used in Ontario classrooms. The current study will address the aforementioned gaps in the literature. First, the current study will examine how teachers currently identify and support students with potential anxiety concerns in Ontario. Second, the current study will explore teachers’ perspectives on using CBT-informed strategies in the classroom. Third, the current study will determine what resources teachers require to better identify and support students with anxiety.

**Literature Review**

**Anxiety in Schools**

Anxiety is prevalent among school-aged children and youth in Ontario. The 2014 Ontario Child Health Study (OCHS) is a provincially-representative survey that examined the mental health of 10,802 children and youth (Georgiades et al., 2019). This survey found that 18% to 22% of children and youth met the criteria for a mental disorder and anxiety disorders were the most common mental disorder reported among adolescents ages 12 to 17. Similarly, the 2017 Ontario Student Drug Use and Health Survey (OSDUHS) used the Kessler 6-Item Psychological Distress Scale to assess symptoms of psychological distress, such as anxiety and depression, among 11,435 students from Grade 7 to Grade 12 (Boak et al., 2018). This study found that nearly 40% of students reported experiencing a moderate-to-serious level of psychological distress, whereas 17% of students reported experiencing a serious level of psychological distress, both of which were significantly higher than the first survey in 2013. Therefore, anxiety
disorders and symptoms are prevalent and may be increasing among children and youth in Ontario.

Students in Ontario have voiced concerns about the impact of anxiety on their success in school. The 2017 Children and Youth Mental Health Survey was conducted with a representative sample of parents, youth and adults in Ontario to examine participants’ current and past experiences with mental illness (Tong & McLeod Macey, 2017). With regards to the parent findings, around one half of parents reported ever having concerns about their child’s level of anxiety and around one third of parents indicated that their child has missed school due to anxiety. With regards to the youth and adult findings, approximately 60% reported ever having concerns about their level of anxiety, 60% reported ever having concerns about their school performance due to anxiety and 50% reported that they have missed school due to anxiety. Likewise, the 2017 OSDUHS found that around 30% of students perceive that their mental health impacts their grades in school a “great deal” or “quite a lot” (Boak et al., 2018). Thus, it is evident that children and adolescents in Ontario are concerned about their level of anxiety and how it affects their school success.

Anxiety can hinder school attendance for children and youth. Finning et al. (2019) conducted a systematic review of the literature and examined eight studies that found associations between anxiety disorders and school absenteeism. For example, one of these studies found large positive associations between school refusal and separation anxiety disorder, social anxiety disorder, generalized anxiety disorder and specific phobias (Egger et al., 2003). There are several possible explanations for the association between anxiety and poor school attendance. Kearney (2008) explains that there are aspects to the school environment that may elicit anxiety from students such as separation from caregivers, social interaction with teachers
and peers and academic stress. As a result, students with anxiety may avoid or refuse school through negative reinforcement. Additionally, students with anxiety often experience somatic symptoms such as stomachaches, headaches, musculoskeletal pain and fatigue (Campo, 2012). These somatic anxiety symptoms can be difficult to distinguish from physical illness, which may contribute to absenteeism among students with anxiety. Lastly, sleep disturbances are prevalent among children and youth with anxiety disorders, which may interfere with their ability to wake up on time for school (Brown et al., 2017). Therefore, it is apparent how anxiety disorders can impact school attendance for children and youth.

Anxiety can also have a negative impact on academic performance. Seipp (1991) conducted a meta-analysis of 126 studies and found a negative relationship between anxiety and academic performance, suggesting that high levels of anxiety are associated with poor academic performance. However, this study found that academic performance may vary according to the type of anxiety. Test anxiety is a “set of phenomenological, physiological and behavioural responses that accompany concern about negative consequences or failure on an exam” (Zeidner, 1998, p. 17). Several studies have linked test anxiety to poor academic performance. Hembree (1988) conducted a meta-analysis with 565 studies and found that high levels of test anxiety negatively correlated with several measures of academic performance including IQ, GPA, problem-solving abilities and academic achievement in English and mathematics for students in third grade and above. Test anxiety may impede academic performance due to cognitive interference with encoding, processing and retrieval; deficits in study and test-taking skills; and negative self-evaluations or self-concepts (Cassady & Johnson, 2002; Hembree, 1988). Therefore, anxiety may interfere with students’ test-taking abilities which can negatively impact academic performance.
The negative impact of anxiety on student success results in substantial costs to society. Research in the United States found that students with anxiety disorders are 1.4 times more likely to fail to complete high school or college than those without anxiety disorders (Kessler et al., 1995). Similarly, research in Canada found that 50% of adult patients with an anxiety disorder reported leaving school prematurely and 24% reported that anxiety was the primary reason for doing so (Van Ameringen et al., 2003). Premature school exit or “dropping out” has far reaching effects on the economy. Comprehensive cost estimates of labour, employment, health, social assistance and the criminal justice system suggest that Canada would save over $7.7 billion dollars per year if the high school graduation rate was increased by one per cent (Hankivsky, 2008). Thus, it is necessary to support students with anxiety to reduce the rate of premature school exit and the financial burden that it poses to society.

**School-Based Mental Health Services**

Despite the negative impact of anxiety, few children and adolescents access mental health services in Ontario. The 2014 OCHS found that only 26% to 34% of the children and youth who met criteria for a mental disorder made contact with a mental health provider (Georgiades et al., 2019). Similarly, the 2017 OSDUHS found that 25% of students contacted a mental health professional within the last year, which constitutes approximately 235,100 students (Boak et al., 2018). However, an even greater proportion, 31% of students, reported that there was a time within the last year that they wanted to talk to someone about a mental health concern but did not know where to turn. Therefore, it is apparent that children and adolescents may be facing barriers to accessing mental health services in Ontario.

Children and adolescents may have low rates of service contact due to reliance on parents and guardians. The Child, Youth and Family Services Act (CYFSA) specifies that parental
consent is required for counselling services when children are under age 12 and all other services until the child is 16 years old (Child, Youth and Family Services Act, 2017). As a result, children and adolescents may not have access to mental health services in cases where the parent or guardian are unable or unwilling to provide consent. The 2014 OCHS also found that rates of service contact differed according to who identified the mental health concern (Georgiades et al., 2019). Specifically, when parents identified the mental health concern, overall rates of service contact were 62% for children and 61% for youth. Alternatively, when youth identified that they had a mental health concern, the rate of service contact was 44%. This suggests that children and youth may be more likely to access mental health services when parents identify the mental health concern, which is limiting for those who identify the mental health concern themselves.

Children and adolescents with anxiety may face additional barriers to accessing mental health services due to the internalizing nature of the disorder. Specifically, internalizing disorders include “over-inhibited or internally-focused symptoms including anxiety, fear, sadness, depression, social withdrawal and somatic complaints” (Willner et al., 2016, p. 2). Conversely, externalizing disorders consist of “disinhibited or externally-focused behavioural symptoms including aggression, conduct problems, delinquent behaviour, oppositionality, hyperactivity and attention problems” (p. 1). As a result, parents and teachers often perceive internalizing disorders as less problematic than externalizing disorders which may lead to less identification and service contact (Tandon et al., 2009). This is consistent with the 2014 OCHS as it found that rates of service contact for children ages 4 to 11 were around 66% for behaviour disorders such as conduct disorder and oppositional-defiant disorder and around 44% for mood or anxiety disorders (Georgiades et al., 2019). This highlights the need to improve access to mental health services for children and youth with internalizing disorders, such as anxiety.
Schools have the potential to improve access to mental health services for students with anxiety. The 2014 OCHS found that schools were the most common setting in which children and adolescents accessed mental health services. Primarily, the school setting is a “natural and important” avenue to improve access to mental health services among children and adolescents due to the amount of time that they spend at school each day (Mental Health Commission of Canada, 2013). As a result, school-based mental health services are convenient and cost-efficient, which can also alleviate transportation and financial burdens for students and families (Herzig-Anderson et al., 2012). Additionally, schools come into contact with a large number of children and youth, making it an ideal environment to identify students with potential mental health concerns (Levitt et al., 2007). Lastly, schools have the capacity to administer broad prevention and intervention programs, which have the potential to reach students who might not otherwise make contact with mental health services (Mental Health Commission of Canada, 2013). Thus, schools are a promising gateway to improve access to mental health services for children and youth with anxiety.

Several federal and provincial reports highlight the importance of schools in supporting the mental health of children and youth (Mental Health Commission of Canada, 2012; School Mental Health Ontario, 2019). With regards to federal initiatives, a top priority in Canada’s Mental Health Strategy is to “increase the capacity of families, caregivers, schools, post-secondary institutions and community organizations” (Mental Health Commission of Canada, 2012, p. 24). Specifically, this priority illustrates the need to carry out broad mental health promotion programs and targeted early intervention programs for infants, children and youth. With regards to anxiety, early identification and intervention is particularly important as anxiety disorders that develop in childhood and adolescence tend to predict anxiety disorders in
adulthood, when left untreated (Smetanin et al., 2011). Additionally, timing is crucial as children and youth may be more responsive to treatment than adults, due to more neuroplasticity and less conditioning of maladaptive thoughts and behaviours (Hirshfeld-Becker & Biederman, 2002). Thus, it is evident that Canada’s Mental Health Strategy acknowledges the benefits of early intervention and the importance of supporting schools in carrying out these programs.

Despite the importance of schools in facilitating early intervention, teachers may not be equipped to accurately identify students with anxiety. Headley and Campbell (2011) provided teachers with hypothetical vignettes and assessed their ability to identify children with anxiety and make referrals. This study found that teachers were significantly more likely to identify and make referrals for students with the most severe and least severe anxiety symptoms. This suggests that teachers may be more inclined to assist students at the extreme ends of the anxiety spectrum and may require training on how to identify those with moderate anxiety symptoms. Similarly, Layne et al. (2006) administered the Multidimensional Anxiety Scale for Children (MASC) to over 450 elementary school children and asked their teachers to select the three most anxious students in their classrooms. This study found that teachers were most likely to select students exhibiting greater physical symptoms, separation anxiety, social anxiety and total anxiety scores. This suggests that teachers are able to accurately identify students with higher levels of self-reported anxiety symptoms. However, it is unknown how teachers make these identification decisions in Ontario and whether they are provided with evidence-based training and resources to do so. Given that standardized screening processes utilizing a case finding methodology to support training and intervention is often not utilized in schools, identifying children and youth on a continuum of risk is limited (Stewart & Toohey, under review).
With regards to provincial action, the Ontario School Mental Health Strategy shares similar goals as the federal initiatives. Specifically, the Ontario School Mental Health Strategy aims to cultivate “school staff and parents/families who notice and respond appropriately when students are experiencing social-emotional problems” through “role-specific resources, training and implementation support” (School Mental Health Ontario, 2019, p. 30). Providing school staff with role-specific resources and training is especially important for students with anxiety as they are often under-identified and under-referred in the school setting (Allison et al., 2014). Additionally, similar to the federal strategy, the Ontario School Mental Health Strategy focuses on fostering “available and accessible prevention and early intervention services at school” that are evidence-based and student-centered (School Mental Health Ontario, 2019, p. 31). Improving evidence-based services in schools is necessary as school staff such as teachers and administration tend to have low and infrequent engagement with research-based information (Lysenko et al., 2014). Additionally, there is often a gap between research and practice in the field of education (Vanderlinde & Van Braak, 2010). Therefore, it is important to improve the use of evidence-based practices in schools to ensure that students are identified and receive services that are associated with positive treatment outcomes.

Schools in Ontario endorse a tiered approach to student mental health. The tiered approach, as outlined by the Ministry of Education (2013a), is a systematic process that facilitates early intervention and ensures appropriate and timely intervention to meet the individual needs of students. Similarly, School Mental Health Ontario (n.d.-c) presents an Aligned and Integrated Model (AIM) with three tiers. Specifically, tier one includes school mental health support that is beneficial for all students. This tier emphasizes fostering a welcoming and inclusive environment; understanding mental health literacy and the needs of individual students;
promoting mental health through the curriculum, teaching and learning; and partnering with home, school and community resources. Next, tier two is necessary for some students that may require additional support. This tier involves preventing further mental health concerns through early intervention services, ongoing classroom support and bolstering skills. Lastly, tier three is essential for students with more significant mental health concerns and involves intervening through assessment and treatment. Together, these tiered approaches provide schools with a framework for supporting the mental health needs of students through early identification and intervention.

Despite these government initiatives, several surveys have demonstrated that Ontario schools have limited access to mental health services. For example, People for Education (2019) conducted a survey with principals from 1,254 elementary and secondary schools in Ontario. This survey found that only 30% of elementary schools and 36% of secondary schools had regularly scheduled access to a school psychologist, which has declined since 2017. Furthermore, this study reported that 22% of elementary schools and 21% of secondary schools had no access to a school psychologist. As a result, to improve access to mental health services, principals from this study recommended increased collaboration between mental health professionals and school staff as well as increased mental health professional development opportunities for teachers. Thus, teachers may be facing increased demands for supporting the mental health needs of students due to limited access to school psychologists and may require additional training to meet these demands.

Teachers have expressed similar concerns. The Ontario Student, Parent and Educator Survey gathered responses from nearly 300 educators across school boards in Ontario about issues in education (Ontario Student Trustees’ Association, 2017). This survey found that 44% of
educators perceived the mental health resources and supports in their schools to be inadequate. Specifically, educators expressed the need for more mental health resources that they could use to support students, as well as improved administrative efforts to inform teachers about the current mental health resources that are available. Therefore, it is likely that classroom teachers would benefit from role-specific evidence-based resources to better identify and support the mental health needs of students in their classrooms.

**Cognitive Behavioural Therapy**

CBT is an effective evidence-based treatment for anxiety disorders that can be applied in the school setting. Chorpita et al. (2011) conducted a meta-analysis of over 300 treatment outcome studies to compare the efficacy of evidence-based treatments for children and adolescents with anxiety. This review found that CBT alone was the most effective treatment for anxiety disorders in childhood and adolescence when compared with other treatments such as CBT and medication, relaxation training and play therapy. As a foundation, CBT is based on the recognition that an individual’s thoughts, feelings and actions are causally-related (Kendall & Gosch, 1994). The cognitive principles of CBT hold that thoughts are “central to our experience of the world” as they impact how an individual perceives and attaches meaning to events which, in turn, influences how they respond (Howells, 2018, p. 4).

Children and adolescents with anxiety disorders tend to have maladaptive patterns of thinking and behaviour. Beck and Burns (1980) explain that abnormal emotional responses, including anxiety, stem from cognitive distortions such as all-or-nothing thinking, overgeneralization, magnification or minimization, disqualifying the positive and personalization. Specifically, overgeneralization occurs when something happens to an individual and they believe that it will happen over and over again. For example, students with
anxiety may exhibit overgeneralization if they perform poorly on a test and believe that they will never do well on a test again. These cognitive distortions can lead to maladaptive behaviour. Kendall (2012) explains that avoidance is the most common behavioural response to anxiety. For example, children and youth may attempt to avoid the person or situation that is making them feel anxious, such as trying to get out of writing a test in school (Southam-Gerow, 2019). Although avoidance leads to initial anxiety reduction, this behaviour is maladaptive as the anxiety only becomes more severe the next time that the individual is faced with the scenario, resulting in a “self-sustaining loop” of anxiety (p. 20).

CBT aims to alleviate distress by challenging individuals’ existing patterns of thinking, feeling and acting through cognitive and behavioural techniques (Fenn & Byrne, 2013). First, psychoeducation is an important component to CBT (Kendall, 2012; Southam-Gerow, 2019). Specifically, psychoeducation typically involves teaching children and adolescents about the fear and anxiety systems and how to identify and distinguish anxiety from other emotional states. For example, Anxiety Canada has several free psychoeducation resources, including “Chester the Cat” which is an illustration of a cat that labels anxiety symptoms on the cat’s body such as shaking legs, butterflies in the stomach and clenched fists (n.d.-a). A meta-analysis revealed that brief psychoeducational interventions are effective at reducing anxiety symptoms (Donker et al., 2009). Additionally, psychoeducation is low-cost and can reach a large number of people. Therefore, psychoeducation is an effective component to CBT that could be applied in the school setting.

Second, with regards to CBT-informed cognitive strategies, cognitive restructuring is a technique that is commonly used to challenge cognitive distortions and establish more adaptive ways of thinking and coping. For example, “Realistic Thinking and Feeling” is a free activity for
educators from School Mental Health Ontario in which students compare negative and realistic thought, feeling and action patterns for ambiguous scenarios (n.d.-a). Children and adolescents with anxiety may also be prone to cognitive deficiencies, which refer to an “absence of thinking” (Kendall, 2012, p. 13). Therefore, CBT may focus on cognitive skill building, such as developing problem-solving skills. For example, “Stop, Think, Go” is a problem-solving exercise from School Mental Health Ontario that uses a traffic light analogy to teach students to stop to examine a problem, think of possible solutions and then test the solutions (n.d.-b). Thus, there are several accessible resources that are designed for educators and align with cognitive strategies from CBT.

Exposure tasks are a common behavioural strategy from CBT to treat anxiety disorders in children and youth (Higa-Mcmillan et al., 2016; Kendall, 2012; Southam-Gerow, 2019). Specifically, exposure tasks address avoidance behaviour as they involve subjecting the individual to the feared stimuli or anxiety-provoking situation (Kendall, 2012; Southam-Gerow, 2019). For example, Anxiety Canada has free downloadable resources such as “Hopping Down the Worry Path” and the “Fear Ladder” which involve developing and carrying out gradual steps of exposure to anxiety-provoking situations for children and youth (n.d.-b). Exposure is well-accepted in the literature as the “active ingredient” to CBT (Ale et al., 2015; Southam-Gerow, 2019). Higa-Mcmillan et al. (2016) conducted a meta-analysis of over 100 treatment outcome studies for child and adolescent anxiety disorders and found that approximately 88% of effective CBT treatments included exposure techniques. Therefore, exposure is an important component to CBT that can be used to reduce the avoidance behaviour associated with anxiety disorders.

Despite the effectiveness of exposure, limited research has explored whether teachers encourage students to face their fears in the classroom setting. Allen and Lerman (2018)
examined teacher responses to hypothetical scenarios in which students exhibited generalized anxiety, social anxiety or separation anxiety symptoms. This study found that teacher characteristics such as gender, experience and position influenced the anxiety management strategies that were used. For example, new teachers were significantly less likely than experienced teachers to use avoidance reinforcement strategies. The researchers explained that this difference may have emerged due to increased attention to mental health training in recent teacher education. Additionally, this study found that the anxiety management strategies differed according to the type of anxiety presentation. Specifically, teachers were significantly less likely to use autonomy-promoting strategies, such as encouragement and rewards for facing fears in scenarios with separation anxiety symptoms. Therefore, teacher characteristics and symptom presentation may influence whether teachers reinforce the avoidance behaviours of students with anxiety. However, more research is needed to explore why teachers might reinforce students’ avoidance behaviours and their perspectives on implementing exposure tasks as a more effective strategy to reduce student anxiety.

Relaxation training is another behavioural strategy from CBT. Relaxation training teaches children and adolescents “awareness and control over their own physiological and muscular reactions to anxiety” (Kendall, 2012). Specifically, relaxation training may include techniques such as breathing retraining, progressive muscle relaxation, guided imagery and mindfulness (Southam-Gerow, 2019). For example, progressive muscle relaxation involves tensing and relaxing the body in a systematic manner to learn how to distinguish between tense and relaxed states. Furthermore, relaxation training is frequently used in combination with exposure tasks to cope with the anxious responses that are associated with confronting the feared stimuli. Higa-McMillan et al. (2016) found that approximately 54% of effective CBT treatments included
relaxation training. However, Ale et al. (2015) performed a meta-analysis with 35 randomized control trials and found that relaxation strategies had no effect on the CBT treatment outcomes for childhood anxiety disorders. Therefore, it is unclear whether relaxation strategies play a role in the effectiveness of CBT. Regardless, children and adolescents may find that relaxation strategies are a useful tool for coping with their anxiety symptoms and can be applied in both individual and group settings.

Although there is limited research in this area, there is some evidence to suggest that teachers can effectively use CBT to reduce students’ anxiety in the classroom. Neil and Christensen (2009) conducted a systematic review of 27 randomized controlled trials that examined the effectiveness of school-based prevention and intervention programs for anxiety. This study found that CBT, or components of CBT, such as psychoeducation and relaxation training, were found in 78% of school-based prevention and intervention programs for anxiety. Furthermore, in the studies that included CBT, 71% of participants reported significantly lower levels of anxiety after completing the program. Notably, program effectiveness did not depend on the type of program facilitator. Specifically, school teachers facilitated 24% of the programs and approximately 88% of the studies that included a teacher as the program facilitator reported significant reductions in anxiety. However, for the studies that included teacher facilitators, the teachers received training and structured program sessions. This suggests that teachers can effectively facilitate CBT when provided with the appropriate training and materials.

With regards to local programs, MindUP is a classroom intervention that was piloted in 15 kindergarten classrooms within the London District Catholic School Board (Western Centre for School Mental Health, 2017). This intervention is implemented by teachers and seeks to promote the development of students’ social and emotional skills through CBT-related strategies such as
mindfulness and relaxation. Overall, teachers reported that the program had a positive impact on students’ social and emotional skills such as an increased ability to communicate emotions, improved focus and a calmer classroom environment. This demonstrates that teachers in Ontario have effectively facilitated CBT-informed strategies, such as relaxation, in the classroom. However, research has not yet examined whether teachers in Ontario are using other key strategies from CBT, such as cognitive restructuring and exposure tasks, to reduce students’ anxiety in the classroom.

The Current Study

Anxiety disorders can have an unfavourable impact on school success for children and youth which poses significant costs to society (Kessler et al., 1995; Van Ameringen et al., 2003). However, children and youth with anxiety tend to face barriers to accessing mental health services in Ontario (Boak et al., 2018; Georgiades et al., 2019). Schools have been identified as a “natural and important” avenue to improve access to mental health services for children and youth with anxiety (Herzig-Anderson et al., 2012; Levitt et al., 2007; Mental Health Commission of Canada, 2013). Yet, due to limited access to school psychologists, teachers in Ontario are facing increased demands to identify and support the mental health needs of students, often without additional resources or training (Ontario Student Trustees’ Association, 2017).

CBT is the most effective treatment for anxiety disorders in children and youth and consists of simple strategies that can be employed by teachers in the school setting (Chorpita et al., 2011). Research has found that teachers can effectively facilitate CBT-informed programs and produce similar results at reducing student anxiety as mental health professionals (Neil & Christensen, 2009). However, it is unknown whether teachers in Ontario are utilizing CBT-informed strategies to support students with anxiety in their classrooms. Additionally, research
has not yet examined what teachers perceive as potential benefits or barriers to using CBT-informed strategies.

The current study addresses the aforementioned gaps in the literature. First, this study examines how teachers identify students with potential anxiety concerns. This will provide insight about the process of making identification decisions in Ontario as well as teacher knowledge of anxiety signs and symptoms in children and youth. This is important as it may highlight areas for additional training opportunities for teachers to more accurately identify students with anxiety. In turn, improved teacher identification can lead to early intervention, which reduces the long-term consequences and costs to society when anxiety is left untreated (Kessler et al., 1995; Van Ameringen et al., 2003). Second, this study investigates how teachers provide intervention for students with potential anxiety concerns. This will determine whether teachers in Ontario are using evidence-based strategies to support students with anxiety in their classrooms and whether they are provided with the appropriate resources and training. This is important as improving access to evidence-based mental health resources can improve treatment outcomes for students with anxiety, which may reduce the need for future service contact (Smetanin et al., 2011).

Third, this study explores teachers’ perspectives in using CBT-informed strategies to support students with anxiety in the classroom. This will provide important insight regarding teachers’ comfort level in employing CBT-informed strategies as well as potential benefits and barriers to implementing these strategies in the classroom. These findings could be used to inform CBT programs for teachers that are both practical and effective in the classroom environment. Lastly, this study will determine the resources that teachers require to better identify and support students with anxiety in the classroom. These findings could be used to
connect teachers with available resources or support that they may require. Additionally, this will provide important directions for future research, to tailor school-based mental health programs to what is needed in the community.

Although this study was largely exploratory in nature, it was expected that several themes would emerge based on the literature. Previous research has found that teachers in Ontario perceive there to be a lack of role-specific mental health training and support, despite increased demands to support the mental health needs of students (Ontario Student Trustees’ Association, 2017; People for Education, 2019). As a result, it was expected that participants would express an overall lack of resources and training to prepare teachers to identify and provide intervention for students with potential anxiety concerns. Although previous studies have examined the effectiveness of teachers in facilitating CBT-informed programs, limited research has explored their perspectives in using these strategies (Neil & Christensen, 2009). Allen and Lerman (2018) found that teachers were more likely to use avoidance strategies, rather than exposure strategies from CBT, with students that exhibited symptoms of separation anxiety. Therefore, it was expected that teachers may express reluctance or barriers to using CBT-informed strategies with particular students or anxiety presentations.

Method

Research Design

The current study employed a qualitative research design using an online focus group discussion. Focus groups can be described as “group discussions exploring a specific set of issues” (Barbour & Kitzinger, 1999). Focus groups aim to obtain a wide range of opinions and perspectives, rather than to form a group consensus (Vaughn et al., 1996). This methodology was appropriate for the current study as the overarching goal was to explore teachers’ diverse perspectives about CBT-informed strategies as well as how they identify and support students
with anxiety in the classroom. Due to technological advances, it is increasingly common for focus groups to take place online and the benefits of online focus groups are well-documented in the literature. Participants from online focus groups have reported feeling more comfortable contributing to discussions and asking questions in comparison to face-to-face interactions (O’Connor & Madge, 2003). Additionally, online focus groups reduce barriers to participation such as transportation and geographical location (James & Busher, 2009). Therefore, due to the physical distancing requirements associated with COVID-19, conducting the focus group sessions online was a viable option.

**Participants**

Participants included 11 classroom teachers from elementary schools in London, Ontario and its surrounding counties (Elgin-Middlesex, Oxford). Participants all identified as female and were between the ages of 25 and 50 years old ($M = 40.8$). The majority of participants held a bachelor’s degree, three participants held a master’s degree and one participant held a college diploma. Participants varied in their years of teaching experience from 2 to 25 years ($M = 14.8$). Participants were qualified to teach in a variety of elementary divisions. Four participants were qualified to teach primary and junior grades; two participants were qualified to teach junior and intermediate grades; two participants were qualified to teach intermediate and senior grades; one participant was qualified to teach primary, junior and intermediate grades; one participant was qualified to teach junior, intermediate and senior grades; and one participant was qualified to teach all elementary grade divisions. Six participants indicated that they had experience working in a special education role, such as through supply teaching or a learning support teacher role. The majority of participants had experience working with students with anxiety, whereas one teacher did not.
Convenience sampling was used to recruit participants. Participants were recruited through Twitter and the email distribution list at the Child and Youth Development Clinic at Western University. Participants were selected based on adherence to the inclusion criteria and availability. Participants were asked to complete an online questionnaire and attend an online focus group session. Participants received a $15 digital Amazon gift card and resource booklet via email as compensation following the study. The resource booklet contained information about child anxiety and evidence-based strategies for supporting students with anxiety in the classroom (see Appendix A).

**Materials**

Participants were recruited using an email script that adhered to the template provided by Western University (“Guidelines and Templates,” n.d.; see Appendix B). The initial recruitment email also included the information and consent forms (see Appendix C). The online questionnaire included seven items related to demographic information such as age, gender, level of education and work experience (see Appendix D). The online survey was administered through Qualtrics, an online survey subscription software that is offered through Western University (“MySurveys,” 2020). The online focus group sessions were held through Zoom, an online video conferencing platform (“Zoom Web Conferencing,” 2020). Precautions were taken to ensure the privacy and security of the meetings. These included providing each participant with a password for the meeting, locking the meeting once participants entered the session and creating an invitation-only email linked to each unique participant. All participants were required to have access to a computer or mobile device in order to complete the online survey and attend the online focus group sessions.
The moderator guide was created and used as a detailed schedule for the focus group sessions (see Appendix E). The moderator guide includes pre-established questions that progressed from general and non-threatening to more specific and thought-provoking to allow participants to gain experience with the focus group process and feel more comfortable sharing their opinions (Vaughn et al., 1996). This guide also ensured that the schedule and questions were consistent throughout the various focus group sessions.

**Procedure**

Ethics approval for this study was obtained from the Non-Medical Research Ethics Board (WREM) at Western University (see Appendix F). Due to the physical distancing requirements associated with COVID-19, all of the study procedures were conducted digitally. First, prospective participants were recruited via email (see Appendix B). The initial recruitment email included the information and consent forms and prospective participants were encouraged to ask questions as needed (see Appendix C). After the prospective participants were given the opportunity to ask questions about the study, those that were interested in participating were required to digitally sign the consent form and send it back via email. At this point, participants were asked to select a time slot for a focus group session. The time slots included various week nights that were after school hours to accommodate the typical work schedule for classroom teachers. Those that were not available for any of the time slots were not able to participate in the study. Participants that selected a time slot were emailed an anonymous link and an online demographic questionnaire through Qualtrics, which was expected to take approximately five minutes to complete.

Next, participants attended an online focus group session through Zoom. Initially, the focus group sessions were intended to take place in-person. However, due to the physical distancing
requirements associated with COVID-19, all of the study procedures were conducted digitally. There was a total of 4 focus group sessions with 2 to 4 participants in each session that were approximately 90 minutes in length. First, each focus group session began with a brief introduction and outline of the group guidelines. For example, one of the group guidelines asked participants to reserve negative comments or judgment towards others, in order to create a respectful environment in which all participants would feel comfortable contributing to the discussion. Next, Dr. Colin King provided a PowerPoint presentation that defined key concepts and terms specific to child anxiety and CBT-informed strategies. Finally, the moderator guided the discussion with pre-established questions related to identifying and supporting students with anxiety as well as perspectives about CBT-informed strategies. The focus group sessions were conducted until data saturation was achieved, meaning that “there [were] no new emerging ideas in the data” (Hancock et al., 2016, p. 2125). The focus group sessions were audio-recorded and transcribed manually. The resulting transcript was reviewed and edited to remove all identifying information and errors to prepare for analysis.

**Thematic Analysis**

Thematic analysis was used for “identifying, analyzing and interpreting patterns of meaning” within the qualitative focus group data (Clarke & Braun, 2017, p. 297). Thematic analysis involves generating codes and themes. Specifically, codes are the smallest unit of thematic analysis that encompass interesting or relevant features of the data. Codes are combined into themes, which are larger patterns of meaning that are organized around a core idea or concept. This study implemented an inductive data-driven approach, meaning that the codes emerged from the data, rather than trying to fit the data into pre-established coding schemes
Patton, 1990). Braun and Clarke (2006) outline six phases of thematic analysis that were used as a framework for analysis in the current study (see Table 1).

**Table 1**

*Phases of Thematic Analysis (Braun & Clark, 2006).*

<table>
<thead>
<tr>
<th>Phase</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarizing yourself with your data</td>
<td>Transcribing, reading and re-reading, recording initial ideas.</td>
</tr>
<tr>
<td>2. Generating initial codes</td>
<td>Coding interesting features across the dataset, organizing all data relevant to each code.</td>
</tr>
<tr>
<td>3. Searching for themes</td>
<td>Organizing codes into potential themes, considering all data relevant to each theme.</td>
</tr>
<tr>
<td>4. Reviewing themes</td>
<td>Considering whether the themes fit with the initial codes and the dataset as a whole, creating a thematic map of the analysis.</td>
</tr>
<tr>
<td>5. Defining and naming themes</td>
<td>Refining the details of each theme and the overall story of the analysis, developing names and definitions for each theme.</td>
</tr>
<tr>
<td>6. Producing the report</td>
<td>Selecting extract examples, analyzing the selected extracts, relating the analysis back to the research question and literature, writing a scholarly report of the analysis.</td>
</tr>
</tbody>
</table>

**Phase One: Familiarizing Yourself with Your Data**

Phase one involves becoming familiar with the data. As the focus group sessions were an interactive process, there was already some prior knowledge and familiarity with the data going into the analysis. Additionally, the audio recordings of the focus group sessions were transcribed manually, which allowed for an even deeper immersion in the data. From there, the transcription was read and re-read several times, while recording initial reactions and ideas for potential codes. The transcript for each focus group session was read separately, to reduce the risk of bias in forming initial reactions and ideas.
Phase Two: Generating Initial Codes

Phase two involves generating initial codes from the transcript. Coding was conducted manually in order to remain fully immersed in the data. This was achieved by using the highlight and comment features on Microsoft Word to identify interesting features and potential patterns in the transcript. Coding was completed one transcript at a time, and then again through the entire dataset, with full and equal attention given to each portion of text. There was not a limit to the number of codes that were used, to ensure that potentially important ideas were not missed. Similarly, the code extracts varied in length, which allowed the context to be considered when sorting the codes into themes. After the first round of coding, the transcripts were examined as a whole and the codes were revised to ensure that the terms were consistent.

Phase Three: Searching for Themes

Phase three involves organizing the codes and extracts into potential themes. Within this phase, the codes and extracts were systematically arranged into Microsoft Excel which allowed the codes from the different transcripts to be viewed together. Next, the codes were examined and combined. This process highlighted the key ideas that were repeated throughout all of the focus group sessions as well as those that were more unique or contradictory. Thematic maps were used to visualize how the different code groups formed subthemes and overarching themes. It was also considered which extracts would best represent each theme. At this point, there were still codes that did not seem to fit within a particular theme. These codes were grouped together for further analysis.

Phase Four: Reviewing Themes

Phase four involves reviewing the set of potential themes. During this phase, the internal homogeneity and external heterogeneity of the themes were considered, meaning that the data
within the themes is coherent with clear distinctions between each theme (Patton, 1990). This involved reviewing the code extracts under each subtheme and theme to ensure that they formed meaningful patterns. At this point, the themes were adapted, created or removed to better represent the code extracts. Specifically, some of the code extracts were moved to themes that were more suitable or removed if there was not enough evidence to support them. Afterwards, the transcripts were re-read and the thematic map was considered in relation to the dataset as a whole. This was conducted to ensure that the themes, subthemes and extracts were an accurate representation of the discussions that occurred in the focus group sessions.

**Phase Five: Defining and Naming Themes**

Phase five involves defining and refining the identified themes. Within this phase, the themes and subthemes were reviewed to determine what each theme was about and what part of the data it represented. The names of the themes and subthemes were finalized to ensure that they were descriptive yet concise for reporting.

**Phase Six: Producing the Report**

Phase six involves writing a report that provides a narrative of the thematic analysis and evidence of the themes that emerged from the data. This is described below.

**Results**

Three key themes emerged from the focus group sessions—opportunities to implement CBT-informed strategies, barriers to implementing CBT-informed strategies, and current knowledge and resources. Each key theme consists of several subthemes (see Figure 1). These key themes and their corresponding subthemes are discussed below. Extracts are included to most accurately reflect the perspectives of participants (see Appendix G).

**Figure 1**

*Thematic Map of the Themes and Subthemes that Emerged from the Focus Group Sessions.*
**Theme: Opportunities to Implement CBT-Informed Strategies**

This theme occurred frequently and was brought up by all of the participants in each of the four focus group sessions. Within this theme, participants discussed what they perceived as potential opportunities or benefits to implementing CBT-informed strategies in the classroom, including connection to the curriculum, exposure and scaffolding, alignment with existing practices and class-wide implementation. This theme was foreseeable as participants were prompted to consider benefits to implementing CBT-informed thinking and behavioural strategies with students in their classrooms. However, participants provided a unique lens as to how these strategies could be implemented by teachers in the classroom environment.

**Subtheme: Connection to the Curriculum**
Participants indicated that there are opportunities to implement CBT-informed strategies in the classroom as they connect to the Ontario elementary curriculum. With regards to the current curriculum, several participants suggested that CBT-informed strategies could be implemented in health and physical education. Specifically, participants shared that “an easy way to incorporate it would be in health” (Participant 5) and that CBT-informed strategies relate to “aspects of mental health in the health and physical education curriculum” (Participant 4). Several participants also referred to the recent emphasis on social-emotional learning in the Ontario mathematics curriculum. Specifically, this portion of the curriculum outlines how social-emotional learning skills can support students in understanding and applying concepts and processes in mathematics (Ministry of Education, 2020). Participants shared that “the new math curriculum is starting to implement supports in building social and emotional learning into the curriculum right from the beginning” (Participant 7) and “now that it’s part of the curriculum I can reference that in their learning skills in the math comments and teach that with intent now” (Participant 1).

More generally, several participants noted that CBT-informed strategies relate to problem-solving skills, which are embedded throughout the Ontario curriculum across subject areas. For example, one participant stated, “now in education we’re looking at problem-solving through all areas in the curriculum…how we can personally solve problems and understand the world around us” (Participant 1). Participants also suggested that there is an opportunity to embed CBT and other mental health strategies directly into the Ontario curriculum. Participants suggested “a required amount of time to be set to include mental health strategies” (Participant 7) and “allowing us to spend time, not just on the academic curriculum, but on the mental health piece” (Participant 6). This participant expanded upon this idea and stated:
…allowing us to put that directly into our plan, like it has to be so many hours of French and so many hours of math and so many hours of language but there’s not really a set number of hours that you need to focus on mental health (Participant 6).

**Subtheme: Exposure and Scaffolding**

Participants highlighted several opportunities for implementing CBT-informed exposure techniques in the classroom that relate to key components of instructional scaffolding. Instructional scaffolding is a metaphor that is used to describe the role that adults can play in providing temporary support to guide children’s learning or problem-solving in a task that they may not otherwise be able to complete, similar to the role of scaffolds in construction (Wood et al., 1976). Within this subtheme, participants discussed how exposure techniques are collaborative, intentional, individualized, gradual, provide students with a sense of autonomy and control, encourage student-buy in and promote increased understanding of the student.

Participants discussed the potential for exposure techniques to be collaborative between the classroom teacher and the student, “being able to work together to come up with a plan” (Participant 4). Several participants highlighted the intentionality of exposure techniques, “it’s really deliberate and intentional” (Participant 2) and “having someone there to intentionally work on it with someone would really help” (Participant 5). Participants also recognized the benefits of CBT-informed exposure techniques being individualized to each student as “different things work for different students” (Participant 4). Participants also seemed to appreciate the gradual nature of CBT-informed exposure techniques. Participants mentioned, “it’s a stepping stone so we’re starting with something and the student can feel successful in that they’ve managed that first hurdle as it relates to their anxiety and then working towards those that cause higher levels of anxiousness” (Participant 4), “working on one thing at a time again not to overwhelm or bombard the student” (Participant 2), and “providing our students with steps 0 through 10 and
not just forcing students to get up and do a presentation when we know that that is a very big fear of theirs” (Participant 1).

Participants indicated that CBT-informed exposure techniques can provide students with a sense of autonomy and control over their anxiety. When referring to exposure, participants stated, “they feel like they’re more in control and they have a say and anxiety often for students is about that control piece” (Participant 6) and “they can feel that they have some control over their anxiety” (Participant 4). As a result, participants expressed that this would likely promote student buy-in and feelings of success, “they could experience success even if they couldn’t get all the way through it, even if they were able to move a little bit that would still probably make a lot of difference” (Participant 5).

Participants explained that implementing CBT-informed strategies in the classroom may promote students’ understanding of themselves and each other. Primarily, participants explained that CBT-informed strategies may help students understand the relationship between their thoughts, feelings and actions, “talking students through things and helping them rationalize or helping them understand why they are feeling a certain way or why they are behaving a certain way” (Participant 3). Participants also indicated that using CBT-informed strategies in the classroom with students who have anxiety may promote understanding among their peers. For example, one participant mentioned, “I think through that empathy of seeing somebody else and seeing how you can help them will then help to build the understanding in the student themselves (Participant 7). Another participant shared:

...it normalizes it for the student who has the anxiety disorder or is experiencing high levels of anxiety and I think it also allows the other students to become supports for one another if they know those strategies then they know how to be there, how to be that supportive person for their buddy (Participant 6).

**Subtheme: Aligns with Existing Practices**
Participants expressed that there are opportunities to implement CBT-informed strategies in the classroom as they align with existing practices. For example, one participant stated, “we’re already kind of implementing indirectly some of the behavioral techniques from CBT whether we know it or not” (Participant 2). With regards to these behavioural techniques, several participants provided examples of how they have previously carried out exposure-related exercises in the classroom. Specifically, one participant shared:

...the biggest thing for me is when students have to do oral presentations, with most of them I’d give them situations like well you still have to do it but maybe let’s do it in front of a small group at recess so that way they’re still doing it (Participant 1).

Another participant compared CBT-informed exposure techniques to reward systems that they use in the classroom:

I was kind of relating it to when we look at token systems for kids and trying to be consistent with it and increasing the length of time that we’re asking them to complete a task or to do something before they get a token (Participant 4).

CBT-informed thinking strategies were also related to existing classroom practices. Specifically, participants related CBT-informed thinking strategies to problem-solving skills, “we’re always looking at the cognitive side of things, how they’re thinking, we’re working on problem-solving” (Participant 1). This participant also suggested that teachers could facilitate CBT-informed thinking strategies through journaling as it is an existing classroom practice, “giving students opportunities to jot down their thoughts...just being able to write it down and list those negative thoughts that they’re feeling” (Participant 1). Another participant described how CBT-thinking strategies connect to the “growth mindset” concept, which teachers often emphasize in the classroom:

I think teachers are doing some of that right now, they’re doing work on having a growth mindset which ties into what you’re talking about, talking about our thoughts and how powerful that they are, so I do think that is manageable and people are doing that (Participant 11).
Several participants also related CBT-informed strategies to mindfulness practices that are currently being used in the classroom environment. Participants stated, “I think some of the stuff that most of us already do in our classrooms in terms of body breaks and mindfulness practices” (Participant 2) and “we do a lot of mindfulness in our classroom and there’s also a lot of information out there on mindfulness” (Participant 3). Another participant discussed the role of teachers in facilitating relaxation strategies, “I see teaching kids breathing strategies as being something that is manageable for a teacher and very beneficial for students and I think a lot of teachers are doing that” (Participant 11).

Participants also identified that visuals are a common classroom practice that could be used to illustrate elements of CBT. Specifically, participants reflected upon the fearmometer visual from the presentation, “it’s a tangible thing that I could have up in the class” (Participant 8) and “I’m just seeing a fearmometer on the wall” (Participant 11). This participant also shared that teachers in their school are already using similar visuals in their classrooms, “we have some visuals we use, some teachers are really good with using breaker system to talk about how full is the child’s beaker or how they’re feeling on a feeling thermometer (Participant 11).

Subtheme: Class-Wide Implementation

Participants indicated that teachers could implement CBT-informed strategies class-wide. Specifically, participants suggested that teachers could facilitate “whole-class lessons on dealing with anxiety” (Participant 5) and “general class strategies and discussions about what it is and how we can recognize it and what are some things that we can do about it” (Participant 4). Another participant proposed, “the teacher can talk about that and point it out as part of a regular daily practice as opposed to talking to each individual child” (Participant 11). Multiple participants outlined the benefits of implementing CBT-informed strategies with the entire class.
rather than with individual students. Specifically, one participant stated, “what’s necessary for some is good for all so while there might be one student in your class for whom doing something to help their anxiety is probably beneficial for the 29 others that are there as well” (Participant 4). Another participant shared, “I think it would be really helpful to implement that into the classroom as a whole rather than focusing directly on that one student, making it a blanket for everybody to know” (Participant 6).

**Theme: Barriers to Implementing CBT-Informed Strategies**

This theme occurred consistently across participants and focus group sessions. Within this theme, participants discussed what they perceived as potential barriers to implementing CBT-informed strategies in the classroom. Participants frequently identified several barriers to implementing CBT-informed strategies in the classroom including time constraints; lack of education, resources and support; variability in practice; complexity of anxiety presentation; role boundaries; and the overburdened mental health system. This theme was somewhat expected as participants were prompted to consider barriers to implementing CBT-informed thinking and behavioural strategies with students in their classrooms.

**Subtheme: Time Constraints**

Participants indicated that time constraints are a potential barrier to implementing CBT-informed strategies in the classroom. Several participants recognized the time required to implement these strategies, “it really does take time to do” (Participant 3) and “do you have the time to talk them through some of those behavioural strategies” (Participant 11). Participants also considered time constraints with regards to the number of students in a typical classroom, “it’s just hard when there are so many other kids in the class as well and to have the time to give them” (Participant 5) and “you also have 32 kids in that classroom that you’re trying to monitor
and touch and feel and check-in on and there is just so much going on in the rooms already” (Participant 10). As a result, participants also highlighted time-related barriers to working one-on-one with students and using individualized strategies from CBT, “to do that for each kid who is at a different level, it’s really just the time and the commitment” (Participant 7).

Participants expressed challenges in balancing the time that it would take to facilitate CBT-informed strategies with the needs of the other students, “I would say that one of the barriers would be some of the other struggles that the students are facing” (Participant 6). Participants implied that there is insufficient time to meet the mental health demands and behavioural concerns of all students. For example, one participant shared, “you’re basically putting out a hot fire almost minimizing the fire so you can run to the next” (Participant 10). Similarly, another participant stated:

...it’s completely a case of the squeaky wheel gets the grease, we are just running with our walkie talkies to wherever we have to go, figuring out what is causing anxiety what is causing this behaviour, it’s like okay you’re okay for now, well I have to go because I have so many things that need to happen (Participant 11).

Participants also communicated time concerns about implementing CBT-informed strategies along with meeting existing expectations. Specifically, one participant shared, “you have to figure out how that’s going to work with everything else” (Participant 7). Similarly, another participant explained:

I think as teachers in the classroom, the expectations and the curriculum don’t always allow for that...in our education system we are locked into having specific subjects that we’re having to cover and specific things in the curriculum and expectations that need to be met and I think our students are feeling that because we as educators would probably prefer to do a lot of other things with them that we think would be more helpful for them and provide them with those life skills and those of us that are interested and are incorporating that within our curriculum but it is very difficult to do that in a way that in a relaxing environment because of all of the excess pressure and all of the things that we need to be covering and all that’s required of us as teachers (Participant 3).

**Subtheme: Lack of Education, Resources and Support**
Participants identified that lack of education, resources and support for classroom teachers pose barriers to implementing CBT-informed strategies in the classroom. With regards to education, participants explained that teachers do not receive adequate education about mental health and anxiety disorders specifically, “in terms of legitimate education for us, I don’t think there’s a lot” (Participant 8). Participants also indicated that additional education and training would be necessary in order for teachers to effectively carry out CBT-informed strategies with their students. For example, one participant shared:

I don’t think it’s a matter of if these strategies are helpful because I totally think they are and being familiar with some of these strategies I can see how I’d apply them in the classroom but I can’t say that the teacher population at large would know how nor do I think that just by reading a book or pamphlet would they even understand the strategies themselves (Participant 2).

Participants also expressed that teachers have limited resources that are tailored towards identifying and supporting students with anxiety in the classroom. Participants stated, “I don’t really know that I’ve been given that many resources to be honest” (Participant 5) and “I would say we have very few resources to deal with anxiety in the building” (Participant 1). When prompted to consider whether teachers have the potential to implement CBT-informed strategies in the classroom, participants explained that teachers are not equipped with the necessary resources, “you don't have the resources, you don't have the stuff to do it with unfortunately” (Participant 10).

Still, participants seemed open to using CBT-informed strategies with their students upon receiving the appropriate resources. Participants expressed, “if we just had a resource that was something that you could pull on and quick little activities that you can do with your students” (Participant 7) and “if things are given to [teachers] they are so happy to have resources and to have some answers for where to go and what to do when they suspect that they have anxious kids
in their classrooms” (Participant 11). When referring to anxiety resources for educators, another participant explained that “teachers just want to have it...and are thrilled to do it as long as they have it” (Participant 10).

Participants also identified that teachers lack support, which may limit their ability to implement CBT-informed strategies in the classroom. Primarily, participants discussed limited support from school staff such as learning support teachers, educational assistants and social workers. For example, one participant shared:

I know that there are learning support teachers who aren’t really seen in the building and so it’s pretty easy as an educator to feel like you’re stuck in a room with 20 anxious kids and you don’t have the understanding of their development (Participant 7).

Similarly, participants noted staffing and funding issues, “we’re struggling day-to-day in our buildings to fill unfilled jobs” (Participant 11) and “there’s a lot of cutbacks to things like social workers and people with actual experience” (Participant 8). As a result, participants explained that classroom teachers face an increasing responsibility to support the mental health needs of students, “it’s really hard to get the support of what am I really supposed to be doing to help this student, a lot of stuff we end up having to create on our own” (Participant 7). Participants also discussed that when support is provided, it tends to be reactive, rather than supporting students through mental health promotion and prevention. For example, one participant shared, “it would be nice if educators could get that support for the students prior to it getting to be worst case scenario” (Participant 6).

Subtheme: Variability in Practice

Participants considered variability in practice as a potential barrier to implementing CBT-informed strategies in the classroom. Primarily, participants discussed the need for teachers to be consistent if they were to use CBT-informed strategies with their students. For example, when referring to exposure, one participant stated:
...you want to be consistent with...just like anything, if a student thinks that we’re not following through on something then they might feel well then why try because I forgot about it the other day and such so it’s just that being able to manage it depending on what the scale is that we’re working towards exposing them to (Participant 4).

Participants also discussed variability in practice between teachers and how it may hinder the effectiveness of using CBT-informed strategies in the classroom. For example, one participant expressed, “I can guarantee you room to room that it’s going to be very different” (Participant 7). Another participant explained:

...if you tried to carry it on throughout the year or there’s a change in teachers or the next year their teacher doesn’t do it you would be abandoning them without being able to help them fully through the process (Participant 5).

Participants implied that variability in practice between teachers may result from inconsistent education and training. When referring to mental health related professional development opportunities for teachers, one participant stated, “they are available to all teachers but a lot of teachers aren’t seeking them out and getting those experiences” (Participant 11). Similarly, participants suggested that not all classroom teachers are prepared to support students with anxiety in their classrooms, “I think if you ask the average teacher I would say they probably don’t feel ready” (Participant 1). Another participant recommended mandatory mental health education for all classroom teachers:

I do wish there was some type of mandated professional development about mental health in the classroom and I also wish that teachers college and education that I had gotten when I was in school had some type of mandatory mental health course because all of the things that I know and that my colleagues also know came from opportunities that we had to seek out ourselves (Participant 2).

Participants also expressed challenges associated with variability in practice between students’ school and home environments. Primarily, participants stressed the importance of continuity of care between teachers and students’ parents and families, “I’d want to see some type of continuity perhaps between what is being done in the classroom and what the child is
working on outside of the classroom” (Participant 2). Participants expressed that continuity of care can be difficult when parents and families lack information about CBT-informed strategies. For example, when referring to supporting a student through exposure to a class presentation, one participant shared:

I have parents who will call me and say nope they’re doing it by themselves in front of you, they don’t want to do it, that’s not going to help, they’ve told you they have anxiety...so it’s just making sure that the parents understand that it really is going to be beneficial for them and we want to work together (Participant 1).

Participants also indicated that mental illness among parents and families may pose a barrier to continuity of care in the home, “the parents don’t know how to handle it, the parents are dealing with their own mental illness a lot of the time and so it’s just a cycle” (Participant 7).

**Subtheme: Complexity of Anxiety Presentation**

Participants expressed that complexity of anxiety presentation may pose a barrier to identifying students with anxiety and applying CBT-informed strategies in the classroom. Participants acknowledged that anxiety presentation is unique to each student, “it manifests in many different ways” (Participant 8), “it shows up in so many different ways” (Participant 7) and “it manifested differently within all of the students” (Participant 2). Participants conveyed that anxiety seems to present on a spectrum, “I think similar to Autism, I almost find anxiety to be a spectrum” (Participant 1). Additionally, participants acknowledged that there are various types of anxiety diagnoses, “they all had quite a range of different types” (Participant 3). Participants also highlighted the importance of distinguishing between normal and problematic levels of anxiety, “it’s going to be really tough coming into September, students saying ‘I have anxiety’ and just getting them to understand the difference between...being anxious and having generalized anxiety” (Participant 1).
Participants indicated that the complexity of anxiety presentation may hinder teachers’ ability to accurately identify students with anxiety. For example, one participant shared:

...just because a student is said to have anxiety doesn’t mean that I can identify it just by knowing how they are going to react or signs because every single student that I have encountered with anxiety is going to show different signs (Participant 1).

As a result, participants admitted that students with anxiety are often overlooked. Participants explained, “often the students that we know of could very well have anxiety disorders but we don’t necessarily know that they do” (Participant 11), “I definitely feel like there were several students that had it and no one said anything or no one knew” (Participant 5), and “I wasn’t thinking in terms of anxiety” (Participant 4). Participants also shared that identification and intervention can be difficult when teachers are not provided with sufficient information about the student, “a lot of times you aren’t told ahead of time and you have to figure it out yourself...you’re trying to learn it as you go” (Participant 5).

**Subtheme: Role Boundaries**

Participants expressed concerns about their role boundaries as classroom teachers which poses a barrier to utilizing CBT-informed strategies in the classroom. Primarily, several participants identified concerns about taking on the role of other professionals without the appropriate qualifications. Participants stated, “making sure that I’m not crossing the line into a job I’m not qualified for” (Participant 8), “finding that balance between we’re not mental health professionals we’re educators” (Participant 6), and “if we ask teachers to now be cognitive behavioural therapists that is not okay” (Participant 11). Several participants seemed particularly opposed to the idea of providing a form of anxiety treatment to students, “teachers should not be the ones diagnosing or treating the anxiety” (Participant 7).

Participants indicated that it would be beneficial to have clear expectations and boundaries for their role as classroom teachers in supporting students’ mental health, “helping us
see the boundaries within which we can attack this and approach this task” (Participant 8).

Although some participants struggled with the notion of providing anxiety treatment, several participants seemed more accepting of applying CBT-informed strategies that were specifically designed for teachers, “the detecting signs of anxiety cat is something that’s within our realm” (Participant 8).

Participants were also prompted to consider what they think their role should be in supporting students with anxiety in the classroom. Several participants indicated that they perceive themselves as advocates for the mental health needs of their students, “I see my role in the classroom is as an advocate for my students” (Participant 2). Another participant highlighted their role as a caring adult, “I think that my role as a teacher is to just be a support system for those students” (Participant 1). Several participants suggested that their role is to connect students to the appropriate people and resources, “I think our role is being that liaison” (Participant 6).

*Subtheme: Overburdened Mental Health System*

Participants identified that there is an overburdened mental health system which poses a barrier to facilitating CBT-informed strategies in the classroom. Participants discussed the increasing prevalence of anxiety in their students. When referring to the prevalence of anxiety disorders in children and youth in Canada, one participant expressed, “I was surprised by the statistic that it was about 6%, that seems low, 6% of kids in a Grade 8 class would be two to three kids and that’s not the case, many are saying they have anxiety” (Participant 8). Another participant shared:

I think that initially at the beginning of my career I had just a few students with identified anxiety disorders…I started to realize that anxiety was prevalent in a lot of my students, not just specifically ones who were identified (Participant 2).
Participants discussed barriers to children and youth with anxiety accessing mental health services in the community. When referring to community-based mental health services, participants shared, “accessing them is very tricky for many families, there are giant barriers to that...people don’t necessarily have the finances or the benefits” (Participant 11) and “I’m in a low-economic school and my families can’t get psychological support, they can’t afford it, they can’t afford the therapy” (Participant 7). Participants also recognized the lengthy wait times that children and youth with anxiety may face when seeking mental health services. Participants stated, “I know that there are waitlists over a year to get into social work at my school for my students and at my own children’s schools, it’s just not feasible” (Participant 6) and “the waitlists for therapy at private practice or with community partners is just insane” (Participant 7).

Due to these proposed barriers to accessing mental health services in the community, participants explained that there is an increasing demand for schools to support the mental health needs of students. When referring to wait lists in the community, one participant shared, “they can never get in and so the parents have to rely on the schools” (Participant 7). However, participants voiced that mental health services in schools are also overwhelmed, “while we do have social workers and support counsellors in place at schools, they are in such high demand” (Participant 7) and “even our school support counsellor who is really quite exceptional is in the same boat...he can't counsel every kid with anxiety in the school” (Participant 11). As a result, participants expressed that students with less severe anxiety symptoms are not likely to receive access to school-based mental health services, “when students are in mainstream they’re not deemed ‘bad enough’...students need to be almost be the worst of the worst in order to access those services that should be available to all students” (Participant 6).
Participants also discussed the evolving mental health responsibilities of classroom teachers, “I feel like more and more the classrooms that I’ve entered I’m really there as a support for their mental health rather than to teach them the curriculum” (Participant 2) and “it’s asking us to run a full-time mental health facility while also trying to educate” (Participant 7). Several participants seemed overwhelmed by the growing expectations to support the mental health needs of their students, which may pose a barrier to teachers implementing CBT-informed strategies in the classroom. Participants shared, “we are pulled in so many directions and spread so thin that there is very limited ability in a school to support students in the way that we would all like to support them” (Participant 11) and “we work at an amazing school where the teachers give 110% but you’re going to add another sock to that pile of laundry and it might be the one that breaks” (Participant 10).

**Theme: Current Knowledge and Resources**

This theme was mentioned consistently across participants and focus group sessions. Within this theme, participants discussed the knowledge and resources that teachers currently possess to identify and support students with anxiety in the classroom. Participants frequently identified community resources, collaboration with school staff, collaboration with parents and families, professional development opportunities and knowledge of anxiety signs and symptoms. This theme was not surprising as participants were prompted to consider strategies that are available to teachers to support students with anxiety in the classroom.

**Subtheme: Community Resources**

Participants identified several community resources that are available to identify and support children and youth with anxiety. Specifically, participants acknowledged family physicians as a community resource that can diagnose anxiety disorders and provide treatment
through medication, “the family doctor” (Participant 7) and “seeking out the medical profession is I think imperative for some of these kids when the anxiety runs really deep” (Participant 9). This participant also highlighted the role that classroom teachers can play in referring parents and families to family physicians for anxiety-related support, “saying have you talked to your family doctor about these signs that you see and are they able to help support or to help refer” (Participant 9).

Participants also identified professionals in the community that may be involved in supporting students with anxiety, such as social workers and psychologists. For example, one participant stated, “extending to the larger community, to their psychologist, to their social workers” (Participant 3). This participant also suggested that classroom teachers can collaborate with community professionals to better support their students, “social workers that might come in and help with the family, if they are already working with the family, or to advise us what to do in that situation” (Participant 3). Participants also mentioned several community-based mental health services that are specific to the London region, “the Child and Youth Development Clinic that’s been really powerful for many families, we have community resources, we’ve got Vanier, we’ve got Craigwood Talk-In Clinics, there’s all sorts of community support” (Participant 11). This participant also recognized the demand for mental health services in the community and proposed a potential partnership between community-based mental health services and schools:

I think that there’s a real need in the community for support for families that are easily accessible and where better to bring those supports than to schools. I think that if we had that in schools we would have people come (Participant 11).

**Subtheme: Collaboration with School Staff**

Participants identified school staff that are involved in identifying and supporting students with anxiety. The majority of participants mentioned collaborating learning support teachers and educational assistants to identify and support students with anxiety in the classroom.
Participants shared, “reaching out to the learning support teacher is often where I would get a lot of my information and collaborating with different colleagues” (Participant 3) and “we do have a good educational assistant team” (Participant 10). Several participants also mentioned collaborating with the school principal and administration team, “I recommend next steps with the help of my principal” (Participant 8) and “if I have a student struggling with anxiety in my classroom I want to know that I have the support of my administration” (Participant 1).

Participants also referred to collaborating with mental health professionals in schools including social workers, mental health leads and counsellors, “talking to people, our social workers assigned to our schools and finding out from them what some good resources are and ideas to work with students” (Participant 4), “our system mental health lead has been a really good source of support for finding resources along with our social workers” (Participant 5) and “we do have social workers and support counsellors in place at schools” (Participant 7).

Participants recognized the benefits of collaborating with school staff to better support the mental health needs of students. For example, one participant explained:

...as educators it’s so important to understand where we’re all coming from...all that stuff is very beneficial, especially if we can do it as a staff so we all understand it and then we all take different things from it and we’re able to work collaboratively (Participant 3).

Another participant shared:

...working in collaboration with your school support team, with your learning support teacher, or if you are blessed to have a social worker that you can contact, and if you’re blessed with an educational assistant as well, if the student has an educational assistant, just all of those partners together and sharing ideas of best practices (Participant 4).

A different participant mentioned:

We have a high needs meeting that we have weekly with the learning support teachers and the school support counsellor and the administrative team and also our attendance support counsellor and we bring students who are having a hard time figuring out what is the underlying lagging skill and what it is that is causing the dysregulation that we’re
seeing at school and then we meet as a team to try to collaboratively problem-solve what the next steps might be for that child and anxiety sometimes comes up (Participant 11).

**Subtheme: Collaboration with Parents and Families**

Participants identified that collaboration with parents and families is a current resource that classroom teachers can use to identify and support students with anxiety. Within this subtheme, participants emphasized the importance of parent and family involvement and home-school connection in identifying and supporting students with anxiety, “I think families need to be involved” (Participant 7), “I rely heavily on my relationship with parents” (Participant 8), and “parent and home connection is so important” (Participant 3). Specifically, participants mentioned communication between classroom teachers and students’ parents and families, “a lot of communication with parents” (Participant 8) and “talking to families” (Participant 9). Several participants suggested that parents and families of students with anxiety can provide resources and support to classroom teachers, “parents of students who have anxiety are a really good resource” (Participant 5) and “trying to look for the support from the parents” (Participant 9). This participant also shared that parents and families can outline important background information about the student, “mom has expressed that this concern with anxiety has been going on for three years and what are you doing kind of as a school as I really do see it as a partnership” (Participant 9).

**Subtheme: Professional Development**

Participants acknowledged that there are professional development opportunities available to classroom teachers. Several participants shared that there are professional development opportunities available to classroom teachers that are related to anxiety and mental health more generally, “there is a lot of different types of professional development that kind of do cover some of it” (Participant 3) and “I know there are some resources out there, I mean today
the entire morning was all about mental health and how are we going to teach and help those kids that are coming in with those mental health issues” (Participant 1). This participant also shared:

...the board had about three weeks ago professional development on supporting anxious students in the classroom, it was a zoom meeting, it was an hour long, and these are opportunities that I think should be available...at that workshop they provided us with strategies and hand-outs just to help students in the classroom, for example one of them was just thinking strategies for helping students with anxiety (Participant 1).

Conversely, several participants shared that although there are professional development opportunities available to teachers, there is a lack of training specific to anxiety and mental health, “I definitely do think that within the school board there are opportunities, do they necessarily really pertain to and are tailored to anxiety or depression in the classroom, no” (Participant 2). Participants also mentioned that current professional development opportunities tend to focus on the social-emotional learning strand in the Ontario mathematics curriculum, “professional development days that are connected to social-emotional...constantly doing three days of math professional development’ (Participant 7) and “when we have full professional development sessions...so much of that time is allocated to math right now” (Participant 3).

Participants also explained that classroom teachers typically have to seek out professional development opportunities on their own, “a lot of us really do take our profession very seriously and seek these opportunities out because they are out there you just have to look for them” (Participant 1) and “there’s a lot of things out there but you have to actively seek them out” (Participant 7). Participants also mentioned that they seek information about anxiety online and through social media, “there’s a lot of like if you’re on Twitter and stuff, people who talk about anxiety” (Participant 8). Another participant shared:

...we’re hearing so much more in the media and in the world in general as it relates to anxiety and mental health, there’s a lot more out there for everyone to see in terms of resources from really reputable websites (Participant 4).
However, participants identified barriers to classroom teachers seeking out information and professional development opportunities independently, “I’ve been doing a lot of research on my own, and again, you can’t expect every educator to have the time, money or availability to do this” (Participant 7).

Participants also recognized that professional development is a current resource that could be used to train teachers on how to implement CBT-informed strategies in the classroom. Most participants expressed that they would require additional training in order to feel comfortable implementing CBT-informed strategies with their students, “allowing us to have the professional development” (Participant 6), “I think that’s something as educators moving forward we need training with” (Participant 7), and “I would need to make sure that I really understand it deeply to impart any of the strategies without potentially doing harm” (Participant 8). Participants provided several recommendations about the type of training that would be helpful including videos, case studies and modelling. With regards to modelling, one participant shared, “seeing that acted out so that it could be modelled and I can learn how to incorporate those strategies in my classroom, I think that would be helpful” (Participant 2). With regards to case studies, one participant explained:

I think some case studies too would also be really nice...case studies that I can relate back to my own classroom and how cognitive behavioural therapy was used in those situations and then how I can relate them back to my classroom because even though everyone is very different, everyone has similar signs and similar symptoms and similar anxiety behaviours and just seeing different case studies written out and how those teachers have dealt with it might just give me some examples of how I can bring that into my own classroom (Participant 1).

*Subtheme: Anxiety Signs and Symptoms (Avoidance, Disengagement, Emotional Dysregulation and Reassurance-Seeking)*
Participants displayed pre-existing knowledge about an array of anxiety signs and symptoms. However, participants most often identified avoidance, disengagement, emotional dysregulation and reassurance-seeking as signs and symptoms of anxiety in their students. With regards to avoidance, participants acknowledged that students with anxiety may avoid school altogether, “we have spotty attendance with a lot of our students” (Participant 7) and “even entering the classroom has been a struggle” (Participant 9). Participants also recognized that students with anxiety may avoid class presentations, “I see the kids not doing so many things in front of the classrooms” (Participant 10). Another participant shared:

I think about my own daughter who had to do a couple of presentations and was really anxiety-producing and in one of these scenarios the teacher said you can just do it after class and do your presentation for me but I think if we put that on the graph that would have been avoidance and is it going to cause her more anxiety the next time that she has to do a French presentation in front of the class (Participant 11).

This participant also explained that students with anxiety may act out in order to avoid something that is anxiety-provoking:

I also see behaviour as avoidance of something that is causing anxiety, acting out. I’m thinking of a student last year who was really anxious about all sorts of things that don’t occur to me even as being things to cause anxiety and then the focus became attention-seeking behaviour even though it was attention that was the issue that he didn’t want and it was causing the problems to begin with but it was like compulsive (Participant 11).

With regards to disengagement, participants explained that students with anxiety may shut down or withdraw from others, “her signs were kind of that shut down” (Participant 1), “shutting down” (Participant 5), and “we’ve seen complete shut-downs” (Participant 6). Participants also indicated that students with anxiety may refuse or be unable to speak, “we’ve had a little one this week he hasn’t spoken yet this week, he’ll write little notes to us and set them on the desk” (Participant 6) and “students who don’t speak up in class” (Participant 7). Additionally, participants expressed that students with anxiety may hide or seek space from others, “hiding
under desks or needing a tent to be able to go in and escape for a moment” (Participant 6), “hiding under desks” (Participant 11), and “leave an area and want that space” (Participant 8).

With regards to emotional dysregulation, many participants explained that students with anxiety may exhibit explosive or unpredictable behaviour, “I’ve had other students that go from 0 to 10 so quickly” (Participant 1), “I had one who was very explosive” (Participant 3), “escalating types of behaviours” (Participant 4), and “freaking out or like almost out of control” (Participant 5). Participants also described students with aggressive behaviour, “a lot of it we see are behavioural, there’s kicking, punching, biting, throwing of objects, smashing of windows, we’ve had to call the police often as well” (Participant 6). Participants also specified that students with anxiety may have frequent bouts of tears and heightened emotionality, “crying for not short periods of time but for long periods of time” (Participant 8) and “really emotional” (Participant 4). Participants implied that the behavioural signs and symptoms of anxiety are most apparent in the classroom setting, “what we’re dealing with is really all of that behaviour piece that comes along with it” (Participant 11). Participants also shared that self-regulation can be difficult among students with anxiety. For example, one participant shared:

...we always had to wait until he kind of came down a bit because he had to calm down in order to discuss it and be able to recognize it which is always so important because at the height of that anxiety then there’s obviously so much going on in the brain that self-regulation is so difficult (Participant 3).

With regards to reassurance-seeking, participants identified that students with anxiety may seek frequent reassurance from classroom teachers, “seeking extra attention, constant need, following you around” (Participant 7) and “one of the students that come to mind was that excessive reassurance required” (Participant 4). This participant shared an experience in which a student “came and asked for help 23 times within the span of about 45 minutes” (Participant 4). Participants also recognized that students with anxiety may seek reassurance or support from
their peers. For example, one participant explained, “she needs to use the stairs with her friend holding her to bring her down the stairs to the washroom” (Participant 1).

Discussion

The purpose of this study was to examine how teachers identify and support students with potential anxiety concerns as well as teachers’ perspectives on implementing CBT-informed strategies in the classroom. Using a qualitative research design, participants attended one of four online focus group sessions and the data was coded through the six phases of thematic analysis as outlined by Braun and Clark (2006). Three major themes were identified—opportunities to implement CBT-informed strategies, barriers to implementing CBT-informed strategies, and current knowledge and resources. Within each theme, several subthemes occurred. These findings are discussed below in relation to previous research, study limitations, implications and directions for future research.

Connection to Previous Research

There are several findings that are consistent with previous research in this area. Previous research has found that children and youth with anxiety face barriers to accessing mental health services in the community, which creates an increased demand for schools and classroom teachers to support the mental health needs of students (Georgiades et al., 2019). This is consistent with findings from the current study as participants identified several barriers to students accessing mental health services in the community, including lengthy waitlists and the financial burden for parents and families. As a result, participants explained that parents and families often turn to the schools to seek mental health support for their children.

Despite this increasing demand for mental health services in schools, participants expressed a lack of resources, education and support related to student mental health. This is
consistent with previous research that reported that 44% of educators in Ontario perceive the mental health resources and support in their schools to be inadequate (Ontario Student Trustees’ Association, 2017). Specifically, participants from the current study reported that there is a lack of resources for classroom teachers that are tailored towards identifying and supporting students with anxiety, despite a seemingly increasing prevalence of students with anxiety. Participants also expressed that there is no mandatory mental health education for teachers and limited formal training opportunities specific to anxiety. This is concerning as classroom teachers are likely taking on additional responsibilities to identify and support students with anxiety in the classroom without the appropriate education and training. As a result, students with anxiety may not be accurately identified or provided with effective evidence-based interventions.

Previous research has found that classroom teachers tend to identify students with the most severe anxiety symptoms (Headley & Campbell, 2011; Layne et al., 2006). Participants from the current study exhibited pre-existing knowledge of a wide range of anxiety signs and symptoms. However, participants explained that students with less severe anxiety symptoms often do not have access to school-based mental health services due to the high demand and lack of resources. This is concerning as it suggests that schools are not engaging in early identification and intervention for students with anxiety. This is important as anxiety disorders that are left untreated in childhood and adolescence tend to predict anxiety disorders in adulthood (Smetanin et al., 2011). As a result, more attention needs to be given to a standardized process of identification and intervention, such as tiered intervention, to ensure that schools are meeting the mental health needs of students at all levels.

Past research has also found that teachers often perceive internalizing disorders, such as anxiety, as less problematic than externalizing disorders which may lead to less identification
and service contact. This is consistent with findings from the current study as participants tended to focus on behavioural symptoms of anxiety that may be seen as disruptive in the classroom. Participants also expressed that the complexity of anxiety presentation may pose a barrier to the ability of classroom teachers to accurately identify students with anxiety. Although participants from the current study demonstrated sufficient knowledge of anxiety signs and symptoms in children, it is unclear whether this extends to all classroom teachers. As a result, it may be beneficial for classroom teachers to receive additional training about the signs and symptoms of anxiety specific to the school environment to aid in accurate identification.

Participants consistently expressed a need for professional development opportunities specific to anxiety and mental health. This expressed need is consistent with the Ontario Mental Health Strategy that aims to provide teachers with “role-specific resources, training and implementation support” (School Mental Health Ontario, 2019, p. 30). However, participants explained that professional development opportunities designed for classroom teachers tend to focus on other areas, such as mathematics. Furthermore, participants clarified that when there are mental health training opportunities available, they are not mandatory and teachers often have to seek them out on their own. Although participants in the current study claimed to actively seek out information and training related to anxiety and mental health, this is likely not true of all teachers. Thus, there is a need for role-specific professional development opportunities related to anxiety and mental health that are more accessible to classroom teachers.

Previous research has recommended increased collaboration between mental health professionals and classroom teachers to better identify and support the mental health needs of students (People for Education, 2019). Interestingly enough, participants from the current study consistently referred to collaborating with school staff such as administration, principals,
learning support teachers, educational assistants and social workers to gather information and resources related to student anxiety. Participants also mentioned collaborating with community services and professionals including family physicians and social workers. However, there was no mention of participants collaborating with school psychologists. This is consistent with previous research that has found that there is limited access to school psychologists in Ontario schools, which continues to decline (People for Education, 2019). However, access to school psychologists is important, not only for assessment, but to provide classroom teachers with mental health training and evidence-based interventions (Anderson et al., 2007).

Research has found that teachers can effectively facilitate CBT-informed programs when they are provided with the appropriate resources and training (Neil & Christensen, 2009). This is consistent with findings from the current study as participants expressed that they would require additional training in order to feel comfortable implementing CBT-informed strategies with their students. Specifically, participants identified that videos, case studies and modelling would be helpful if they were to be trained on how to use CBT-informed strategies with students in their classrooms. Participants also outlined several opportunities to implement CBT-informed strategies in the classroom such as through connection to the curriculum, scaffolded instruction and alignment with existing practices. This provides important insight about the type of professional development that teachers perceive as practical and effective when learning how to implement CBT-informed strategies, which has not yet been examined in the literature.

The literature on teacher-led mental health interventions tends to focus on relaxation and mindfulness techniques (Shelemy et al., 2020). There are also several teacher-led mindfulness programs that are local to London, Ontario such as MindUp and Making Mindfulness Matter (Western Centre for School Mental Health, 2017; Western Mary J. Wright Research and
Education Centre at Merrymount, 2019). This is consistent with findings from the current study as participants identified relaxation and mindfulness techniques as existing practices that teachers are currently implementing in the classroom to support the mental health needs of students. However, there was less evidence to suggest that teachers are currently using CBT-informed thinking and behavioural strategies in the classroom, such as exposure. Previous research with mental health professionals outlined concerns about using exposure techniques, such as misconceptions that exposure would be harmful to the child or that the child would refuse to participate (Becker et al., 2004; Deacon et al., 2013). Although this was not mentioned in the current study, it is possible that classroom teachers have hesitancies or concerns about using CBT-informed exposure techniques in the classroom. This is an important consideration to address as exposure techniques play a critical role in the effectiveness of CBT at reducing anxiety among children and youth (Ale et al., 2015; Southam-Gerow, 2019).

The Role of Teachers in Tiered Intervention

There are several components to the current study that allude to the role of teachers in tiered intervention. First, teachers’ understanding of mental health literacy is emphasized within tier one (School Mental Health Ontario, n.d.-c). Although participants in the current study did not directly reference this model, participants consistently expressed the need for mental health education and training for classroom teachers. This is crucial as classroom teachers are often the first people to observe signs that indicate that a child or youth is experiencing a mental health concern and play an important role in identification (Rodger et al., 2019; Whitley et al., 2013). There is evidence to suggest that mental health literacy courses can significantly improve teachers’ knowledge and attitudes regarding student mental health and teachers’ confidence in delivering school mental health programs (Jorm et al., 2010; Rodger et al., 2020). Therefore, it is
crucial for schools to invest in role-specific mental health literacy courses for classroom teachers in order to improve identification and referral to appropriate evidence-based interventions.

Second, the foundation of tiered intervention is universal school mental health support for all students (Ministry of Education, 2013b; School Mental Health Ontario, n.d.-c). This was mirrored by teachers in the current study as they perceived that there is an opportunity to implement CBT-informed strategies class-wide to benefit all students. Participants also identified that this could be achieved through connection to the curriculum and alignment with existing practices. This corresponds with tier one of the AIM that emphasizes the role of classroom teachers in promoting student mental health through the curriculum, teaching and learning. Conversely, participants expressed concerns about role boundaries and providing a form of mental health treatment. Weston et al. (2019) explain that teachers often experience a lack of clarity about their role in supporting the mental health needs of students which can result in role conflict, such as competing expectations and feelings of inadequacy. Therefore, there is potential for teachers to carry out tier one mental health interventions, such as CBT-informed strategies. However, it is necessary to provide teachers with clear expectations and interventions that are tailored to the classroom environment.

Partnerships between home, school and the community are another important aspect to tiered intervention (Ministry of Education, 2013b; School Mental Health Ontario, n.d.-c). This was evident in the current study as participants explained that they collaborate with parents and families, school staff and community services to share information and resources related to student mental health. Although this is essential at tier one, there was limited discussion about teachers making referrals to mental health professionals, which is necessary at tiers two and three to ensure that students with more complex needs are provided with comprehensive assessment
and intensive intervention. Thus, there seems to be a gap in which teachers may not be aware of the referral processes for students to receive more intensive mental health support in the school setting. Short et al. (2019) explains that in order for tiered systems to be effective, there must be “a clear strategy for operationalization and implementation that needs to be strategic and deliberate” (p. 69). As a result, there is a demonstrated need to provide teachers with clear referral processes to ensure that students receive appropriate mental health care through an interdisciplinary team.

Limitations

Although this study yielded important findings, there are several limitations that should be considered. First, there was a relatively small sample size. Traditionally, it is recommended for focus groups to contain 6 to 12 participants in each group (Folch-Lyon & Trost, 1981). More recently, it has been suggested that 6 to 8 participants can produce “lively” discussion and focus groups with 5 participants allows each participant to play a role (Crang & Cook, 2007; Wibeck et al., 2007). With regards to the number of focus group sessions, it is recommended to conduct at least two focus group sessions with different participants or until data saturation is achieved, meaning that “there are no new emerging ideas in the data” (Hancock et al., 2016, p. 2125).

The current study aimed to conduct 2 to 4 focus group sessions with 5 to 8 participants in each group. However, it proved to be difficult to recruit participants. For example, several participants expressed an interest in the study but were unavailable to attend a focus group session despite being provided with various dates and time slots. It is likely that the COVID-19 pandemic played a role in participant recruitment as many classroom teachers were experiencing changes in classrooms or were in the midst of shifting to online learning. As a result, there were a total of 11 participants and 4 focus group sessions with 2 to 4 participants in each group. Still,
participants in all four focus group sessions engaged in rich discussion and data saturation was achieved. There is evidence to suggest that “mini” focus groups are feasible (Onwuegbuzie et al., 2009). However, it would have been preferable to have a larger sample size to gather more perspectives and improve generalizability.

Second, it is possible that the COVID-19 pandemic may have skewed participant responses. For example, participants expressed staffing and funding issues. However, it is unknown whether these issues were existing or resulted from the pandemic. Third, all participants identified as female. However, this is somewhat consistent with the demographics of teachers in Canada. Statistics Canada (2017) reports that teaching continues to be a “profession dominated by women” with approximately 84% of elementary school teachers identifying as women. Still, it would have been interesting to consider the perspectives of male teachers, especially as previous research has found gender differences in teachers’ use of anxiety management strategies (Allen & Lerman, 2018). Fourth, there are inherent sampling biases in those that choose to participate in research. Within the current study, it was apparent that participants actively sought out information and training opportunities related to mental health. Additionally, several participants from the current study indicated that they had experience in a special education role. As a result, their perspectives may not have been representative of the wider teacher population.

Implications and Future Directions

The findings from the current study present important implications for practice and directions for future research. Primarily, the results from this study can be used to inform the development of CBT-informed programs for teachers that are both practical and effective in the classroom environment. Specifically, teachers perceived opportunities for CBT-informed
strategies in the classroom that connect to the curriculum and align with existing practices. Additionally, teachers identified barriers to implementing CBT-informed strategies such as time constraints and role boundaries. Therefore, it may be helpful for CBT-informed programs to be developed that are role-specific and relate to what teachers are doing already. Furthermore, these suggestions may promote the uptake of CBT-informed programs for teachers.

This study confirms previous findings that teachers in Ontario require additional training and support to meet the increasing demands associated with supporting the mental health needs of their students. Teachers from the current study expressed that there is a lack of formal education and training opportunities related to anxiety. As a result, teachers in Ontario may not be accurately identifying students with anxiety and implementing evidence-based interventions in the classroom. Participants also expressed concerns about variability in practice with implementing CBT-informed strategies in the classroom without mandatory school-wide training. Participants explained that videos, case studies and modeling would be helpful if they were to be trained on how to implement CBT-informed strategies in the classroom. Thus, the findings from this study could be used to inform professional development programs for teachers that are specific to anxiety and CBT in order to improve identification and access to evidence-based intervention.

Teachers in the current study displayed prior knowledge of anxiety signs and symptoms. However, participants seemed to be less aware of how to support students with anxiety and make appropriate referrals within the school system. This implies that teachers in Ontario are not following tiered intervention or any standardized process of identification and intervention to support students’ mental health needs. This is concerning as mild mental health conditions that are left untreated in childhood tend to predict negative life outcomes in adulthood such as
attempted suicide, hospitalization and work disability which pose significant costs to society (Kessler et al., 2003; Smetanin et al., 2011). Therefore, efforts need to be made to make tiered intervention more visible and accessible to classroom teachers in order to improve mental health screening, identification and intervention in the school setting.

The current study also poses important directions for future research. First, participants from the current study explained that classroom teachers often collaborate with learning support teachers, educational assistants and the administration team to seek information and resources about childhood anxiety. Conversely, there was no mention of classroom teachers working alongside school psychologists. As a result, it would be worthwhile to examine perspectives from different types of school staff about utilizing CBT-informed strategies and how potential anxiety concerns are identified and supported in the school setting. Second, participants expressed that there is a lack of formal education and training opportunities for teachers related to mental health. However, teachers from the current study had an average of around 14 years of teaching experience. Therefore, it would be interesting to conduct research with current teacher candidates or recent graduates to examine whether mental health education and training in teacher’s college has improved. Lastly, it would be valuable to build upon the current study using a different methodology, such as observation or teacher responses to case studies. This would provide greater insight about the identification and intervention strategies that teachers use in different scenarios within the classroom environment.

**Conclusion**

Schools play an important role in addressing the barriers that children and youth with anxiety may face when seeking mental health services in the community. Schools in Ontario maintain a tiered approach to supporting the mental health needs of students, a systematic
process in which school staff can work as an interdisciplinary team to screen, identify, assess and provide intervention for students with varying levels of mental health concerns. Specifically, anxiety disorders are the most common mental illness among children and youth which can negatively impact school success and pose significant costs to society. Fortunately, CBT is widely recognized as an effective evidence-based treatment for childhood anxiety. However, limited research has examined teachers’ perspectives and effectiveness to implementing CBT-informed strategies in the classroom.

The current study demonstrated that due to an overburdened mental health system, teachers in Ontario are facing increased demands to support the mental health needs of students often without appropriate resources and training. Participants acknowledged the seemingly increasing prevalence of students with anxiety and expressed the need for professional development opportunities related to identifying and supporting students with anxiety in the classroom. Participants described several recommendations for the type of training that would be helpful, which could be used to inform professional development programs for teachers. Participants also shared their perspectives on opportunities and barriers to implementing CBT-informed strategies in the classroom. These insights could be used to create CBT-informed programs for teachers that are both practical and effective in the classroom setting. Throughout the study, participants seemed to lack awareness about how to make appropriate referrals and provide evidence-based interventions within the school system. As a result, there is a need to make tiered approaches more accessible to classroom teachers to improve identification and intervention among students with potential mental health concerns.
References


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Appendix A

Resource Booklet

ANXIETY RESOURCE BOOKLET FOR TEACHERS
Exploring Teachers’ Perspectives on Child Anxiety:
Opportunities to Promote Anxiety Management Skills
in the Classroom

Dr. Colin King and Sydney Coleman
TABLE OF CONTENTS

School Mental Health Ontario Resources ........... 3
  Realistic Thinking and Acting ................... 44
  Mood Diary ........................................ 6
  2-Minute Mindfulness ................................. 8
  Tense and Relax ................................... 10
  Deep Belly Breathing ................................. 12
  Illusions ............................................. 14

Anxiety Canada Resources .......................... 16
  Chester the Cat ...................................... 17
  How Do You Feel Anxiety in Your Body? ........ 18
  STOP Plan ........................................... 19
  Worry Diary ......................................... 20
  Realistic Thinking Form ............................ 21
  Challenge Negative Thinking ..................... 23
  Fear Ladder ......................................... 24
  Hopping Down the Worry Path .................... 26

Additional Resources ................................. 28
SCHOOL MENTAL HEALTH ONTARIO

Everyday Mental Health Classroom Resource

1. Realistic Thinking and Acting
2. Mood Diary
3. 2-Minute Mindfulness
4. Tense and Relax
5. Deep Belly Breathing
6. Illusions

Additional Resources:
https://smh-assist.ca/semhc/
**REASONABLE THINKING AND FEELING**

**Purpose**

Intermediate students can start to find reasonable thinking and feelings can lead to:

- Students can generate and record problem situations on cards.
- Give students a chance to work in pairs or small groups to complete the worksheet.
- Use a THINK- FEEL- ACT worksheet to highlight common negative thoughts and how these can lead to negative emotions.
- Emphasize that when we make negative assumptions, it makes us think negative thoughts and feel.

### Instructions

1. Begin with an example to illustrate how easy it is to misinterpret the emotions and behaviors of others.

### Time Required

10 minutes to introduce; 15-20 minutes for the activity.

### Division

- Immediate

### Materials

- Blank THINK- FEEL- ACT worksheets
- Set of scenarios illustrating behaviors that are easily misinterpreted

---

**Emotion Identification Skills**

---

---

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<table>
<thead>
<tr>
<th>References</th>
<th>Evidence</th>
<th>Resources</th>
</tr>
</thead>
</table>
MOOD DIARY

Emotion Identification Skills

Materials

- Materials
- Time Required

Objective

- Help students recognize feelings and become aware of their resulting emotions.
- Understanding the connection between thoughts and feelings is a powerful skill to develop. This activity will

Instructions

1. Discuss what the function of a mood diary is to learn about yourself and to help notice patterns of thoughts

2. Help students recognize feelings and become aware of their resulting emotions.

3. Afterward, ask students to sketch how they would like to keep a mood journal. Then be sure to schedule this

Combining all of these elements to see which one students like best


- Drawing an image that symbolizes their mood in the moment (this can be a small symbolic or an emotional

- Expressing ideas on how students might document these emotions. For example:

- Journal Another day, or emotion vocabulary

- Time Required

- All
<table>
<thead>
<tr>
<th>Emotion Identification Skills</th>
</tr>
</thead>
</table>

**References**


**Evidence**

- All students demonstrate understanding of thoughts that occur in both positive and negative emotions.

**Adaptation**

- Provide visual aids and concrete examples to help students understand the concepts.

**Resources**

- "Do you feel me? Feeling words game" (Short video of children describing a time when they felt deeply.)

**Supplementary**

- Development of emotion recognition skills.
2-Minute Mindfulness

NOTE: Mindfulness is for everyone and might trigger certain students. Know student needs and be prepared to offer an alternative.

Consider incorporating mindfulness practices with various academic disciplines during daily school routines.

This can be done at school-wide level during morning announcements or in a class.

Preparation

Consider using webcasts to promote calming techniques (e.g., calm.com).

Supplementary resources

Posters self-reflection questions. See suggestions for some ideas.

Encourage students to tune into their breathing, do a body scan activity, or engage in a mindfulness practice each day.

Have a mindful message every day, during morning announcements or during transition times. For example:

Mindful meditation/relaxation exercises can be found on the web, such as:

10 minutes (or) 2 minutes during morning announcements/teacher announcements.

Division

All

Purpose

Paying attention to thoughts and feelings without judgment leads students that there is no right or wrong way to think or feel in a given moment. When students practice mindfulness, it allows them to be aware of what is happening, moment to moment.

78
<table>
<thead>
<tr>
<th>Evidence</th>
<th>References</th>
</tr>
</thead>
</table>
# Tense and Relax

**Purpose:** To have students understand how different body parts feel when tense, and when tense, to develop the skill to notice how their bodies feels in both instances and to learn how to relax tensions and to self-regulate.

<table>
<thead>
<tr>
<th><strong>Steps</strong></th>
<th><strong>Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold this for the count of 1-2-3</td>
<td>FeedMind</td>
</tr>
<tr>
<td>Push your feet down into the floor (as if you were sailing into mud)</td>
<td></td>
</tr>
<tr>
<td>Hold this for the count of 1-2-3</td>
<td></td>
</tr>
<tr>
<td>Square your shoulders in as if you were trying to squeeze through a fence</td>
<td></td>
</tr>
<tr>
<td>Hold this for the count of 1-2-3</td>
<td></td>
</tr>
<tr>
<td>Square your hands together like fists (as if you were squeezing lemons)</td>
<td></td>
</tr>
<tr>
<td>Hold this for the count of 1-2-3</td>
<td></td>
</tr>
<tr>
<td>Square your shoulders away from the count of 1-2-3</td>
<td></td>
</tr>
<tr>
<td>Push your shoulders up to your ears (as if you were hiding inside a turtle shell)</td>
<td>chest and back</td>
</tr>
</tbody>
</table>

**Education:** Help students notice how they feel when they tense their muscles, and when they relax them.

**Materials:**
-วด

**Time:** 5-10 minutes

**Division:** All
Deep Belly Breathing

Instructions

- Close your eyes if you choose. 
- Place your hands on your stomach. 
- Inhale through your nose, feeling your abdomen rise. 
- Hold your breath for five seconds. 
- Exhale slowly through your mouth, feeling your abdomen fall. 
- Repeat this cycle five times. 

Materials

- Time required: 10-15 minutes 
- Division: All

Purpose

- To help students develop a deeper mind/body connection by practicing deep breathing to support self-regulation, awareness of emotions, and resilience.

Coping & Stress Management
**Coping & Stress Management**

**Evidence**

- Education should feel comfortable seeking additional resources to facilitate this exercise.
- Education should be modeling and actively participating in the practice.
- In a moment and get ready for participation in the practice.
- Be sure that the students don’t take the practice too slowly. If you don’t, you’re building a moment in the coping skill folder.
- Additional activities may be added for certain students. It may be necessary to propose a different strategy in the coping skills folder.
- Consider addressing music. Perhaps play this with students the day before. During students may find it

---

**References**

- Groves, J., & Moore, L. (2013). The effectiveness of the learning to
<table>
<thead>
<tr>
<th>Purpose</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching the illusion can be helpful. This activity also inspires relaxation and analytical thinking and learning.</td>
<td></td>
</tr>
<tr>
<td>Materials</td>
<td>Several examples of illusions to try over time (shown on Smart Board or in printed format).</td>
</tr>
<tr>
<td>Time Required</td>
<td>It may take 15-20 minutes to set up for this activity. By this point, the first time it is used, afterwards, it could be introduced</td>
</tr>
<tr>
<td>Description</td>
<td>Find an image that has some of illusion (see examples provided). Ask the class what they see. If students have difficulty seeing the illusion, give them two choices to select from. You may wish to have a discussion.</td>
</tr>
<tr>
<td>Instructions</td>
<td>The important message is that both groups are right... It simply depends on the perception. Further discussion can introduce other different lenses or biases in situations (that are conscious or not) and trying to understand one another, even if we have conflicting views.</td>
</tr>
<tr>
<td>Resources</td>
<td>N/A</td>
</tr>
<tr>
<td>Preparation</td>
<td>Resources</td>
</tr>
<tr>
<td>Expectations</td>
<td>N/A</td>
</tr>
<tr>
<td>Notes</td>
<td>N/A</td>
</tr>
<tr>
<td>Creation of illusion (simple and complex) and conflict sometimes stem from differences in perception. Illusion can be helpful. This activity also inspires relaxation and analytical thinking and learning.</td>
<td></td>
</tr>
</tbody>
</table>

**ILLUSIONS**

Positive Motivation Skills
<table>
<thead>
<tr>
<th>Evidence</th>
</tr>
</thead>
</table>


References

ANXIETY CANADA

Educator Resources

1. Chester the Cat
2. How Do You Feel Anxiety in Your Body?
3. STOP Plan
4. Worry Diary
5. Realistic Thinking Form
6. Challenge Negative Thinking
7. Fear Ladder
8. Hopping Down the Worry Path

Additional Resources:
https://www.anxietycanada.com/resources/educator-resources/

https://www.anxietycanada.com/free-downloadable-pdf-resources/
Chester the Cat feels anxious!
How does Chester feel anxiety in his body?

- Headache
- Face goes red
- Lump in throat
- Big eyes
- Can't talk
- Clenched fist
- Butterflies in stomach, or sore tummy
- Cold hands and feet
- Shaking legs
2.

How do YOU feel anxiety in your body?
3.

This STOP Plan is for:

- Scared?
- Thoughts?
- Other helpful thoughts?
- Praise and Plan!

<table>
<thead>
<tr>
<th>Scared?</th>
<th>Thoughts?</th>
<th>Other helpful Thoughts?</th>
<th>Praise and Plan!</th>
</tr>
</thead>
<tbody>
<tr>
<td>What's going on in your body?</td>
<td>What are you thinking?</td>
<td>What is something else you can think?</td>
<td>What is something nice you can say to yourself? What can you do next time?</td>
</tr>
</tbody>
</table>

www.anxietycanada.com
<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Situation</th>
<th>Worry (E.g., What f...)</th>
<th>Anxiety Rating (0 = none, 10 = extreme)</th>
</tr>
</thead>
</table>

© Anxiety Canada
<table>
<thead>
<tr>
<th>Feeling</th>
<th>Anxious Thoughts</th>
<th>Realistic Thoughts</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Feeling</td>
<td>Realistic Thoughts</td>
<td>Anxious Thoughts</td>
<td>Intense Emotion</td>
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</tbody>
</table>

**REALISTIC THINKING FORM**
6.

Anxiety
Canada

CHALLENGE NEGATIVE THINKING

Questions to ask yourself to help challenge your negative thoughts or self-talk:

- Am I falling into a thinking trap (e.g., catastrophizing or overestimating danger)?
- What is the evidence that this thought is true? What is the evidence that this thought is not true?
- Have I confused a thought with a fact?
- What would I tell a friend if he/she had the same thought?
- What would a friend say about my thought?
- Am I 100% sure that ________ will happen?
- How many times has ________ happened before?
- Is ________ so important that my future depends on it?
- What is the worst that could happen?
- If it did happen, what could I do to cope with or handle it?
- Is my judgment based on the way I feel instead of facts?
- Am I confusing "possibility" with "certainty"? It may be possible, but is it likely?
- Is this a hassle or a horror?
7.

<table>
<thead>
<tr>
<th>STEP</th>
<th>Description</th>
<th>FEAR RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Use toilet at mall</td>
<td>10+/10</td>
</tr>
<tr>
<td>12</td>
<td>Use hands to open and close stall door</td>
<td>10/10</td>
</tr>
<tr>
<td>11</td>
<td>Touch counter and taps in mall bathroom</td>
<td>9/10</td>
</tr>
<tr>
<td>10</td>
<td>Touch knob on mall bathroom door</td>
<td>9/10</td>
</tr>
<tr>
<td>9</td>
<td>Touch garbage can in the mall</td>
<td>8/10</td>
</tr>
<tr>
<td>8</td>
<td>Use public phone at mall</td>
<td>8/10</td>
</tr>
<tr>
<td>7</td>
<td>Use hands to push open doors to mall entrance</td>
<td>7/10</td>
</tr>
<tr>
<td>6</td>
<td>Touch table in the food court</td>
<td>7/10</td>
</tr>
<tr>
<td>5</td>
<td>Sit on bench at mall and touch bench with hands</td>
<td>6/10</td>
</tr>
<tr>
<td>4</td>
<td>Touch railing at mall</td>
<td>6/10</td>
</tr>
<tr>
<td>3</td>
<td>Touch items in a store</td>
<td>5/10</td>
</tr>
<tr>
<td>2</td>
<td>Sit on bench at mall</td>
<td>4/10</td>
</tr>
<tr>
<td>1</td>
<td>Walk around public places, such as the mall</td>
<td>2/10</td>
</tr>
</tbody>
</table>
**Fear Ladder**

*What is my goal?*

<table>
<thead>
<tr>
<th>STEP</th>
<th>FEAR RATING</th>
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</tbody>
</table>

© Anxiety Canada
Step 1: Pretend you are Buster the Bunny. You are a hungry bunny. Every time you face something scary, you move one step closer to the carrot garden.

Step 2: Take small steps here I go! I will get to the end. I will just keep moving forward.

Step 3: Hop down the worry path.
Notes about Activity:

Important:

- Read through Helping Your Child Face Fears: Exposure guidelines for instructions on how to do this activity (as well as examples of Fear Ladders for different fears/goals)
- This activity is best done after your child is familiar with anxiety, can recognize his symptoms, and has learned how to use the Fear Thermometer.

Goals of this Activity:

- To slowly introduce to young children the idea of taking small steps towards goals
- To track progress and build confidence through success
- To give opportunities for praise and rewards!

Hint: Make sure the steps are not too far apart! Remember, you can create several new "Worry Paths" and build on smaller goals!

For example:

Goal = *Sit on the edge of pool next to mom* (working towards larger goal of overcoming fear of water/swimming)

- **Step 1.** Hold mom's hand and stand 5 feet away from pool
- **Step 2.** Hold mom's hand and stand 2 feet away from pool
- **Step 3.** Sit beside mom right next to pool, feet not touching water
- **Step 4.** Sit beside mom right next to pool, feet touching water
ADDITIONAL RESOURCES

BOOKS FOR KIDS
Help Your Dragon Deal With Anxiety - Steve Herman
Whimsy's Heavy Things Hardcover – Julie Kraulis
What to Do When You Worry Too Much: A Kid's Guide to Overcoming Anxiety - Dawn Huebner
Outsmarting Worry: An Older Kid's Guide to Managing Anxiety - Dawn Huebner
Don't Feed The WorryBug - Andi Green
Sam's Big Secret - Stephanie Margolese, Ph.D.
Your Fantastic Elastic Brain: Stretch It, Shape It – JoAnn Deak & Sarah Ponce

BOOKS FOR PARENTS
Freeing Your Child from Anxiety – Tamar Chansky, Ph.D.
Helping Your Anxious Child: A Step-by-Step Guide for Parents – Ronald Rapee PhD
Anxious Kids, Anxious Parents – Reid Wilson, Ph.D. & Lynn Lyons
Keys to Parenting Your Anxious Child Paperback – Katharina Manassiss
Drop The Worry Ball - Alex Russell and Tim Falcone

WEBSITES
https://psychologyfoundation.org/
https://childmind.org/
https://cmho.org/parent-resources/
http://worrywisekids.org/

OVERVIEW OF ANXIETY IN CHILDREN AND YOUTH
https://childmind.org/guide/anxiety-basics/

Fight, Flight, and Freeze – A Guide to Anxiety for Kids
www.youtube.com/watch?time_continue=5&v=FfSbWc3O_5M&feature=emb_title

WHERE TO LOOK FOR HELP
Find Help in Your Community: https://cmho.org/findhelp/

Kids Help Phone:
https://kidshelpphone.ca/
1-800-668-6868

London-Area Supports:
Vanier Children’s Services: https://www.vanier.com/programs-services/
519-433-0334

Craigwood Youth Services: https://www.craigwood.ca/
519-432-2623

Reach Out Crisis Service
1-866-933-2023
EMAIL SCRIPT FOR RECRUITMENT

Subject Line: Invitation to Participate in Research

Hello,

You are being invited to participate in a study that Dr. Colin King is conducting called “Exploring Teachers’ Perspectives on Child Anxiety: Opportunities to Promote Anxiety Management Skills in the Classroom.” Individuals who currently work as a classroom teacher at an elementary school in London and its surrounding counties (Elgin-Middlesex, Oxford) are eligible to participate.

Briefly, the study involves an online demographic questionnaire (5 minutes) and an online focus group (90 minutes) about child anxiety and supports in the classroom. Participants will receive a digital $15 Amazon gift card and anxiety resource booklet.

For more information about this study, or to volunteer for this study, please contact:

Sydney Coleman
Faculty of Education
Western University

Thank you,
Leesa Couper
Office Manager, Child and Youth Development Clinic

Version Date: 01/06/2020
Appendix C

Information and Consent Form

CONSENT LETTER FOR PARTICIPANTS

Project Title: Exploring Teachers’ Perspectives on Child Anxiety: Opportunities to Promote Anxiety Management Skills in the Classroom

Principal Investigator
Dr. Colin King, Ph.D., C. Psych
Associate Professor & Director, Child and Youth Development Clinic
Faculty of Education, Western University, [redacted]

Invitation to Participate
You are being invited to participate in this research study because you are a classroom teacher at an elementary school in London or its surrounding counties (Elgin-Middlesex, Oxford).

Purpose of Letter
The purpose of this letter is to provide you with the information required for you to make an informed decision regarding your participation in this study.

Purpose of Study
The purpose of this study is to explore teachers’ perspectives about identifying and supporting students with anxiety in the classroom.

Inclusion Criteria
Individuals who currently work as a classroom teacher at an elementary school in London or its surrounding counties (Elgin-Middlesex, Oxford) are eligible to participate in this study.

Study Procedures
If you agree to participate in this study, you will be asked to:
1. Complete an online demographic questionnaire on Qualtrics (5 minutes).
2. Attend a 90-minute focus group session through Zoom. Zoom is an online video conferencing software that can be downloaded to your phone or computer for free. The focus group will involve discussions about child anxiety and supports in the classroom. The focus group will be audio-recorded using a handheld voice recording device (this is mandatory). The resulting transcript will be reviewed and edited to remove all identifying information. Participants will be assigned a unique code number that will be used in place of any identifying information in the transcript and research reports.
Confidentiality
We will be collecting minimal identifying information in order to protect your privacy. We will be collecting your full name on this document for consent purposes but it will not be attached to the data. We will also be collecting your email address in order to provide you with the digital gift card and electronic resource booklet.

Confidentiality cannot be guaranteed in focus groups, but the focus group participants will be reminded of the importance of confidentiality. However, all data collected will remain confidential and accessible only to the investigators of the study.

Your survey responses will be collected anonymously through a secure online survey platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. In addition, Western’s Qualtrics server is in Ireland, where privacy standards are maintained under the European Union safe harbour framework. The data will then be exported from Qualtrics and securely stored on Western University’s server. Your survey responses will not be linked to your other data. Instead, your responses will be used to describe the characteristics of the focus group as a whole.

You may provide the researchers with consent to use deidentified quotes contained within transcripts in study dissemination. Your responses to the questionnaire and focus group questions will be transferred to an electronic database on a secure server that is only accessible by the research team at the Child and Youth Development Clinic. All information collected for the study, including the questionnaire, will be stored securely at the Child and Youth Development Clinic. The information will be retained for 7 years following study completion, at which point it will be destroyed. Representatives of the University of Western Ontario Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

Possible Risks and Harms
There are no known or anticipated risks or discomforts associated with participating in this study.

Possible Benefits
Participating in this focus group may provide insight about how other teachers identify and support children with anxiety in the classroom. Furthermore, participating in this focus group might help inform the anxiety management strategies that are available to teachers.

Voluntary Participation
Participating in this study is voluntary. You may withdraw your participation at any time without any negative consequences. However, in the event that you choose to withdraw from the focus group during or after the session, we cannot guarantee that comments made in the focus group session will be removed from researchers’ notes as it is an active discussion and we will be unable to reliably track who said each comment.
Similarly, in the event that you choose to withdraw from the demographic survey after it has been submitted, we cannot guarantee that your responses will be removed as the survey is anonymous and we will be unable to identify individual responses.

You may refuse to answer specific questions or withdraw any information that has been collected without any negative consequences. You do not waive any legal rights by signing this consent form. No new information will be collected without your permission.

You will receive a $15 digital Amazon gift card and resource booklet for participating in this study. The resource booklet will contain information about child anxiety and strategies for supporting students with anxiety in the classroom. You will receive the digital gift card and resource booklet through email even if you choose not to finish the focus group.

**Publication**
The results from this study may be published in academic journals and presented at conferences. The results from this study will be available once the study is complete (estimated completion: April 2021). If you would like to receive a summary of the results you may contact Colin King at the phone number or email address listed below in “For Additional Information.” Only information about the results of the entire study will be available, not information on individual responses.

**For Additional Information**
If you would like more information about this project, or your role in it, you may contact Sydney Coleman, Research Assistant, by phone at [insert phone number] or by email at [insert email address]. If you have any questions about your rights as a research participant or the conduct of this study, you may contact Western University’s Office of Human Research Ethics by phone at 519-661-3036 or by email at ethics@uwo.ca.

This letter is yours to keep for future reference.

Please complete the attached form and return it to the research assistant.

Sincerely,
Colin King, Ph.D., C. Psych
Project Title: Exploring Teachers’ Perspectives on Child Anxiety: Opportunities to Promote Anxiety Management Skills in the Classroom

Principal Investigator
Dr. Colin King, Ph.D., C. Psych
Associate Professor & Director, Child and Youth Development Clinic
Faculty of Education, Western University

I have read the attached Letter of Information regarding the study entitled, “Exploring Teachers’ Perspectives on Child Anxiety: Opportunities to Promote Anxiety Management Skills in the Classroom” and all questions have been answered to my satisfaction.

I consent to the use of de-identified quotes obtained during the study in the dissemination of this research.

Yes  No

Name of Participant: __________________________________________________________

Signature: __________________________________________________________________

Date: ______________________________________________________________________

Name of Witness: ______________________________________________________________

Signature: __________________________________________________________________

Date: ______________________________________________________________________

My signature means that I have explained the study to the participant named above. I have answered all questions.

Name of Researcher: __________________________________________________________

Signature: __________________________________________________________________

Date: ______________________________________________________________________
Appendix D

Qualtrics Demographic Questionnaire

Demographic Questionnaire

Q1 What is your age?
- Please Specify
- Prefer Not to Say

Q2 What is your gender?
- Male
- Female
- Prefer Not to Say

Q3 What is the highest level of education you have completed?
- High School Diploma
- College Diploma
- Bachelor's Degree
- Master's Degree
- Doctorate Degree
- Other (Please Specify)
- Prefer Not to Say

Q4 By the end of this school year, how many years have you been teaching?
- Please Specify
- Prefer Not to Say

Q5 What grade division are you qualified to teach?
- Primary/Junior
- Junior/Intermediate
- Intermediate/Senior
- Other (Please Specify)
- Prefer Not to Say

https://www.cn.qualtrics.com/Q/Editors/Blocks?SurveyId=SV_dbZMPtAlPnJMY1
Appendix E
Moderator Guide

Focus Group Moderator Guide

Welcome (2 minutes)

Hello everyone. Thank you for taking time out of your busy schedules to participate in this focus group today. My name is Dr. Colin King and I am the Director of the Child and Youth Development Clinic at Western University. This is Sydney Coleman and we are collaborating on this project for her Master’s research. The purpose of this focus group is to explore your perspectives about supporting students with anxiety in the classroom. The session will run for 90 minutes. However, we will take a 10-minute break at the 45-minute mark.

Group Guidelines (5 minutes)

Next, we will be going over some group guidelines to ensure that we have an effective discussion.

1. Only one person speaks at a time. We will be audio recording the session and creating a written transcript. Therefore, it is important that only one person speaks at a time. Additionally, to reduce background noise, we ask that you keep your audio on mute when you are not speaking.
2. Please stay on topic. We might have to redirect the discussion as we have a lot of information to cover with limited time.
3. Everyone does not need to answer every question. However, we value everyone’s opinion and hope to hear from each of you as the discussion progresses.
4. This is a confidential discussion. Therefore, we ask that you are alone and in a private space for the duration of the session. Additionally, we ask that what is said in this discussion is not repeated elsewhere. Lastly, although we will be audio recording the session for research purposes, we will be changing your names when reporting the research to protect your identity.
5. There are no right or wrong answers, just different opinions. The goal is to explore everyone’s unique perspectives. Therefore, please say what is true for you, even if you are the only one in the group who feels that way.
6. Please reserve negative comments or judgement towards others. We would like to create a respectful environment in which everyone feels comfortable contributing to the discussion.

Do you have any questions?

Overview (5 minutes)

Before we begin the discussion, I am going to give a quick presentation to provide an overview about child anxiety and strategies from Cognitive Behavioural Therapy (CBT).

Opening Question (5 minutes)

Next, I would like each of you to introduce yourself. Please tell me:
1. Your first name
2. Your favourite thing about being an educator

**Introductory Question (5 minutes)**

1. What experience do you have working with students with anxiety?

**Transition Questions (5 minutes/question)**

1. What signs might indicate that a student has anxiety within the classroom?
2. What strategies are available to teachers to support students with anxiety in the classroom?
   a. How are teachers informed about these strategies?
   b. How might teachers view these strategies as beneficial?
   c. How might teachers view these strategies as challenging?

**Key Questions (10-15 minutes/question)**

1. As a teacher, what do you think your role should be in supporting students with anxiety?
   a. Who else do you think should be involved?
2. To what extent do you feel prepared to support students with anxiety in your classroom?
3. How would you feel about using CBT-informed thinking strategies with students in your classroom?
   a. What do you perceive as potential benefits?
   b. What do you perceive as potential barriers?
4. How would you feel about using CBT-informed behavioural strategies with students in your classroom?
   a. What do you perceive as potential benefits?
   b. What do you perceive as potential barriers?
5. What kind of support would you need to feel comfortable using these strategies?

**Ending Question (10 minutes)**

1. Overall, what is your opinion about teachers using CBT-informed thinking and behavioural strategies to support students with anxiety within the classroom?

**Summary (2-3 minutes)**

(Summarize the key ideas and perspectives that emerged from the discussion).

1. How well does this capture what we discussed today?

**Closing Remarks (2 minutes)**

Thanks again for taking the time to participate in this discussion.
Appendix F

Non-Medical Research Ethics Board Approval

Date: 6 August 2020

To: Dr Colin King

Project ID: 115560

Study Title: Exploring Teachers' Perspectives on Child Anxiety: Opportunities to Promote Anxiety Management Skills in the Classroom

Short Title: Exploring Teachers’ Perspectives on Child Anxiety

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 04/Sept/2020

Date Approval Issued: 06/Aug/2020 17:59

REB Approval Expiry Date: 06/Aug/2021

Dear Dr Colin King

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Document Type</th>
<th>Document Date</th>
<th>Document Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderator Guide</td>
<td>Focus Group(s) Guide</td>
<td>24/May/2020</td>
<td></td>
</tr>
<tr>
<td>Recruitment Poster</td>
<td>Recruitment Materials</td>
<td>29/May/2020</td>
<td>1</td>
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<tr>
<td>Email Script</td>
<td>Recruitment Materials</td>
<td>01/Jun/2020</td>
<td>1</td>
</tr>
<tr>
<td>Anxiety CBT Presentation</td>
<td>Other Data Collection Instruments</td>
<td>23/Jun/2020</td>
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<tr>
<td>Online Survey</td>
<td>Online Survey</td>
<td>30/Jul/2020</td>
<td>2</td>
</tr>
<tr>
<td>Info_Consent3</td>
<td>Written Consent/Assent</td>
<td>30/Jul/2020</td>
<td>3</td>
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</tbody>
</table>

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Katelyn Harris, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).
## Appendix G

### Themes, Subthemes, Codes and Sample Extracts

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Codes</th>
<th>Sample Extract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities to Implement CBT-</td>
<td>Connection to the Curriculum</td>
<td>Curriculum</td>
<td>“…now in education we’re looking at problem-solving through all areas in the curriculum...how we can personally solve problems and understand the world around us” (Participant 1).</td>
</tr>
<tr>
<td>Informed Strategies</td>
<td></td>
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<tr>
<td>Exposure and Scaffolding</td>
<td>Collaboration with</td>
<td></td>
<td>“…it’s a stepping stone so we’re starting with something and the student can feel successful in that they’ve managed that first hurdle as it relates to their anxiety and then working towards those that cause higher levels of anxiousness” (Participant 4).</td>
</tr>
<tr>
<td></td>
<td>Students, Intentionality,</td>
<td></td>
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<tr>
<td></td>
<td>Gradual Process, Sense of</td>
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<td></td>
<td>Autonomy and Control,</td>
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<tr>
<td></td>
<td>Student Buy-In, Increased</td>
<td></td>
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<tr>
<td></td>
<td>Understanding</td>
<td></td>
<td></td>
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<tr>
<td>Aligns with Existing Practices</td>
<td>Existing Practices, Mindfulness,</td>
<td></td>
<td>“I think teachers are doing some of that right now, they’re doing work on having a growth mindset which ties into what you’re talking about, talking about our thoughts and how powerful that they are, so I do think that is manageable and people are doing that” (Participant 11).</td>
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<tr>
<td></td>
<td>Relaxation, Visuals</td>
<td></td>
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<tr>
<td>Class-Wide Implementation</td>
<td>Class-Wide</td>
<td></td>
<td>“I think it would be really helpful to implement that sort of into the classroom as a whole rather than focusing directly on that one student, I think making it like a blanket for everybody to know” (Participant 6).</td>
</tr>
<tr>
<td>Barriers to Implementing</td>
<td>Time Constraints</td>
<td>Lack of Time</td>
<td>“…it really does take time to do” (Participant 3).</td>
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<tr>
<td>CBT-Informed Strategies</td>
<td></td>
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<tr>
<td>Theme</td>
<td>Subtheme</td>
<td>Codes</td>
<td>Sample Extract</td>
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<tr>
<td>Lack of Education, Resources</td>
<td>Lack of Education, Lack of</td>
<td>…in terms of legitimate education for us, I don’t think there’s a lot” (Participant 8).</td>
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<tr>
<td>and Support</td>
<td>Resources, Lack of Support</td>
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<tr>
<td>Complexity of Anxiety</td>
<td>Complexity of the Disorder,</td>
<td>…just because a student is said to have anxiety doesn’t mean that I can identify it just by knowing how they are going to react or signs because every single student that I have encountered with anxiety is going to show different signs” (Participant 1).</td>
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<tr>
<td>Presentation</td>
<td>Anxiety as a Spectrum</td>
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<tr>
<td>Variability in Practice</td>
<td>Need for Consistency,</td>
<td>…if you tried to carry it on throughout the year or there’s a change in teachers or the next year their teacher doesn’t do it you would be abandoning them without being able to help them fully through the process” (Participant 5).</td>
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<td></td>
<td>Continuity of Care</td>
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<tr>
<td>Role Boundaries</td>
<td>Role Boundaries</td>
<td>…making sure that I’m not crossing the line into a job I’m not qualified for” (Participant 8).</td>
<td></td>
</tr>
<tr>
<td>Overburdened</td>
<td>Overburdened System,</td>
<td>“I feel like more and more the classrooms that I’ve entered I’m really there as a support for their mental health rather than to teach them the curriculum” (Participant 2).</td>
<td></td>
</tr>
<tr>
<td>Mental Health System</td>
<td>Waitlists, Demands on Schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Knowledge and Resources</td>
<td>Community Services,</td>
<td>“…the Child and Youth Development Clinic that’s been really powerful for many families, we have community resources, we’ve got Vanier, we’ve got Craigwood Talk-In Clinics, there’s all sorts of community supports” (Participant 11).</td>
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<td></td>
<td>Family Physicians</td>
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<tr>
<td>Collaboration with School</td>
<td>School Staff</td>
<td>“...working in collaboration with your school support team, with your learning support teacher, or if you are</td>
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<tr>
<td>Staff</td>
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</tr>
<tr>
<td>Theme</td>
<td>Subtheme</td>
<td>Codes</td>
<td>Sample Extract</td>
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</tr>
<tr>
<td>Collaboration with Parents and Families</td>
<td>Parents and Families</td>
<td>Professional Development, Self-Education, Social Media</td>
<td>“…trying to look for the support from the parents” (Participant 9).</td>
</tr>
<tr>
<td>Professional Development</td>
<td></td>
<td>Avoidance, Emotional Dysregulation (Crying, Emotionality, Behavioural Concerns), Disengagement (Withdrawal, Shutting Down), Reassurance-Seeking</td>
<td>“…professional development days that are connected to social-emotional...constantly doing three days of math professional development” (Participant 7).</td>
</tr>
<tr>
<td>Anxiety Signs and Symptoms</td>
<td></td>
<td></td>
<td>“…crying for not short periods of time but for long periods of time” (Participant 8)</td>
</tr>
</tbody>
</table>

blessed to have a social worker that you can contact, and if you’re blessed with an educational assistant as well, if the student has an educational assistant, just all of those partners together and sharing ideas of best practices” (Participant 4).
Curriculum Vitae

Name: Sydney Coleman

Post-secondary Education and Degrees:

Western University
London, Ontario, Canada
2019-2021 M.A. Education Studies, School and Applied Child Psychology

University of Guelph
Guelph, Ontario, Canada
2014-2018 B.A. Honours Psychology

Honours and Awards:

Canada Graduate Scholarship Master’s (CGS-M)
2020-2021

University of Guelph Dean’s Honour List
2014-2018

University of Guelph Entrance Scholarship
2014

Related Work Experience:

Research Assistant
Improving Accessibility and Application in School Psychology Lab (IAASP), Western University
2019-2021

Research Assistant
Child Development Research Unit, University of Guelph
2017-2018