

**THE EFFECT OF CAREGIVER OPINION LEADERS TO INCREASE DEMAND  
FOR EVIDENCE-BASED PRACTICES FOR YOUTH ANXIETY:  
A RANDOMIZED CONTROLLED TRIAL**

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by  
Margaret Ellen Crane, M.A.  
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Examining Committee Members:

Dr. Philip C. Kendall, Advisory Chair, Department of Psychology and Neuroscience  
Dr. Richard G. Heimberg, Department of Psychology and Neuroscience  
Dr. Thomas M. Olino, Department of Psychology and Neuroscience  
Dr. Deborah A.G. Drabick, Department of Psychology and Neuroscience  
Dr. Wilson Vincent, Department of Psychology and Neuroscience  
Dr. Gabriella M. Mcloughlin, College of Public Health

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## ABSTRACT

**Background:** Despite implementation efforts, most anxious youth do not receive evidence-based treatment. Dissemination initiatives can increase consumer knowledge of evidence-based treatments. Opinion leaders (OLs) have been used in public health campaigns, but this strategy has not been examined for the dissemination of mental health treatments. This study uses the theory of planned behavior to test the dissemination strategies of (1) involving an OL and (2) using an educational presentation to increase caregiver demand for CBT for youth anxiety.

**Methods:** Participants ( $N=262$ ; 92% Female; 69% White, 82% non-Hispanic) were caregivers who registered for a virtual presentation on youth anxiety and how to seek treatment. Caregivers were cluster-randomized by school ( $N=25$ ) to the OL condition (presented by a clinical researcher and local caregiver OL) or the researcher-only condition (presented by two clinical researchers). Presentations occurred from May 2021-May 2022. Measures were completed pre- and post-presentation, and at three-month follow-up.

**Results:** One hundred and nine participants attended the presentations. Relative to the researcher co-presenter, participants rated the OL as significantly more relatable, familiar, similar, and understanding of their community, but significantly less credible. Across conditions, there was a significant increase in participants' (a) knowledge of, (b) subjective norms related to, and (c) intention to seek CBT for youth anxiety, but no change in stigma or attitudes about CBT. Presentation conditions did not differ in change on these measures, or on rates of seeking youth anxiety CBT at three-month follow-up.

Conclusion: Although involvement of a caregiver OL did not increase caregiver demand for EBT for youth anxiety, the overall outreach presentation was an effective dissemination strategy. Involving OLs may not be necessary for all consumer audiences, but may be beneficial for individuals with higher levels of stigma or scientific skepticism than participants in this study.

### **Plain language summary**

Although cognitive behavioral therapy (CBT) is an effective treatment for youth anxiety, most anxious youth receiving services in the community do not receive CBT. Research supports educational dissemination strategies for improving knowledge, attitudes, and stigma related to seeking treatment. Evidence regarding the best messenger of dissemination campaigns is mixed. This study tested two dissemination strategies (1) use of a local caregiver opinion leader, and (2) educational presentation on youth anxiety for caregivers. We compared presentations facilitated by two clinical researchers and by a clinical researcher and an opinion leader. We found that both conditions were equally effective at improving knowledge, subjective norms, and intention to seek CBT. It is possible that the lack of difference between conditions was because the caregiver presenter may not have been a potent opinion leader. Although participants rated the opinion leader as being more similar to them, more familiar to them, and more understanding of their community, they also rated the opinion leader as being a less credible source of mental health information. The opinion leader did not affect how participants viewed the researcher. Nonetheless, findings suggest that involving a local caregiver in dissemination efforts may not be necessary for many

individuals. The findings support educational presentations as an effective dissemination strategy for those who attend. However, this strategy was less likely to reach individuals who identified as Black, who have lower levels of education, and who have lower incomes. Additional research is needed to identify optimal dissemination strategies to reach underserved populations.

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## CHAPTER 1

### INTRODUCTION

Anxiety disorders are highly prevalent among youth, affecting 10-20% of youth, with prevalence rates increasing during the COVID-19 pandemic (Cartwright-Hatton et al., 2006; Kessler et al., 2005; Racine et al., 2021). Without intervention, these disorders rarely remit and have adverse sequelae, including future psychopathology, occupational underachievement, and impaired social relationships (Copeland et al., 2014; Konnopka et al., 2009; Swan & Kendall, 2016; Vergunst et al., 2023). Research has identified cognitive behavioral therapy (CBT) as an effective psychological treatment for youth anxiety (Higa-McMillan et al., 2015; Kendall et al., 2005; Walkup et al., 2008; Weisz et al., 2017). CBT includes exposure, which is one of the most effective strategies for treating anxiety (Higa-McMillan et al., 2015; Kendall et al., 2005).

Despite research identifying treatments that work, CBT is underutilized in community settings (McHugh & Barlow, 2010). Only one third of youth with mental health disorders are estimated to receive any treatment (Merikangas et al., 2011), and far fewer receive CBT (Shafran et al., 2009). Caregivers have reported difficulty finding therapists who offer CBT with exposures, resulting in it taking many years to find a provider who offers this evidence-based treatment for their youth (Frank et al., 2023). The majority of dissemination and implementation efforts to increase the use of evidence-based practices (EBPs) have focused on a “top-down” approach that targets service providers, primarily by increasing the number of practitioners trained in EBPs (Baker et al., 2021; Damschroder et al., 2022). Within dissemination and implementation science, dissemination strategies have been understudied

relative to implementation strategies (Baker et al., 2021; Leeman et al., 2017; Powell et al., 2015; Purtle et al., 2020).

Direct-to-consumer (DTC) marketing offers a promising approach. DTC dissemination approaches are “bottom-up,” targeting the consumer to improve their understanding of mental health problems, shape their treatment-seeking behavior, and ultimately, increase public demand for CBT (Becker, 2015; Friedberg & Bayar, 2017). In one study, consumer demand was a factor motivating providers to become trained in evidence-based practice (Frank et al., 2022). For youth, caregivers are considered the consumer, as they determine and pay for the youth’s services (Becker, 2015; Berridge et al., 2018; Kang et al., 2019). DTC initiatives are important given patient-barriers to youth receiving treatment. Patient barriers include lack of recognition that treatment is needed, lack of knowledge on how to seek effective treatment, and associated stigma (Frank et al., 2023; Green et al., 2020; Gulliver et al., 2010; Ryan et al., 2015). Attitudinal barriers (e.g., not perceiving a need for therapy) have a greater impact on treatment utilization than structural barriers (e.g., cost; Andrade et al., 2014). However, of those who want therapy, most do not know how to seek effective treatment (Coles & Coleman, 2010; Henderson et al., 2013). Additionally, many people hold the belief that treatments are equally effective (Gallo et al., 2013; Jorm, 2012). Many caregivers seeking treatment for youth anxiety simply are unaware that CBT with exposures is the most effective treatment option (Frank et al., 2023).

DTC dissemination efforts use strategies to increase knowledge, stimulate emotion, increase attention, and facilitate social comparison (Baker et al., 2021). Dissemination research often uses the theory of planned behavior to evaluate its impact. The theory of

planned behavior states that attitudes about a behavior, perceived subjective norms about doing a behavior (i.e., belief that others do/value the behavior), and perceived behavioral control predict an individual's intention to complete a behavior, which subsequently predicts their actual behavior (Ajzen, 1991). Stigma (an important barrier to treatment seeking; Corrigan, 2004; Gulliver et al., 2010; Owens et al., 2002) can be conceptualized as being related to both subjective norms and attitudes about CBT.

Previous DTC research has primarily examined the effectiveness of educational campaigns (*what* is being delivered), with some work examining *how* the message is delivered, and *who* is delivering a message. Findings suggest that brief DTC educational videos, relative to control videos without information about EBPs, increase knowledge, decrease stigma, and increase intention to seek psychological therapy (Amsalem & Martin, 2022; Brecht et al., 2010; Gallo et al., 2015; Ponzini & Schofield, 2019). Mental health literacy programs have been shown to improve mental health literacy and decrease stigma by using educational presentations and interactive education modules (Hurley et al., 2020; Wei et al., 2013). More generally, tailoring health messages to the audience improves the effectiveness of dissemination efforts (Kreuter & Wray, 2003). Regarding how to deliver dissemination campaigns, infographics, visual elements, and narratives can increase attention and stimulate emotion for the audience of dissemination efforts (Becker et al., 2020; Dahlstrom, 2014; Purtle et al., 2022). Limitations of previous DTC research include the use of non-representative samples (i.e., undergraduate or online participant pools; Amsalem & Martin, 2022; Barnett et al., 2020; Brecht et al., 2010; Gallo et al., 2015; Hurley et al., 2020;

Ponzini & Schofield, 2019), and many studies on mental health literacy and contact strategies lacked controlled designs (Hurley et al., 2020; Jorm, 2020).

Dissemination research examining the optimal messenger of dissemination campaigns (i.e., who delivers the message) has primarily examined the effect of individuals with lived experience. Although contact-based strategies (increasing contact with someone with a mental illness) may reduce stigma more than education alone in the short-term (Corrigan et al., 2012), there is a lack of evidence supporting the notion that contact-based strategies lead to behavior changes or sustained reductions in stigma (Jorm, 2020). Two studies found that testimonials given by previous recipients of treatment, relative to information given by a therapist, did not significantly increase treatment-seeking (Barnett et al., 2020; Morawska et al., 2011). In fact, Spanish speaking individuals had a greater intention of seeking treatment after receiving information from an expert (Barnett et al., 2020). Additionally, in one study, testimonials reduced homophily (perceived similarity between two individuals) and increased critical thoughts about the messenger (Johnson et al., 2017). However, other studies have supported the use of caregivers as messengers of mental health information. A study on National Alliance for Mental Illness seminars about seeking treatment found that, relative to a waitlist condition, a seminar led by a caregiver of a youth with mental illness increased intention to engage in therapy (Bearman et al., 2022). Finally, in a DTC survey, caregivers reported that they preferred receiving information from pediatricians or other parents (Becker et al., 2018). Taken together, the evidence is mixed regarding whether individuals with lived experience are the optimal messengers in dissemination campaigns aimed at increasing engagement with treatment.

One strategy used in implementation research, but not yet examined in DTC dissemination research, is collaborating with opinion leaders (OLs). OLs are trustworthy members of a local community who can use their social influence to enhance the relevance, acceptability, and credibility of DTC initiatives (Daniels et al., 2017; Flodgren et al., 2019; Frazier et al., 2007; Gustafson et al., 2018; Rusch et al., 2018; Valente & Pumpuang, 2007). OLs may be effective because people are more likely to use interventions that are used by people who are similar to them (Neal et al., 2011). OLs often have a high degree of homophily to other members of their social group (Rogers, 2003). OLs do not necessarily have lived experience with mental illness. Nonetheless, OLs could provide personal narratives about strategies used in CBT for youth anxiety. They also could help tailor DTC messages to their local community. In general, social support, encouragement from others, and social norms facilitate treatment seeking and decrease stigma (Gulliver et al., 2010; Pescosolido et al., 2008), and such encouragement is more influential when it comes from an OL (Flodgren et al., 2019). Use of OLs has been found to be an effective strategy in communicating health messages both within healthcare settings and the community (Atkins et al., 2008; Flodgren et al., 2019; Li, Lin, et al., 2013; Nelson, 2019). Specifically, OLs increase the likelihood of EBP implementation (Atkins et al., 2008; Flodgren et al., 2019), increase the dissemination of health information (Flodgren et al., 2019), and decrease stigma (Li, Wu, et al., 2013; Nelson, 2019). The involvement of OLs in DTC efforts would harness the importance of social relationships in the diffusion of innovations (Berwick, 2003; Rogers, 2003).

The present study (Project CHAT: Caregivers Hearing about Anxiety Treatments) evaluated the effects of involving a local caregiver OL in the modification and presentation of an educational outreach presentation for caregivers on youth anxiety by comparing two approaches for outreach presentations about CBT (Crane et al., 2021). Thus, it examined two dissemination strategies: (1) the use of OLs, and (2) an educational presentation on youth anxiety for caregivers. In this study, one presentation was facilitated by a clinical researcher and an OL (OL condition), and the other was facilitated by two clinical researchers (researcher-only condition). We hypothesized that (1) Relative to the researcher-only condition, the OL condition would result in a greater (a) increase in subjective norms about seeking CBT, (b) improvement in attitudes about CBT, (c) caregiver intention to seek CBT with exposures for their youth, and (d) decrease in caregiver stigma about mental illness. We further hypothesized that (2) relative to the researcher-only condition, the OL condition would result in more caregivers seeking CBT with exposures for their youth at the three-month follow-up. We also hypothesized that (3) both presentation conditions would result in a similar increase in knowledge about how to seek EBPs. Finally, we hypothesized that (4) participants would view Presenter 1 (MEC) more favorably when she presented with an OL, relative to when she presented with another researcher.



## CHAPTER 2

### METHOD

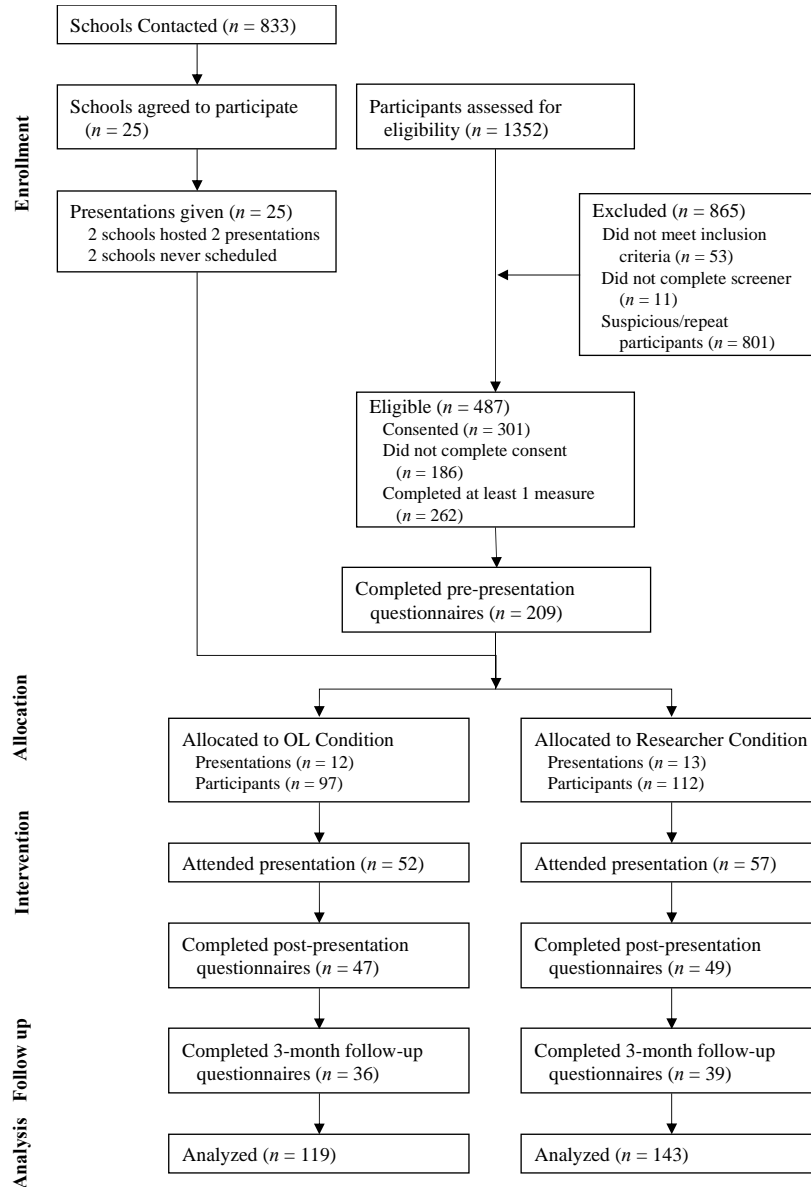
Further details of the study protocol are available in (Crane et al., 2021). The methods section of the protocol paper is included in APPENDIX A.

#### Participants

Participants ( $N = 262$ ) were primary caregivers who attended a presentation on youth anxiety at their youth's school. Elementary, middle, and high schools ( $n = 833$ ) located within a 1.5-hour drive of Philadelphia were recruited by emailing their school mental health workers/other school administrators; 25 schools were enrolled in the study. School administrators advertised presentations as they advertise other school events (e.g., email list, Facebook groups). Eligibility criteria included: being at least 18 years of age, being fluent in English, being the primary caregiver of a youth aged 5 to 18 years, and having a child at one of the schools offering a presentation. Caregivers were cluster randomized by school using restricted randomization with Excel's random number generator. Randomization occurred after the school agreed to participate, but before caregivers enrolled in the study. MEC randomized schools to presentation condition and enrolled all participants. The researchers and the participants could not be masked to study condition; however, participants were unaware of study hypotheses. The CONSORT diagram is presented in Figure 1. Participants received \$20 compensation to attend the presentation and complete the pre- and post-presentation questionnaires and \$10 to complete the three-month follow-up questionnaire. Participants were predominantly female (92%), White (69%), non-Hispanic (82%) individuals with a college degree or higher (61%), with a household income above \$50,000

(62%), and a mean age of 40.66 years (see Table 1). Most (93%) participants were the biological parent of their child.

**Figure 1**  
Consort Diagram



*Note.* OL = opinion leader; participants were block randomized by school & presentation date

**Table 1**

## Participant Demographics and Mental Health History

	Caregivers		Youths	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age	40.66	6.78	9.64	3.27
Number of Children	2.47	1.31		
Satisfaction with previous therapy experience	3.61	1.02	3.46	1.02
RCADS-A			59.28	15.00
	<i>n</i>	%	<i>n</i>	%
Gender <sup>a</sup>				
Female	194	92	102	49
Male	14	7	97	46
Non-binary / Transgender	0	0	4	2
Prefer not to say / Unsure	2	1	6	3
Race <sup>a</sup>				
American Indian or Alaska Native	4	2	5	2
Asian	8	4	13	6
Black or African American	40	18	53	23
White	145	67	146	62
A race not listed / Prefer not to say	20	9	18	8
Ethnicity <sup>a</sup>				
Hispanic	34	16	39	18
Not of Hispanic origin	173	82	166	79
Prefer not to say	4	2	6	3
Total household income				
Less than 24,999	23	13		
\$25,000-\$49,999	28	15		
\$50,000-\$74,999	20	11		
\$75,000-\$99,999	34	19		
\$100,000 and over	77	42		
Prefer not to say	28	15		
Child Health Insurance Coverage <sup>a</sup>				
Employer/private health insurance			150	67
Medicaid / CHIP			63	28
None			2	1
Prefer not to say / Unsure			9	4
Highest education completed				
Less than 4 years of college	79	38		
College graduate (4-year)	61	29		
Graduate School	68	32		
Prefer not to say	2	1		

Table 1 (continued)

	Caregivers		Youths	
	<i>n</i>	%	<i>n</i>	%
<b>Mental Health History</b>				
Previous diagnosis of mental disorder: Yes	91	43	65	31
Seen a mental health professional: Yes	135	64	83	40
Therapist did cognitive behavioral therapy <sup>b</sup>				
Yes	44	33	32	39
No	38	28	15	18
Unsure	53	39	36	43
Therapist used exposures <sup>b</sup>				
Yes	26	19	17	20
No	88	65	36	43
Unsure	21	16	30	36

*Note.* *n* = 210; <sup>a</sup> = Percentages may sum to over 100% because participants could select more than one identity. <sup>b</sup> = Out of the total number of participants who have been to a mental health professional; RCADS-A = Brief Revised Child Anxiety and Depression Scale-Parent Version, anxiety subscale t-score; CHIP = Children's Health Insurance Program

## Measures

### *Treatment Seeking Evaluation*

Pre- and post-presentation, caregivers rated how likely they were to seek a therapist who uses exposure therapy in the next three months on a scale ranging from 1 (*very unlikely*) to 5 (*very likely*; see Appendix B). At the three-month follow-up assessment, caregivers indicated if they had sought therapy for their youth since the presentation (yes or no). If yes, they were asked if the child had started therapy, if they requested a therapist who uses exposure therapy, and for the name of their child's therapist. MEC and undergraduate research assistants coded whether the therapist offered exposure therapy (Treatment Seeking

Evaluation – Actual) using existing knowledge of the therapist or by asking the therapist directly whether they offered exposure therapy for youth anxiety.

### ***Knowledge about Seeking CBT***

The Parent Engagement in Evidence-Based Services Questionnaire (PEEBS) is a 39-item questionnaire assessing factors associated with seeking mental health care (Chang et al., 2019). Response options ranged from 1 (*strongly disagree*) to 5 (*strongly agree*); some items were reverse coded. Caregiver ratings were summed to create five subscales (Choy & Nakamura, 2022); this study used the knowledge subscale (PEEBS-K) to measure caregivers' perceived understanding of how to seek EBPs (i.e., perceived behavioral control). Higher PEEBS-K scores indicate higher levels of perceived knowledge about seeking evidence-based practice. Evidence supports the PEEBS-K's internal consistency ( $\alpha = .72$ ) and convergent validity with measures of health seeking, attitudes and intentions, and stigma, and family empowerment in mental health decisions ( $r = .25-.41$ ; Choy & Nakamura, 2022). In the present sample, internal consistency of the PEEBS-K was .74.

### ***Internalized Stigma***

The Parents' Internalized Stigma of Mental Illness Scale (PISMIS; Zisman-Ilani et al., 2013) is a 10-item measure of caregiver perception of internalized stigma for having a youth with a mental illness. Response options ranged from 1 (*strongly disagree*) to 4 (*strongly agree*); some items are reverse coded. Higher scores indicate higher levels of family stigma. It is an adaptation of the well-validated Internalized Stigma of Mental Illness Scale (Boyd et al., 2014; Ritsher et al., 2003), which has demonstrated sensitivity to change in the expected direction after stigma reduction interventions (Boyd et al., 2014). The

PISMIS has acceptable internal consistency ( $\alpha = .76$ ; Zisman-Ilani et al., 2013). In the present sample, internal consistency of the PISMIS was .88.

### ***Caregiver Attitudes about Cognitive Behavioral Therapy***

The Caregiver Attitudes about CBT (CACBT) evaluates caregivers' perceptions of the helpfulness of 18 strategies used in CBT for youth anxiety. Response options ranged from 1 (*very unhelpful*) to 5 (*very helpful*). All items were summed; higher scores indicate more favorable attitudes. The CACBT was developed for the present study. Items were generated using an expert consensus (three clinical psychologists specializing in exposure treatment and one advanced doctoral candidate in clinical psychology). Some items were modeled on the Knowledge of Evidence Based Services Questionnaire (Stumpf et al., 2008). In the present sample, internal consistency of the CACBT was .96.

### ***Therapy Subjective Norms***

The Therapy Subjective Norms Questionnaire is a six-item measure of caregiver perception of subjective norms for seeking CBT (TSN-CBT). This scale was developed for the present study and was modeled from previously used measures of subjective norms (Glanz et al., 2008; Park & Smith, 2007) and assessed both injunctive norms (i.e., how other people would view an action the participant does) and descriptive norms (i.e., the participant's view about what other people are doing). Response options ranged from 1 (*strongly disagree*) to 7 (*strongly agree*). Items were summed to create a score for overall subjective norms (all six items). In the present sample, internal consistency of the TSN-CBT was .95.

### ***Impression of Presenters***

On the Relatability Evaluation, caregivers rated each presenter on the following 10 dimensions: relatability, likeability, similarity, similarity in thinking, similarity of beliefs, credibility, trustworthiness, understanding of the local community, familiarity, and friendship. This scale was developed for the present study; items were based on characteristics of homophily (McCroskey et al., 1975). Responses ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Items were evaluated separately.

### ***Youth Anxiety***

The Brief Revised Child Anxiety and Depression Scale-Parent Version (RCADS) is a 25-item caregiver report measure of anxiety and depressive symptoms (Ebesutani et al., 2017). Responses ranged from 0 (*never*) to 3 (*always*). This study used the 15-item Total Anxiety subscale (RCADS-A). Previous research supports the RCADS-A internal reliability ( $\alpha = .80 - .86$ ), retest reliability ( $r = .85$ ), convergent validity ( $r = .59$ ), and discriminant validity for anxiety diagnoses (AUC = .81; Ebesutani et al., 2017). In the present sample, the internal consistency of the RCADS-A was .81.

### ***Client Satisfaction***

Caregivers indicated their satisfaction with the presentation using the Client Satisfaction Questionnaire (CSQ; Attkisson & Zwick, 1982). This scale includes eight Likert-scale questions (range = 1-4) and three short answer questions. Higher composite scores indicate greater program satisfaction. Psychometric analyses support the CSQ's internal consistency ( $\alpha = .93$ ) and convergent validity ( $r = -.40 - .23$ ; Attkisson & Zwick, 1982). In the present sample, internal consistency of the CSQ was .91.

### ***Demographics***

A demographics questionnaire assessed caregiver and youth age, gender, race, ethnicity, and country of origin; caregiver level of education, income, and religious service attendance; and youth health insurance status. The presenters also indicated their age, gender, country of origin, number of children, and level of education to assess their similarity to participants.

### ***Mental Health History***

On the mental health history questionnaire, participants indicated whether they or their youth have been diagnosed with or treated for a mental disorder, whether they or their youth have received CBT with exposures, and their level of satisfaction with their youth's previous treatment experience.

### ***Fidelity and Manipulation Checks***

A Knowledge Test and Fidelity checklist were used to assess whether the presentations in each condition were delivered consistently and whether participants learned a similar amount of information from the presenters. A research assistant functioned as an independent evaluator and completed a content checklist, coded for presenter and audience member self-disclosure about experience receiving therapy for themselves or their child, and noted the total amount of time each presenter spoke. Two research assistants were present for 25% of presentations to assess for interrater reliability. Presentation content was delivered with 100% fidelity ( $\kappa = 1$ ).

A 20-item Knowledge Test (KT) assessed caregivers' knowledge of the content reviewed in the presentation (i.e., identifying anxiety disorders, strategies for caregivers to



manage youth anxiety, EBPs to treat youth anxiety, and strategies for finding a therapist).

The KT was modeled after one used to assess therapist training of CBT for anxiety (Beidas et al., 2009). Items were true/false and multiple-choice format. Responses were coded such that 1 = correct and 0 = incorrect, for a maximum of 20 points. The KT was piloted on caregivers during outreach presentations conducted prior to the project. Items were retained if they were answered correctly by approximately 60-90% of respondents, representing a desirable difficulty. The KT was used as a manipulation check to assess participants' understanding of the presentation material.

### **Procedures**

All questionnaires were completed and stored on REDCap (a HIPAA secure platform; Harris et al., 2019). Participants and OLS provided informed consent via REDCap before completing questionnaires. Before (pre) and after (post) the presentation, participants completed the Treatment Seeking Evaluation, PEEBS, PISMIS, CACBT, TSN-CBT, and KT. They also completed the RCADS, demographics, and mental health history questionnaire before the presentation; the Relatability Scale and the CSQ after the presentation; and the Treatment Seeking Evaluation at 3 month follow up. After they completed the pre-questionnaires, they were sent the zoom link to the presentation. They completed the post-presentation questionnaires within 1 week of the presentation ( $M_{\text{days}} = 2.12$ ,  $SD_{\text{days}} = 2.56$ ). Follow-up questionnaires were sent to participants 3 months after the presentation and were completed an average of 3.12 months ( $SD_{\text{months}} = 0.13$ ) after the presentation. The three month follow up period was selected to be long enough to provide

participants enough time to begin reaching out to therapists, while being short enough to minimize attrition.

Caregivers in both conditions attended an outreach presentation (i.e., a live webinar) which lasted an average of 75.38 minutes ( $SD = 10.3$ ), including an average of 16.88 minutes ( $SD = 8.12$ ) for caregiver questions. Presentations occurred via Zoom, primarily in the evening, although one presentation occurred during the day. Presentations were hosted from May 2021 – May 2022 during the school year. Each presentation included information about identifying anxiety disorders (to increase awareness of potential need for treatment and to cue relevance; Petty et al., 1983), strategies for caregivers to help their youth with anxiety (to reduce stigma by demonstrating anxiety is treatable), and CBT for youth anxiety, as well as strategies for finding a therapist who uses CBT with exposures (to provide information on seeking CBT). Exposure therapy was emphasized given that exposure therapy is underutilized by therapists in the community despite being a core ingredient of CBT (Chu et al., 2015). Participants were sent a PDF of the presentation after it occurred, along with a referral list of local therapists who provide CBT with exposures, a list of self-help resources, a summary of the key strategies reviewed, and an infographic about youth anxiety and CBT (See Appendices D-F). The presentation was cofacilitated by two presenters. Presenter 1 (MEC) was the same across all presentations, while Presenter 2 varied based on condition. Presenter demographics are found in Table 2.

**Table 2**

## Presenter Demographics

	Presenter 1	Presenter 2: Researcher		Presenter 2: Opinion Leader	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age	29	27.33	1.23	40.46	4.46
Number of Children	0	0.11	0.33	2.55	1.13
	<i>n</i>	<i>n</i>	%	<i>n</i>	%
Gender <sup>a</sup>					
Cisgender	1	9	100	11	100
Female	1	7	78	11	100
Male	0	2	22	0	0
Race <sup>a</sup>					
Black or African American	0	1	12	2	18
White	1	8	88	8	73
Ethnicity <sup>a</sup>					
Hispanic	0	0	0	1	9
Not of Hispanic origin	1	9	100	10	91
Country at Birth					
In the United States	1	9	100	11	100
Highest education completed					
Some college	0	0	0	1	9
College graduate (4-year)	0	3	33	4	36
Master's degree or equivalent	1	6	67	4	36
Doctoral degree or equivalent	0	0	0	2	18

*Note.* <sup>a</sup> = Percentages may sum to over 100% because participants could select more than one identity; Presenter 1 was the same person (MEC) across conditions.

***Researcher-Only Condition***

The clinical researcher presenters (presenter 1 and presenter 2 in the researcher-only condition) were clinical psychology PhD students who had specialized training in CBT for youth anxiety and who worked as therapists in a specialty clinic for youth anxiety at Temple University. They were introduced using these characteristics during the presentation to establish credibility. Presentation content was the same for all schools randomized to the

researcher-only condition, although examples were slightly modified based on brief feedback via email from the school staff member organizing the presentation.

### ***OL Condition***

In the OL condition, Presenter 2 was an OL. To select the OLs, school parent groups were contacted (e.g., parent-teacher association) and asked, “please nominate a caregiver who is well-known and respected within your community, and who reflects the diversity of the school as a whole.” If a school did not have an active parent group, the school staff selected the OL. The OLs did not necessarily have experience (professional or personal) with mental health. Previous research supports OL nomination by knowledgeable community members (e.g., caregivers in the parent teacher association) and by nomination of a well-known individual (Rogers & Cartano, 1962; Valente & Pumpuang, 2007). Prior to serving as presenters, the OLs attended two training meetings with MEC with the goal of teaching them presentation content, tailoring the presentation as needed, and, leveraging the OLs as champions of CBT. Additional information regarding OL training is found in the study protocol (Crane et al., 2021), as well as APPENDIX A. During the presentation, the OLs were introduced as members from their school who had worked with the researcher to tailor the presentation to their community. Presentation content was similar across schools but varied in terms of specific examples. OLs were encouraged to share personal stories and examples of how the presentation material can apply to the school community to increase a sense of homophily to the OL, as well as local relevance of the information. Although there was one OL per school, one school in the OL condition offered the presentation twice. Thus,

there were a total of 11 OLs in the study. OLs were paid \$200 for their involvement with the study (approximately \$40/hour).

### **Analytic Plan**

Study analyses were preregistered in the study protocol paper (Crane et al., 2021) and on [clinicaltrials.gov](https://clinicaltrials.gov) (NCT04929262). Analyses used multilevel modeling using restricted maximum likelihood estimation with a random intercept to account for the nesting of repeated measures within caregivers, as well as to provide unbiased parameter estimates when data are missing at random. Differential rates of attrition were assessed using multiple logistic regression analyses examining whether key predictors at baseline (i.e., Knowledge Test, PEEBS-K, PISMIS, TSN, CACBT, Treatment Seeking Evaluation, and demographics) were associated with study retention. Significant predictors were added as covariates in subsequent regression analyses. Analyses considered intention to seek CBT with exposures (Treatment Seeking Evaluation - Intention to seek CBT), subjective norms about seeking CBT (TSN-CBT), attitudes about CBT (CACBT), caregiver stigma about mental illness (PISMIS), and knowledge about how to seek EBPs for youth anxiety (PEEBS-K) as person-level dependent factors; condition (caregiver or researcher co-facilitator) as a person-level predictor; and time (pre- and post-presentation) as an observation-level predictor. In separate multilevel models, (a) intention to seek CBT, (b) TSN-CBT, (c) CACBT, (d) PISMIS, and (e) PEEBS-K subscale were regressed on time, condition, and the interaction between time and condition; a random intercept was included in all five multilevel models. A binary logistic regression was conducted with CBT service seeking at the three-month follow-up (Treatment Seeking Evaluation - Actual CBT seeking) entered as the dependent variable,

condition entered as the independent variable, and youth anxiety (RCADS-A) entered as a control variable. *T*-tests were used to examine the difference between conditions for each item on the Relatability Evaluation of Presenter 1 and Presenter 2 (exploratory analysis). This study examined caregiver demographic factors, youth anxiety (Brief Revised Child Anxiety and Depression Scale–Total Anxiety), racial similarity to the presenter (Demographics, same race), and self-disclosure (Content Checklist, self-disclosure) as potential moderators of the effect of presentation condition on intention to seek CBT. In separate multilevel models, intention to seek CBT was regressed on time, condition, each potential moderator, and their three-way interaction.

Prior to data collection, a Monte Carlo-based power estimate was derived using Mplus with 10,000 replications. For the sample size of 180, assuming a Type I error rate of 5%, a two-tailed test and 10% attrition, statistical power was .83 to detect a medium-sized effect ( $r = .30$ ) of randomization group on longitudinal changes, given an expectation of a small ( $r = .15$ ) effect for the comparison group. Additional participants were recruited given higher than expected rates of attrition.

## CHAPTER 3

### RESULTS

#### Preliminary Analyses

Preliminary analyses examined school based-clustering, reach (including attrition), and descriptive statistics. ICCs for the effect of school on TSN-CBT, PEEBS-K, treatment seeking intention, and treatment seeking actual models were very small, ranging from .01-.114. ICCs could not be computed for the CACBT and PISMIS models examining the effect of school-based clustering; this was due to the between-cluster variance being trivially small. Taken together, subsequent models were estimated without considering the role of school-based clustering. There was no significant difference between conditions for participant demographics variables (caregiver age, gender, race, ethnicity income, level of education) or baseline values of primary dependent variables (intention to seek CBT, TSN-CBT, CACBT, PISMIS, PEEBS-K, and KT),  $bs \leq 3.49$ ,  $SEs \geq .04$ ,  $ps \leq .20$ . Descriptive statistics for study outcome variables are presented in Table 3 (pre and post) and Table 4 (follow-up). Correlations of study variables at baseline are presented in APPENDIX C, Table C 1.

**Table 3**

Descriptive Statistics for Dependent Variables: Pre- and Post-Presentation

	Pre				Post			
	Researcher		Opinion Leader		Researcher		Opinion Leader	
	M	SD	M	SD	M	SD	M	SD
KT	66.09	20.64	62.60	24.58	84.80	18.05	80.59	25.57
PEEBS-K	3.01	0.74	3.06	0.74	3.56	0.61	3.70	0.72
PISMIS	15.07	4.26	15.01	5.00	14.90	4.30	14.60	5.90
TSN-CBT	32.60	6.98	31.36	7.40	34.28	6.71	33.81	6.35
CACBT	80.35	11.94	79.04	8.63	82.98	8.24	81.13	7.52
Exp Seeking: Intention	3.23	1.18	3.02	1.22	3.67	1.20	3.79	1.18

*Note.* KT = knowledge test; PEEBS-K = Parent Engagement in Evidence-Based Services

Questionnaire, Knowledge Subtest; PISMIS = Parents' Internalized Stigma of Mental Illness

Scale; CACBT = Caregiver Attitudes about Cognitive Behavioral Therapy; Exp = exposure

therapy



**Table 4**

Descriptive Statistics for Dependent Variables: 3-Month Follow-Up

	Researcher		Opinion Leader	
	N	%	N	%
<b>Sought Treatment</b>				
Yes	13	36	12	31
No	17	47	21	54
Child was already in therapy	6	17	6	15
<b>Sought Exp (self-report) <sup>a</sup></b>				
Yes	3	23	3	25
No	9	69	6	50
Unsure	1	8	3	25
<b>Sought Exp (coded) <sup>b</sup></b>				
Yes, new therapist	4	22	5	29
Yes, child was already seeing	4	22	3	18
No	3	17	3	18
Unable to determine	7	39	6	35

*Note.* <sup>a</sup> = Out of the total number of participants who sought therapy for their child; <sup>b</sup> = out of those who either sought a new therapist, or whose child was already seeing a therapist; Exp = exposure therapy; Coded = research team coded the therapist as completing exposure therapy

### ***Reach/Attrition***

Was there a significant difference between caregivers who were recruited and caregivers who attended the presentation? The schools that enrolled in the study ( $M\% = 62.66$ ,  $SD\% = 34.70$ ) had a significantly higher proportion of students from a racial/ethnic minoritized background (percent of students who are not White and/or Hispanic) relative to the schools contacted ( $M\% = 53.57$ ,  $SD\% = 30.97$ ),  $t(829) = 2.07$ ,  $p = .04$ ,  $d = 0.29$ .

Additionally, the schools that enrolled in the study ( $M\% = 54.00$ ,  $SD\% = 33.10$ ) had a significantly higher proportion of students eligible for free school meals (approximately

\$25,000 annual income) relative to the schools contacted ( $M\% = 42.51$ ,  $SD\% = 34.37$ ),  $t(749) = 2.44$ ,  $p = .02$ ,  $d = 0.35$ . However, caregivers who participated in the study were more likely to be White (69%) and less likely to have income that would qualify for free school meals (13%) than the racial/ethnic and economic background of the students who attended the schools hosting the presentations,  $ts(181) \leq 13.51$ ,  $p < .001$ . Additionally, participants who were Black, had an income less than \$50,000, and who had a college degree or fewer years of education were significantly less likely to attend the presentation,  $bs \leq 0.18$ ,  $SEs \geq .003$ ,  $ps \leq .04$ . Given these demographic variables (race being Black, income, and level of education) were associated with participant attrition, these variables were entered as covariates in all multilevel models. Caregiver age, gender, and ethnicity, as well as the primary dependent variables (intention to seek CBT, TSN-CBT, CACBT, PISMIS, PEEBS-K, and KT), were not significantly associated with presentation attendance (and thus attrition).

### ***Presentation***

Presentations ( $N = 25$ ) were attended by an average of 4.36 caregivers ( $SD = 4.32$ , range = 0-20). Presenter 1 spoke for an average of 46.75 minutes ( $SD = 7.18$ ). For Presenter 2, there was no significant difference between the speaking time of the researcher presenters spoke ( $M = 25.00$  min,  $SD = 8.24$ ), and the OL presenters ( $M = 21.42$  min,  $SD = 5.20$ ),  $t(22) = 1.27$ ,  $p = .216$ ,  $d = 0.52$ . Presenter self-disclosures were rated on 24 codes and included disclosures about themselves or their child having anxiety or seeking/receiving therapy. Across the codes, kappa ranged from 0-1, with an average kappa of .90. The researcher presenters (presenter 1, and presenter 2 in the research only condition), while 66% ( $n = 8$ ) of the OLs self-disclosed about personal/familial experience with mental health and/or therapy.

There was no significant difference in presentation satisfaction (CSQ) between the researcher only ( $M = 28.04$ ,  $SD = 3.74$ ) and OL ( $M = 27.64$ ,  $SD = 3.36$ ) conditions, with both conditions having favorable presentation ratings,  $t(94) = 0.55$ ,  $p = .58$ ,  $d = 0.11$ . There was no significant interaction between condition and time on knowledge of presentation material (KT),  $b = 4.20$ ,  $SE = 3.72$ ,  $p = .26$ , but the main effect of time on knowledge of presentation material was significant,  $b = 10.01$ ,  $SE = 1.89$ ,  $p < .001$ , indicating that participants' knowledge of presentation material increased across conditions as hypothesized.

### **Theory of Planned Behavior**

There was no significant difference between conditions regarding the seeking of both therapy and exposure therapy as coded by the study team,  $bs \leq 0.04$ ,  $SEs \leq 0.18$ ,  $ps \geq .74$ . There was no significant interaction between time (pre to post presentation) and condition (researcher vs. OL) on knowledge of seeking EBPs (PEEBS-K), subjective norms about seeking CBT (TSN, CBT total), stigma (PISMIS), attitudes about CBT (CACBT), and intention to seek exposure therapy,  $bs \leq 0.31$ ,  $SEs \leq 2.08$ ,  $ps \geq .33$ . The main effect of time on stigma and attitudes about CBT was not significant,  $bs \leq 1.44$ ,  $SEs \leq 1.21$ ,  $ps \geq .24$ .<sup>1</sup> There was a statistically significant main effect of time on knowledge of seeking EBPs,  $b = 0.67$ ,  $SE = 0.09$ ,  $p < .001$ , subjective norms about seeking CBT,  $b = 1.87$ ,  $SE = 0.69$ ,  $p = .01$ ,

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<sup>1</sup> The main effect of time on attitudes about CBT was significant without controlling for demographic variables that were significantly associated with attrition (race being Black, income, and level of education),  $b = 2.18$ ,  $SE = 1.03$ ,  $p = .04$ .

and intention to seek CBT,  $b = 0.59$ ,  $SE = 0.13$ ,  $p < .001$ . None of the variables tested (caregiver gender, age, race, ethnicity, education level, income; youth anxiety; self-disclosures; and being the same race or ethnicity as Presenter 2) significantly moderated the interaction between condition and time on intention to seek exposure therapy,  $bs \leq 0.63$ ,  $SEs \leq 0.89$ ,  $ps \geq .19$ . Together, this indicates that contrary to hypotheses, the presentation condition was not differentially associated with study outcomes. However, the presentations in both conditions were effective in improving participants knowledge of how to seek EBPs, subjective norms about seeking CBT, and intention to seek exposure therapy.

### **Impressions of Presenters**

Participants' impressions of the presenters are displayed in Table 5. Differences in impressions of the presenters were calculated using t-tests. Contrary to our hypothesis, participants' perceptions of Presenter 1 (MEC) were not significantly different when she presented with another researcher relative to when she presented with an OL,  $ts(94) \geq 0.04$ ,  $ps \geq .50$ ,  $ds \leq .14$ . To further explore this, we examined the difference between participants' perceptions of Presenter 2 (the second researcher vs. the OL). As expected for an OL, participants rated the OL as significantly more similar, more understanding of their community, more familiar, and more likely to be a friend relative to the researcher,  $ts(94) = 2.45$ ,  $ps \leq .046$ ,  $ds \geq 0.50$ . However, there was no significant difference between the OL and the researcher presenter in terms of being relatable, being likeable, thinking similarly, having similar beliefs about mental health, and being trustworthy,  $ts(94) \leq 1.95$ ,  $ps \geq .054$ ,  $ds \leq 0.40$ . Furthermore, participants rated the researcher presenter to be a significantly more credible source of mental health information than the OL,  $t(94) = 3.35$ ,  $p = .001$ ,  $d = 0.68$ .

**Table 5**

## Perceptions of Presenters

	Presenter 1				Presenter 2			
	Clinical Researcher		Opinion Leader		Clinical Researcher		Opinion Leader	
	M	SD	M	SD	M	SD	M	SD
Similar to me	3.71	0.87	3.72	0.80	3.61	0.86	4.02*	0.77
Familiar with the presenter	1.41	0.84	1.70	0.95	1.31	0.65	2.53*	1.52
Friends with the presenter	1.18	0.49	1.34	0.52	1.18	0.49	1.96*	1.20
Understood my community	4.10	0.85	4.13	0.82	4.00	0.84	4.32*	0.69
Relatable	4.12	0.78	4.19	0.68	4.00	0.76	4.28	0.62
Likable	4.61	0.57	4.62	0.53	4.51	0.58	4.55	0.54
Thinks like me	3.94	0.69	3.85	0.75	3.90	0.71	3.89	0.79
Similar beliefs about MH	4.27	0.67	4.28	0.62	4.18	0.70	4.13	0.61
Trustworthy	4.55	0.61	4.47	0.58	4.47	0.65	4.23	0.63
Credible MH info source	4.59	0.57	4.57	0.58	4.51	0.65	4.00*	0.83

*Note:* \*  $p < .05$ ; Presenter 1 is the same person (MEC) in both conditions. Presenter 2

differed across the presentations; MH = mental health

## **CHAPTER 4**

### **DISCUSSION**

The present study (Project CHAT) examined the use of a caregiver OL as a DTC strategy to increase caregiver demand for CBT for youth anxiety. Contrary to hypotheses, there was no significant difference between the researcher and OL facilitated presentation in terms of improving caregiver subjective norms, attitudes, knowledge, stigma, and intention to seek CBT for youth anxiety, or actual seeking of CBT for their child at three-month follow-up. However, both versions of the presentation resulted in improvements in subjective norms, knowledge, and intention to seek CBT. This study offers useful information about selecting OLs, understanding how dissemination audiences perceive sources of information, and the use of educational presentations as a dissemination strategy.

Before concluding that OLs are not an effective dissemination strategy, it is important to consider whether the caregiver presenters in this study can be considered OLs. The OLs in this study had some characteristics of OLs—being similar to and familiar to the participant and being understanding of their community (Valente & Pumpuang, 2007). However, they also were viewed as being less credible sources of mental health information, thus suggesting that participants may not have viewed them as potent OLs for mental health information (Flodgren et al., 2019; Valente & Pumpuang, 2007). Of note, the present sample included individuals who were highly educated and had low levels of stigma and thus may have been more inclined to view a researcher as a valuable source of information. It is possible that restricting OL nomination to include a caregiver they would go to for mental health help or OL identification using sociometric identification would have resulted in the OL presenters

being viewed as more credible (Grimshaw et al., 2006). However, these more complex OL identification methods may not have been as feasible (Valente & Pumpuang, 2007). OLs can be challenging to identify given that OLs may vary based on the topic or an individual's social network (Grimshaw et al., 2006). Grimshaw et al. (2006) suggested that OLs are best used for specialized groups, but this is a difficult strategy to scale across settings. Given that use of OLs is a costly implementation strategy (Szewczyk et al., 2022), they may not be preferable for universal dissemination campaigns. Instead, OLs may be more useful for individuals who have a higher degree of stigma or who are less trusting of alternative messengers.

Study findings may be considered as a comparison of clinical researchers and local caregivers co-facilitating a presentation. Contrary to our hypothesis, participants' perceptions of Presenter 1 did not change when she co-presented with a local caregiver versus another clinical researcher. Thus, in the present sample, collaborating with local caregivers may not have been necessary to increase perceived credibility and acceptability of clinical researchers. The lack of a significant effect of the OL condition on factors related to treatment seeking is in line with previous studies that have found no significant effect of testimonials (i.e., a messenger with lived experience) relative to mental health professionals (Barnett et al., 2020; Morawska et al., 2011). It is possible that caregivers' use of self-disclosure may have reduced their perceived credibility and homophily with study participants (Johnson et al., 2017). However, given the role of peer influence (Corrigan et al., 2014; Pescosolido et al., 2008), it is somewhat surprising that engaging a local community member did not further improve subjective norms on seeking treatment.

Regardless of the presenter, the present findings support the use of educational presentations as a dissemination strategy to improve caregiver subjective norms about, knowledge of, and intention of seeking CBT for youth anxiety. Although the project lacked a waitlist control condition, a higher percentage of participants' children who were in therapy had seen an exposure therapist at follow-up than before the presentation. These findings are in line with previous research supporting educational dissemination strategies to improve knowledge, attitudes, and help seeking behavior for mental health (Amsalem & Martin, 2022; Barnett et al., 2020; Bearman et al., 2022; Brecht et al., 2010; Gallo et al., 2015; Hadlaczky et al., 2014; Hurley et al., 2020; Ponzini & Schofield, 2019). The lack of a significant main effect of time on stigma and attitudes about CBT may have been due to a ceiling effect, as participants had low levels of stigma and favorable views about CBT.

Contrary to previous research (Amsalem & Martin, 2022; Barnett et al., 2020; Becker et al., 2018, 2020), this study did not identify significant moderators of presentation effectiveness, suggesting that all individuals who participated benefited similarly. However, analyses examining presentation reach suggest that this education presentation was less likely to reach individuals who identify as Black, who have lower levels of education, and who have lower incomes. Differences in reach were seen in participant recruitment and retention, not from the recruitment of schools. This finding suggests that attitudinal and structural barriers impacting participants, rather than schools, may affect the reach of educational presentations about mental health. Additional research is warranted to identify dissemination strategies that may be more acceptable and feasible for individuals who are often medically



underserved and may face more structural barriers to engaging in mental health care (Green et al., 2020).

There are limitations that warrant discussion. First, there were high rates of attrition in this study: approximately half the participants who completed registration (pre-questionnaires) attended the presentation. Although this may be representative of attrition from presentation registration to attendance, aforementioned underserved and minoritized individuals were less likely to attend. This finding provides useful information about the reach of presentations as a dissemination strategy but also may bias study results. Moderation analyses of the effect of demographic variables on the effect of condition were underpowered. Previous research suggests that race and ethnicity (likely representing underlying cultural factors and structural barriers associated with these demographic variables) may impact individuals' level of stigma, knowledge of EBPs, and preferred messengers of health information (Barnett et al., 2020; Becker et al., 2018; Green et al., 2020; Taylor & Kuo, 2019; Turner et al., 2015). Thus, it is possible that the OL may have been more effective for individuals from specific backgrounds. Additionally, participants were predominantly female. Although this may be reflective of the fact that mothers tend to seek mental health treatment for their children, future research could examine how to engage fathers more in the treatment process. Second, the participant demographic form was completed as one of the final pre-questionnaires. Thus, we were unable to examine whether the research burden of the presentation registration (pre-questionnaires) differentially impacted certain individuals. Third, school and participant recruitment, and participation retention were likely negatively impacted by stressors of the COVID-19 pandemic. Fourth,

the study included many measures that were created for this study and were not psychometrically validated. However, results provide preliminary support for internal consistency, sensitivity to change, and convergent validity for the TSN-CBT and CACBT. Intention to seek CBT and the characteristics of the presenters (Presenter Evaluation) were assessed using single items, thus limiting variance between subjects. Finally, a three-month follow-up period, while perhaps more feasible for study retention, may not have provided participants sufficient time to find a provider with availability who offers exposure therapy given waitlist lengths.

This study also has many strengths. First, it was a preregistered randomized controlled trial of a dissemination strategy with an active control condition. Second, participants in this study were caregivers interested in seeking information on youth anxiety, rather than online participants; this is in contrast to previous direct-to-consumer marketing studies that primarily used undergraduate or online participant pools (Amsalem & Martin, 2022; Barnett et al., 2020; Brecht et al., 2010; Gallo et al., 2015; Hurley et al., 2020; Ponzini & Schofield, 2019). Third, this study examined actual treatment seeking three months after the intervention, rather than just treatment seeking intentions. Finally, by examining participants' perceptions of presenters, we were able to theorize about the potential reasons for the lack of significant effect of the OL condition.

Given the need for research on dissemination (Baker et al., 2021), there are numerous directions for future research. Research is needed to examine dissemination strategies (e.g., infographics, social media, presentations, media campaigns) and to examine both the reach and effectiveness of each method. In dissemination research it is important to examine the

reach of dissemination efforts to ensure that these initiatives equitably provide benefits, rather than only reaching specific groups. Future research could examine the feasibility of caregivers presenting educational DTC presentations on mental health without the presence of a clinical researcher, as well as other strategies to engage caregivers in dissemination initiatives using less resource intensive methods (e.g., audience participation, posting on a discussion forum). School parent liaisons or other lay mental health workers may be a more sustainable method to involve parents in DTC marketing initiatives than recruiting a parent for the purpose of a specific initiative. It is possible that OLs and parents may be more impactful if they are involved with designing dissemination campaigns from the beginning, rather than just tailoring and presenting a predetermined presentation. Finally, in addition to DTC research, additional research is needed to reduce structural barriers to seeking mental health treatment.

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**APPENDIX A**  
**EXTENDED METHODS SECTION**

**Methods/Design**

**Participants**

Participants ( $N = 180$ ) will be primary caregivers who are interested in seeking additional information about youth anxiety; specifically, caregivers who attend a presentation on youth anxiety at their youth's school. Schools located in a metropolitan area in the northeastern United States will be recruited via their school mental health workers/other school administrators. School administrators will be contacted via email; local school partners (i.e., school psychologists and social workers) will assist with school recruitment as needed. To increase the racial, ethnic, and financial diversity of the sample, schools will only be contacted if they had at least 60% minority student enrollment or at least 60% of students eligible for school meals (*Public School Review*, 2021). School administrators will advertise presentations as they advertise other school events (e.g., email list, Facebook groups). To be eligible for this study, participants must be least 18 years of age, be fluent in English, be the primary caregiver of a youth aged 5 to 18 years, and have a child at one of the schools offering a presentation. Caregivers will be cluster randomized by school using restricted randomization with Excel's random number generator. Randomization will occur after the school has agreed to participate in the study, but before caregivers enroll in the study. The principal investigator (clinical psychology candidate with a master's degree) will randomize schools to the presentation condition and will enroll all participants. Neither the researchers nor the participants were masked to study condition. Participants will be paid \$20 to attend

the presentation and complete the pre- and post-presentation questionnaires; \$10 to complete the three-month follow-up questionnaire; and \$20 for the qualitative interview.

### **Opinion Leaders**

To select the OLs, the principal investigator will contact the school parent-teacher association (or a similar parent group), and ask, “please nominate a caregiver who is well-known and respected within your community, and who reflects the diversity of the school as a whole.” If a school does not have an active parent teacher association (or similar group of active parents), the school staff may select the OL. The OLs do not necessarily have to be a member of the parent-teacher association or have experience (professional or personal) with mental health. Previous research supports OL nomination by knowledgeable community members (e.g., caregivers in the parent teacher association) as a valid method for identifying trusted individuals in the community (Rogers & Cartano, 1962; Valente & Pumpuang, 2007). The principal investigator will ask if the first OL on the list is interested in participating in the project. The OL must be willing to endorse CBT with exposures. Should the OL decline to participate, the parent-teacher association will be asked to nominate a second caregiver OL. There will be one OL per school; the total number of OLs will depend on the number of schools needed to recruit 180 caregiver participants.

OLs from at least two schools in the OL condition will participate in a two-hour feedback meeting with the principal investigator, with the goal of leveraging the OLs to be champions of CBT. During this meeting, the OLs will discuss their experiences with youth anxiety, factors about their communities that may affect how anxiety symptoms present or are understood, and how caregivers in their community typically seek therapy. The OLs will

be sent a draft of the presentation to review prior to the meeting. During the meeting, the principal investigator will review the presentation materials and encourage the OLs to discuss their reactions and provide feedback. The OLs will consider which strategies they can endorse as being effective (e.g., remaining calm when their child becomes emotional). Motivational interviewing techniques will be used should OLs be skeptical about the value of CBT (Miller & Rollnick, 2012). The principal investigator will then modify the outreach presentation based on OL feedback. Presentations will be modified separately for each school, so the OLs who meet together do not need to come to consensus on presentation content. Following the group OL feedback meeting, the principal investigator will meet with each OL individually to (1) review/approve the modifications made; (2) answer remaining OL questions about the content; (3) determine which sections the OL is comfortable presenting, and which strategies they are willing to endorse; and (4) give the OL an opportunity to practice to ensure comprehension. OL meetings will take place via zoom. OLs will be paid \$40 per hour (5 hours=\$200 per OL).

The OL training checklist will be used to ensure that the OL training is delivered consistently (see Appendix A). The principal investigator will complete this checklist following the OL training. She will mark whether the group training discussed OL experiences with youth anxiety and reviewed the presentation materials, as well as whether the phone call reviewed modifications made to the presentation, allowed the OL to ask questions, determine which parts of the presentation the OL will present, which strategies the OL will endorse, and allows the OL the chance to practice.

## **Outreach Conditions**

Caregivers in both conditions will be invited to an outreach presentation, which lasts 75 minutes with an additional 15 minutes for caregiver questions. Presentations will occur in the evening via Zoom, separate from parent-teacher association meetings. Each presentation will include information about identifying anxiety disorders, strategies for caregivers to help their youth with anxiety, CBT for youth anxiety, and strategies for finding a therapist who uses CBT with exposures. Exposure therapy will be emphasized given that exposure therapy is underutilized by therapists in the community despite being a core ingredient of CBT (Chu et al., 2015). The text on the presentations is written at a 5.3 grade reading level.

Presentations will incorporate stigma reduction strategies, such as education to dispel myths, and behavioral decision-making tools to elicit hope, empowerment, and motivation (Larson & Corrigan, 2008; Pettigrew & Tropp, 2008; Yanos et al., 2015). Presentation content is manualized and is presented using PowerPoint.

## ***Researcher-Only Condition***

Half the schools will be cluster randomized to receive a researcher-facilitated presentation, led by two clinical psychology graduate students. Content will be the same for all schools randomized to the researcher-only condition. This is an active control condition. Researcher facilitated outreach presentations are one strategy research groups use to disseminate information to the community (Gallo et al., 2013; Powell et al., 2011; Szymanski, 2012).



### ***Opinion Leader Condition***

The other half of the schools will receive an OL co-facilitated presentations with the principal investigator (a clinical psychology PhD candidate). The OLs will be introduced as a member from their school who has worked with the principal investigator to tailor the presentation to their community. Although the presentation is manualized and will contain the same core principles, content may vary by school in terms of specific examples and content emphasized based on OL feedback. OL will be encouraged to share personal stories and examples of how the presentation material can apply to the school community (to increase a sense of homophily to the OL, as well as local relevance of the information).

### ***Fidelity and Manipulation Checks***

A 20-item Knowledge Test will assess caregivers' knowledge of the content reviewed in the presentation (i.e., identifying anxiety disorders, strategies for caregivers to manage youth anxiety, EBPs to treat youth anxiety, and strategies for finding a therapist). The knowledge test is modeled after one to assess therapist training of CBT for anxiety (Beidas et al., 2009). Questions are true/false and multiple-choice format. Responses will be coded such that 1 = correct and 0 = incorrect, for a maximum of 20 points. The Knowledge Test will be used as a manipulation check to test participants' understanding of the presentation material.

A content checklist will assess the core components of the presentation (i.e., identifying anxiety disorders, strategies for caregivers to help their youth with anxiety, how anxiety is treated, and strategies for finding a CBT therapist). A research assistant will function as an independent evaluator to complete this measure and evaluate the content of the outreach presentations. The research assistant will code for presenter and audience member

self-disclosure about experience receiving therapy for themselves or their child. The research assistant also will record the total amount of time each presenter speaks. Two research assistants will be present for at least 20% of presentations calculate interrater reliability of the evaluators ( $\kappa$ ).

### **Quantitative Measures**

All questionnaires will be completed and stored on REDCap (a HIPAA secure platform (Harris et al., 2019)) hosted at Temple University. Participants will provide informed consent via REDCap before completing questionnaires. Figure 2 provides a summary of the schedule of enrolment, interventions, and assessments using the SPIRIT flow diagram (Chan et al., 2013). All measures that were created for Project CHAT are in Appendix A and are elaborated below.

#### ***Treatment Seeking Evaluation***

Pre and post presentation, caregivers will rate how likely they are to both seek a therapist for their child, as well as a therapist who uses exposure therapy, in the next three months. Rating scale ranges from 1 (*very unlikely*) to 5 (*very likely*). At the three-month follow-up assessment, parents will be asked if they have sought therapy for their youth since the presentation. If so, they will be asked if the child has started therapy, if they requested a therapist who uses exposure therapy, and for the name of their child's therapist.

#### ***Knowledge about Seeking CBT***

The Parent Engagement in Evidence-Based Services Questionnaire (Chang et al., 2019) is a 39-item measure of factors associated with seeking mental health care based on the theory of planned behavior (Ajzen, 1991). Caregivers rate each statement on a 5-point Likert

scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*); some items are reverse coded. Caregiver ratings are summed to create five subscales (Choy & Nakamura, 2022); this study will use the knowledge subscale to measure caregivers' perceived understanding of how to seek EBPs (i.e., perceived behavioral control). On this subscale, higher scores indicate higher levels of perceived knowledge about seeking evidence-based practice. Evidence supports knowledge subscale's internal consistency ( $\alpha = .72$ ) and convergent validity ( $r = .25-.41$ ) (Choy & Nakamura, 2022).

### ***Internalized Stigma***

The Parents' Internalized Stigma of Mental Illness Scale (Zisman-Ilani et al., 2013) is a 10-item measure of caregiver perception of internalized stigma for having a youth with a mental illness. Caregivers rate each statement on a 4-point Likert scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*); some items are reverse coded. Higher scores indicate higher levels of family stigma. The Parents' Internalized Stigma of Mental Illness Scale has acceptable internal consistency ( $\alpha = .76$ ). It is an adaptation of the well-validated Internalized Stigma of Mental Illness Scale (Boyd et al., 2014; Ritsher et al., 2003), which has demonstrated sensitivity to change in the expected direction after stigma reduction interventions (Boyd et al., 2014).

### ***Caregiver Attitudes about Cognitive Behavioral Therapy***

The Caregiver Attitudes about CBT includes 18 strategies used in CBT for youth anxiety. Caregivers rate how helpful they believe each strategy would be for treating their child on a five-point scale ranging from 1 (*very unhelpful*) to 5 (*very helpful*). All items will be summed; higher scores indicate more favorable attitudes. Items were generated using an

expert consensus (three clinical psychologists specializing in exposure treatment and one advanced doctoral candidate in clinical psychology). Some items were modeled on the Knowledge of Evidence Based Services Questionnaire (Stumpf et al., 2008).

### ***Therapy Subjective Norms***

The Therapy Subjective Norms Questionnaire is a six-item measure of caregiver perception of subjective norms for seeking therapy. It was modeled from previously used measures of subjective norms (Glanz et al., 2008; Park & Smith, 2007). Caregivers rate each item on seven-point scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Three items assess injunctive norms (i.e., how other people would view an action the participant does; injunctive norms subscale), and three items assess descriptive norms (i.e., the participant's view about what other people are doing; descriptive norms subscale). Items will be summed to create a score for overall subjective norms (all six items), as well as the injunctive and descriptive norms subscales; higher scores indicate more positive subjective norms about seeking therapy. Participants will complete two versions of this measure (12 items total): in one version, they will rate subjective norms related to seeking therapy, and in the other version, they will rate subjective norms related to seeking CBT.

### ***Impression of Presenters***

On the Relatability Evaluation, caregivers will rate each presenter (the OL and the researcher, or the two researchers) on the following 10 dimensions: relatability, likeability, similarity, similarity in thinking, similarity of beliefs, credibility, trustworthiness, understanding of the local community, familiarity, and friendship. Scores will be given on a

scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). These items are based on characteristics of homophily (McCroskey et al., 1975).

### ***Youth Anxiety***

The Brief Revised Child Anxiety and Depression Scale-Parent Version is a 25-item caregiver report measure of anxiety and depressive symptoms (Ebesutani et al., 2017). Items are rated on a 4-point Likert-scale from 0 (*never*) to 3 (*always*). It yields three scores: Total Anxiety, Total Depression, and Total Anxiety and Depression. This study will use the Total Anxiety score. Previous research supports the Brief Revised Child Anxiety and Depression Scale total anxiety subscale's internal reliability ( $\alpha = .80 - .86$ ), retest reliability ( $r = .85$ ), convergent validity ( $r = .59$ ), and discriminant validity for anxiety diagnoses ( $AUC = .81$ ) (Ebesutani et al., 2017).

### ***Client Satisfaction***

Caregivers will evaluate their satisfaction with the presentation using the Client Satisfaction Questionnaire (Attkisson & Zwick, 1982). This scale includes eight Likert-scale questions and three short answer questions. On the Likert-scale questions, caregivers will rate their level of satisfaction on a 4-point scale ranging from 1 to 4, with higher composite scores indicating greater program satisfaction. Psychometric analyses indicate excellent internal consistency ( $\alpha = .93$ ) and convergent validity ( $r = -.40 - .23$ ) (Attkisson & Zwick, 1982).

### ***Demographics and Mental Health History***

A demographics questionnaire will assess caregiver and youth age, gender, race, ethnicity, and country of origin; caregiver level of education, income, and religious service attendance; and youth health insurance status. The presenters also will indicate their age,

gender, country of origin, number of children, and level of education to assess their similarity to participants. On the mental health history questionnaire, participants will indicate whether they or their youth have ever been diagnosed with or treated for a mental disorder, whether they or their youth have received CBT with exposures, and their level of satisfaction with their youth's previous treatment experience.

### **Qualitative Interviews**

After participants have completed the three-month follow-up questionnaire, 40 participants will be contacted to complete a qualitative interview via a Zoom videoconference. Participants will be purposefully sampled such that 20 participants who have sought treatment (10 per condition) and 20 who have not sought treatment (10 per condition) will be selected using Excel's random number generator. Additional participants will be recruited until thematic saturation is reached (Guest et al., 2006).

Semi-structured interviews (see Appendix A for the interview guide) will be conducted by undergraduate research assistants ( $N = 4$ ) using a funnel-approach, with open ended questions followed by specific required and optional probes for details (Spradley, 1979). Interviews will elicit information about barriers to seeking treatment, and the role of the presentation in reducing those barriers. Primary topics will include: (1) their perception of presenters; (2) ways in which the presenters affected their decision to seek treatment; (3) factors they considered when seeking treatment; (4) strategies they have used from the presentation; (5) their perception of exposure therapy; and (6) general ways that the mental health system could be improved to improve access to therapy. Interviews will close with a

question asking for general additional feedback. Interviews will last approximately 30 minutes and will be digitally recorded via Zoom.

After each interview, the interviewer will rate the participant's level of interest and involvement in answering the questions (1 = *very low* to 5 = *very high*), their understanding of the interview (1 = *limited* to 5 = *complete*), and their impression of the participant's knowledge of the topics discussed (1 = *highly questionable* to 5 = *highly knowledgeable*). The interviewer also will comment on discrepancies in the interview and circumstances that may have affected quality of responses. Zoom transcripts of the interviews will be used, and a research assistant will check the transcription for accuracy. Transcripts will be deidentified.

### **Analytic Plan**

#### ***Missing data***

The primary analytic tool will be multilevel modeling using maximum likelihood estimation, which provides unbiased parameter estimates when data are missing at random. The missing at random assumption will be tested by multiple logistic regression analyses examining whether key predictors at baseline (i.e., Knowledge Test, Parent Engagement in Evidence-Based Services Questionnaire–knowledge subscale, Parents' Internalized Stigma of Mental Illness Scale, Therapy Subjective Norms, Caregiver Attitudes about CBT, Treatment Seeking Evaluation, and demographics) are associated with study retention. Should analyses reveal that dropout is differentially associated with outcomes, multiple imputation will be used (Enders, 2017; Graham, 2009; Schafer & Graham, 2002). Every effort will be made to prevent missing data, such as by using REDCap options that remind participants to answer blank questions, and by emailing participants who have not completed all questionnaires.

### ***Power Analysis***

For Primary Aim 1, a Monte Carlo-based power estimate was derived using Mplus with 10,000 replications. For the sample size of 180, assuming a Type I error rate of 5%, a two-tailed test, statistical power was .83 to detect a medium-sized effect ( $r = .30$ ) of randomization group on longitudinal changes, given an expectation of a small ( $r = .15$ ) effect for the control group. For Primary Aim 2, power was calculated using G\*Power. Given the brevity of the three-month follow-up questionnaire, a 10% attrition rate was assumed. Assuming a Type I error rate of 5%, a two-tailed test, and a 25% rate of seeking CBT in the researcher-only condition, statistical power was .82 to detect a medium effect (odds ratio = 1.72).

### ***Data analysis and interpretation***

**Quantitative Analyses.** Quantitative analyses will use multilevel modeling to account for the nesting of repeated measures within caregivers. Preliminary analyses will examine the effect of clustering of caregivers within schools. If schools account for more than 10% of variance in the outcomes after controlling for condition, a three-level multilevel model will be used to account for nesting of repeated measures within caregivers within schools.

Analyses will consider intention to seek CBT with exposures (Treatment Seeking Evaluation - Intention to seek CBT), subjective norms about seeking CBT (Therapy Subjective Norms Questionnaire–CBT), attitudes about CBT (Caregiver Attitudes about CBT), caregiver stigma about mental illness (Parents' Internalized Stigma of Mental Illness Scale), and knowledge about how to seek EBPs for youth anxiety (Parent Engagement in



Evidence-Based Services Questionnaire–Knowledge Subscale) as person-level dependent factors; condition (caregiver or researcher co-facilitator) as a person-level predictor; and time (pre- and post-presentation) as an observation-level predictor. In separate multilevel models, (a) intention to seek CBT, (b) Therapy Subjective Norms Questionnaire–CBT, (c) Caregiver Attitudes about CBT, (d) Parents’ Internalized Stigma of Mental Illness Scale, and (e) Parent Engagement in Evidence-Based Services Questionnaire–Knowledge subscale will be regressed on time, condition, and the interaction between time and condition; a random intercept will be included in all five multilevel models. A binary logistic regression will be conducted with CBT service seeking at the three-month follow-up (Treatment Seeking Evaluation - Actual CBT seeking) entered as the dependent variable, condition entered as the independent variable, and youth anxiety (Brief Revised Child Anxiety and Depression Scale–Total Anxiety) entered as a control variable. T-tests will be used to compare difference between conditions for each item on the Reliability Evaluation of the principal investigator. This study will examine caregiver demographic factors, youth anxiety (Brief Revised Child Anxiety and Depression Scale–Total Anxiety), racial similarity to the presenter (Demographics, same race), and self-disclosure (Content Checklist, self-disclosure), as potential moderators of the effect of presentation condition on intention to seek CBT. In separate multilevel models, intention to seek CBT will be regressed on time, condition, each potential moderators, and their three-way interaction.

**Qualitative Analyses.** The transcribed qualitative interviews will be entered into NVivo software for analysis. Qualitative analyses will use a direct content analysis approach (Hsieh & Shannon, 2016). The coding team will create an initial codebook using the primary

topics asked in the qualitative interviews. Additional codes will be added to code text that does not fit into the initial categories, either to split the initial codes into two, or to create new codes. Coding will occur through a consensus process in which each transcript will be coded independently by two raters, who will arrive at consensus through discussion (Hill et al., 2005). Thematic responses will be examined by both condition and by whether the caregiver has sought treatment for their youth (4 groups total).

**Integration Procedures.** Mixed methods integration will follow a QUAN → qual structure with an expansion approach (Palinkas et al., 2010); quantitative methods being used to test hypotheses about the intervention and qualitative methods being used to contextual the results.

**APPENDIX B**  
**MEASURES CREATED FOR PROJECT CHAT**

## Treatment Seeking Evaluation

### Pre- and post-presentation

For the following questions, please consider your child (initials:\_\_\_\_\_)

In the next three months, how likely are you to seek a therapist for your child?

- (1) Very unlikely
- (2) Unlikely
- (3) Neither likely nor unlikely
- (4) Likely
- (5) Very likely

In the next three months, how likely are you to seek a therapist who uses exposure therapy (i.e., slowly helps a child face their fears) for your child?

- (1) Very unlikely
- (2) Unlikely
- (3) Neither likely nor unlikely
- (4) Likely
- (5) Very likely

### 3-month follow-up

*For the following questions, please consider your child with initials, [child initials].*

Have you sought therapy for your child?

- Yes
- No

*Yes, sought therapy for child*

Has your child started therapy?

- Yes, they have had their first appointment
- They haven't started, but their first appointment is scheduled
- No, they don't have an appointment scheduled

When you were looking for a therapist, did you request a therapist who uses exposure therapy (i.e., slowly helps a child face their fears)?

- Yes
- No
- Unsure

*We are interested in learning more about the therapeutic approach your therapist uses.*

What is the name of your child's therapist? \_\_\_\_\_

What clinic does your child's therapist work at? \_\_\_\_\_

## Caregiver Attitudes about Cognitive Behavioral Therapy

The items below describe strategies that may be used in therapy for youth with anxiety. Please rate how **helpful** you think each strategy would be if you were seeking treatment for your child's anxiety.

1	2	3	4	5
Very unhelpful	Unhelpful	Neutral	Helpful	Very helpful

1.	Therapist provides information about normal anxiety level in children.	1	2	3	4	5
2.	Therapist helps your family identify how your child's anxiety is getting in the way for your child/for your family	1	2	3	4	5
3.	Therapist teaches you and your child about the difficulties the child is having, and how therapy activities are meant to help.	1	2	3	4	5
4.	Therapist creates an individualized treatment plan for your child.	1	2	3	4	5
5.	Therapist sets specific therapy goals in collaboration with you and your child.	1	2	3	4	5
6.	Therapist asks you and your child to fill out questionnaires weekly to monitor how your child is doing.	1	2	3	4	5
7.	Therapist coaches you to use therapy skills at home.	1	2	3	4	5
8.	Therapist demonstrates a behavior they want your child to do.	1	2	3	4	5
9.	Therapist gives your child activities to practice therapy skills between sessions.	1	2	3	4	5
10.	Therapist teaches the child to identify and effectively communicate their feelings.	1	2	3	4	5
11.	Therapist teaches your child to relax their body.	1	2	3	4	5
12.	Therapist teaches the child to identify anxious thoughts, consider how true an anxious thought is, and come up with a more realistic or helpful thought.	1	2	3	4	5
13.	Therapist teaches your child problem solving.	1	2	3	4	5
14.	Therapist rewards your child for brave/desirable behavior.	1	2	3	4	5
15.	Therapist teaches you to reward your child for brave/desirable behavior.	1	2	3	4	5
16.	Therapist teaches you to pay more attention to positive behavior and to ignore minor distress or misbehavior.	1	2	3	4	5
17.	Therapist supports your child to help them slowly face their fears.	1	2	3	4	5
18.	Therapist helps your child plan how to address future problems to prevent difficulties from coming back.	1	2	3	4	5

## **Scoring**

- Sum all items

## Therapy Subjective Norms

### Cognitive Behavioral Therapy

Cognitive-behavioral therapy has been shown to be the most effective therapy for youth anxiety. In this therapy, youth learn to coping skills and practice using their coping skills by slowly facing their fears.

#### Injunctive norms

If my child needed help for anxiety, most people who are important to me would...

1. Think I should take my child to a therapist who uses cognitive behavior therapy.	1	2	3	4	5	6	7
2. Approve of me taking my child to a therapist who uses cognitive behavior therapy.	1	2	3	4	5	6	7
3. Want me to take my child to a therapist who uses cognitive behavior therapy.	1	2	3	4	5	6	7

#### Descriptive norms

If another caregiver's child had anxiety...

4. Most caregivers who are important to me would take their child to a therapist who uses cognitive behavior therapy.	1	2	3	4	5	6	7
5. Most caregivers who are like me would take their child to a therapist who uses cognitive behavior therapy.	1	2	3	4	5	6	7
6. Other caregivers who are like me have taken their child to a therapist who uses cognitive behavior therapy.	1	2	3	4	5	6	7

### Scoring

- Items are summed to create a score for overall subjective norms (all six items), as well as the injunctive and descriptive norms subscales (three items each)

### Relatability Evaluation

We would love to hear more about your thoughts on \_\_\_\_\_.  
Please use the following scale to rate the statements below.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly Agree

1.	I could relate to the presenter.	1	2	3	4	5
2.	The presenter was likeable.	1	2	3	4	5
3.	The presenter was similar to me.	1	2	3	4	5
4.	The presenter thinks like me.	1	2	3	4	5
5.	The presenter and I have similar beliefs about mental health.	1	2	3	4	5
6.	The presenter was a credible source of information about mental health.	1	2	3	4	5
7.	The presenter was trustworthy.	1	2	3	4	5
8.	The presenter understood my community.	1	2	3	4	5
9.	Before the presentation, I was familiar with the presenter.	1	2	3	4	5
10.	Before the presentation, I was friends with the presenter.	1	2	3	4	5



## Mental Health History

### Caregiver mental health history:

*Please answer the following questions based on YOUR history.*

Have you ever been diagnosed with a mental disorder?

- Yes
- No

Have you seen a mental health professional?

- Yes
- No

*If yes:*

Did your therapist do cognitive behavioral therapy?

- Yes
- No
- Unsure

Did your therapist use exposures (i.e., slowly helped you face your fears)?

- Yes
- No
- Unsure

Please rate your overall level of satisfaction with your previous therapy experience(s):

- (1) Very dissatisfied
- (2) Dissatisfied
- (3) Neither satisfied nor dissatisfied
- (4) Satisfied
- (5) Very satisfied

### Child mental health history:

*Please answer the following questions based on your child's (initials: \_\_\_\_\_) history.*

Has your child ever been diagnosed with a mental disorder?

- Yes
- No

Has your child seen a mental health professional?

- Yes
- No

*If yes:*

Did their therapist do cognitive behavioral therapy?

- Yes
- No
- Unsure

Did their therapist use exposures (i.e., slowly helped your child face their fears)?

- Yes
- No
- Unsure

Please rate your overall level of satisfaction with your child's previous therapy experience(s):

- (1) Very dissatisfied
- (2) Dissatisfied
- (3) Neither satisfied nor dissatisfied
- (4) Satisfied
- (5) Very satisfied

## Demographic Questionnaire

### Caregiver demographics

**For the following questions, please enter/select your demographic information. As a reminder, all information collected remains confidential.**

Age (in years): \_\_\_\_\_

What sex were you assigned at birth?

- Male
- Female
- A sex not listed: \_\_\_\_\_
- Prefer not to say

How would you describe your gender? (check all that apply)

- Agender
- Cisgender
- Female
- Genderqueer
- Male
- Non-binary
- Transgender
- A gender not listed: \_\_\_\_\_
- Prefer not to say

Sexual orientation (check all that apply):

- Asexual
- Bisexual
- Gay or Lesbian
- Queer
- Straight/heterosexual
- A sexual orientation not listed: \_\_\_\_\_
- Prefer not to say

Race (check all that apply):

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- A race not listed: \_\_\_\_\_
- Prefer not to say

Are you of Hispanic, Latino/a/x, or of Spanish origin? (check all that apply)

- No, not of Hispanic, Latino/a/x, or Spanish origin
- Yes, Cuban
- Yes, Mexican, Mexican American, Chicano/a/x
- Yes, Puerto Rican
- Yes, another Hispanic, Latino/a/x or Spanish origin
- An ethnicity not listed: \_\_\_\_\_
- Prefer not to say

Where were you born?

- In the United States
- In another country
- Prefer not to say

Relationship status (check all that apply):

- Divorced
- Married, currently living separate from partner
- Married, currently living with partner
- Not married, currently living with partner
- Remarried
- Single, never married
- Widow/widower
- Relationship status not listed: \_\_\_\_\_
- Prefer not to say

Which of the following best describes your relationship to your child?

- Adoptive parent
- Biological parent
- Foster parent or legal guardian
- Grandparent or other family member
- Step-parent
- Relationship not listed: \_\_\_\_\_
- Prefer not to say

Does your child (initials:\_\_\_\_) currently live with you?

- Yes
- No
- Prefer not to say

What is the custody arrangement for your child?

- Joint custody --- I share custody with another legal guardian
- Sole custody --- I am the only legal guardian (even if remarried)
- No formal custody arrangement
- Custody arrangement not listed: \_\_\_\_\_
- Prefer not to say

What is the primary language spoken in your home?

- English
- Other: \_\_\_\_\_
- Prefer not to say

Number of children: \_\_\_\_\_

Number of children living in your home: \_\_\_\_\_

Highest education level completed:

- Less than high school
- High school graduate
- College graduate (2-year)
- College graduate (4-year)
- Some college
- Master's degree or equivalent
- Doctoral degree or equivalent (MD, Ph.D., Psy.D., J.D.)
- Prefer not to say

What religion are you? (check all that apply)

- Catholic
- Protestant
- Other Christian: \_\_\_\_\_
- Jewish
- Buddhist
- Muslim
- Hindu
- Agnostic
- Atheist
- A religion not listed: \_\_\_\_\_
- Prefer not to say

How often do you usually attend religious services?

- Never
- Less than one a month
- One to three times a month
- About once a week
- More than once a week
- Prefer not to say

Total household income

- Less than \$15,000
- \$15,000-\$24,999
- \$25,000-\$34,999
- \$35,000-\$49,999
- \$50,000-\$74,999
- \$75,000-\$99,999
- \$100,000-\$149,999
- \$150,000-\$199,999
- \$200,000 and over
- Prefer not to say

Child demographics

**For the following questions, please enter your child's information (initials: \_\_\_\_\_) to the best of your knowledge.**

Age (in years): \_\_\_\_\_

What sex was your child assigned at birth?

- Male
- Female
- A sex not listed: \_\_\_\_\_
- Prefer not to say

How would your child describe their gender? (check all that apply)

- Agender
- Cisgender
- Female
- Genderqueer
- Male
- Non-binary
- Transgender
- Unsure
- A gender not listed: \_\_\_\_\_
- Prefer not to say

Sexual orientation (check all that apply):

- Asexual
- Bisexual
- Gay or Lesbian
- Queer
- Straight/heterosexual
- Unsure
- A sexual orientation not listed: \_\_\_\_\_
- Prefer not to say

Race (check all that apply):

- American Indian or Alaska Native
- Asian
- Black or African American
- Native American/Alaskan Native
- Native Hawaiian or Other Pacific Islander
- White
- A race not listed: \_\_\_\_\_
- Prefer not to say

Is your child of Hispanic, Latino/a/x, or of Spanish origin? (check all that apply)

- No, not of Hispanic, Latino/a/x, or Spanish origin
- Yes, Cuban
- Yes, Mexican, Mexican American, Chicano/a/x
- Yes, Puerto Rican
- Yes, another Hispanic, Latino/a/x or Spanish origin
- An ethnicity not listed: \_\_\_\_\_
- Prefer not to say

Where was your child born?

- In the United States
- In another country
- Prefer not to say

Is your child covered by any of the following types of health insurance? (check all that apply)

- Health insurance obtained through an employer or union
- Health insurance purchased directly from an insurance company (e.g., healthcare.gov)
- Military health insurance
- Medicaid (e.g., PA Medical Assistance, ACCESS, NJ Family Care, Choose Health Delaware)
- CHIP
- Other: \_\_\_\_\_
- No
- Prefer not to say

## Knowledge Test

Instructions: Please answer these questions to the best of your ability. If more than one question appears to be correct, please choose the best answer to the question. You are not expected to know all the answers. Please do not look up the answers. We want to know what you think off the top of your head.

1. Kids with anxiety are referred for help more often than kids with behavioral problems.
  - a. True
  - b. **False**
  
2. A child may refuse to go to school because something about school makes them anxious.
  - a. **True**
  - b. False
  
3. Trouble concentrating may be a sign of anxiety.
  - a. **True**
  - b. False
  
4. In the long-term, it is helpful for parents to protect their child from feelings of anxiety.
  - a. True
  - b. **False**
  
5. When some children feel nervous, they may ask the same question over and over again. To make the child less anxious in the long-term, the caregiver should answer the question each time it's asked.
  - a. True
  - b. **False**
  
6. Cognitive behavioral therapy is the most effective psychological treatment for anxiety.
  - a. **True**
  - b. False
  
7. The goal of therapy for anxiety is to get rid of a child's anxiety.
  - a. True
  - b. **False**
  
8. You should not put your child's name on many therapy waitlists at a time.
  - a. True
  - b. **False**



9. Therapists for youth anxiety all charge at least \$100 per session.
- True
  - False**
10. Cognitive behavioral therapy takes at least a year to be effective.
- True
  - False**
11. Anxiety is a problem when
- It is experienced by a youth
  - It is before or during a stressful experience
  - It causes a lot of distress or gets in the way of daily life**
  - It is not fully experienced
12. Which of the following is most commonly seen in social anxiety disorder?
- Frequently asking caregivers if things will turn out okay
  - Trying to avoid social interactions**
  - Worrying about health
  - Wanting to be close to a caregiver
13. A child may procrastinate homework because:
- They find homework to be boring
  - They're worried about how well they will do on the assignment
  - They want to complete the assignment quickly
  - A&B can both be true**
14. Anxious youth may ask questions about what will happen in the future. Which of the following is the most helpful way to think about uncertainty?
- When youth feel unsure, they should always seek answers to feel more certain
  - Children should learn to be okay with some amount of uncertainty about the future**
  - Children should learn to toughen up and stop trying to feel more comfortable
  - Wanting certainty about the future is a valuable skill to help them succeed
15. When a child feels anxious, as a caregiver, it is a good idea to do all of the following EXCEPT:
- Change your behavior to reduce their anxiety**
  - Accept that the child feels the emotion
  - Reward them when they engage in brave behavior
  - Model coping behaviors

16. Your child tells you they feel worried about an upcoming situation and asks not to go. What's the most helpful way for you to respond?
- Allow them not to go. There is no reason for them to feel distressed
  - Have them face the situation head on and get it over with
  - Encourage them to approach the situation by breaking it down into manageable steps**
  - Find an alternative situation that is less stressful
17. A child faced their fear of asking a friend to come over to hang out. Which of the following rewards could be used?
- 20 minutes extra screen time
  - Getting to pick what's for dinner
  - Either A or B**
  - Neither – children should not be rewarded for doing things they should be able to do
18. Which therapy strategy is most helpful for decreasing anxiety in the long-term?
- Deep breathing
  - Exposure (i.e., helping a child practice slowly facing their fears)**
  - Coping thoughts
  - Problem solving
19. How are caregivers usually involved with treatment?
- Caregivers can help the youth practice skills at home between sessions**
  - Caregivers should go to the same therapist as their child
  - Caregivers should sit in on all of their youth's therapy sessions
  - Caregivers should not get involved in the youth's "private and personal" treatment
20. How would you know if a therapist actually provides the most effective strategies used to treat youth anxiety?
- Ask if they provide cognitive behavioral therapy
  - Ask if they conduct cognitive behavioral therapy with exposures
  - Ask if they assign youth therapy homework between sessions
  - B & C are true**

### **Scoring**

- Correct answer is bolded
- Items are scored such that 1 = correct; 0 = incorrect for a maximum of 20 points

## Project CHAT Opinion Leader Training Checklist

*Check off the following items if they occurred:*

1. Sent opinion leaders (OLs) ppt ahead of time to review
  - Yes
  - No

### Meeting 1

- Discuss what made them want to be involved with the presentation
- Discuss their experiences with anxiety
- Discuss anxiety in their community
- Review cycle of avoidance
- Review exposure therapy
- Review presentation
- Get feedback on presentation
- Discuss what strategies they could endorse

Training length (minutes): \_\_\_\_\_

### Presentation Modification

- Presentation modified based on OL feedback

### Meeting 2

- Review/approved modifications made
- Answer OL questions about the content
- Determine which sections the OL is comfortable presenting
- Determine which strategies the OL is willing to endorse
- Give the OL an opportunity to practice to ensure comprehension

Phone call length (minutes): \_\_\_\_\_

Notes about OL Training: \_\_\_\_\_

*Note:* Material not yet covered during the first meeting was covered during the second meeting.

## Project CHAT Presentation Content Checklist

Who is filling out this checklist?: \_\_\_\_\_

### Presentation Length

Start time: \_\_\_\_\_

End Time: \_\_\_\_\_

Presentation time (minutes): \_\_\_\_\_

Q&A start time: \_\_\_\_\_

Q&A length (minutes): \_\_\_\_\_

### Presenter Speaking Time

Presenter 1 (Margaret) speaking time (minutes): \_\_\_\_\_

Presenter 2 speaking time (minutes): \_\_\_\_\_

Which sections of the presentation did Presenter 2 give?

- Recognizing anxiety
- Strategies for caregivers
- Seeking additional support

Which sections of the presentation did Presenter 2 provide comments during?

- Recognizing anxiety
- Strategies for caregivers
- Seeking additional support
- Q&A

### Anxiety Overview

- Overview of anxiety
- Separation anxiety
- Social anxiety
- Generalized anxiety
- COVID anxiety
- Physical symptoms of anxiety
- Behavioral problems
- School refusal
- Avoidance overview

**Strategies for parents**

- Label and validate a child’s emotions
- Break down anxious situations into small steps
- Avoid unnecessary accommodations
- Responding to reassurance seeking
- Reward brave behavior
- Stay calm

**Seeking additional support**

- When is treatment needed?
- CBT overview
- Medication treatment
- How to find a therapist
- Questions to ask a therapist
- Ask for exposure therapy
- Process of starting therapy

**Did any of the following disclosures occur?**

<b>Disclosure</b>	<b>Margaret</b>	<b>Presenter 2</b>	<b>Example about another family</b>	<b>Participant self-disclosure (e.g., during Q&amp;A)</b>
Receiving therapy for self				
Receiving CBT for self				
Having anxiety				
Child receiving therapy				
Child receiving CBT				
Child having anxiety				
None				

**Other**

Were the handouts send in the chat

- Yes
- No

Notes: \_\_\_\_\_

## APPENDIX C

**Table C 1**

Correlation of Dependent Variables at Baseline

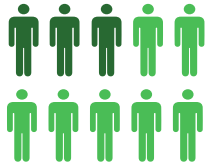
Variable	M	SD	1	2	3	4	5
1. KT	60.61	26.71					
2. PEEBS-K	3.03	0.74	.02				
3. PISMIS	15.04	4.60	-.22*	-.19*			
4. TSN: CBT Total	32.03	7.18	-.004	.26*	-.16*		
5. CACBT	79.74	10.53	.11	.01	-.13	.20*	
6. Exp Seeking: Intention	3.13	1.20	.01	.01	-.15*	.22*	.04

*Note.* \*  $p < .05$ ; KT = knowledge test; PEEBS-K = Parent Engagement in Evidence-Based Services Questionnaire, Knowledge Subtest; PISMIS = Parents' Internalized Stigma of Mental Illness Scale; CACBT = Caregiver Attitudes about Cognitive Behavioral Therapy; Exp = exposure therapy

**APPENDIX D**  
**Anxiety Infographic**

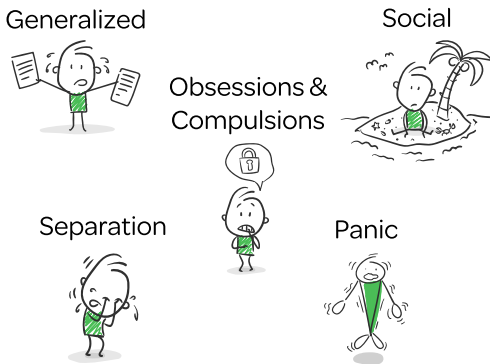


# Anxiety in Children

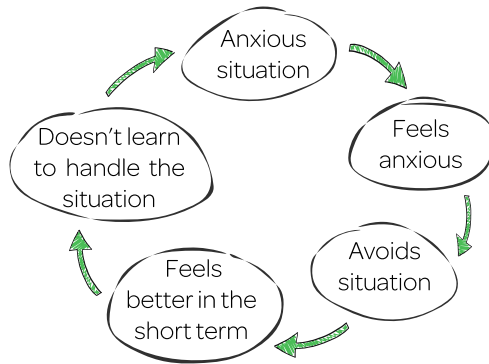


3 in 10 Children have an anxiety disorder by age 18

There are many types of anxiety:



Many things cause anxiety, but **avoidance maintains it.**



Good news!  
Therapy can help.

Some therapies work better than others.



Cognitive behavioral therapy with **exposures** works best.

Exposure therapy aims to stop the cycle of anxiety.



Brave practice helps kids slowly face their fears.

To connect with a therapist, talk to your primary care doctor or search [findcbt.org](http://findcbt.org) and [adaa.org](http://adaa.org)



Help your child be in charge, not their anxiety!

## **APPENDIX E**

### **Handouts Sent to Participants**

## **Project CHAT Anxiety Resources**

### **Recommended Therapy Clinics**

Sliding Scale (fees can be less than \$30)

- Temple University Child and Adolescent Anxiety Disorders Clinic (215-204-7165): [www.childanxiety.org](http://www.childanxiety.org)
- Center for Brief Therapy at PCOM (215-871-6487): <https://pcomhealth.org/cbt/>
- Drexel Psychological Services Center (215-553-7128): <https://drexel.edu/coas/academics/departments-centers/psychology/clinic/>

In Network<sup>1</sup> / Medicaid<sup>2</sup>

- Southampton Psychiatric Associates<sup>1</sup> (215-355-2011): <https://www.southamptonpsychiatric.com/>
- Center for Emotional Health of Greater Philadelphia<sup>1</sup> (856-220-9672): <http://thecenterforemotionalhealth.com/>
- Lifestance Health<sup>1,2</sup> (610-892-3800): <https://lifestance.com>
- Asociación Puertorriqueños en Marcha<sup>2</sup> (267-296-7220): <http://apmphila.org/>
- UPenn Pediatric Anxiety Treatment Center at Hall-Mercer<sup>2</sup> (PATCH; 215-829-5524): [https://www.med.upenn.edu/hallmercer/patch\\_about.html](https://www.med.upenn.edu/hallmercer/patch_about.html)

Out of Network – Philadelphia

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- Council for Relationships (215-382-6680): <https://councilforrelationships.org/>

Out of Network – PA

- CBT Center for Anxiety and OCD (610-529-1875): <https://cbtcenterforanxiety.com>
- Home for Anxiety, Repetitive Behaviors, OCD, and Related Disorders (HARBOR): <https://www.harborpa.com/>
- Bala Child and Family Associates (610-667-7137): <https://balachildfamily.com/>
- Council for Relationships (215-382-6680): <https://councilforrelationships.org/>
- Anxiety and OCD Center (484-947-8820): <https://anxietyocd.com/services/treatment/>
- Anxiety and Agoraphobia Treatment Center (610-667-6490): <https://aatcphila.com/>

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- Center for Family Guidance (609-265-0408): <https://ctrfamilyguidance.com>
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- Center for Counseling and Education (856-985-9091): <https://cfcenj.com>
- CBT Center for Anxiety and OCD (610-529-1875): <https://cbtcenterforanxiety.com>

Intensive Outpatient

- Rogers Behavioral Health (267-787-6600): <https://rogersbh.org/locations/philadelphia>

## **Therapist Directories**

*Note: To make sure the therapist does the most effective therapy for anxiety, ask if they do cognitive behavior therapy with exposures!*

- Anxiety and Depression Association of America:  
<https://members.adaa.org/page/FATMain>
  - Most therapists on this list offer cognitive behavior therapy with exposures (the therapy that works best for anxiety)
- Association for Behavioral and Cognitive Therapies: <http://www.findcbt.org/FAT/>
  - Most therapists on this list offer cognitive behavior therapy with exposures (the therapy that works best for anxiety)
- Psychology Today: <https://www.psychologytoday.com/us/therapists>
  - Useful insurance filter option
- Therapy 4 the People: <https://therapy4thepeople.org>
  - List of mental health services that cost less than \$30
- Your Insurance Company's "Find a Doctor"
  - Easy way to make sure insurance covers it!

## **Books for Caregivers**

- *The Resilience Recipe: A Parent's Guide to Raising Fearless Kids in the Age of Anxiety.* Khanna & Kendall
- *Breaking Free of Child Anxiety and OCD: A Scientifically Proven Program for Parents.* Lebowitz
- *Helping your Anxious Child: A Step-by-Step Guide for Parents.* Rapee, Spence, Cobham, Wignall
- *Monsters Under the Bed and Other Childhood Fears: Helping your Child Overcome Anxieties, Fears, and Phobias.* Garber, Garber, & Spizman
- *Straight Talk about Psychiatric Medications for Kids.* Wilens.
- *Good Friends are Hard to Find: Help your Child Find, Make, and Keep Friends.* Frankel & Wetmore.

## **Books for Children**

- *Wemberly Worried.* Henkes.
- *Anxiety Relief for Teens.* Galanti.
- *When Harley Has Anxiety: A Fun CBT Skills Activity Book to Help Manage Worries and Fears.* Galanti.
- *Guts.* Telgemeler
- *Scary Night Visitors: A Story for Children with Bedtime Fears.* Marcus, Marcus, Jesche.
- *I Don't Know Why...I Guess I'm Shy: A Story About Taming Imaginary Fears.* Cain & Smith-Moore.
- *First Day Jitters.* Danneberg.
- *Night Light: A Story for Children Afraid of the Dark.* Dutro & Boyle.
- *Cat's Got Your Tongue? A Story for Children Afraid to Speak.* Schaefer & Friedman.
- *Up and Down the Worry Hill.* Wagner. (OCD)

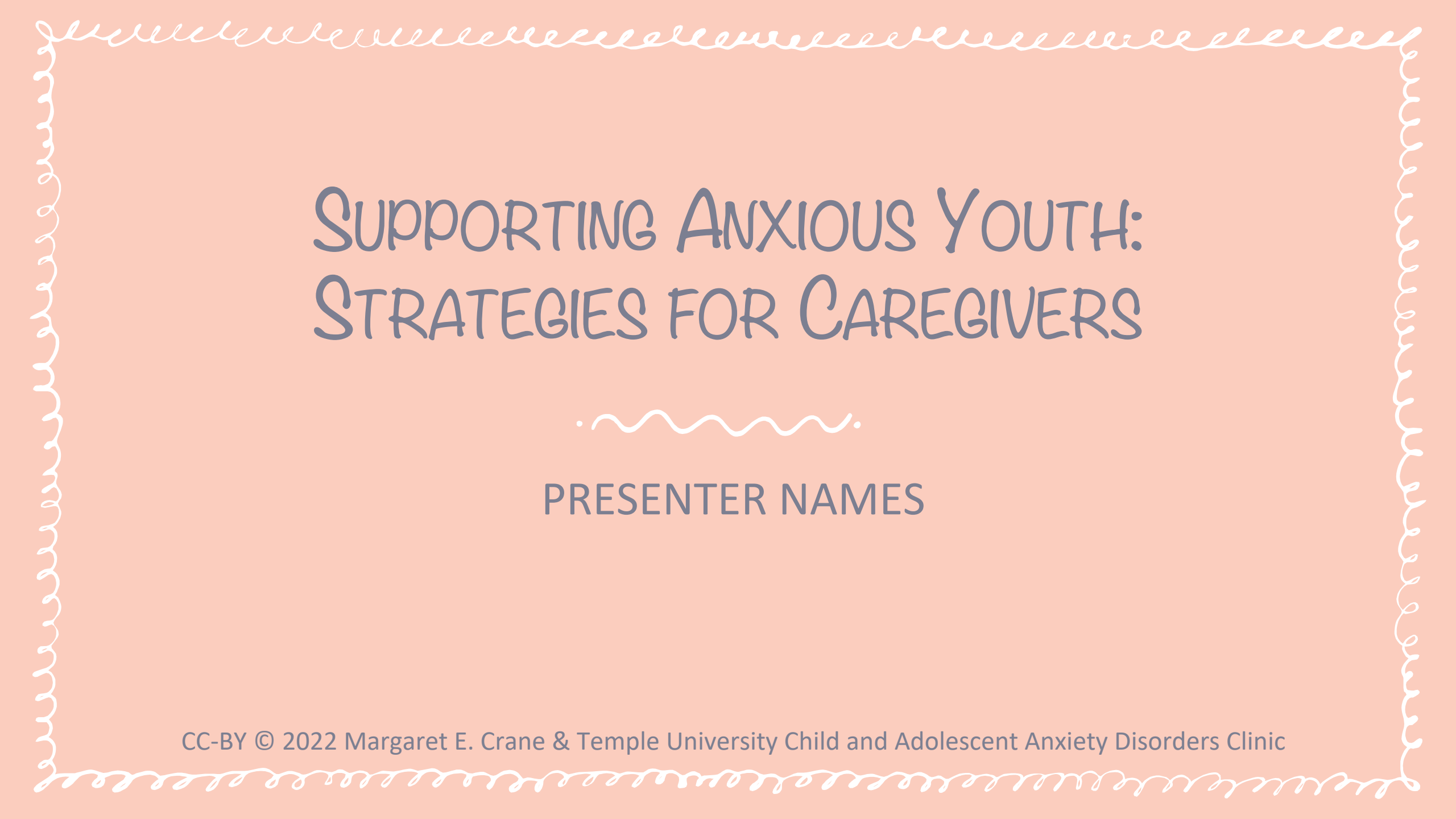
### **Internet Resources**

- Child Anxiety Tales: <http://www.copingcatparents.com/>
- The Child Anxiety Network: [www.childanxiety.net](http://www.childanxiety.net)
- Anxiety Disorders Association of America: [www.adaa.org](http://www.adaa.org)
- Effective Child Therapy: <https://effectivechildtherapy.org>
- Anxiety Tip Sheets: <https://carescenter.ucla.edu/resources>
- Tips for finding a therapist: <https://www.abct.org/get-help/how-do-i-choose-a-therapist/>
- SPACE (parent only treatment for youth anxiety): <https://www.spacetreatment.net>
- School Refusal: <https://adaa.org/find-help/by-demographics/children/school-refusal>
- American Academy of Pediatrics Screen Time Plan: <https://www.healthychildren.org/English/media/Pages/default.aspx>
- Everyday Parenting: The ABCs of Child Rearing (tips for managing children’s behavior – free course!): <https://alankazdin.com/everyday-parenting-the-abcs-of-child-rearing/>
- Therapists on Instagram: @dr.rachelgoldman, @drbeckyatgoodinside, @the.parent.therapist

## **Project CHAT: Supporting Anxious Youth: Strategies for Caregivers**

- **Label and validate a child's emotions.** Youth often have difficulty identifying anxiety, and may even think they are sick. Use compassion to label and validate emotions, and avoid minimizing their distress by saying it is "silly" to be nervous. Instead, express confidence they can handle it ("It looks like you're feeling pretty nervous. I know how hard tests are for you. Even though it's hard, I know you'll be able to try your best.")
- **Break down anxious situations into small steps to encourage approach, rather than avoidance.** The nature of anxiety is to avoid. The problem is that avoiding scary situations helps in the moment, but then teaches your kid to keep avoiding in the future. So, in the long run, it actually makes fear worse. A key part of overcoming anxiety is helping a youth re-enter feared situations in small, manageable steps We call these "challenges" or exposures in therapy, and parents can do this too:
  - Identify a reasonable starting point. The first step should push your child slightly but be likely to be successful
  - Practice as much as possible. The more we try things that are hard for us, the easier they get
  - Continue to raise the bar as child is successful
- **Avoid unhelpful accommodations.** It is your instinct as a caregiver to protect your child from stressful situations. But this is counter to the goal of helping children approach their fears! Some accommodations may be a necessary as a temporary support for the child's growth. But how do you know? A helpful accommodation...
  - helps a child achieve a goal, rather than removing expectations
  - asks "what does this child need to be successful" rather than "what does this child need to be less upset?"
  - is a moving target, removed when a kid no longer needs them to be successful
- **Avoid excessive reassurance.** Sometimes children need some reassurance to face their fears. Other times, reassurance doesn't allow the child to learn to face uncertainty. Notice if your child repeatedly comes to you for reassurance for the same topic, or asks you the same question over and over. Validate their uncertainty, and ask them "what did I say last time when we talked about this?"
- **Reward brave behavior.** Rewards increase the frequency of a behavior. Your job as a caregiver is to notice and praise a child for their bravery. Rewards can be privileges (extra screen time), activity-driven (getting to pick what's for dinner, getting to pick the family movie, breakfast for dinner, going to the park with grandma), or tangible (stickers, extra dessert).
- **Stay calm & take care of yourself.** Its normal to get upset or frustrated when your kid is anxious! But try not to get angry or upset in the moment ("You're fine, just do it!"). Instead, model the behavior you want to see in your kid. It's very hard to stay calm if you are generally overwhelmed. Taking care of yourself makes it easier to use all these strategies.

**APPENDIX F**  
**Presentation Powerpoint**



# SUPPORTING ANXIOUS YOUTH: STRATEGIES FOR CAREGIVERS



PRESENTER NAMES



# PRESENTATION OVERVIEW



What is anxiety?  
Recognizing anxiety disorders  
Strategies for caregivers  
Treatment of anxiety  
Finding a Therapist  
Q&A

# WHAT IS ANXIETY?

- Everyone has anxiety!
- How do we know it's a problem?
  - Does it cause significant distress?
  - Does it cause interference in daily life, family, or social relationships?
  - Is it developmentally appropriate?
  - Is the anxiety out of proportion to the threat?



# IN GENERAL...

10%

of kids and teens have an anxiety disorder



Children with anxiety are referred for help less often than those with behavioral problems

# ANXIETY DISORDERS

- **Separation Anxiety Disorder**
- **Social Anxiety Disorder**
- **Generalized Anxiety Disorder**
- Specific Phobia
- Panic Disorder
- Agoraphobia
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder



# SEPARATION ANXIETY DISORDER

- Developmentally inappropriate and excessive anxiety about being away from caregiver
- May involve fear that something bad is going to happen to caregiver or them when they're a part
- May refuse to go to sleep or school for fear of being away from caregiver

# RECOGNIZING SEPARATION ANXIETY

- Difficulty at drop off (school, playdates)
- Visibly upset upon separation
- Frequent reassurance seeking (“Is mom okay?”)
- Calls/texts caregiver throughout the day
- Has bad dreams about being away from caregivers
- Can’t sleep alone



# SOCIAL ANXIETY DISORDER

- Worries about what other people are thinking of them in social situations
- Social worries can come up at school or with peers
- Tries to avoid social situations

# RECOGNIZING SOCIAL ANXIETY DISORDER

- Very shy
- Nervous in performance situations
- Avoids answering questions, talking to strangers, ordering in restaurants
- Hesitant to participate in social situations
- Difficulty with peer relationships





# GENERALIZED ANXIETY DISORDER

- Excessive worry about everyday life matters
- Worry is hard to control
- Associated with physical symptoms
  - Restlessness, easily fatigued, difficulty concentrating, irritability, muscle tension, sleep disturbance

# RECOGNIZING GENERALIZED ANXIETY DISORDER

- Perfectionistic about work
- Avoids work for fear of making mistake
- Upset when mildly scolded
- Frequent reassurance seeking
- Appears jittery, tense, unable to relax
- Excessive health worries



# COVID ANXIETY

- Some anxiety about COVID is normal!
- Can be helpful to have a guideline your family follows (e.g., school or county guidelines)
- Ask yourself: Is their COVID anxiety getting in the way of things our family wants them to do?



# PHYSICAL SYMPTOMS OF ANXIETY

- Anxiety often manifests as physical symptoms
- Physical symptoms can include
  - Stomachache, headache, trouble sleeping
- Kids may genuinely think they are sick
- Ask yourself: does this problem always show up around a stressor?



# BEHAVIOR PROBLEMS AND ANXIETY

- Anxiety can look like behavioral problems
  - Irritability
  - Temper tantrums
  - Difficulties paying attention
  - Trouble sitting still
- Ask yourself: Do they only act like this when they are feeling anxious?

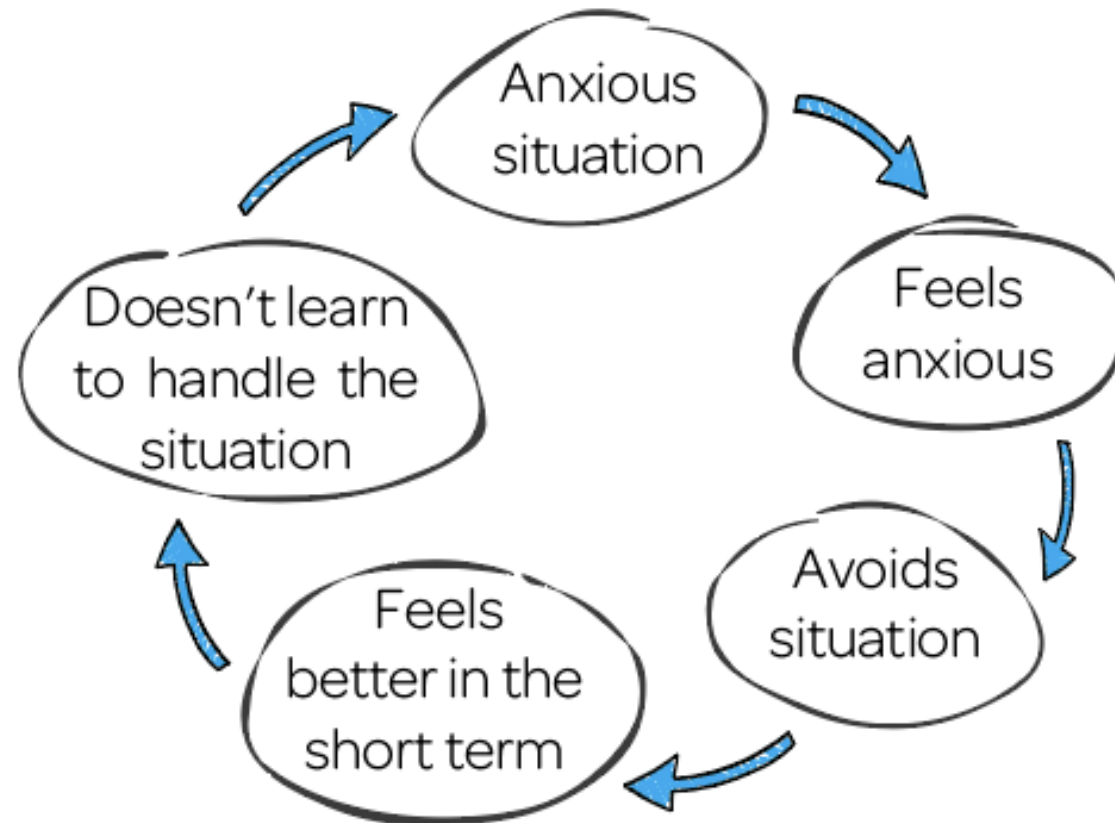


# SCHOOL REFUSAL

- Identify the function of refusal
  - Is there something at school that makes the child nervous?
  - Make sure staying home isn't more fun
- More than school "jitters" – often a symptom of a deeper problem



# MANY THINGS CAUSE ANXIETY, BUT AVOIDANCE MAINTAINS IT



# STRATEGIES FOR CAREGIVERS



- Label and validate a child's emotions
- Break down anxious situations into small steps
- Avoid unhelpful accommodations
- Responding to reassurance seeking
- Reward brave behavior
- Stay calm



# LABEL AND VALIDATE EMOTIONS

- Youth often have difficulty identifying anxiety
  - May think they are sick
- Use compassion to validate
  - Avoid minimizing their distress by saying it is “silly” to be nervous
- Express confidence they can handle it





*It looks like you're feeling pretty nervous about completing all the school assignments. I know how hard these assignments can be. Even though it's hard, I know you can do this.*



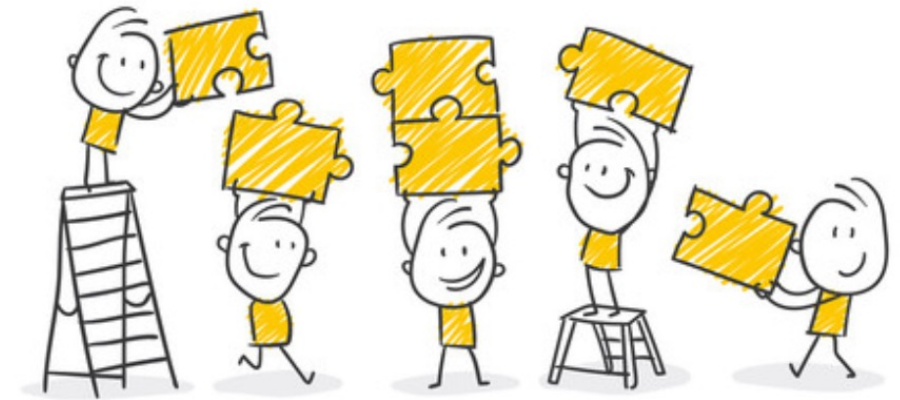
# BREAKING SITUATIONS INTO STEPS

- Part of overcoming anxiety is helping a youth re-enter feared situations in small, manageable steps
- We call these “challenges” or exposures
  - Caregivers can do this too



# BREAKING SITUATIONS INTO STEPS

- Identify a reasonable starting point
  - The first step should push your child slightly but be likely to succeed
- Continue to raise the bar as child is successful
- Practice as much as possible
  - The more we try things that are hard for us, the easier they get



# EXAMPLE: GOING TO SCHOOL

- Step 1: Visit public places (e.g., grocery stores, parks)
- Step 2: Visit the school outside the school day
- Step 3: Drive to school with their best friend; only attend half day
- Step 4: Child attends school all day, but can call parents 2x if needed
- Additionally... Focus on positive aspects of in person school



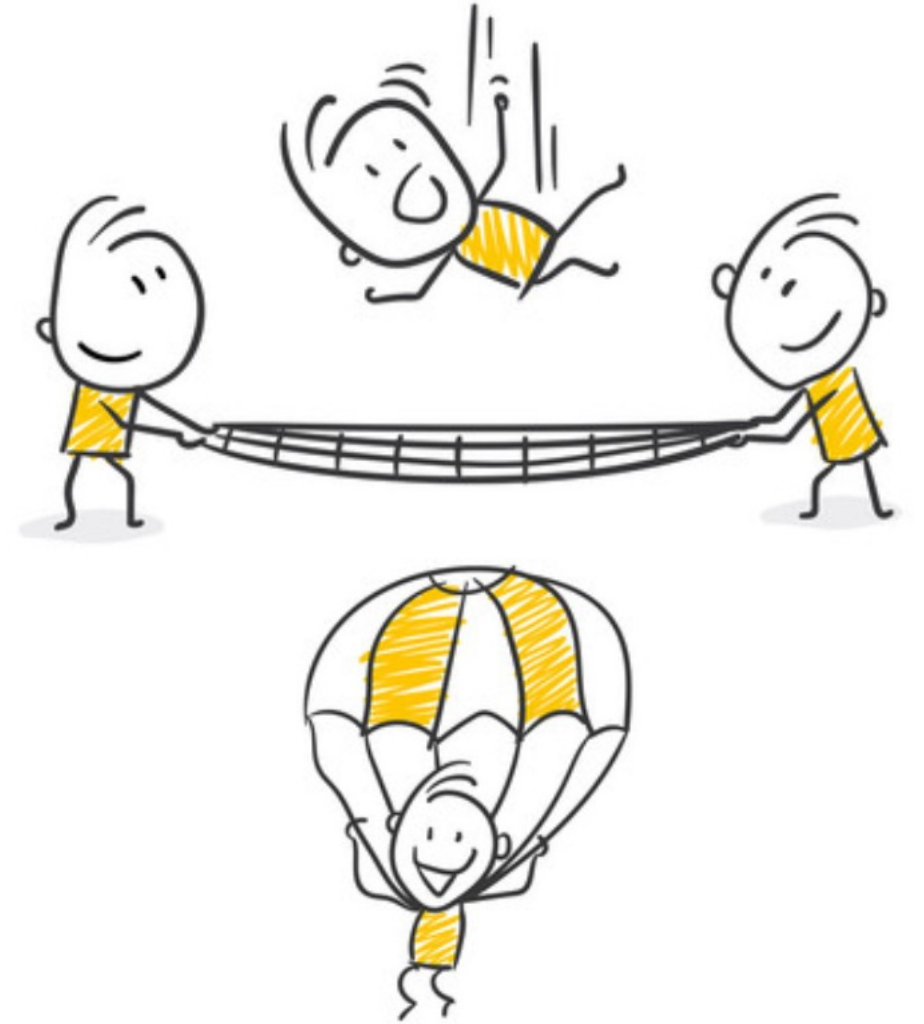
# EXAMPLE: ORAL PRESENTATION

- Step 1: Practice presentation in front of caregiver, teacher, small group
- Step 2: Gradually increase the size or difficulty of the audience
- Step 3: Allow child to go first or last when presenting in front of the whole class



# AVOID UNHELPFUL ACCOMMODATIONS

- It is your instinct as a caregiver to protect your child from stressful situations
- Often counter to the goal of approaching anxiety
- May necessary as temporary support for the child's growth



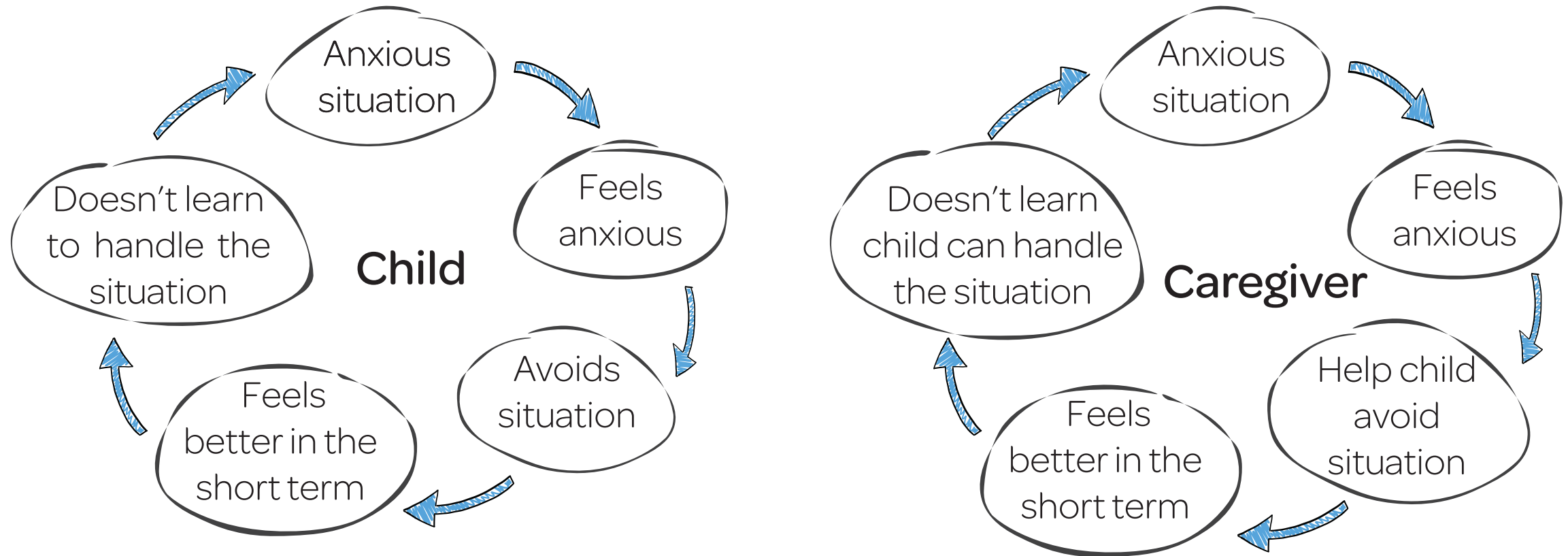
# AVOID UNHELPFUL ACCOMMODATIONS

- What accommodations are helpful?
  - Helps achieve a goal, rather than removing expectations
  - Asks “what does this child need to be successful” rather than “what does this child need to be less upset?”
- A moving target – remove when no longer needed to be successful



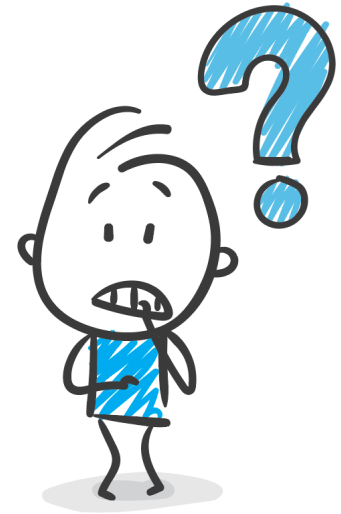


# AVOIDANCE CYCLE FOR CAREGIVERS



# RESPONDING TO REASSURANCE SEEKING

- Provide factual information, at age-appropriate level
- Help children tolerate uncertainty, rather than providing repeated reassurance seeking
  - Only respond to questions once
  - Ask child to tell you what you said the last time they asked



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||

*I can tell you're feeling unsure about  
whether you'll have fun at soccer.  
What did I tell you last time you asked  
about this?*

— • • —

# REWARD BRAVE BEHAVIOR

- Rewards increase the frequency of a behavior
- Notice and praise a child for bravery
  - Use labeled praise
- Rewards can be
  - Privileges (extra screen time)
  - Activities (picking what's for dinner, going to park with grandma)
  - Tangible (stickers, extra dessert)



# STAY CALM

- It's normal to get upset or frustrated when your kid is anxious!
- Try not to get angry or upset in the moment ("You're fine, just do it!")
- Model the behavior you want to see



# SEEKING ADDITIONAL SUPPORT



When is treatment needed?

Treatment options: Medication and Therapy

How to Find a Therapist

# WHEN IS TREATMENT NEEDED?

- Are regular coping strategies insufficient to help with anxiety?
- Is anxiety getting in the way at home, school, or with friends?
- Is anxiety causing the child and/or family a lot of distress?



# TREATING ANXIETY

- Anxiety can be treated with either **medication** or **therapy**
  - Medication and therapy are equally effective
- Cognitive behavior therapy with **exposures** is the therapy that works best





# COGNITIVE BEHAVIORAL THERAPY (CBT)

- Three aspects to anxiety
  - Physical: feel anxiety in their body
    - Relaxation
  - Cognitive: “Expecting bad things to happen”
    - Flexible thinking
  - Behavioral: Avoidance of threat
    - Problem Solving
    - Gradual Exposure



# CBT - WHAT'S COVERED

- First portion - psychoeducation
  - Learn to recognize the connection between thoughts, feelings, physical reactions in anxiety provoking situations
  - Learn coping strategies such as relaxation, flexible thinking, problem solving
- Second portion - exposure
  - Practice skills learned by slowly facing fears



# CBT STRUCTURE

- Short-term treatment with a standard structure
- Includes therapy homework
- Caregivers are involved
  - Give therapists feedback about the child's anxiety
  - Help the child use therapy skills



# TREATING ANXIETY - MEDICATION

- SSRIs, such as Zoloft<sup>®</sup> (sertraline), help regulate neurotransmitters (chemical messengers in the brain)
- Should be managed by a pediatrician or psychiatrist
- Generally well-tolerated
- Onset of effects takes about 1-2 months



# RECOMMENDED THERAPY CLINICS

## Project CHAT Anxiety Resources

### Recommended Therapy Clinics

Sliding Scale (fees can be less than \$30)

- Temple University Child and Adolescent Anxiety Disorders Clinic (215-204-7165): [www.childanxiety.org](http://www.childanxiety.org)
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- CBT Center for Anxiety and OCD (610-529-1875): <https://cbtcenterforanxiety.com>

#### Intensive Outpatient

- Rogers Behavioral Health (267-787-6600): <https://rogersbh.org/locations/philadelphia>

# HOW TO FIND A CHILD THERAPIST

- Who to ask?
  - Your child's pediatrician
  - Your school's counselor, social worker, psychologist
  - A friend
  - The internet!
- What to look for: Therapist licenses
  - Licensed psychologist
  - Licensed psychiatrist
  - Licensed social worker
  - Licensed counselor
  - Licensed marriage and family therapist



# THERAPIST DIRECTORIES

- Anxiety and Depression Association of America
  - <https://members.adaa.org/page/FATMain>
- Association for Behavioral and Cognitive Therapies
  - <http://www.findcbt.org/FAT/>
- Psychology Today
  - <https://www.psychologytoday.com/us/therapists>
- Therapy 4 the People
  - <https://therapy4thepeople.org>
- Your Insurance Company's "Find a Doctor"



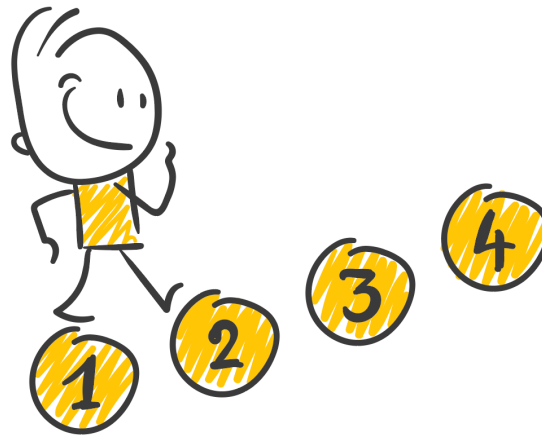
# QUESTIONS TO ASK THE THERAPIST

- Have you treated children with X problem/from Y background?
- What language do you speak?
- How long do you usually see clients for?
- Do you use evidence-based treatments?
- Do you give therapy homework?
- Will you provide a treatment plan?
- Did your training include supervised experience?
- What's your fee? Do you take insurance?
- Do you offer therapy in person? How long do you plan on continuing telehealth?



//

**Do you do exposure therapy?**



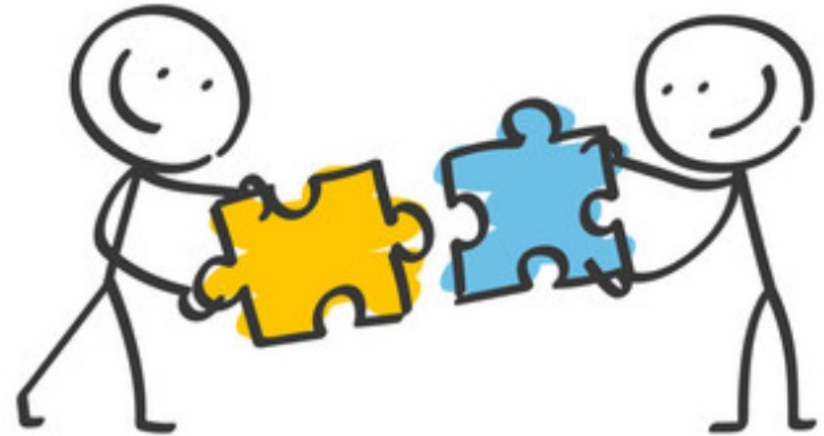
# STARTING THERAPY

- Waitlists: get on many of them!
- The Intake process
  - Screening (5-20 min)
  - Intake (50 min or longer)
- Starting therapy
  - Initial session: Rapport building



# ONCE THERAPY HAS STARTED...

- Check for “fit”
  - Ideally, you want someone who both creates a space that feels safe and that pushes your child out of their comfort zone so they can grow
- Look for progress
  - Talk to your therapist if you aren't seeing as much progress as you'd like
  - Consider switching therapists



# ADDITIONAL RESOURCES HANDOUT



Referral List

Therapist Directories

Internet Resources

Books for Caregivers & Children

COVID-19 Coping Resources

# SELF HELP RESOURCES

## For Kids/Teens

- *When Harley Has Anxiety: A Fun CBT Skills Activity Book to Help Manage Worries and Fears.* Galanti. (Kids)
- *Anxiety Relief for Teens.* Galanti. (Teens)
- *Up and Down the Worry Hill.* Wagner. (OCD)

## For Caregivers

- *The Resilience Recipe: A Parent's Guide to Raising Fearless Kids in the Age of Anxiety.* Khanna & Kendall (coping skills)
- *Breaking Free of Child Anxiety and OCD: A Scientifically Proven Program for Parents.* Lebowitz (caregiver responses)

# UNHAPPY WITH THE SYSTEM? CALL YOUR REPRESENTATIVE!

- Federal
  - Mental Health Reform Reauthorization Act of 2022
  - Mental Health Services for Students Act
  - Comprehensive Mental Health in Schools Pilot Program Act
- Find your representative:  
<https://www.legis.state.pa.us/cfdocs/legis/home/findyourlegislator/>
- For more information:
  - Federal: <https://www.apa.org/advocacy>
  - State: <https://www.papsy.org/page/PPAAdvocate>

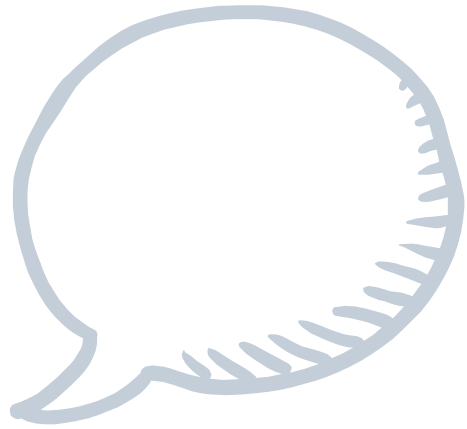


# ANXIETY IN YOUTH: RECAP



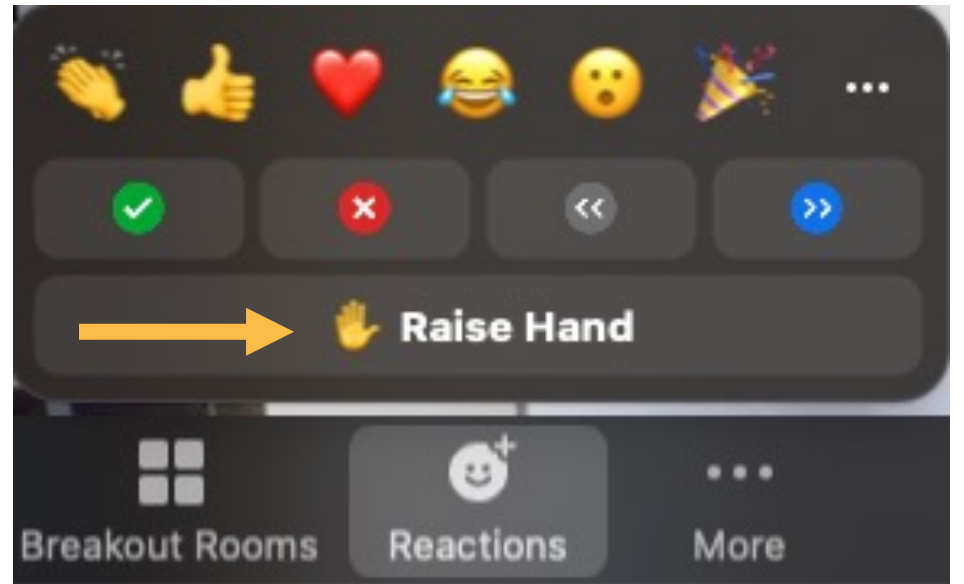
- Anxiety can present as worries, physical symptoms, and avoidance
- Goal is to help kids gradually face their fears
- Cognitive behavior therapy with exposure and medication are both available and effective for kids who need extra support





THANKS!

Any questions?





# ANXIETY IN YOUTH: RECAP



- Anxiety can present as worries, physical symptoms, and avoidance
- Goal is to help kids gradually face their fears
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