Student Anxiety and Depression in Our Schools

Cindilee Hayden

SELU Research Review Journal, 1(2), 29–48.

SELU
Saskatchewan Education Leadership Unit
selu.usask.ca

SELU Research Review Journal

volume 1
issue 2
2016

selu.usask.ca

Editorial
Vicki Squires 3

Engaging the Middle Years' Male Students
Paul Strueby 5

Examining Mental Health in Schools and the Role it Plays in Supporting Students
Mark Engelhardt 17

Student Anxiety and Depression in Our Schools
Cindilee Hayden 29

Make Space for Indigeneity: Decolonizing Education
Tiffany Smith 49

First Nations Instructional Leadership for the Twenty-first Century
Rosemary Morin 61

Unpacking the Impact of School Culture: A Principal's Role in Creating and Sustaining the Culture of a School
Jamie Prokopchuk 73

How to Create a Resistance-Free Environment for Successful Distributed Leadership in Education
Ashraf Salem 83

© Saskatchewan Educational Leadership Unit Research Review Journal, 2016

Inquiries

Dr. David Burgess, Associate Dean of Research, Graduate Support and International Initiatives;
Director of Saskatchewan Educational Leadership Unit
University of Saskatchewan
28 Campus Drive
Saskatoon SK S7N 0X1
Canada

or by e-mail to selu.info@usask.ca

The *SELU Research Review Journal (SRRJ)* is a forum for graduate student research reviews capturing the state of current research in Educational Administration. Topics related to leadership, policy, and the administration of K-12 education, post-secondary education, and other educational institutions are the focus of this journal. The work published in the journal reflects graduate students' work throughout their program at the University of Saskatchewan. This *Journal* is intended to provide a resource for educational practitioners to access current and comprehensive overviews of research. The reviews presented in the *Journal* represent diverse perspectives and findings from academic research that will aid in policy development and the improvement of practice in educational institutions.

College of Education | Department of Educational Administration

selu.usask.ca

Student Anxiety and Depression in Our Schools

Cindilee Hayden

Abstract

According to numerous scholarly articles, books, and professional research, mental health issues in the schools have become more prevalent and much is being done to assist these children at becoming more successful in the classroom. Two emotional behavioural disorders that plague children are anxiety and depression. Engaging in diagnosis and assessment, examining causal factors, and planning effective intervention need to be closely investigated if children are to become successful as youth and into adulthood. Early diagnosis and intervention is key for these children to recover. School connectedness, positive peer interactions, stable home environments, effective instruction in the classroom, and compassionate leadership are all necessary when interacting and teaching these children positive behaviours. Implementing a wrap-around approach to assist children with emotional behavioural disorders is key and has proven effective in many school settings.

Keywords: anxiety disorder, depressive disorder, causal factors, prevention, assessment, treatment, intervention

Mental health issues in schools lead to negative outcomes and results because of a variety of reasons. Kauffman (2013) stated that negative outcomes can be, "[p]overty, abuse and neglect, harsh and inconsistent discipline, and a variety of factors related to family, neighbourhood, school and societal conditions" (p. 55). The impacts mental illness can have on all factors of a child's life are well documented and research supports that early intervention is best (Scharfstein, Alfano, Beidel, & Wong 2011; Ellis & Hudson, 2010; Tomb & Hunter, 2004). Causal factors of emotional behavioural disorders in children range from ineffective parenting practices (Barry, Frick, & Grafeman, 2008) to fears and anxieties of gifted learners (Lamont, 2012) to social contexts such as: infant temperament, socio-economic factors, characteristics of the neighbourhood, capacity of the extended family, and stressors that impact the family (Kauffman, 2013). There is a need for school based mental health programs and presently there are many that are being delivered in the schools. With provincial funding being an issue many of these programs are not as intensive as they should be and delivery of them is not as frequent either. Effective interventions need to be implemented early and contact with students needs to be frequent (Kauffman, 2013). Cognitive behavioural therapy (CBT) can be done at the school level and parental involvement increases the effectiveness of the intervention being used. There are a variety of intervention programs that involve the parents and brief cognitive behavioural therapy (BCBT) is effective because of the early intervention and parental involvement (Beidas, Mychailyszyn, Podell, & Kendall, 2013). In order to implement these programs at the school level, effective leadership needs to be in place to offer supports as needed. Timetabling can impact program delivery and facilitate effective teaching strategies that provide students with emotional behavioural disorders (EBD) opportunities for success. Collaboration of family, school, community, and mental health systems contributes to positive educational outcomes and proves to be more effective than a fragmented approach (Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007). Inclusive leadership practices can be instrumental in this process.

Further bridging of research needs to be done in the area of mental health in schools and further analysis into the emerging fields of school mental health (SMH), prevention, and implementation of intervention programs (Weist, Steigler, Stephan, Cox, & Vaughn, 2010). Future research into programs like the Coping Cat program that involves the parents, needs to be done as well as examining a larger sample size and facilitating booster treatment sessions (Keehn, Lincoln, Brown, & Chavira, 2013). It is necessary that further research into treatment and assessment be done in order to design individualised treatment for children with EBD (Frick, 2012). More efficient use of school time for assessment and intervention and staff training could lead to an increase in the amount of children who will be able to receive intervention programs (O'Callaghan & Cunningham, 2015). Early intervention is necessary for prevention of EBD and co-morbidity issues also need to be examined if treatment is going to be successful and accurate (Kaufmann & Landrum, 2013).

Purpose

The purpose of this study is to examine two mental health issues that are prevalent in the schools: anxiety and depression. Often when one mental health disorder is present another one is as well. This cooccurrence of disorders is referred to as comorbidity. If leaders and educators are aware of the challenges these students face, then intervention and recovery can take place.

Research Questions

The goal of this research is to examine school based mental health (SBMH) programs and what makes them successful. There are many programs in place and all are successful to some degree. The research questions I will examine are:

1. What are the most prevalent mental health disordersin school children?
2. What are the underlying correlational or causal factors of these disorders?
3. What can be done to prevent these mental health disorders?
4. What are appropriate and effective intervention strategies that can be implemented in the classroom and home of struggling students?
5. Given these findings, what are the key recommendations or strategies that we can implement to assist these students?

Significance of the Study

This research is important because of the growing need for intervention in schools. In Saskatoon Public School Division (SPSD) there are many programs in place that have been established to meet the needs of students with mental health issues (Saskatoon Public Schools, n.d.). These programs are ever evolving as new research and programming is discovered and the team of educational psychologists provide leadership for the entire school division in this area. Programs have been created to meet the needs of students from 3-22 years of age. Research will further benefit the development and evolution of these programs. Recently I have begun teaching in the Resource Room and I see the need for these programs to continue to be developed and modified to meet individual students' needs. Greene (2009) stated, "[c] hallenging behaviour occurs when the demands and expectations being placed upon a child outstrip the skills he has to respond adaptively" (p. 27). It is up to us as educators to know when we are placing too high of expectations on children and to know what to do to modify their environment or learning in order to facilitate success. Allowing them to voice their frustrations is a good starting point and that is what Green (2009) proposed in his book, *Lost at School*. There is a need for developing effective school-based mental health programs, including developing classroom management plans long before the students enter the classroom (Simonsen, Fairbanks, Briesch, Myers, & Sugai, 2008). This research

will examine: what effective collaboration looks like, what programs are in place that are successful, and what effective leadership strategies need to be implemented to make sure mental health is a priority.

This research will provide more strategies and programs that can be implemented in the schools to support school-based mental health programming. Effective ways of supporting our students without excluding them will also be examined. Researching effective programming and the impact it has on student achievement might facilitate implementation of future programs implemented in school divisions. Identifying needs in schools might also influence the ministry's decision when deciding on priorities for programs and funding allocation. School boards can also use this information when making decisions regarding how student needs will be met. This research also will outline effective, collaborative leadership practices that continue to support mental health in schools and will examine how these practices impact student achievement, well- being, and success.

Methodology

This research included a synthesis of studies that used both quantitative and qualitative measurements. ERIC (Ovid) Education Resources Information Center, Google Scholar, the Education Library, the Murray Library, and the Stewart Resources Center were used to conduct the literature searches. I also conducted online searches at the University of Saskatchewan Library to gather a variety of resources that were scholarly, peer-reviewed articles as well as books that fit with the two areas of mental health that I am researching

When researching I looked for articles in the various themes: anxiety in school aged children; depression in school aged children; causal factors of both, diagnosis and assessment; intervention and treatment; and effective leadership and teaching practices when dealing with mental health in the schools. There is a significant amount of research in the field and I had to further refine my searches to access resources that were going to be the best fit for what I was studying.

Anxiety in School Age Children

Hayden (2015) stated, "[a]ccording to numerous scholarly journal articles, books and professional research, anxiety in school age children is the number one mental health disorder in schools" (p. 2). In fact, 90% of teachers report mental health issues are their biggest concern in todays classroom (Canadian Teachers' Federation, 2012). There are a significant number of problems that have been detected as a result of untreated anxiety, ranging from decreased educational and vocational achievement, to suicide (Dadds & Roth, 2007). It is interesting to note that 12-20 % of children are affected by anxiety and yet they rarely receive appropriate or effective intervention (L. Miller, personal communication, March 29, 2015). There are several anxiety disorders and they can co-exist. According to Kearny, Pawlukewicz, and Guardino (2014) the disorders can be: "separation anxiety disorder, generalized anxiety disorder, social phobia, specific phobia, panic disorder, post-traumatic stress disorder, obsessive-compulsive disorder, and selective mutism" (p. 59). Aschenbrand and Kendall (2012) stated, " children with anxiety disorder also met criteria for attention-deficit/hyperactivity disorder (ADHD) or oppositional defiant disorder" (p. 233).

Causal Factors and Prevention

Anxiety and low self-concept can result from a lack of social competence and withdrawal that results in further isolation (Kauffman & Landrum, 2013). Biological and genetic factors also play a role (Kauffman, 1997).

Parents. Parental overrestrictiveness and parents who are socially obtuse or awkward are likely to have children whose social skills are not developed because they model social awkwardness and may not have the coping skills necessary to deal with their emotions (Kauffman et al., 2013; Kearny et al., 2014). Parents who suffer from anxiety tend to disengage from their children and their child is left to

deal with their emotions on their own (Kearny et al., 2014). Those parents who intervene too soon can also contribute to anxiety in their children (Aschenbrand & Kendall, 2012). Parents of children with anxiety disorder (PAD) and children who did not have anxiety-disorder (PNAD) were tested by listening to a taped interaction between a mother and a child. The parents were asked to press a button when they thought the mother should do what the child was asking. It was noted that PNAD took longer to respond and give in to child requests when they thought the child was anxious (Aschenbrand & Kendall, 2012). If parents are able to manage their own distress they will be better equipped to refrain from interference and avoidance (Aschenbrand & Kendall, 2012). Further research needs to be done when assessing intervention of parents with anxious child behaviour.

Peer and teacher relationships. Students who perceived themselves as less competent in the school setting, in either academics or sports, tended to exhibit anxious behaviour when transitioning from one school to the next and more specifically from elementary to junior or middle school. According to Loke and Lowe (2014), “students mentioned concerns about older students, bullies, and the development of friendships” (p. 213). As students try to make new friends in high school, the unfamiliarity of finding new peers and exposure to bullying can increase anxiety (Loke & Lowe, 2014). Students also experience anxiety when transitioning from elementary to middle and junior high school. They worry about teacher expectations and teacher-student relationships and have identified developing relationships with teachers as one of the most difficult aspects of high school (Loke & Lowe, 2014). Topping (2011) found that, “students in transition had an intense focus on interpersonal relationships, such as social networks in and out of school” (p. 218). Leyfer, Gallo, Cooper-Vince, and Pincus (2013) alluded that, by identifying risk factors such as lack of perceived control, treatment measures could be determined.

Gifted learners. According to Lamont (2012), “gifted learners report more insomnia and fear of the unknown than regular education students” (p. 271). Students who are perfectionists can also suffer from depression and anxiety. Gifted learners may also be affected by their asynchronous development, which refers to uneven levels of cognitive and social maturity. They may be able to understand difficult concepts such as death but are not ready to handle it emotionally (Lamont, 2012). Research shows gifted students exhibit fear more than their non-gifted counterparts (Derevensky & Coleman, 1989). There are many reasons why gifted learners are more anxious than their non-gifted peers.

Prevention. Since anxiety and depression can be comorbid, looking at prevention programs that target both can be more effective than looking at them separately. Dadds and Roth (2008) contended that, “waiting until children are in late childhood or adolescence may not be the most effective way to prevent internalizing disorders” (p. 321). These disorders are elevated levels of anxiety and depression. Early intervention is key to prevention. Changes in parenting style can also magnify or diminish internalizing problems in children (Dadds & Roth, 2008). Intervening when children are young will steer them to a more resilient path of development (Dadds & Roth, 2008). A program titled REACH for RESILIENCE was run with parents for six sessions over three months. These participants were parents of youth who had been recently diagnosed with anxiety. The sessions were organized in the following manner: empathic responding, encouragement, behaviour management, building self-esteem, cognitive behavioural sessions for self-talk, problem solving, and integration and review (Dadds & Roth, 2008). Parents found the program useful and enjoyed the positive approach of the sessions (Dadds & Roth, 2008). These results support the necessity for early intervention for youth with anxiety issues.

Tomb and Hunter (2004) stated, “[p]reventive intervention can reduce the number or significance of risk factors that may contribute to the onset of a disorder” (p. 89). Teaching coping skills to children as early as possible will help them deal with stress and lower anxiety (Tomb & Hunter, 2004). These preventive interventions should target various environments, such as home and school (Tomb & Hunter, 2004). Tomb and Hunter described several promising intervention models. For example, the three tiered model of preventive intervention was first outlined by a 1994 Institute of Medicine report (Tomb & Hunter, 2004). Ready…Set…R.E.L.A.X. (Allen, Klein, & Rodger, 1996) is a mental health program that can be used with an entire school and smalls groups of children. The program integrates music, self-talk, and relaxation exercises to promote positive self-esteem and promote learning. The School

Transitional Environment Project (STEP) (Felner, Favazza, Brand, Gu, & Noonan, as cited in Tomb & Hunter, 2004) creates an easier transitional environment to a new school by restructuring the role of the homeroom teacher to be one that is more supportive with a stable group of peers for homeroom classes. Prior to school start up teachers receive training on adolescent emotional and developmental issues that might arise. Tomb and Hunter (2004) outlined:

> [t]he FRIENDS for Children program (Barrett, Lowry-Webster, & Turner, as cited in Tomb & Hunter, 2004) is a 12 session cognitive-behavioural intervention based on Kendall's (1994) Coping Cat program and targets children who are at risk of anxiety disorders as well as those who may not be at risk. (p. 95)

There are ten weekly sessions for students and four evening sessions for parents. This program can be led in classrooms and improvement from pre to post self-assessment on anxiety was noted. Tomb and Hunter maintained, "[b]y adopting a prevention model, schools can increase their ability to identify and treat students and minimize or prevent the development of anxiety disorders" (p. 98). Tomb and Hunter's findings support the research of Shortt, Barrett and Fox (2001), who similarly found promising results with the use of this program.

Assessment, Treatment and Intervention

The Community Initiatives Fund (CIF) invested $3,902,490 through 213 grants in the 2011-2012 year to support community-based initiatives that help improve the health and well- being of vulnerable children, youth, and families in Saskatchewan (Saskatchewan Community Grant Programs, 2012). Health Canada also has a wealth of resources and programs to access to assist communities in developing community-based approaches to better health (Canada, n.d. Health Canada).

Children who do not exhibit appropriate behaviours can begin to improve their self- image when they are taught social interaction skills and and can interact with children who have appropriate behaviours. Kauffman and Landrum (2013) explained that:

> specific intervention strategies based on social learning principles include these: reinforcing social interaction (perhaps with praise, points, or tokens), providing peer models of social interaction, providing training (models, instruction, rehearsal, and feedback) in specific social skills, and enlisting peer confederates to initiate social interactions and reinforce appropriate social responses. (p. 288)

School. Ellis and Hudson (2010) maintained, " [r]esearch suggests that there are strong links between worry and anxiety" (p. 152). Children worry about a range of situations. They can worry about: being separated from loved ones, academic performance, social situations, teachers, and bullying (L. Miller, personal communication, March 29, 2015). Worrying about school situations can also impact attendance. Knowing that this behaviour can happen gives educators insight into how they can intervene and assist children struggling with anxiety. Students experiencing social anxiety disorder have a fear of embarrassing themselves and being negatively evaluated by others (L. Miller, personal communication, March 29, 2015). They have a tendency to try and interpret what others are thinking and avoid social situations. Students can also fear: tests, writing on the board, reading aloud, eating in public, joining a group, and initiating a conversation (L. Miller, personal communication, March 29, 2015). If educators and administrators are aware of these fears then intervention and treatment can take place.

Assessment. McLoone, Hudson, and Rapee (2006) reported, "[c]hildren who are experiencing high levels of anxiety can be identified in the school setting in several ways" (p. 225). Self-report questionnaires can be used but not in isolation. The Spence Children's Anxiety Scale (SCAS) (Spence, 1998) is one tool that can be used to measure anxiety (McLoone et al., 2006). Clinical interviews reveal what types of anxiety are present, the severity of these symptoms, and the resulting impairments (Mcloone et al., 2006). The most common interview used is the Anxiety Disorders Interview Schedule for Children (Silverman & Albano, 1996). This interview has a component for both the parent and the child. It is important to remember to keep parents informed and involved throughout this assessment process (McLoone et al., 2006).

Treatment and intervention. There are several programs that are presently available for schools. Three programs that have been evaluated in the school setting are: The Cool Kids Program (Misfud & Rapee, 2005), The FRIENDS Program (Lowry-Webster, Barrett & Dadds, 2001), and The Skills for Social and Academic Success (SSAS) Program (Fisher, Masia-Warner, & Klein, 2004). Central components to all of the Cognitive Behaviour Therapy (CBT) are cognitive restructuring and graded exposure (McLoone et al., 2006). Graded exposure is necessary to help children address their fears and realise that certain situations are not as intimidating as they thought they might be. This exposure also teaches children that they have skills to cope with situations (Mcloone et al., 2006). Rewards can be used to keep the child motivated as they develop courageous behaviour. The FRIENDS program is universal and can be implemented as part of the school curricula to an entire classroom (Barrett, Lowry-Webster, & Holmes, 1998). This approach removes the risk of stigmatization of children and incorporates peer support and modelling (McLoone et al., 2006). It is run in ten hourly sessions, once weekly and is followed up with booster sessions that are held one month and three months after completion of the program. FRIENDS focuses on peer support and learning, making more friends, and increasing social networks. This program is especially helpful for children with Social Anxiety Disorder (SAD) because these children interact less with peers, initiate fewer interactions, and receive fewer positive comments from their peers (McLoone et al., 2006; Scharfstein et al., 2011).

The Cool Kids Program is administered to small groups of children based on screening (McLoone et al., 2006). A school counsellor leads the small group through ten hourly sessions held weekly. Sessions can be held during the day or after school and there are also two parent-therapist meetings to encourage at home practice and facilitate ongoing communication (McLoone et al., 2006). The program has been run with children ages seven to sixteen and produced reduced levels of anxiety in children upon completion.

The SSAS program is designed to treat social phobia (Fisher et al., 2004). Students are selected based on self-reports and teacher recommendations and is led by a clinical psychologist. It consists of twelve, forty-five minute sessions with two individual and booster sessions. Two sessions are held for parents, two for staff, and four weekend events that involve a peer-assistant, who is a classmate that has agreed to befriend a child in the program (McLoone et al., 2006). The real life challenges that are presented in the classroom are dealt with at the school level making this an effective intervention that allows the teacher to monitor progress (McLoone et al., 2006).

Over time, anxiety symptoms can rob children of normative development and achievements. Parents vacillate between trying to help their children and becoming frustrated when their child refuses to go to school (Miller, Short, Garland, & Clark, 2010). Classroom intervention is effective because teachers see their students more frequently and can implement early intervention (Miller et al., 2010). If children are treated in their natural environment, optimal and meaningful change can take place, peer support is possible, and teachers can become familiar with effective intervention strategies (Miller et al., 2010). Miller et al., (2010) reported, "[t]aming Worry Dragons (TWD; Garland & Clark, 2000) is a locally developed CBT program for anxiety disorders that uses language, pictures, and images familiar to North American Children" (p. 434). The materials are available to schools and can be taught to entire classrooms with children ranging from seven to twelve years of age. Teachers can receive a one-day training session and the entire class completes the Multidimensional Anxiety Scale for Children (MASC) (March, Parker, Sullivan, Stallings, & Conners, 1997). This tool is a self-reporting checklist that measures physiological symptoms, worry, and inattentiveness (Miller et al., 2010). This group-based treatment teaches children to use: thought-stopping, distraction, physical exercise, changing self-talk, and exposure strategies to help them cope with and overcome their anxiety (Miller et al., 2010). The Behaviour Assessment for Children-Parent Rating Scales (BASC-PRS) (Reynolds & Kamphaus, 1992) is also easily administered and provides a measurement of parental assessment of their child's behaviour (Miller et al., 2010). Following the intervention the students complete the MASC and parents complete the post intervention BASC. In Miller et al.'s study, data analysis and results revealed symptom reduction and students reported that they liked the relaxation techniques and found at least one skill helpful in the program (Miller et al., 2010). This program was facilitated at the University of British Columbia.

Children also reported that they were less scared because they had ways to calm themselves (Miller et al., 2010). Additionally, clinicians can also give talks to teachers on anxiety and share evidence-based approaches. The family and school setting are very important in helping children manage their anxiety and these skills can be taught universally (Miller et al., 2010). In school intervention alleviates cost issues, long wait lists, and transportation barriers.

Parents. Parents need to realize that anxiety personality traits create stress and anxiety and that the goal should be to manage the trait that is causing the stress and not to try to change the child's personality (Foxman, 2004). There are certain strategies that parents can teach their child to assist them in managing their anxiety. Parents need to help their child recognise the difference between perfectionism and excellence and set realistic expectations for themselves (Foxman, 2004). Furthermore, Barrett, Rapee, Dadds and Ryan (1996) contended that children's choices of strategies for dealing with issues was highly influenced by their family dynamics and patterns of behaviour. By helping children use positive self-talk and teaching them that they cannot control other people, anxiety can be lessened. Teaching children relaxation techniques, providing them with positive feedback, and assisting them with assertiveness skills, parents can decrease the intensity of the anxiety (Foxman, 2004). Helping children realise that worry is not a good way to prepare for upcoming events, encouraging children to remove "I should" from their vocabulary, and teaching them to refrain from all or nothing thinking, will assist them in dealing with their anxiety.

Programs of intervention. Children with anxiety are more likely to have parents with a variety of disturbance and anxiety problems (Rutter et al., 1990). In Rutter et al.'s (1990) study, parents and children were presented with situations and asked how they would respond and although the parents were told they could assist their child, the final solution was the child's. The Family Enhancement of Avoidant Responses (FEAR) was used for this gathering of evidence (Barrett, Dadds, & Rapee, 1996). Families of anxious children were also involved in a comprehensive program where parents were trained in skills that would help their child manage their anxiety and avoidance as well as improve family problem solving. Kendall's (1994) Cognitive Behaviour Therapy (CBT) program provides this training. Barrett, Dadds, and Rapee (1996) concluded that, "Kendall's (1994) controlled treatment study showed that 64% of children who had received CBT intervention no longer met diagnostic criteria at posttreatment" (p. 340). CBT plus family management (FAM) was also evaluated and it was noted that younger children (7 to 10 year olds) responded better to the CBT + FAM condition, but for older children (11 to 14 year olds) there was no significant difference (Barrett, Dadds, & Rapee, 1996).

Epidemiological research suggests that fewer than half of children with anxiety disorders receive care for the disorders (Egger & Burns, 2004) and more than two thirds of the children who meet criteria for an anxiety disorder in primary settings, have never received treatment (Chavira, Stein, Bailey, & Stein, 2004). If left untreated, childhood anxiety may develop into chronic anxiety, depression, and substance abuse (Kendall, Safford, Flannery-Schroeder, & Webb, 2004). The Coping Cat treatment program is for youth who suffer from separation anxiety disorder, social phobia and generalized anxiety disorder and is conducted over the course of 16 one-hour sessions. There is also the Brief Cognitive Behavioural Therapy (BCBT), which is eight 60-minute sessions, two of those having a parent consultation component. The first four sessions focus on psychoeducation and the latter four on practising skills learned through exposure tasks. BCBT has a therapist manual, child workbook, and a parent companion guide (Kendall, Podell, Gosch, & Behr, 2010). Beidas et al., (2013) concluded that, " [i]f parents accommodate their child's anxiety by allowing them to avoid exposures, or if they are under-involved and do not facilitate exposures, it is likely that the effects of BCBT may be limited" (p. 143). BCBT provides a structured two parent session and parent manual and the Coping Cat Parent Companion provides a session-by-session guide. Giving children choice is often motivational as well when introducing exposure to tasks, which is important for transfer of control from therapist to parent (Beidas et al., 2013).

Intervention strategies such as peer tutoring and co-teaching also resulted in decreased referral to special education programs, increased students achievement, decreased disruptive problems, and referrals for behavioural problems (Villa, Thousand, & Nevin, 2013).

Anxiety has also been identified as an associated feature of autism spectrum disorder (ASD). Children with ASD tend to lack the social skills they need and this deficit contributes to higher levels of anxiety (Keehn et al., 2013). An intervention program, The Multi-Component Integrated Treatment (MCIT) (White et al., 2010) is based on components of CBT but has social skills for ASD integrated into it (Keehn et al., 2013). It is delivered over 11 weeks and is the first known empirical study to use the Coping Cat program including modifications, with children with ASD (Keehn et al., 2013). Although only 36% of those who received the treatment remained free of their anxiety symptoms, scores from pre-treatment to follow-up reveal that treatment gains were made (Keehn et al., 2013). Parents had also perceived that their children had displayed lower levels of anxious behaviour.

It is evident that there are a multitude of programs and literature available to children, educators, and parents for intervention and treatment of anxiety. Children who have one type of anxiety disorder often have another mental health issue. This cooccurrence is referred to as co-morbidity. As more research is completed, there may be better treatments made available and further gains in this area of study.

Depression in School Age Children

According to Kauffman (2013), "[d]epression has been relatively neglected in special education research, even though it's become clear that depression is closely related to a variety of other disorders, and to academic and social difficulties" (p. 295). Childhood depression may also be accompanied by other disorders such as: anxiety disorders, conduct disorders, attention deficit-hyperactivity disorder, learning disabilities, school failure, and has also been found to affect some children with autism (Kauffman, 2013). Children may also exhibit inappropriate conduct such as: aggression, stealing, and social withdrawal (Kauffman, 2013). Weight gain or loss may also be observed. It is important to note that there are two main groups of causes of depression, biological and environmental, with social and environmental being the most prevalent (Lebrun, 2007; McKnew, Cytryn, & Yahraes, 1983).

Causal Factors and Prevention

School connectedness. Shochet, Dadds, Ham and Montague (2006) conducted a sampling of 2,022 students (999 boys and 1,023 girls) ages 12 to 14 twice, at intervals of twelve months apart to determine if school connectedness was a factor in adolescent depressive symptoms. School connectedness was described as school engagement, bonding, and attachment as students begin to rely less on family and more on extrafamilial relationships found in friends (Goodenow, 1993). School connectedness accounted for 13% to 18% of the emotional distress in various age groups (Resnick et al., 1997) although there has been little research on the relation between school connectedness and anxiety and depression symptoms in adolescents (Shochet et al., 2006). Overall, school connectedness predicted future mental health problems, rather than mental health problems predicting future school connectedness (Shochet et al., 2006). Self-worth is also a risk factor for depression in youth. It is important to analyse self-worth contingencies before depressive symptoms surface in early adolescence (Burwell & Shirk, 2006).

Rumination. Nolen-Hoeksema (1991) posited that, "rumination, a cognitive style that involves passively brooding about one's mood, would lead to increases in depressive symptoms, while distraction and problem-solving would lead to decreases in symptoms" (p. 545). Rumination has been identified as a risk factor for the development of depressive symptoms in adolescents and those who engage in rumination worry excessively but passively about their depression (Hilt, McLaughlin & Nolen-Hoeksema, 2010; Nolen-Hoeksema, 1994). Ruminative responses appear to interfere with individuals' ability to generate solutions while accessing negative thought and memories, which enhances the depressed mood (Nolen-Hoeksema, 1994).

Parents. Parents who become hostile and critical when their children are experiencing problems might impact their child's sense of inability to solve problems and decrease their enthusiasm (Nolen-Hoeksema, Wolfson, Mumme, & Guskin, 1995). When a child reacts with frustration to a task, a parent may also become frustrated and perhaps hostile (Nolen-Hoeksema et al., 1995). Some studies also show that children of mothers who have depression are at risk for developing a sense of learned helpless-

ness (Nolen-Hoeksema et al., 1995). Conversely, parents who were over-restrictive and controlled their children's opportunities for decision making had children who were more passive and withdrawn from difficult social situations (Baumrind, 1973). Marital conflict and poverty can also negatively affect the child and the mother (Hammen, Adrian, Gordon, Burge, Jaenicke, & Hiroto, 1987).

Gender. The Response Styles Theory (Just & Alloy, 1997) was used to explain the differences in rumination amongst men and women. The theory suggests that women are more likely to ruminate than men while men are more likely to use distraction or problem-solve (Nolen-Hoeksema, 1987, 1991). Nearly one in five adolescents will experience a major depressive episode in their teen years with females twice as likely to suffer from depression (Crisp, Gudmundsen, & Shirk, 2006). Hilt et al., (2010) concluded that, "[a]lthough some research indicates that girls are more likely to report using a ruminative response style compared to boys, gender differences in the tendency to distract and problem-solve have rarely been examined in youth" (p. 547).

Symptoms

There are a variety of checklists that may guide teachers and parents as they work and interact with children. Lebrun (2007) noted that some of these checklists have been adapted from those developed by the National Institute of Mental Health to help teachers and parents identify a variety of symptoms. These checklists focus on four general areas: major depression in children, major depression in adolescents, early onset bipolar disorder (manic depression), and bipolar disorder in adolescence (Lebrun, 2007). When interpreting the data from the checklists it is important to study all aspects and identify the situations that are presenting challenges. Collaboration with medical practitioners, parents, and educators is necessary to identify and address dysfunctional behaviours (Lebrun, 2007).

Assessment, Treatment and Intervention

Assessment. There are numerous assessment tools in place to determine cognitive, social, environmental and biological causes of depressive symptoms. There are also numerous treatment and intervention programs in place to assist youth with depression. The Beck Depressive Inventory (BDI) is a 21-item, self-report scale that measures the symptoms of depression (Burns & Nolen-Hoeksema, 1991). The Self-Help Inventory (SHI) is a 45-item inventory that asks people about their coping skills when they are depressed (Burns & Nolen-Hoeksema, 1991). Students can also be screened on the Anxiety, Depression, and Self-Concept inventories of the Beck Youth Inventories (second edition) (O'Callaghan & Cunningham, 2015). Other tools for assessing are: the Children's Depression Inventory (CDI) (Kovacs, 1992), the Children's Response Styles Questionnaire (CRSQ) (Abela, Brozina, & Haigh, 2002), the rumination subscale from the CRSQ, the distraction subscale from the CRSQ, and the problem-solving subscale from the CRSQ.

Treatment and intervention. Evidence-based research reveals that CBT is an effective therapy for depression (Burns & Nolen-Hoeksema, 1991, 1992; O'Callaghan & Cunningham, 2015). Treatment and intervention strategies vary depending on the age of the children. Burns and Nolen-Hoeksema (1991), asserted that people suffering from depression who receive CBT with an active coping style tend to recover more quickly than those who have a ruminative coping style. Completion of homework assignments also affected the extent of improvement (Burns & Nolen-Hoeksema, 1991; O'Callaghan & Cunningham, 2015). Burn and Nolen-Hoeksema reported that homework assignments consisted of "recording and refuting negative thoughts, scheduling more rewarding and productive activities, and improving interpersonal communication, among others" (p. 308). Therapy sessions were scheduled once or twice a week and ran for 12 weeks. Willingness to practise coping strategies impacted how much patients' depression levels declined and homework completion also enhanced the rate of recovery (Burns & Nolen-Hoeksema, 1991). Patients in CBT were also more likely to complete their self-help assignments and homework if they had warm and empathic therapists (Burns & Nolen-Hoeksema, 1991). Those who did not complete the self-help assignments and terminated therapy, reported their therapists as less empathic and improved less (Burns & Nolen-Hoeksema, 1992).

Mindfulness meditation has also shown to reduce rumination in patients (Jain et al., 2007; Kingston, Dooley, Bates, Lawlor, & Malone, 2007; Ramel, Goldin, Carmona, & McQuaid, 2004). Another inter-

vention for youth depression targets children's self-regulation of distress by identifying their responses to distressing situations, analyzing them, and providing alternate responses (Kovacs, Sherrill, George, Pollock, Tumuluru, & Ho, 2006). By reducing rumination and increasing problem solving and responses to distressing situations, children can reduce their depressive symptoms (Kovacs et al., 2006). There is also evidence that psychotherapy can successfully treat adolescent depression (Crisp et al., 2006).

School. The Anxiety, Depression and Self-Concept inventories of the Beck Youth Inventories (second edition) are used to measure fearfulness, worry, anxious bodily symptoms, sadness, negative thoughts, associated bodily symptoms, competence, and self-worth (O'Callaghan & Cunningham, 2015). The Adolescent Mood Project (AMP) is a study that uses evidence-based CBT delivered by therapists in a school-based setting (Crisp et al., 2006). Nearly one in five adolescents will experience a major depressive episode in their lifetime and this depression is associated with diminished achievement and poor school performance (Birmaher, et al., 1996). Manic Depressive Disorder (MDD) is strongly related to suicidal behaviour, mood disorders in adulthood, substance abuse, and school drop-out (Rohde, Lewinsohn, & Seeley, 1991). For these reasons, MDD targeted intervention should take place during adolescence (Crisp et al., 2006). Youth who do receive mental health treatment periodically miss appointments and often drop out early at a rate of 40-60 %, which prolongs treatment (Crisp et al., 2006). Barriers that are associated with youth attrition are: transportation, family crises, cost, perceived effectiveness of treatment, and scheduling difficulties (Kazdin, Holland, Crowley, & Breton, 1997). By transporting treatment to the schools, some of these barriers might be eradicated although parental involvement might also be limited (Crisp et al., 2006). Extant literature supports mental health treatment in schools for many reasons: schools are in close proximity to youth and are trusted, transportation issues are solved, school is a natural context where many professionals can gain information about an individual's functioning in different situations, and students are practising the skills they are learning in a realistic context (Crisp et al., 2006). The project AMP was created to look at the specific needs of each school and how to gather students from each school to attend their session differed according to scheduling along with the availability of school personnel to assist in retrieving students (Crisp et al., 2006). Another difference among the schools was how accepting staff was when the appointments were scheduled during class time, after school, during lunch, or during spare periods (Crisp et al., 2006). AMP intervention consists of 12 weekly individual sessions broken into three modules, led by therapists who traveled to the schools. The cognitions module focused on identification and restructuring of negative thoughts and emerged because therapists were aware of the many stressors with which their students were dealing with. The activities module included pleasant and mastery activities with student generated lists of what they liked to do. Relaxation and relational techniques were added to this mix. The relational issues module dealt with interpersonal issues such as anger management, problem solving, and social issues. It also dealt with short-term goal setting. There was also a homework component and a Personal Mood Manager (PMM) teen manual. This cognitive treatment demonstrated efficacy and taught specific skills that focused on activities and how they affected mood. Teachers, counsellors, nurses, or administrators could refer participants. Once this is done the participants are informed about the program and depressive symptomatology is assessed using the mood modules of the Computerized Diagnostic Interview Schedule for Children (C-DISC) (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) and the self-report BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Of the participants, 78% expressed concomitant experiences of fear, helplessness, or horror based on major life events, school hassles, family conflict and divorce, thoughts of pregnancy and sexually transmitted disease, and skipping meals due to a lack of money (Crisp et al., 2006). Students also expressed suicidal ideation and attempts and 50% reported that they had never received prior mental health treatment (Crisp et al., 2006). School personnel and administrators felt positive about the progress that participants made and how smoothly the integrated treatment worked in the schools. Crisp et al. (2006) noted that participants stated, "[n]ow I have the tools that I can use when depression comes back; I have learned how to think about things differently in a more helpful way; I wouldn't have gotten this help if this wasn't at school" (p. 302). Difficulties with the program are that part-time coordinators are not in regular contact with the students and staff when students are being discussed. Another obstacle is availability of space to hold sessions. Students periodically miss sessions due to fire alarm and assemblies or other school functions. Also, several

students dropped out due to moving schools or being expelled from school (Crisp et al., 2006). Schools do not have adequate funding in place to employ counsellors to the extent that they are needed and if a school does have a full time counsellor much time is taken up testing and performing other duties that are expected of them (Crisp et al., 2006). Project AMP also has external funding that can be provided to schools to allow staff compensation when working on this program. In order to make evidence-based therapy available to schools, funding allocations need to be examined and changed and community mental health systems integrated with educational systems (Crisp et al., 2006). Studies need to be shared with schools to determine what programming needs to be in place to best serve students and work alongside parents. Project AMP shows promise when transferring evidence-based treatment to the schools.

Cool Connections (Seiler, 2008) is a group-based, early intervention strategy that uses illustrations, games, theory and fun activities to encourage positive thinking and how to deal with worries and anxieties (O'Callaghan & Cunningham, 2015). Seiler (2008) outlined that "[t]he Cool Connections Programme is closely linked with the National Curriculum, especially in relation to PSHE (Personal, Social and Health Education) guidelines at Key Stage 2 (7-11 years) and 3 (11-14 years)" (p. 19). Qualitative data were gathered from children who were a part of the program asking them if they found the program helpful or useful (Seiler, 2008). The feedback was positive. All nine participants would recommend the program to other children and reported that it helped them understand, accept, and settle their feelings (Seiler, 2008). The children felt that it helped them with anger and stress and gave them opportunities to make new friends (Seiler, 2008). To boost homework completion rates in this program, personal choice was added and a prize was given for those who completed a set number of tasks (Seiler, 2008). Limitations of the study were that no follow up was done to see if progress was retained. The evidence was also self-reported and would have been better if triangulated from other responders. It was also noted that some of the children knew the facilitators while others did not, which might have impacted their growth (Seiler, 2008). In summary, this pilot study provided evidence for the efficacy of group-based CBT intervention delivered at the school level (Seiler, 2008).

Figure 1 provides the improvements in symptoms of anxiety, depression, and self-concept in the intervention group after the 10-week, Cool Connections cognitive behavioural therapy (CBT) intervention.

Based on paired samples, improvements in symptoms of anxiety, depression and self-concept were noted. Symptoms of anxiety and depression were reduced by half and self concept increased. Lebrun (2007) maintained that teachers need to remain flexible and learn about mood disorders. By identifying and reducing stressors in a classroom, the atmosphere becomes safer and depressive symptoms in children can be reduced (Lebrun, 2007). Teacher awareness around bullying, boredom, and competition can provide succour for a child who is depressed and can prevent them from slipping into depression (Lebrun, 2007). Teachers can also work out signals with students who need their help for a variety of reasons. Children with depression are often late due to fatigue and punishing them for being late will not cure the tardiness (Lebrun, 2007). Communication between home and school is vital and can be done in many ways. Allowing children to have body breaks and something as simple as a drink of water can help, due to the fact that water is a calming agent in addition to the child being able to leave a stressful situation momentarily (Lebrun, 2007). Depressed children will often experience lower grades and will not transition well. Flexibility with assignments and allowing extra time and giving notice when transitioning will help to alleviate these fears (Lebrun, 2007).

Figure 1. Northern Ireland Pilot Study of Cool Connections Intervention 2015

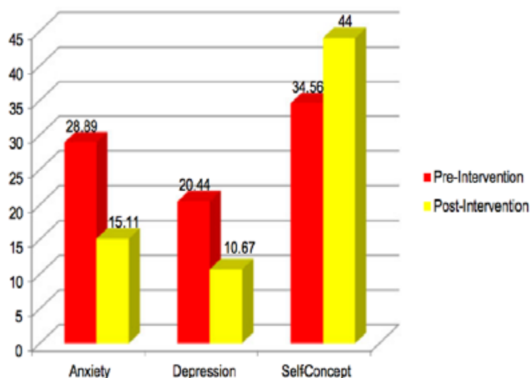

Figure 1**:** Improvements in symptoms of anxiety, depression and self-concept in the intervention group after the 10-week, Cool Connections cognitive behavioural therapy (CBT) intervention. Reprinted from O'Callaghan and Cunningham, 2015, p. 318.

Reilly (2015) also gave a variety of suggestions for classroom teachers. Suggestions include giving movement breaks, using multiple methods of instruction and reminders during transitions, and incorporating students' interest and strengths into assignments. In addition, teachers can segment assignments, identify assignments that make the child anxious, offer different ways for a child to have notes and instructions, provide alternatives to class presentations, schedule the more demanding assignments in the afternoon, and encourage input from the student. Reilly offered a multitude of lessons for: identifying feelings, cognitive restructuring, contingency management, behaviour support, increasing positive affect, and relaxation skills. Reilly also outlined a plan upon re-entry to the classroom from a psychiatric hospitalization and what to do when self harm, and suicidal attempts and thoughts are voiced. Students with depression need supportive, patient, and flexible teaching.

Merrell (2013) has written a practical guide to assist teachers in helping students to overcome depression and anxiety. He has chapters that offer: assessment and intervention planning, social and emotional tools, cognitive therapy interventions, and other strategies for dealing with anxiety and depression. There is a host of literature written to assist educators when dealing with students who have depression or depressive symptoms. Knowing what signs to look for in students with mental health issues is key to addressing their needs and offering support.

Parents. Lebrun (2007) argued that, "[i]t is crucial for parents to remember that their parenting did not cause the child's depression" (p. 75). A series of events may have triggered the depression, which is known as situational depression. Chemical depression is a functional problem with the brain. Encouraging outdoor activity but not forcing it is good as it causes the brain to release endorphins and improve the mood of the child (Lebrun, 2007). Using positive feedback when a child has done something good is also effective. Observing sleep patterns is also beneficial to ensure that children do not receive too little sleep or are oversleeping. Ongoing communication is important to encourage children to talk about their feeling to family and friends (Lebrun, 2007). It is also a good idea to have children

journal their feelings. A diary can be used to document incidents and how effective interventions are. Ongoing communication with the school to develop an instructional plan that work best for children is paramount. Lebrun (2007) noted that, "triggers may be bright lights, noise, large stores, and groups, which can be over-stimulating and overwhelming" (p. 77). "Once the child is home, use gentle music, relaxation tapes, dim lights, warm baths, and massage to help with the calming, and eventually, sleep" (Lebrun, 2007, p. 77).

Gentle and patient communication is important when a child is reaching out for support. Stability of family meals and predictability of routines is also necessary. Validating feelings when a child is acting out and setting appropriate age and ability expectations is key to keeping the communication lines open. Lebrun (2007) maintained that parental monitoring is important

Keeping the computer in a public place so parents can watch for prurient people on line can save a child's life (Lebrun, 2007). If the family needs counselling, it is a good idea for the parents to go first so they can receive counselling and education on the issues that the family is facing. Spend time not money with your children and ignore critical comments by friends, relatives, and strangers (Lebrun, 2007). It is crucial to maintain a sense of hope and to take care of oneself. Society has a tendency to blame parents for how their children are. Lebrun (2007) concluded that, "[h]opefully with more awareness, mental-health issues will be received with more of an open mind, and thus, more tolerance" (p. 81).

How the Study Addressed the Research Questions

The purpose of this study was to examine the prevalent mental health disorders and determine what the causal or correlational factors were. Researchers have concluded that anxiety is often comorbid with depressive symptoms. Girls between the ages of 12 and 15 were more likely to suffer from depression than boys due to their tendency to be more helpless in their ruminative reactions to situations (Nolen-Hoeksema, 1994). Causal or contributing factors ranged from hereditary to environmental and had varying levels of impact on children. Parental over-restrictiveness and intrusiveness puts children at risk for anxiety disorders (Aschenbrand & Kendall, 2012; Vaughn, Feinn, Bernard, Brereton, & Kaufman, 2013; Kearny, et al., 2014). Children who had parents suffering from anxiety were also at greater risk. Peer and teacher relations also impacted students with anxiety. Feelings of lack of inclusion and not being able to meet teacher expectations worried students (Loke & Lowe, 2014). School connectedness was a factor in children with depressive symptoms (Shochet et al., 2006). Ruminative behaviour was also a causal factor. Children who have parents who are hostile, critical or suffer from depression are also at risk for developing depression (Nolen-Hoeksema et al., 1995).

Studies concluded that prevention needs to be implemented early in order for it not to carry on into adulthood (Dadds & Roth, 2008). Preventive measures and early intervention can reduce the risk of an onset of a disorder and if schools adopt this type of approach, they can identify, treat and possibly prevent the onset of a disorder (Tomb & Hunter, 2004). There are a number of preventive programs that are currently being used in schools.

There are a host of tools that can be used to assess and diagnose children. CBT intervention strategies range from programs that are run by clinicians and counsellors to school wide and classroom-based instruction. FEAR and Coping Cat are two intervention programs that are successful in the schools. Programming that has a parent component also yields greater results in minimising depressive and anxious symptoms and gives parents strategies to support their children in skill acquisition. CBT and BCBT interventions usually take place with a therapist across a range of clinical settings (Keehn et al., 2013). There are also homework components to many programs and if students complete this part of the therapy, they tend to have better results with recovery (Burns & Nolen-Hoeksema, 1991). Parents who are receptive to family-based treatment can also play a role in the recovery of their child and perhaps themselves. In order to continue to assist these students, further research needs to be done into developing school-based mental health programming to minimize cost, missed appointments, and transportation barriers.

Implications

Implications for Research

This study confirms the recommendation of Barett (1996) that further research is needed to examine the optimum intervention length. It also confirms that parental involvement in treatment improves outcomes in the CBT of children. Beidas et al. (2013) also recommended that further research is needed to explore why some individuals did not respond to treatment; researchers need to study baseline characteristics of youth in order to decide which treatment works best for whom. Additional studies are needed to determine why willing patients improve more and if these effects are limited to CBT (Burns & Nolen-Hoeksema, 1991). There are several methods for screening for anxious symptomatology although few studies have been done to investigate the best method for screening and selection of children for anxiety treatment programs (McLoone et al., 2006). Literature in the area of treatment is limited and further research needs to be done to make more informed conclusions. Despite the significant amount of untreated depressive disorders in schools, school systems do not regularly screen or identify students (Crisp et al., 2006). Future research is also needed to clarify the relationship of gender differences in response style (Hilt et al., 2010). Developing programs that reduce rumination and enhance problem-solving skills as well as examining cultural differences in response styles, are also vital goals for future research (Hilt et al., 2010). It is clear that the literature repeatedly recommends that more research needs to be done in the area of addressing the needs of children with mental health issues in schools.

Implications for Practice

This literature review confirms the recommendation of Miller et al., (2010) that evidence-supported, school based treatment overcomes many of the barriers associated with treatment. With school based treatment, cost, long waiting periods, and the risk of developing additional mental health issues are alleviated (Miller et al., 2010). Early emphasis on exposure tasks is the most important ingredient in CBT when treating anxiety (Beidas et al. 2013). If left untreated these issues can carry on into adulthood and worsen. It is also recommended that parents also receive treatment in the accompanying parent sessions to ensure the success of the CBT and BCBT. O'Callaghan and Cunningham (2015) maintained that studies found that both CBT and non-CBT based interventions were successful in reducing symptoms of anxiety and depression. Group-based programming, such as Circle Time, can also be implemented in the schools without the need for a specific program (O'Callaghan & Cunningham, 2015). Crisp et al., (2006) concluded that evidence-based treatment, such as AMP is a feasible area of research for further investigation into who will benefit from which treatment. It is equally important that students cope actively with their problems in order to experience greater clinical improvement (Burns & Nolen-Hoeksema, 1991). The literature confirms that more programs are being developed to meet the needs of students and their families at the school level on an individual, small group, and class wide basis.

Conclusions

It is apparent that CBT and Social Emotional Learning (SEL) are needed in schools on a day-to-day basis to meet the needs of students with mental health issues. These programs assist with the development of self-concept, school adjustment, motivation, and engagement as well as relational development (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Teaching these intervention strategies benefits all students as they interact with each other; explicit instruction in this regard would assist all learners. Research suggests that school based mental health programs best serve all students and has reduced the need for suspensions (Bruns Moore, Stephan, Pruitt, & Weist, 2005). Collaboration between school mental health, social services, school staff, and the community is also important to the success of the programming (Brener, Weist, Adelman, Taylor, & Vernon-Smiley, 2007). The role that parents play in treatment and recovery is very important, too. Equally important is supportive leadership to maintain and sustain this programming. Having a full time staff member in one building to deliver this intervention is optimal. Due to financial constraints and budgeting, this support often is not a possibility.

There are a variety of causal factors that impact students with anxiety and depression ranging from environmental to biological and a plethora of intervention strategies to assist these children in recovery as well as numerous on line resources to assist personnel working with children. There is a preponderance of evidence that supports CBT as a treatment (Crisp et al., 2006). Prevention programming also increases successful treatment of students. As more research is conducted, programs are being refined and altered to meet the needs of individuals, small groups of students, and classrooms. With policies and initiatives shifting and changing, mental health issues and school-based programming need to be maintained and given priority. The future success of these students depends on the collaborative efforts of all stakeholders and their commitment to future development and implementation of school-based mental health programming.

References

Abela, J. R., Brozina, K., & Haigh, E. P. (2002). An examination of the response styles theory of depression in third-and seventh-grade children: A short-term longitudinal study. *Journal of Abnormal Child Psychology, 30*(5), 515-527. doi:10.1023/A:1019873015594

Allen, J. S., Klein, & Roger J. (1996). *Ready, set, relax: A research-based program of relaxation, learning, and self-esteem for children*. Watertown, WI: Inner Coaching.

Aschenbrand, S. G. & Kendall, P. C. (2012). The effect of perceived child anxiety status on parental latency to intervene with anxious and nonanxious youth. *Journal of Consulting and Clinical Psychology, 80*(2), 232-238. doi:10.1037/a0027230

Barrett, P. M. (1996). Family treatment of childhood anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology, 64*(2), 333-342. Retrieved from http://www.apa.org/pubs/journals/ccp/

Barrett, P. M., Dadds, M. R., & Rapee, R. M. (1996). Family treatment of childhood anxiety: A controlled trial. *Journal of consulting and clinical psychology*, *64*(2), 333-342.

Barrett, P. M., Lowry-Webster, H., & Holmes, J. (1998). *The FRIENDS programme*. Brisbane, Australia: Australian Academic Press.

Barrett, P. M., Rapee, R. M., Dadds, M. M., & Ryan, S. M. (1996). Family enhancement of cognitive style in anxious and aggressive children. *Journal of Abnormal Child Psychology, 24*(2), 187-203. doi:10.1007/BF01441484

Barry, C. T., Frick, P. J., & Grafeman, S. J. (2008). Child versus parent reports of parenting practices: Implications for the conceptualization of child behavioral and emotional problems. *Assessment*, *15*(3), 294-303.

Baumrind, D. (1973). The development of instrumental competence through socialization. *Minnesota Symposium on Child Psychology,* Minneapolis, MN: University of Minnesota.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of general psychiatry*, *4*(6), 561-571.

Beidas, R. S., Mychailyszyn, M. P., Podell, J. L., & Kendall, P. C. (2013). Brief cognitive-behavioral therapy for anxious youth: The inner workings. *Cognitive and Behavioral Practice, 20*(2), 134-146. doi:10.1016/j.cbpra.2012.07.004

Birmaher, B., Ryan, N. D., Williamson, D. E., Brent, D. A., Kaufman, J., Dahl, R. E., & Nelson, B. (1996). Childhood and adolescent depression: A review of the past 10 years. part I. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*(11), 1427-1439. doi:10.1097/00004583-199611000-00011

Brener, N. D., Weist, M., Adelman, H., Taylor, L., & Vernon-Smiley, M. (2007). Mental health and social services: Results from the school health policies and programs study 2006. *Journal of School Health, 77*(8), 486-499. doi:10.1111/j.1746-1561.2007.00231.x

Bruns, E. J., Moore, E., Stephan, S. H., Pruitt, D., & Weist, M. D. (2005). The impact of school mental health services on out-of-school suspension rates. *Journal of Youth and Adolescence, 34*(1), 23-28. doi:10.1007/s10964-005-1333-z

Burns, D. D., Shaw, B. F., & Croker, W. (1987). Thinking styles and coping strategies of depressed women: An empirical investigation. *Behaviour Research and Therapy, 25*(3), 223-225. doi:10.1016/0005-7967(87)90049-0

Burns, D. D. & Nolen-Hoeksema, S. (1991). Coping styles, homework compliance, and the effectiveness of cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology, 59*(2), 305-311.

Burns, D. D. & Nolen-Hoeksema, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal of Consulting and Clinical Psychology, 60*(3), 441-449.

Burwell, R. A. & Shirk, S. R. (2006). Self processes in adolescent depression: The role of self-worth contingencies. *Journal of Research on Adolescence, 16*(3), 479-490. doi:10.1111/j.1532-7795.2006.00503.x

Canada. (n.d.) Health Canada. Retrieved from http://www.hc-sc.gc.ca/index-eng.php

Canadian Teachers' Federation (2012). Understanding teachers' perspectives on student mental health: Findings from a national survey. *Ottawa, Ontario:'Author.*

Chavira, D. A., Stein, M. B., Bailey, K., & Stein, M. T. (2004). Child anxiety in primary care: Prevalent but untreated. *Depression and Anxiety, 20*(4), 155-164. doi:10.1002/da.20039

Crisp, H. L., Gudmundsen, G. R., & Shirk, S. R. (2006). Transporting evidence-based therapy for adolescent depression to the school setting. *Education and Treatment of Children, 29*(2), 287-309.

Dadds, M. R. & Roth, J. H. (2008). Prevention of anxiety disorders: Results of a universal trial with young children. *Journal of Child and Family Studies, 17*(3), 320-335. doi:10.1007/s10826-007-9144-3

Derevensky, J. & Coleman, E. B. (1989). Gifted children's fears. *Gifted Child Quarterly, 33*(2), 65-68. doi:10.1177/001698628903300203

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405-432. doi:10.1111/j.1467-8624.2010.01564.x

Egger, H. & Burns, B. (2004). Anxiety disorders and access to mental health services. In T. Ollendick, & J. March (Eds.), *Phobic and anxiety disorders in children and adolescents* (pp. 530-549). New York, NY: Oxford University Press.

Ellis, D. M. & Hudson, J. L. (2010). The metacognitive model of generalized anxiety disorder in children and adolescents. *Clinical Child and Family Psychology Review, 13*(2), 151-163. doi:10.1007/s10567-010-0065-0

Felner, R. D., Favazza, A., Shim, M., Brand, S., Gu, K., & Noonan, N. (2001). Whole school improvement and restructuring as prevention and promotion: Lessons from STEP and the project on high performance learning communities. *Journal of School Psychology, 39*(2), 177-202. doi:10.1016/S0022-4405(01)00057-7

Fisher, P. H., Masia-Warner, C., & Klein, R. G. (2004). Skills for social and academic success: A school-based intervention for social anxiety disorder in adolescents. *Clinical Child and Family Psychology Review, 7*(4), 241-249. doi:10.1007/s10567-004-6088-7

Foxman, P. (2004). *The worried child: Recognizing anxiety in children and helping them heal*. Alameda, CA: Hunter House.

Frick, P. J. (2012). *Conduct disorders and severe antisocial behavior*. New York: Springer Science & Business Media.

Garland, J., & Clark, S. (2000). *Taming Worry Dragons: a manual for children, parents and other coaches* (Revised). Vancouver, BC: British Columbia Children's Hospital.

Goodenow, C. (1993). The psychological sense of school membership among adolescents: Scale development and educational correlates. *Psychology in the Schools, 30*(1), 79-90.

Greene, R. W. (2009). *Lost at school: Why our kids with behavioral challenges are falling through the cracks and how we can help them*. New York, NY: Simon and Schuster.

Hammen, C., Adrian, C., Gordon, D., Burge, D., Jaenicke, C., & Hiroto, D. (1987). Children of depressed mothers: Maternal strain and symptom predictors of dysfunction. *Journal of Abnormal Psychology, 96*(3), 190-198. doi:10.1037/0021-843X.96.3.190

Hayden, C. (2015). *Anxiety in school age children.* Unpublished manuscript, Department of Educational Administration, University of Saskatchewan, Saskatoon, Canada.

Hilt, L. M., McLaughlin, K. A., & Nolen-Hoeksema, S. (2010). Examination of the response styles theory in a community sample of young adolescents. *Journal of Abnormal Child Psychology, 38*(4), 545-556. doi:10.1007/s10802-009-9384-3

Jain, S., Shapiro, S. L., Swanick, S., Roesch, S. C., Mills, P. J., Bell, I., & Schwartz, G. E. (2007). A randomized controlled trial of mindfulness meditation versus relaxation training: Effects on distress, positive states of mind, rumination, and distraction. *Annals of Behavioral Medicine, 33*(1), 11-21. doi:10.1207/s15324796abm3301_2

Just, N., & Alloy, L. B. (1997). The response styles theory of depression: tests and an extension of the theory. *Journal of abnormal psychology*, *106*(2), 221.

Kauffman, J. M. (1997). *Characteristics of emotional and behavioral disorders of children and youth*. New York, NY: Pearson.

Kauffman, J. M., & Landrum, T. J. (2013). *Cases in emotional and behavioral disorders of children and youth*. New York, NY: Pearson.

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry, 38*(8), 1051-1062. doi:10.1111/j.1469-7610.1997.tb01621.x

Kearny, R., Pawlukewicz, J., & Guardino, M. (2014). Children with anxiety disorders: Use of a cognitive behavioral therapy model within a social milieu. *Journal of Research in Childhood Education, 28*(1), 59-68. doi:10.1080/02568543.2013.850130

Keehn, R. H. M., Lincoln, A. J., Brown, M. Z., & Chavira, D. A. (2013). The coping cat program for children with anxiety and autism spectrum disorder: A pilot randomized controlled trial. *Journal of Autism and Developmental Disorders, 43*(1), 57-67. doi:10.1007/s10803-012-1541-9

Kendall, P. C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 62*(1), 100. doi:10.1037/0022-006X.62.1.100

Kendall, P. C., Podell, J. L., Gosch, E. A., & Behr, R.. (2010). *The coping cat: Parent companion*. Ardmore, PA: Workbook Publishing.

Kendall, P. C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: Outcomes in adolescence and impact on substance use and depression at 7.4-year follow-up. *Journal of Consulting and Clinical Psychology, 72*(2), 276-287. doi:10.1037/0022-006X.72.2.276

Kingston, T., Dooley, B., Bates, A., Lawlor, E., & Malone, K. (2007). Mindfulness-based cognitive therapy for residual depressive symptoms. *Psychology and Psychotherapy: Theory, Research and Practice, 80*(2), 193-203. doi:10.1348/147608306X116016

Kovacs, M. (1992). *Children's depression inventory: Manual*. North Tonawanda, NY: Multi-Health Systems.

Kovacs, M., Sherrill, J., George, C. J., Pollock, M., Tumuluru, R. V., & Ho, V. (2006). Contextual emotion-regulation therapy for childhood depression: Description and pilot testing of a new intervention. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(8), 892-903. doi:10.1097/01.chi.0000222878.74162.5a

Lamont, R. T. (2012). The fears and anxieties of gifted learners tips for parents and educators. *Gifted Child Today, 35*(4), 271-276. doi:10.1177/1076217512455479

Lebrun, M. (2007). *Student depression: A silent crisis in our schools and communities*. Lanham, MD: Rowman & Littlefield Education.

Leyfer, O., Gallo, K. P., Cooper-Vince, C., & Pincus, D. B. (2013). Patterns and predictors of comorbidity of DSM-IV anxiety disorders in a clinical sample of children and adolescents. *Journal of Anxiety Disorders, 27*(3), 306-311. doi:10.1016/j.janxdis.2013.01.010

Loke, S. W. & Lowe, P. (2014). Development and validation of the interpersonal school transition anxiety scale for use among fourth-to sixth-grade students. *Social Work Research, 38*(4), 211-221. doi:10.1093/swr/svu025

Lowry-Webster, H. M., Barrett, P. M., & Dadds, M. R. (2001). A universal prevention trial of anxiety and depressive symptomatology in childhood: Preliminary data from an Australian study. *Behaviour Change, 18*(1), 36-50. doi:10.1375/bech.18.1.36

March, J. S., Parker, J. D., Sullivan, K., Stallings, P., & Conners, C. K. (1997). The Multidimensional Anxiety Scale for Children (MASC): factor structure, reliability, and validity. *Journal of the American academy of child & adolescent psychiatry*, *36*(4), 554-565.

McKnew, D. H., Cytryn, L., & Yahraes, H. C. (1983). *Why isn't Johnny crying*. New York: WW Norton.

McLoone, J., Hudson, J. L., & Rapee, R. M. (2006). Treating anxiety disorders in a school setting. *Education and Treatment of Children, 29*(2), 219-242.

Merrell, K. W. (2013). *Helping students overcome depression and anxiety: A practical guide*. New York, NY: Guilford Press.

Mifsud, C., & Rapee, R. M. (2005). Early intervention for childhood anxiety in a school setting: Outcomes for an economically disadvantaged population. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(10), 996-1004. doi:10.1097/01.chi.0000173294.13441.87

Miller, L. D., Short, C., Garland, E. J., & Clark, S. (2010). The ABCs of CBT (cognitive behavior therapy): Evidence-Based approaches to child anxiety in public school settings. *Journal of Counseling & Development, 88*(4), 432-439. doi:10.1002/j.1556-6678.2010.tb00043.x

Nolen-Hoeksema, S. (1987). Sex differences in unipolar depression: Evidence and theory. *Psychological Bulletin, 101*(2), 259-282. doi:10.1037/0033-2909.101.2.259

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology, 100*(4), 569-582. doi:10.1037/0021-843X.100.4.569

Nolen-Hoeksema, S. (1994). An interactive model for the emergence of gender differences in depression in adolescence. *Journal of Research on Adolescence, 4*(4), 519-534.

Nolen-Hoeksema, S., Wolfson, A., Mumme, D., & Guskin, K. (1995). Helplessness in children of depressed and nondepressed mothers. *Developmental Psychology*, *31*(3), 377-387.

O'Callaghan, P. & Cunningham, E. (2015). Can a targeted, group-based CBT intervention reduce depression and anxiety and improve self-concept in primary-age children? *Educational Psychology in Practice, 31*(3), 314-326. doi:10.1080/02667363.2015.1060587

Ramel, W., Goldin, P. R., Carmona, P. E., & McQuaid, J. R. (2004). The effects of mindfulness meditation on cognitive processes and affect in patients with past depression. *Cognitive therapy and research*, *28*(4), 433-455.

Reilly, N. (2015). *Anxiety and depression in the classroom: A teacher's guide to fostering self-regulation in young students* (pp. 133-204). New York, NY: WW Norton & Company.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., & Shew, M. (1997). Protecting adolescents from harm: Findings from the national longitudinal study on adolescent health. *Jama, 278*(10), 823-832. doi:10.1001/jama.1997.03550100049038

Reynolds, C. R., & Kamphaus, R. W. (1992). *BASC, behavior assessment system for children*. Circle Pines, MN: American Guidance Service.

Rohde, P., Lewinsohn, P. M., & Seeley, J. R. (1991). Comorbidity of unipolar depression: II. comorbidity with other mental disorders in adolescents and adults. *Journal of Abnormal Psychology, 100*(2), 214-222. doi:10.1037/0021-843X.100.2.214

Rutter, M., Macdonald, H., Le Couteur, A., Harrington, R., Bolton, P., & Bailey, A. (1990). Genetic factors in child psychiatric disorders?II. empirical findings. *Journal of Child Psychology and Psychiatry, 31*(1), 39-83. doi:10.1111/j.1469-7610.1990.tb02273.x

Saskatchewan Community Grant Programs (2012). *Community Initiatives Fund: All programs*. Retrieved from http://www.cifsask.org/uploads/CGP%20OCT%20grants%202012.pdf

Saskatoon Public Schools (n.d.). *Special education: programs and services for students with special needs.* (2015-2016). Retrieved March 25, 2016, from Saskatoon Public School Division website: http://www.spsd.sk.ca/Schools/specialEd/Documents/SpecialEducation.pdf

Scharfstein, L., Alfano, C., Beidel, D., & Wong, N. (2011). Children with generalized anxiety disorder do not have peer problems, just fewer friends. *Child Psychiatry and Human Development, 42*(6), 712-723. doi:10.1007/s10578-011-0245-2

Seiler, L. (2008). *Cool connections with cognitive behavioural therapy: Encouraging self-esteem, resilience and well-being in children and young people using CBT approaches.* Philadelphia, PA: Jessica Kingsley Publishers.

Shaffer, D., Fisher, P., Lucas, C. P., Dulcan, M. K., & Schwab-Stone, M. E. (2000). NIMH diagnostic interview schedule for children version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(1), 28-38. doi:10.1097/00004583-200001000-00014

Shochet, I. M., Dadds, M. R., Ham, D., & Montague, R. (2006). School connectedness is an underemphasized parameter in adolescent mental health: Results of a community prediction study. *Journal of Clinical Child and Adolescent Psychology, 35*(2), 170-179. doi:10.1207/s15374424jccp3502_1

Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS program: A cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child Psychology, 30*(4), 525-535. doi:10.1207/S15374424JCCP3004_09

Silverman, W. K. & Albano, A. M. (1996). *Anxiety disorders interview schedule for DSM-IV : Child version*. San Antonio, TX: Psychological Corporation.

Simonsen, B., Fairbanks, S., Briesch, A., Myers, D., & Sugai, G. (2008). Evidence-based practices in classroom management: Considerations for research to practice. *Education and Treatment of Children*, *31*(3), 351-380.

Spence, S. H. (1998). A measure of anxiety symptoms among children. *Behaviour Research and Therapy, 36*(5), 545-566. doi:10.1016/S0005-7967(98)00034-5

Tomb, M. & Hunter, L. (2004). Prevention of anxiety in children and adolescents in a school setting: The role of school-based practitioners. *Children and Schools, 26*(2), 87-101.

Topping, K. (2011). Primary–secondary transition: Differences between teachers' and children's perceptions. *Improving Schools, 14*(3), 268-285. doi:10.1177/1365480211419587

Vaughan, E. L., Feinn, R., Bernard, S., Brereton, M., & Kaufman, J. S. (2013). Relationships between child emotional and behavioral symptoms and caregiver strain and parenting stress. *Journal of Family Issues*, *34*(4), 534-556.

Villa, R. A., Thousand, J. S., & Nevin, A. I. (2013). *A guide to co-teaching: New lessons and strategies to facilitate student learning*, Thousand Oaks, CA: Corwin Press.

Weist, M. D., Rubin, M., Moore, E., Adelsheim, S., & Wrobel, G. (2007). Mental health screening in schools. *Journal of School Health, 77*(2), 53-58. doi:10.1111/j.1746-1561.2007.00167

Weist, M. D., Stiegler, K., Stephan, S., Cox, J., & Vaughan, C. (2010). School mental health and prevention science in the Baltimore city schools. *Psychology in the Schools, 47*(1), 89-100. doi:10.1002/pits.20453

White, S. W., Albano, A. M., Johnson, C. R., Kasari, C., Ollendick, T., Klin, A., . . . Scahill, L. (2010). Development of a cognitive-behavioral intervention program to treat anxiety and social deficits in teens with high-functioning autism. *Clinical Child and Family Psychology Review, 13*(1), 77-90. doi:10.1007/s10567-009-0062-3