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Childhood Anxiety and Roles of Parents, Educators, and Pediatric Healthcare Providers in Addressing Protective Factors

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Abstract

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in Addressing Protective Factors

by

Gabriela Zamora-Ahlstrom

MSW, Wayne State University, 1997

BS, University of Minnesota, 1994

Dissertation Submitted in Partial Fulfillment of

the Requirements for the Degree of

Doctor of Philosophy

Social Work, Clinical Expertise

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Abstract

Childhood anxiety affects over 32% of youth in the United States, and when left untreated, contributes to poor school performance, social difficulties, truancy, school dropout rates, juvenile delinquency, substance abuse, and family and community difficulties. Preventing childhood anxiety by implementing effective protective factors for children can eliminate many of these outcomes. Using the biopsychosocial theory and social work systems theories, this study involved exploring the beliefs and attitudes of parents, educators, and pediatric healthcare providers in an affluent suburban community of Detroit (Rochester/Rochester Hills, MI), regarding their roles in providing protective factors against childhood anxiety. A generic qualitative research design using 12 semi-structured open-ended questions via Zoom and telephone interviews with 16 participants was used, including parents, educators, and pediatric health care providers. Results from a thematic content analysis yielded five themes regarding participants' beliefs and attitudes involving witnessing different degrees of childhood anxiety, believing in prevention, and feeling responsibility to provide protective factors, recognizing the negative impact of anxiety while feeling unprepared and unsupported, having knowledge of active use of protective and risk factors despite feelings of inadequacy, awareness of early signs and precursors as well as implementing early assessments despite feelings of uncertainty, and recognizing systemic barriers and strong belief in intersystem collaboration. Addressing protective factors which prevent childhood anxiety or greatly decrease its prevalence and impact in terms of developmental outcomes is possible and can in turn lead to long lasting social change for children and families.

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Dedication

I dedicate this work to my now grown children who in spite of our best efforts developed childhood anxiety, it was a different era, and we did not know enough regarding the prevention of childhood anxiety. Yet, they learned to embrace their super charged brains and they learned how to tame anxiety and how to overcome every obstacle along the way. Zack and Margo, raising you both has been the greatest inspiration of my life which impacts everything, including my work. As you both grew, I focused more and more on working with children and adolescents who struggled with anxiety. I also dedicate this work to this generation of young children and adolescents, not only my own nieces and nephews and great nieces and nephews, but also the children that I work with have worked with, or will work with, you were the catalyst for my academic pursuit to further understand protective factors and the prevention of childhood anxiety.

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Thank you to a handful of Walden PhD candidate peers from different disciplines that I met and worked with along the way as we supported each other through endless iterations of our work.

Also, thank you to my husband, Dennis, for the endless cups of coffee that were hand delivered to me, especially during the last 3 years, the dissertation years. And thank you to my sister, Dr. Dora Zamora-Flores for holding down the fort caring for our aging parents, as I caught up to her academically.

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Chapter 1: Introduction

Childhood anxiety affects over 32% of this country's youth (NIMH, 2018). Anxiety impacts children's academic, social, and physical wellbeing, and if left untreated, can contribute to low school-performance, social difficulties, truancy, school dropout rates, juvenile delinquency, substance abuse, and family and community difficulties. Preventing childhood anxiety by implementing effective protective factors for children can eliminate many of these outcomes. Parents, educators, and pediatric healthcare providers can address these protective factors. No research has been identified regarding parents', educators', and pediatric healthcare providers' beliefs and attitudes regarding their roles in terms of providing protective factors. This study involves filling in that gap in the literature by further exploring beliefs and attitudes of parents, educators, and pediatric healthcare providers regarding their roles in providing protective factors against childhood anxiety.

This chapter includes a discussion of problems that untreated and unprevented childhood anxiety can produce in the lives of children, parents, and communities. I explore how to engage children's natural support systems in terms of providing protective factors against childhood anxiety. I share statistical information regarding prevalence, types of anxiety disorders, support systems, and current roles in terms of providing protective factors. I also discuss risk factors and how they correlate with possible protective factors. This was explored via the biopsychosocial and general social work systems theories. This chapter also includes a description of the purpose of the intended study. I discuss why participants were chosen. In the background section, the most

current literature regarding this topic is briefly explored; I discuss the nature of the intended study, its design and methods, and the research question. This chapter includes the significance of the study and why understanding this topic helps to further inform effective prevention programming against childhood anxiety. Lastly, I address identified limitations in current literature and the proposed study.

Background

There is some research regarding risk factors and methods of providing protective factors and prevention, which is key to creating long-lasting social change in terms of childhood anxiety, but there is almost no research looking at roles of those who need to provide these protective factors.

Genetics is the predominant risk factor for developing childhood anxiety (Drake & Ginsburg, 2012). Heredity creates a probabilistic risk factor, not a deterministic one, meaning that genetics creates a predisposition for anxiety that can later be activated by environmental factors (Arnold & Tallefer, 2001). Three of the main environmental factors that can impact the outcome of child development are family and bonding, health, and learning (Arnold & Tallefer, 2001). Three community systems which might be able to provide factors which mitigate the development of childhood anxiety would be healthcare, educational, and family systems, as these are the three systems related to family and bonding, health, and learning. These systems face challenges in terms of providing treatment and providing supports and resources that might help prevent the onset of childhood anxiety disorders (Alyanak et al., 2013; Neil & Smith, 2017; O'Brien et al., 2017).

Parental factors have an impact on childhood anxiety because of attachment issues, parental psychological problems, conflicts in the home, or lack of childhood development knowledge (Alyanak et al., 2013). Teachers have a difficult time identifying children who are exhibiting early symptoms of anxiety (Neil & Smith, 2017). In addition, family practitioners feel il-prepared to identify, manage, and make appropriate referrals regarding childhood anxiety (O'Brien et al., 2017). Additionally, the field of healthcare involves encouraging annual check-ups and frequent wellness visits and providing health education and safe practices programs (Fox et al., 2008). Once risk factors are identified at early onset or prior to disease onset, patients can be instructed about behavioral biopsychosocial changes to possibly prevent full onset of the disease (Fox et al., 2008). Although recent research, which is explored in Chapter 2, has identified both risk and protective factors for childhood anxiety, I did not find any information indicating prevention or early identification are taking place within the healthcare system in the United States in the area of childhood mental health.

Mitigating factors which affect childhood anxiety include secure attachment, lowconflict home environments, and proper management of caregivers' own mental health issues. Educators and pediatricians' roles in providing protection against childhood anxiety include knowing how to identify children at risk of developing childhood anxiety disorders, knowing how to recognize precursors or early signs of anxiety, and making appropriate referrals to prevention programs and community resources. Educators and

pediatricians can also provide psychoeducation to parents regarding child development and parenting skills, including teaching children how to solve problems, conflict resolution, mindfulness, and modeling non-fear-based cognition. Parents, educators, and pediatric healthcare providers must be prepared to identify, manage, and provide protective factors to prevent childhood anxiety from either developing or worsening. The role of identifying, managing, and possibly preventing childhood anxiety involves parents, educators, and pediatric healthcare providers.

Problem Statement

Untreated childhood anxiety can place children and adolescents of all racial and socio-economic backgrounds at risk of academic failures, social difficulties, and conflicted family relationships (Chorpita et al. 2016). According to the National Institute of Mental Health (NIMH, 2018), childhood anxiety affects 32% of adolescents in the United States. Additionally, 33.8% of all adults have been diagnosed with an anxiety disorder at some point in their lifetime, and currently 7.1% of all children are diagnosed with anxiety disorders (Centers for Disease Control and Prevention [CDC], 2019). Despite this, many children and adolescents with anxiety disorders never receive interventions (Ginsburg et al., 2014). Criminal activity, school dropout rates, unemployment, and substance abuse problems result from untreated childhood mental health challenges such as childhood anxiety (Weir, 2017). Juvenile delinquency, academic failure, substance abuse, and chronic mental illness may be prevented by providing protective factors to at-risk school-aged children (Ginsburg et al., 2014).

Mitigating factors against childhood anxiety can be provided via well-informed prevention programs within school and public health systems.

Protective factors are characteristics, traits, skills, supports, or resources at the biological, psychological, family, or community level that are associated with a lower likelihood of problematic outcomes or reduce the negative impact of risk factors on these outcomes (O'Connell et al., 2009). Ecological levels associated with mitigating factors against childhood anxiety include individual, family, educational, community, biological, psychological, and social factors. Therefore, any inquiry involving roles of those providing resources and supports which protect against childhood anxiety must look at open social systems involved in children's life, meaning systems that interact with and influence each other. There does not appear to be any literature involving whether parents, educators, and pediatricians know about protective factors for children in order to prevent the onset of anxiety disorders, nor if they want to assume or prepared for those roles. No articles have been identified involving parents', teachers', or pediatricians' attitudes, beliefs, or experiences involving protective factors against childhood anxiety, and I was interested in addressing this gap in the literature. Limited information has been identified involving social workers' roles in terms of empowering parents, educators, and pediatricians in order to be better able to address protective factors to offset childhood anxiety.

Although there are a limited number of school-based prevention programs aimed at educating parents and teachers about teaching children emotional regulation and cognitive processing, no follow-up investigations have been identified regarding experiences, beliefs, or attitudes of the frontline task force involved in these programs, including parents, educators, and healthcare providers. By exploring attitudes and beliefs of parents, teachers, and pediatricians regarding their roles in addressing protective factors which mitigate childhood anxiety, social workers can further understand where these open systems currently stand in terms of their ability to fill the role of providing protective factors, particularly in communities that do not have any school- or healthcarebased childhood anxiety prevention programs, such as the communities of Rochester and Rochester Hills, Michigan, a suburb of Detroit. This information can help inform both school- and healthcare-based programs that empower parents, teachers, and pediatricians to comfortably assume roles of addressing protective factors which mitigate childhood anxiety.

Purpose

The purpose of this generic qualitative study is to explore beliefs and attitudes of parents, educators, and pediatricians regarding their roles in terms of addressing protective factors which mitigate the onset of childhood anxiety for school-aged children in Rochester Hills, Michigan. Mitigating factors against childhood anxiety involves secure attachment, low-conflict home environments, and proper management of caregivers' own mental health issues. Educators' and pediatricians' roles in terms of providing protection against childhood anxiety include knowing how to identify children

who are at risk of developing childhood anxiety disorders, knowing how to recognize precursors or early signs of anxiety, and making appropriate referrals to prevention programs and community resources. Educators and pediatricians can also provide psychoeducation to parents regarding child development and parenting skills, including teaching children how to problem solve, conflict resolution, mindfulness, and modeling non-fear-based cognition. Pediatricians can also help identify problems with attachment early on and provide education to parents regarding secure attachment.

Research Question

My research question is: What are the beliefs and attitudes of parents, educators, and pediatricians regarding their roles in terms of addressing protective factors which mitigate childhood anxiety for school-aged children in Rochester Hills, MI?

Conceptual Framework

Childhood anxiety is multifaceted in terms of its development and prevalence and persistence in our communities. Engel's (1977) Biopsychosocial Model involves biological, psychological, and social factors. Biological factors that determine developmental outcomes include genetics, neuroscience of anxiety, temperament, and physical manifestations of anxiety. Psychological factors include cognition, attachment, emotional regulation, and psychological sensitivities which create vulnerabilities. Engel's Biopsychosocial Model stems from the need to look at pathology not only from a biological perspective but also from the psychological and social systems that impact

outcome. This holistic approach is necessary in exploring the prevention of childhood anxiety via protective factors. Social Work systems theories involve environmental perspectives. The Social Work systems theory involves providing a holistic perspective to look at childhood anxiety as a social problem that does not happen in isolation; therefore, its prevention and treatment requires the active participation of parents, educators, and healthcare providers (Germain & Gitterman, 1976; Lathorpe, 1969; Meyer & Matainee, 1998).

Overall, exploring the beliefs and attitudes of those involved within their local social context is important. Qualitative research involves exploring a topic of interest within real-world parameters, with well-grounded and rich descriptions of thoughts, beliefs, attitudes, and behaviors of those involved within unique settings (Babbie, 2017). Studying beliefs and attitudes of parents, educators, and pediatric healthcare providers in Rochester/Rochester Hills, MI might yield different results compared to the city of Detroit or a rural area such as Mt. Pleasant, MI. Rochester/Rochester Hills, MI is a suburb of Detroit with a primarily White and affluent population. I explored participants' (parents, educators, and healthcare providers) attitudes and beliefs to further understand their roles in terms of addressing protective factors which mitigate childhood anxiety within a particular social context. I also chose to only explore one geographic setting, Rochester and Rochester Hills, MI, because it provides a deeper context and understanding of the roles of professionals and parents in a community that is homogenous in terms of demographics. The conceptual framework is further explored in Chapter 2.

Nature of the Study

A generic qualitative inquiry design was appropriate for this study. Because I was not assessing predetermined variables to measure or test hypotheses (see Rudenstam & Newton, 2015), quantitative research was not suitable. Themes were identified to answer the research question, making the qualitative research design appropriate.

Definitions

In this study, the following terms are used:

Generalized Anxiety: Excessive worry about situations and events, involving frequent nightmares, headaches, or stomachaches (American Psychological Association [APA], 2013).

Obsessive Compulsive Disorder: A disorder which involves intrusive and disruptive thoughts and spending more than 1 hour a day engaged in nonproductive repetitive behaviors (such as handwashing, checking, arranging, counting) in order to alleviate intrusive thoughts (APA, 2013).

Open System: A social system that has external interactions for exchanging resources, energy, and knowledge, effectively working with other open systems to fill the needs of the whole, such as society or community [Bertalanffy], 1969).

Panic Disorder: Disorder which involves reacting to fear by freezing, clinging, or having tantrums, in addition to experiences involving shortness of breath and rapid heartbeat for no apparent reason (APA, 2013).

Performance Anxiety: Excessive worry about competence or abilities which often involves redoing tasks due to excessive worry about less than perfect performance (APA, 20130).

Protective factors: Factors associated with a lower likelihood of negative outcomes, or which reduce a risk factor's impact. Protective factors may be seen as positive countering events (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020).

Risk factors: Characteristics that are associated with a higher likelihood of negative outcomes (SAMHSA, 2020).

Secure Attachment: A positive parent–child relationship, in which the child displays confidence when the parent is present, shows mild distress when the parent leaves, and quickly reestablishes contact when the parent returns [Ainsworth], 1969).

Selective Mutism: Condition which involves refusing to to speak in certain situations in school or with anyone except immediate family, in spite of being fully capable of speaking (APA, 2013).

Separation Anxiety: Refusing to leave parents or familiar persons when necessary, which leads to tantrums (APA, 2013).

Social anxiety: Ongoing fear of social situations involving unfamiliar people and being nervous around and actively avoiding peers and social situations (APA, 2013).

Social System: A relational bond of personal or environmental roles that are part of a whole, such as society, or a community [Zastrow], 1992).

Specific Phobias: Persistent and unreasonable fears of certain objects or situations such as flying, heights, spiders, school, water, medical procedures, and enclosed spaces (APA, 2013).

Assumptions

I assumed that parents, educators, and pediatric healthcare providers who participated in this study were aware of or have some awareness of childhood anxiety and its impact on child wellbeing. I also assumed they had some interest in exploring their role in terms of addressing protective factors which mitigate the development of childhood anxiety disorders.

Another assumption was that there were differences regarding childhood anxiety and protective factors depending on geographical location, as well as socioeconomic status, cultural differences, racial differences, and rural versus urban versus suburban settings. Due to this assumption, participants were all from Rochester and Rochester Hills, MI.

Last, I assumed that enough parents, educators, and pediatric health care providers would be interested in participating and answered interview questions sincerely.

Scope and Delimitations

The scope of my study is guided by the research question. I only explored implications regarding childhood and not adult anxiety. I chose this particular scope because of the biopsychosocial theory which affirms the importance of attachment,

education, and health on outcomes. The study was focused on those living in the Rochester/Rochester Hills community and school district in Michigan. This helped to make the study manageable, as all of the participants either lived, have children who attend school at, or worked in the community of Rochester and Rochester Hills, MI. Rochester/Rochester Hills, MI are two adjoining suburbs of Detroit which make up one large community. The following information was obtained from the US Census (2010). Combined both Rochester and Rochester Hills, MI have a population of over 97,000 people. Eighty-five percent of the population is white, and almost 13% of the population is Asian. The median household income is $95,000. The median price of a home between both suburbs in $330,000. More than 97% of adults in the community have completed high school, and at least 58% have a bachelor's degree. Overall, the community of Rochester/Rochester Hills, MI is an affluent suburb 20 miles north of Detroit, with a predominantly white population. Other boundaries set for this study were not including any participants who knew me personally or professionally to mitigate for researcher bias or influence. A significant criterion for parent participants aside from having a child who is a student in one of the many public and private schools within the Rochester/Rochester Hills, MI community and school district, was that they have a history of anxiety symptoms themselves, as this accounts for the risk factory of heredity.

Due to the scope and delimitations, results as with most qualitative studies are not transferable and apply only to this population with these social parameters. However, the study itself is replicable in other settings and populations due to steps and measures which were taken and described in Chapter 3 to ensure replicability.

Limitations

The primary limitation of this study is the small sample size for each category of participants. Due to the scope of a dissertation, and to having only one researcher doing all of the interviews and coding, interviewing up to 10-31 participants for each category, which is often what is recommended to achieve saturation (Young & Casey, 2019), was not possible. However, I chose to try to mitigate for this limitation because it was important to explore beliefs and attitudes of the individuals representing three primary systems that were indicated in literature: family (parents), education(educators), and primary health (pediatric healthcare providers). Due to the particularly homogenous make-up of the population in Rochester and Rochester Hills, MI, interviewing six participants from two of the categories (parents and educators) and four from the last category (pediatric health care providers) a total of 16 participants yielded valuable results about the beliefs and attitudes of parents, educators, and pediatric healthcare providers living and working within the Rochester/Rochester Hills, MI community, regarding their roles in terms of providing protective factors against childhood anxiety. Another limitation is the homogenous make-up of the participant sample. Rochester and Rochester Hills, MI are two suburbs of Detroit, geographically right next to each other, which share a school district. The population within Rochester and Rochester Hills, MI is primarily White and affluent. I chose to address a demographic specific location because it would provide a deeper context. I explored beliefs and attitudes about a particular topic,

for people in a geographic location with similar backgrounds and demographics. Results may differ in different communities, which would be worth exploring in the future.

The final limitation of this study is my past personal and work experiences, which have the potential to lead to biases and prejudices. Culture, socioeconomic status, gender and ethnic identity, past personal traumas, and experiences all contribute to researcher biases. In addition to over 20 years of work experience within the childhood mental health field, and founding the Anxiety Wellness Program, I also have added biases associated with being a parent, although my children are no longer school-aged. In addition, I live and work in the community where I was recruiting participants and gathering data. Steps I took to manage researcher bias involved first ensuring I did not accept any participants in the study whom I know personally or professionally. Rochester and Rochester Hills, MI is a large suburban community of Detroit with one large, combined school district with many different schools and healthcare facilities. I was able to recruit enough participants who did not know me personally or professionally. I also managed researcher bias by maintaining awareness via reflective journaling, a strategy that helped ensure reflexivity, which is further explored in Chapter 3, as well as having my committee members provide constant feedback, which ensured rigor of the entire study. I also had participants review transcriptions and results, and I used the interview guide to ensure all interview questions were open-ended and not leading in any way, were respectful of participants, and involved engaging the reflexivity process, which is further described in Chapter 3.

Significance

By empowering those with the primary roles of addressing conditions that protect against childhood anxiety, then perhaps we can help decrease the prevalence of childhood anxiety disorders. By exploring and understanding beliefs, experiences, and attitudes of parents, educators, and pediatric healthcare providers in the Rochester and Rochester Hills, MI community social workers as professionals who works with children who struggle with childhood anxiety, can more effectively communicate with the school community, primary health care community, and parents about untreated, unidentified, or improperly managed childhood anxiety which continues to affect children and their families. Addressing biological, psychological, family, and community conditions to prevent childhood anxiety or greatly decrease its prevalence and impact might be possible. Identifying obstacles that parents, teachers, and pediatricians face in terms of being able to address protective factors to mitigate childhood anxiety can inform home-, community-, healthcare, and school-based prevention programs, which can alleviate social issues that are directly related to untreated childhood anxiety such as substance abuse, school dropout rates, unemployment, juvenile delinquency, and chronic forms of adult mental illness (Alyonok et al., 2013; Higa-McMillan et al., 2016). This in turn can lead to long-lasting social change for children and families in the Rochester and Rochester Hills, MI community.

Summary

In this chapter, I explored the importance of protective factors which mitigate childhood anxiety as provided by immediate support systems consisting of parents, educators, and pediatric healthcare providers. I described using the qualitative study design to further understand beliefs and attitudes of these adults in their children's life in terms of their roles addressing these factors. This was done using the biopsychosocial theory. Three main environmental factors that can impact the outcome of child development are family and bonding, learning, and health (Arnold & Tallefer, 2001). I introduced the concept of protective factors as characteristics, traits, skills, supports, or resources at the biological, psychological, family, or community level that are associated with a lower likelihood of or reduce the negative impact of risk factors on problem outcomes. Therefore, this exploration of the roles of those providing resources and supports which protect against childhood anxiety involves addressing open systems which are involved in children's lives. This chapter includes an outline of my intended study via the lenses of biopsychosocial and social work systems theories. I described in detail the study, including the background of the stated problem, purpose of the study, and research methods. I also discussed the significance of this study due to current gaps in literature, and how a further understanding of the roles of parents, educators, and pediatric healthcare providers in terms of addressing protective factors to mitigate against childhood anxiety can help to inform school- and healthcare-based prevention programs. Chapter 2 includes a review of the historical context of childhood anxiety, current issues related to this topic, and current literature regarding roles of parents, educators, and

pediatric healthcare providers in terms of addressing protective factors which mitigate against childhood anxiety. Chapter 2 also includes gaps and limitations in current literature and beliefs and attitudes of parents, educators, and pediatric healthcare providers in the Rochester and Rochester Hills, MI community regarding their roles in terms of addressing these factors.

Chapter 2: Literature Review

Untreated childhood anxiety can lead to children and adolescents of all racial and socioeconomic backgrounds being at risk of academic failure, social difficulties, and conflicted family relationships (Higa-McMillan et al., 2016). According to the National Institute of Mental Health (NIMH, 2018), childhood anxiety is known to affect 32% of adolescents in the United States. Additionally, 33.8% of all adults have been diagnosed with an anxiety disorder at some point in their lifetime, and currently, 7.1% of all children are diagnosed with an anxiety disorder (CDC, 2019). Despite this, many children and adolescents with anxiety disorders never receive interventions (Ginsburg et al., 2014). Criminal activity, school dropout rates, unemployment, and substance abuse problems result from untreated childhood mental health challenges such as childhood anxiety (Weir, 2017). Juvenile delinquency, academic failure, substance abuse, and chronic mental illness may be prevented by addressing protective factors involving at risk school-aged children in communities (Ginsburg et al., 2014). Mitigating factors against

childhood anxiety can be addressed via well-informed prevention programs within school and public health systems.

The purpose of this generic qualitative study is to explore beliefs and attitudes of parents, educators, and pediatric healthcare providers regarding their roles in terms of addressing protective factors which mitigate against the onset of childhood anxiety for school-aged children in a suburb of Detroit, the community or Rochester and Rochester Hills, MI. Parental factors have an impact on childhood anxiety because of attachment issues, parental psychological problems, conflicts in the home, and lack of childhood development knowledge (Alyanak et al., 2013). Teachers have a difficult time identifying children who are exhibiting early symptoms of anxiety (Neil & Smith, 2017). In addition, family practitioners feel ill-prepared to identify, manage, and make appropriate referrals regarding childhood anxiety (O'Brien et al., 2017). Parents, educators, and pediatric healthcare providers must be prepared to identify, manage, and possibly prevent childhood anxiety.

This literature review involved identifying the biopsychosocial nature of the development of childhood anxiety disorders, as well as the ecological nature of both risk and protective factors. I address roles of primary systems which involve parents, educators, and pediatric healthcare providers. There does not appear to be any literature explaining whether parents, educators, and pediatric healthcare providers know how to address protective factors to possibly prevent the onset of anxiety disorders, nor if they want to or are prepared to assume that role. No articles have been identified about parents', teachers', and pediatricians' attitudes, beliefs, and experiences about addressing

protective factors which mitigate against childhood anxiety, and I was interested in addressing this gap in literature. Further understanding this gap in the literature can help social workers in school settings, healthcare settings, and community settings provide support and resources for parents, educators and pediatric healthcare providers to aid in providing protective factors against childhood anxiety. Limited information has been identified about social workers' roles in terms of empowering parents, educators, and pediatricians in children's life to be better able to address protective factors to offset childhood anxiety. This literature review includes a detailed account of the history of childhood anxiety as well as past and current policies that impact prevention of childhood anxiety. I also explore limited current literature about the roles of parents, teachers, and pediatric healthcare providers in terms of both treatment and prevention of childhood anxiety. This review also contains definitions of important terms and literature regarding risk and protective factors.

Literature Review Strategy

This literature review was completed using the following databases: PsycINFO, SocINDEX, SAGE Journals, Social Work Abstracts, and Thoreau, and Google Scholars, which led to peer-reviewed academic journal articles in the areas of social work, psychology, nursing, and education. I used the following search terms: *anxiety*, *child*, *childhood*, *children*, *risk factors*, *protective factors*, *early identification and prevention*, *parents*, *educators*, *pediatricians*, *teachers*, *healthcare providers*, *prevention programs*,

school-based prevention, *home-based prevention*, *biopsychosocial theory*, *systems theory*, *healthcare-based prevention,* and *roles*. I located articles that were specifically about my topic of interest using many combinations of search terms with Boolean operators.

Conceptual Foundation

Because childhood anxiety is multifaceted in terms of its development, prevalence, and persistence, I used the biopsychosocial model. The biopsychosocial model was a complex lens which I used to explore protective factors which mitigate childhood anxiety. This literature review based on the biopsychosocial model involved exploring biological, psychological, and social risk factors as they related to genetics, the neuroscience of anxiety, temperament, and physical manifestations of anxiety. Psychological factors which were explored include cognitions and attachment as discussed by Bowlby and Ainsworth as well as emotional regulation and psychological sensitivities that create vulnerabilities. Social factors that were explored include environmental perspectives. Due to the ecological nature of both risk and protective factors in terms of childhood anxiety, I used the systems theory in order to address individual, family, educational, health, community, and societal factors. The social work systems theory involves a holistic perspective which I used to look at childhood anxiety as a social problem that does not happen in isolation; therefore, its prevention and treatment require the active participation of other members of parents, educators, and healthcare providers.

Three main environmental risk factors that can impact the outcome of child development are family and bonding, health, and learning (Arnold & Tallefer, 2001). Protective factors are characteristics, traits, skills, supports, or resources at the biological, psychological, family, or community level that are associated with a lower likelihood of problem outcomes or reduce the negative impact of risk factors on problem outcomes (O'Connell et al., 2009). Therefore, this exploration of the roles of those who provide resources and supports which protect against childhood anxiety involved looking at open systems via qualitative research.

Because childhood anxiety has specific origins, exploring beliefs and attitudes of those involved within this local social context was important. Qualitative research involves exploring a topic of interest within real-world parameters with well-grounded and rich descriptions of thoughts, beliefs, attitudes, and behaviors of those within unique settings (Babbie, 2017). Studying beliefs and attitudes of parents, educators, and pediatric healthcare providers in Rochester/Rochester Hills, MI would probably yield different results compared to the city of Detroit, or rural areas such as Mt. Pleasant. Rochester/Rochester Hills, MI is a suburb of Detroit with a primarily White and affluent population. I explored the attitudes and beliefs of parents, educators and pediatric health care providers in the Rochester and Rochester Hills community to further understand their roles in terms of addressing protective factors which mitigate against childhood

anxiety. I chose to only explore this one specific geographic location because narrowing down demographics of participants provided a deeper context.

History of Childhood Anxiety

The historical context of this research topic begins in antiquity. Anxiety was first mentioned in the Hippocratic Corpus, a written collection of Greek medical texts, thought to be written by either Hippocrates or his disciples between 460BC and 370AD (Crocq, 2015). In these texts is a case study of a man named Nicanor who developed a fear of a flute playing girl that greatly affected him but only at night. The second mention of anxiety in texts of antiquity is in the Tusculan Disputations by Cicero (106BC to 43BC). He wrote that affliction, worry, and anxiety are called disorders due to the analogy between a troubled mind and a diseased body (Crocq, 2015). He was the first to consider anxiety a medical disorder. Cicero first described treatment for anxiety as Cognitive restructuring. Around the same time another philosopher, Seneca, wrote his books *Of Peace of Mind,* and *On the Shortness of Life,* where he speculates that fear of death is the main cognition contributing to anxious states. Seneca wrote approximately 4 B.C.-65 A.D., his work was translated into English in 1663, he said that to be free from the clutches of anxiety is to focus our attention on the present moment, rather than worrying about the future. Seneca (1663) said, “He makes his life, long, by combining all times into one”. This notion is similar to today’s notions of mindfulness meditation, which is an evidence-based practice for treating anxiety (Kabat-Zin, 2008). Ironically, from these times of antiquity forward, no mention of interventions is made regarding not only anxiety but mental disorders in general. For the following thousands of years after Cicero and Seneca,

individuals whose symptoms grew to greatly effect functioning were housed in asylums, but not treated (Crocq, 2015).

From these mentions of anxiety during the times of antiquity until the 1700's, the only other mentions of anxiety are found in the Bible, where anxiety is seen as a crisis of faith. Then Boissier de Sauvages published the first French medical nosology in the late 1700's, last medical work to be written in Latin, in which he names 10 categories of illness, the 8th one being Mental Disorders, which were further broken down into 4 orders, one of them being what we would today consider Anxiety Disorders (Crocq, 2015). Back then, these included: Pica, Bulimia, Polydipsia, An-tipathia, Nostalgia, Panophobia (panic terror), Sa-tyriasis, Nymphomania, Tarantism (immoderate craving for dance), and Hydrophobia (Crocq, 2015).

Then onto the 19th and 20th centuries, George Miller Beard first described neurasthenia in 1869, as an anxiety disorder that mostly manifested itself in physical symptoms produced by the unconscious. The diagnosis persists in today's ICD 10 codes (Crocq, 2015). In the early 1900s, Pierre Janet, Sigmund Freud, and Emil Kraepelin as contemporaries made contributions that identified further manifestations of anxiety triggered by the subconscious, separating neurosis anxiety from neurasthenia, and terming many of the anxiety diagnosis still in use today. Around this time anxiety was identified as a symptom that could also be associated with other diagnosis (Crocq, 2015).

In 1956 the DSM I was published, including variations of many of today's adult anxiety disorders, but it was not until the DSM-III that a chapter on Childhood and Adolescent Anxiety Disorders was included (DSM-III, 1980). Prior to the late 19th century, no mention of childhood psychopathology was mentioned in research or texts. Although care for children in social services was addressed it was due to poverty and loss of parents.

A real interest in childhood anxiety disorders can be traced back to the emergence of Developmental Psychology, and the publication of *The Mind of the Child* by German Psychologist, Wilhelm Preyer (1882), (Rey, 2015). In 1891 G. Stanley Hall (1891) started the first American journal of Child Psychology and thus formal research in childhood anxiety and other childhood pathologies began. An early contributor to childhood pathology research was Sigmund Freud (1905) who developed a theory of child development which focused on the child's libido and speculated that neurosis or anxiety could be explained by the child getting stuck in any of the developmental phases due to trauma or external experiences and could be "cured" using psychoanalysis (Rey, 2015). From this, other psychoanalysts developed theories of child development and the first theories of child treatment approaches, starting with Anna Freud and Melanie Klein who developed psychoanalytic approaches to treating children and influenced the Child Guidance Movement that emerged in the 1920's (Rey, 2015).

History of Treatment and Interventions for Childhood Anxiety

The 20th century was known as the century of the child after Allen Key wrote a book titled The Century of the Child in 1900, which was influential in how

society started to view children (Key, 1900 as cited in Rey, 2015). During the 20th century much was learned finally, about the development of children and its effect on later outcomes. Jean Piaget (Switzerland) studied cognitive development in children (1923-1971), Lev Vygotsky (Russia) studied social development (1924-1937), and John Bowlby (UK) studied attachment in children to their primary caregivers (1958). Their theories have greatly influenced childhood psychological treatment, education, and welfare policy worldwide (Rey, 2015).

The historical context of social work interventions for childhood anxiety is a challenge to piece together because it appears that prior to the 19th century childhood anxiety was a) not recognized and b) not seen as something that required intervention, but rather punishment or banishment. Children with behavioral problems that were caused by anxiety were seen as having moral difficulties and were punished sometimes to the extent of being put in asylums, which only housed them and did not treat them (Rey, 2015). Interventions for childhood anxiety start in the 1920's with Anna Freud's and Melany Klein's psychoanalytic practice models, leading to the creation of the Child Guidance Movement that attempted to provide psychoanalysis to children exhibiting symptoms to curb juvenile delinquency (Rey, 2015). It was initiated by lawyers, social workers, doctors, and philanthropists, and was the first prevention program. However, its goal was to prevent juvenile delinquency, a biproduct of anxiety itself.

In the 1930's, 40's, and 50's Behavior Therapy approaches founded by B.F. Skinner (1938) started to be implemented, as these approaches demonstrated that behaviors could be modified by their consequences. In the 1960's Cognitive Behavioral Therapy evolved from behavioral theories, finding that thoughts can influence behaviors and feelings and vice-versa (Rey, 2015). In the 1980's a shift was made towards involving the family more in the interventions by providing parent management training and family systems interventions, particularly by social workers (Rey, 2015). Finally, in 1980 Childhood Anxiety was recognized as a psychiatric condition, when it was added to the DSM-III, that required multi-disciplinary interventions, including medical intervention and either social work or psychological intervention (Rey, 2015 & DSM-III, 1980).

Current Issues Regarding Childhood Anxiety

Prevalence of Childhood Anxiety Disorders

According to the NIMH, 2018), childhood anxiety is known to affect 32% of adolescents in the United States. Additionally, 33.8% of all adults have been diagnosed with an anxiety disorder at some point in their lifetime and currently, 7.1% of all children are diagnosed with an anxiety disorder (CDC, 2019). Despite this, many children and adolescents with anxiety disorders never receive intervention (Ginsburg et al., 2014). Six out of ten children with anxiety disorders receive treatment (CDC, 2020), meaning that forty percent of children with anxiety disorders are still not accessing treatment, much less prevention or early intervention.

Definition of Childhood Anxiety Disorders

Presently, according to the DSM-V, the following are classified as childhood anxiety disorders: Disorders that share features of excessive fear and anxiety and are related to behavioral disturbances that cause impairment in a child's day-to-day functioning, including socially, academically, and /or at home (DSM-V, 2013).

Generalized Anxiety: Excessive worry about situations and events happening, overwhelmed with thoughts of "what if", experiences frequent nightmares, headaches, or stomach aches.

Obsessive Compulsive Disorder: Disorder in which one experiences intrusive, disruptive thoughts, spends more than one hour a day engaged in non-productive repetitive behaviors (handwashing, checking, arranging, counting) in attempts to alleviate intrusive thoughts.

Panic Disorder: Disorder which involves reacting to fear by freezing, clinging, or having tantrums, or experiences shortness of breath and rapid heartbeat for no apparent reason.

Performance Anxiety: Excessive worry about their competence or abilities, often re-doing tasks due to excessive worry about less than perfect performance.

Selective Mutism: Condition in which one refuses to speak in certain situations such as school or with anyone except immediate family despite being fully capable of speaking.

Separation Anxiety: Condition in which one refuses to leave parent or familiar person when necessary, such as for school or babysitter, having tantrums when forced to.

Social anxiety: Ongoing fear of social situations involving unfamiliar people, nervous around peers, actively avoiding peers and social situations.

Specific Phobias: Persistent and unreasonable fears of certain objects or situation such as flying, heights, spiders, school, water, medical procedures, and enclosed spaces.

Other less common anxiety disorders or symptoms include Posttraumatic Stress Disorder, Processing Integration Disorder, eating disorders, hair pulling, skin picking, bed wetting, bowel movement problems, and anxious adjustment reactions.

Current Policy for Prevention and Protective Factors for Childhood

Currently, effective programs for the treatment and prevention of childhood anxiety are guided by public health policies which focus on addressing basic child welfare needs such as appropriate education, access to health care, and proper communication between treating professionals, all of which are protective factors against childhood anxiety. One law that empowers school-based services and programs is the 1986 Individuals with Disabilities Education Act (IDEA) P.L. 101-119. The federal law that guarantees a free, appropriate public education for children with disabilities, such as severe anxiety, or developmental delays. Funding is provided to states to assist with special education and related services. Children need to be evaluated to determine eligibility, and a written plan—the Individualized Education Program (IEP)—theoretically identifies the services and resources and supports that will be provided to meet the child's needs, as well as educational goals for the child. (CASA, n.d.). Second,

is the Patient Protection and Affordable Care Act of 2010, which ensures that every child have access to mental health treatment, by mandating that all private and public health insurance plans provide mental health coverage, and by mandating that all children have access to health insurance, if not through their parent's private options, then through their state's public options. Both policies operate under the assumption that children with mental health needs, such as childhood anxiety, are a vulnerable population that are afforded universal access to specialized education and treatment. A third legislative piece that is currently in place regarding childhood anxiety disorders is the 2010 Patient's Bill of Rights component of the Affordable Care Act, which ensures confidentiality for the child and family, and consent for treatment in addition for consent to communicate with all the service providers that will help improve outcomes regarding the child's anxiety.

Analysis of Current Policy

The three social policies have contributed to bringing treatment options for childhood anxiety disorders a long way from the days when the only interventions available for children were those of being housed due to being orphaned or banished if they exhibited mental health symptoms (Rey, 2015). However, none of these social policies have done much in the area of prevention, other than pediatricians being mandated to include a mental health assessment during a well-child visit for adolescents (ACA, 2010). In spite of these legislative changes, social policy still has a long way to go

before fully providing appropriate services for children suffering with anxiety disorders and services to decrease the prevelance of anxiety via prevention services.

Although the Affordable Care Act of 2010 does address prevention and protective factors for health in general, by mandating that dozens of prevention and early screening measures be provided free of cost to all patients, policies aimed at the prevention of childhood anxiety or mental health disorders do not exist. Currently there is no social policy or federal legislature in place that mandates prevention programs in the schools, the community, or in healthcare settings for childhood anxiety disorders.

The Affordable Care Act (2010) mandates mental health and substance abuse screening for adolescents 12 and over during well-child check-ups, each health care provider can use an assessment tool of their choice. Additionally, the ACA (2010) mandates behavioral screening for all children during their well-child visits that can be completed by the pediatric healthcare provider using a standardized tool of their choice. These are the only 2 pieces of federal legislature aimed at the prevention of childhood mental health disorders. At the state level, for those children covered under Medicaid for health and mental health services, 12 states allow for screening of maternal depression during well-child visits, 25 states recommend maternal depression screening, 6 states require maternal depression screening, and 8 states do not have any maternal screening policy in place (Cooper & Hanlon, 2020).

Research shows that caregiver's untreated mental health problems are a risk factor for childhood anxiety (Lam et al, 2018), this means that the 6 states which mandate maternal depression screening at well-child visits for patients covered by their state health

insurance are providing a protective factor against childhood anxiety. Mothers or caregivers who are found to be struggling with depression can be referred for services to treat their depression. Additionally, a caregiver treating their mental health difficulties will ensure a higher likelihood of a secure attachment between the caregiver and child, which is another protective factor against childhood anxiety (Bowlby, 1958). An exploration of pediatric health care providers attitudes, beliefs and experiences regarding their roles in providing protective factors against childhood anxiety will help to further understand how they go about assessing for mental and behavioral health problems in children and adolescents, and their roles in assessing maternal depression in well-child visits. Although there is numerous assessment tools recommended in the literature, such as the Pediatric Symptoms Checklist (Blucker et al, 2014) and the Anxiety Sensitiviy Index (Silverman et al, 1991) for both educators and pediatricians to use for identifying children at-risk of developing anxiety disorders, no standard methods of child mental health assessment or maternal mental health assessment by pediatric health care providers during well-child visits have been identified in a search of the literature.

Risk Factors/Protective Factors

Risk factors, according to the SAMHSA (2020) are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events (SAMHSA, 2020).

Regarding childhood anxiety disorders, this literature review explores risk factors via the biopsychosocial lens, and protective factors via the social work system's theory lens. The biopsychosocial model looks at the biological, psychological, and social factors including family history of anxiety, the neuroscience of anxiety, temperament, and the many physical manifestations of anxiety, fear-based cognitions, attachment as discussed by Bowlby and Ainsworth (Bretherton, 1994), emotional regulation and psychological sensitivities that create vulnerabilities, plus environmental factors such SES, acculturation, ethnicity, social difficulties, and academic challenges. Both risk factors and protective factors in childhood anxiety are ecological in nature, therefore, we must also look at a systems theory that addresses the different levels of a child's social system; individual, family, educational, health, community, and societal levels (Tomb and Hunter, 2004).

Wu et al. (2016) explored both risk and protective factors for social anxiety among Chinese children. They looked to estimate the two-year trajectory of change in childhood social anxiety symptoms by looking at the study cohort as a whole and as subgroups, and they looked at factors associated with social anxiety based on literature reviews in the field. The first assessment involved administering the Social Anxiety Scale for Children (La Grecca, 1988), Children's Self-Esteem Scale (Smilkstein, 1978), The Family Adaptation Scale (Smilkstein, 1978), The Trait Coping Style Questionnaire

(Wang et al., 1999), The Quality-of-Life Scale (Wang & Lin, 2007), and the Children's Depressive Inventory (Kovacs, 1992) to 2,917 fifth through ninth grade students in 2009, out of which $N = 1{,}047$ met criteria for the longitudinal study. The second assessment was completed in 2010 to 914 students that remained in the study, and the third assessment was in 2010 to the 816 participants that remained active in the study. The results demonstrated that social anxiety symptoms persisted or worsened in correlation to perceived family dysfunction, negative coping skills, and depressive symptoms. Conversely, participants with a perceived higher quality of life, increased positive coping styles, and higher self-esteem level were found to be at a decreased risk for developing social anxiety symptoms.

Voltas et al. (2017) identified similar risk factors by exploring the course of anxiety persistence during early adolescence. The researchers identified that participants that presented with the following risk factors had a higher likelihood of exhibiting persisting symptoms over the course of 3 years: genetics (having a family history of anxiety disorders), overprotective parenting style, insecure attachment, past and present parental problems, family income below poverty level, stressful life events (abuse, bullying, loss), and the acculturation process for foreign children. This study did not look at mitigating factors directly, but it stands to reason that the opposite of these risk-factors would provide protections against the development and persistence of childhood anxiety disorder.

Voltas et al (2017) found that previous anxiety manifestations were the best predictor of its persistence, and that being male was a protective factor. In other words, a female and a male could have both had separation anxiety at the first assessment, but the girl had a higher likelihood of having other more chronic forms of anxiety by the third assessment. This study also found that, overall, the rate of anxiety decreased each consecutive year. However, this was a limitation in this study in that we don't know if the rate of anxiety decreased due to those with higher levels of anxiety dropping out by the third assessment, or if it was due to them receiving treatment during those 3 years.

The social work systems theory provides a holistic perspective to look at childhood anxiety as a social problem that does not happen in isolation, therefore, its prevention and treatment will require the active participation of other members of a child's open social system, including parents, educators, and healthcare providers.

Role of Healthcare Providers

The field of healthcare has long been providing prevention and early identification services by encouraging annual check-ups and frequent well-ness visits. The medical field also provides health education programs and safe practices programs, usually free of charge to the patient, as the third party usually will cover the entire service including the patient co-pay (Fox et al., 2008). This emphasis on prevention and early identification in all areas of health make sense because once identified at early onset, or even prior to disease onset, or identified only by identifying risk factors, then the patient can be instructed in behavior changes to possibly prevent the full onset of the disease. Biopsychosocial changes have been found to mitigate, possibly stop or reverse many of

today's health problems such as cancer, HIV, heart disease, diabetes, STDs (Fox et al., 2008).

Not only are these preventative interventions of identifying risk-factors and educating patients on protective factors fiscally cost effective, but they are also effective in the alleviation of human suffering. The same cannot be said about the availability of such prevention measures for mental health, and in particular, childhood mental health such as childhood anxiety.

In the US, there is no mandated or recommended mental health wellness visit for children under the age of 12, other than a brief behavioral screening at well-child visits. Even during routine mandated behavior screenings for children, a search of the literature did not identify a standardized way to conduct these assessments. Since the 1980's the Pediatric Symptoms Checklist has been found to be a reliable screening tool for early onset childhood mental health problems (Jellineken et al, 1999). By exploring the role of pediatric primary care providers as one of the front-line systems to identify risk factors and early onset childhood anxiety, we may be able to best inform public health-based prevention programs.

In a qualitative study, twenty general practitioners across England were randomly recruited to participate in a semi-structured interview about their beliefs, their experiences, their roles, and their concerns regarding childhood anxiety (O'Brien et al., 2017). The general practitioners had uncertainty about identifying anxiety in children.

They believed parents should have a bigger role in bringing up any concerns regarding childhood anxiety to them, and that the general practitioner's role was to refer to mental health professionals. General practitioners also acknowledged they have limited access to mental health professionals (O'Brien et al., 2017). A follow-up mixed-methods study, by the same researchers, which greatly increased the sample size of general practitioners, looked at the answers of self-report questionnaires of 971 general practitioners in England to identify barriers and facilitators for identifying and managing childhood anxiety disorders (O'Brien et al., 2019). This larger scale study mimicked the results of the original qualitative study. Fifty-one percent of GPs felt confident in identifying childhood anxiety disorders, but only 13% felt confident in managing childhood anxiety. The majority (79%) felt that their training in identification was inadequate, and a larger majority (90%) felt that their training in management was inadequate. Barriers to identification were time restraints plus lack of training. Barriers to management were lack of training and long wait times for mental health specialists. Facilitators to identifying childhood anxiety were based on life experiences vs. training, such as being a female practitioner with school aged children, plus practicing in more affluent settings.

One role which pediatric providers do often have regarding mental health is prescribing medications. One qualitative study looked at the willingness of pediatricians to prescribe antidepressants to children suffering with symptoms of anxiety. Fourteen pediatricians were interviewed, and results showed that they were much less likely to prescribe antidepressants to children with anxiety versus children with depression (Tulisiak et al., 2017). This hesitation to prescribe medicine to children exhibiting

symptoms of anxiety was present despite similar levels of impairment compared to children suffering with depression, and similar efficacy and tolerability profiles. Pediatricians tended to use therapy first for children with anxiety versus children with depression, as they perceived anxiety as being less impairing, and tended to blame symptoms on family dysfunction instead of a biomedical condition (Tulisiak et al., 2017). Pediatricians also noted higher degree of parental ambivalence about medication for anxiety as compared to parent's comfort level with medication for childhood depression.

A review of current literature did not identify any studies that explored or examined the role of pediatric healthcare providers in providing protective factors for the prevention of childhood anxiety, which would be similar to the protective factors they provide for the prevention of other health problems, including identifying at-risk children before disease onset, and providing education to parents about attachment, child development, and risk-factors to be mindful of in the home (Fox et al., 2008). This study, which explores pediatric healthcare provider's beliefs and attitudes regarding providing possible protective factors against childhood anxiety is a starting point in addressing this gap in the literature.

Next, this literature review will explore the impact on mental health outcomes that the two primary environments that children spend the most time in can have: home and school. Recent research has shown that targeted prevention programs that address the multiple levels of influence in a child's life, which include protective factors that span

and interact across both primary environments of school and home can be the most effective at preventing negative mental health outcomes in children, such as childhood anxiety (Twum-Antwi et al., 2020). Some of these protective factors include exposure to nurturing and supportive social environments and other positive experiences such as effective parenting, strong caregiver- and teacher-child relationships, and school connectedness (Twum-Antwi et al., 2020). More negative home environment such as poor family congeniality, low comfort level with sharing problems with parents, parental care, parental interference, and parental pressure for academic performance, and parent personality including short-temperedness and perceived friendliness were significantly associated with a child's anxiety, their emotional adjustment, self-concept, and selfconfidence (Twum-Antwi et al., 2020). Increased conflict in the teacher-child relationship also contribute to increased problem behaviors among school children (Twum-Antwi et al., 2020). Due to the implications of this latest research, my next step was to further explore the roles of educators and parents in providing protective factors against childhood anxiety.

Role of Educators

Educators, including teachers, school counselors, coaches, school-psychologists, principles, and specialty class instructors have a unique opportunity to contribute to the well-being of a child because of the frequent close proximity and influence they have on a child's life. Some prevention programs, such as the Australian FRIENDS for Life program to prevent childhood anxiety, do incorporate teachers in identifying children who might benefit from prevention or early intervention programs. Even though often

teachers run the program, there is limited research indicating their ability to provide protective factors such as early identification, and teaching of important skills such as emotional regulation, problem-solving, mindfulness, and social skills.

One study found that teachers show limited sensitivity to children exhibiting symptoms of anxiety. Teachers struggle to identify pupil's different levels of anxiety, except for situations where children show high levels of somatic complaints (Neil & Smith, 2017). Children with other signs of anxiety, or pre-cursors to anxiety are not being identified, and are not receiving interventions or support (Neil & Smith, 2017) Goulet (2013) recommended training teachers in early identification; kindergarten and first grade teachers were interviewed to see if they recognized behaviors drawn from the current literature that point towards pathological childhood anxiety that would create a disruption in the child's education. A mixed methods study was utilized including a semi-structured interviews for the teachers, and a prototype rating scale. The study failed to provide the results of the semi-structured interviews but did make a correlation between the prototype scale and parental self-reports of childhood anxiety (Goulet, 2013). The author acknowledge that the study did not contribute to any further knowledge regarding teacher's attitudes regarding their roles in identifying precursors or early symptoms of anxiety or of possibly having to administer rating scales. It also does not discuss what the teacher's role would be once any precursors or early symptoms are identified. Further in-depth information from educators regarding their beliefs and

attitudes about their roles in providing protective factors against childhood anxiety and ways of identifying children in need will contribute towards filling in this gap in the literature (Goulet, 2013).

One study did look at one possible intervention teachers can engage in to identify children with a particular type of anxiety disorder, selective mutism (Martinez et al., 2015). The purpose of this study was very specific, to assess the validity and reliability of a new assessment tool for teachers; The *Teacher Telephone Interview: Selective Mutism and Anxiety in the School Setting* (TTI-SM), which was developed by a group of researchers across three large children's hospitals in Canada. Twenty-nine children who had been referred to the Children's Hospital's in Canada, and who met diagnostic criteria for either SM diagnosis plus 10 of them had an anxiety diagnosis. The researchers identified who the children's teachers were and had them complete the TTI-SM for each child via a phone interview with the research assistants, in particular the SM subscale of the tool, and the School and Classroom Behavior Subscale. Parents filled out written inventories regarding the child's anxiety and symptoms. The theoretical background for both the development of the teacher assessment scale, and the testing of its validity and reliability was based on current knowledge that SM isn't often diagnosed until the child starts school, and it is frequently the child's teacher who first notices how the child's inability to speak will impact her education, social and emotional development.

This study is purely quantitative, which purpose is to answer one question, the effectiveness of the TTI-SM. The results indicated that the SM subscale of the TTI-SM provided evidence of both validity and reliability. It measured a construct that was

similar, but different than just anxiety or even social anxiety. It was able to differentiate between children struggling with SM versus other anxiety disorders. The subscale also correlated with clinician diagnosis, giving it predictive validity. Based on these results, the researchers concluded that the TTI-SM was an effective tool for teachers to assess for SM (Martinez et al., 2015).

The purpose of the study is significant given the large part teachers play as the first line identifiers of this rare childhood disorder. The authors provided a review of the literature that had led them to identify the need for such an assessment tool, and they made the original contribution of developing a teacher's assessment scale and confirming its validity and reliability. The quantitative, deductive approach to answering a specific question with numerical data was the only way to confirm the tool's reliability and validity. The sample size was enough to provide some preliminary raw data, and to possibly replicate the results on a larger scale, but it was not large enough to generalize the results, except for maybe SM children within clinical settings. There were adequate controls for research bias, due to inter-rater questionnaire scoring.

Limitations to the study included the small sample, the fact that it was a clinical sample versus just a school setting sample, which makes the results even less generalizable and not universally applicable. Another limitation is that the researchers did not consider English as a Second Language students, or students with any other kind special learning needs, despite the fact that these cohorts of children have an incidence of

SM 4 times larger than the general student population. Lastly, other possible confounding factors not taken into consideration were socio-economic demographics, plus ethnic and cultural differences. Despite these limitations, the study did contribute a new scale that empowers teachers to assess for SM, and this fills a gap in service delivery in the school settings.

Future research should include a larger, school-based sample to make the results more universal and generalizable, and it should include questions that mitigate for ethnic, language, cognitive, and social-economic differences.

Overall, this section of the literature review involved exploring effective protective factors which mitigate against childhood anxiety that can be implemented by educators, such as teaching problem solving and coping skills, gradual exposures to feared situations that present themselves in the classroom, rewards for brave behavior, identifying positive role models and support networks, establishing strong teacher-child relationships, ensuring classroom and school connectedness, teaching positive self-talk, teaching mindfulness skills, breathing techniques and other physiological skills for relaxation (Kozina, 2020; Twum-Antwi et al., 2020). I did not find any articles about the role of educators in identifying students who might benefits from school-based programs that would provide the above-mentioned protective factors, nor about educator's beliefs and attitudes regarding this role in providing protective factors against childhood anxiety, in addition to providing an academic education. Identifying student's at-risk of developing anxiety, or with early onset symptoms will help to inform programming for protective factors against childhood anxiety, such as the FRIENDS for life program in

Australia. Exploring teacher's beliefs and attitudes about taking on the role of providing protective factors is a starting point in filling in this gap in the literature, which can in turn help inform prevention programs against childhood anxiety. Prevention involves helping children to normalize day-to-day anxiety, develop resiliency via protective factors, and prevent development of full-blown anxiety disorders (Twum-Antwi et al., 2020).

Role of Parents

Generally, studies have made recommendations to mitigate for a genetic predisposition towards childhood anxiety by providing programming for parents that educate them in ways to provide protective factors, such as treating their own anxiety, reducing conflict in the home, and teaching kids non-fear-based cognitions (Alyanak et al., 2013; Drake & Ginsburg, 2012). The familial role, as an environmental pathway to anxiety development in children is explored in this section of the literature review.

One study showed that tiger parenting, defined as parents putting extreme demands for excellence on children, has been positively associated with childhood anxiety (Tam et al., 2018). The same study sought to uncover protective factors to mitigate for the risk factor of tiger parenting on children. Results showed that children having the psychological traits of optimism and gratitude moderated the effect of tiger parenting on childhood anxiety. This means that parents would need to also assume the

role of teaching children how to think with optimism and gratitude by teaching cognitive restructuring and by modeling these cognitive traits.

Future research should look at a more culturally diverse sample, including ethnically, language, cognitively and at social economic status, in addition to exploring the beliefs and attitudes of parents regarding their role in providing the above-mentioned protective factors: psychological traits of gratitude and optimism.

A Delphi consensus study identified 171 parenting strategies which were endorsed as protective factors against childhood anxiety (Yap et al., 2015). These were written into a parenting guidelines document, with 11 subheadings: establish and maintain a good relationship with your child, be involved and support increasing autonomy, encourage supportive relationships, establish family rules and consequences, encourage good health habits, minimize conflict in the home, help your child to manage emotions, help your child to set goals and solve problems, support your child when something is bothering them, help your child to manage anxiety, and encourage professional help seeking when needed. These strategies were identified by conducting a literature search which identified 289 recommendations for parents. These 289 recommendations were then presented to a panel of 44 international experts over three survey rounds, who rated them in terms of importance. This Delphi consensus study explored the views of experts from Western countries therefore the strategies may not be relevant for all ethnic groups and cultures. Nonetheless it did produce new parenting guidelines that are supported by research. Future research should explore parent's beliefs and attitudes about their role in

providing such extensive strategies to protect their children from developing childhood anxiety.

Another parental factor to be explored regarding the role of parents in providing protective factors against childhood anxiety is secure attachment and all the factors that might get in the way of a secure attachment between child and mother/caregiver developing (Bowlby, 1958). There is strong evidence to indicate that insecure and disorganized attachment styles can result in childhood and adolescent anxiety (Lam et al., 2019). This can be due to a variety of reasons. For example, insecure attachment has been found to be positively correlated with poor emotional regulation skills, poor social skills, poor communication skills and low self-esteem, all of which are risk factors for childhood anxiety (Lam et al., 2019). Additionally, factors which might contribute to the insecure attachment between a child and a mother/caregiver need to be considered, including a mother's own anxiety disorder, stress and traumas during pregnancy, relationship stress and home conflict, or even a basic lack of knowledge of child development (Lam et al., 2019). When considering protective factors against the risk factor of insecure attachment, we should consider other primary systems to help mitigate. For example, the mother's primary doctor, or OB-gyn can begin providing education about secure attachment prior to a child's birth. Also, the child's health care provider can provide education about secure attachment and child development, and asses during well-child visits, plus provide supports and services if

attachment is presenting as a problem (Lam et al., 2019). Early childhood educational programs can also provide protective factors against insecure attachment by providing assessment, education, and early intervention programs (Lam et al., 2019).

Gaps in Literature and Barriers

The field of childhood mental health has come a long way from a century ago, when the only childhood social issues considered were poverty and parental abandonment (Rey, 2015), and from 50 years ago when childhood anxiety disorders had barely made their way into the Diagnostic Manual for Mental Health Professionals (DSM III, 1980). We now know that childhood anxiety has a genetic predisposition but that this predisposition is not a predestiny and that many factors can act as either risk factors or as protective factors (; Arnold & Tallerfer, 2001; Drake & Ginsburg, 2012). There are decades worth of research about child development, and the trajectory of childhood anxiety. There is also more recent research in the past 10 to 20 years about evidencebased treatment, and about risk factors. The last frontier regarding childhood anxiety is researching protective factors and prevention programs, although there are some studies done in these areas, not many of these programs have been identified in a thorough search of the literature.

This literature review has identified the biopsychosocial nature of the development of childhood anxiety disorders, and the ecological nature of both risk factors and protective factors. Therefore, as we continue to explore possible ways of developing prevention programs, we must take a closer look at the roles of the primary systems in a child's life, parents, educators, and pediatric healthcare providers. There does not appear

to be any literature as to whether parents, teachers, and pediatricians know how to assume the role of providing protective factors to children to possibly prevent the onset of anxiety disorders, nor if they want to assume that role, or are prepared to assume that role. This extensive literature review did not identify any articles about parents', teachers', and pediatricians' beliefs and attitudes about providing protective factors against childhood anxiety and this study begins to address this gap in the literature. Limited information has been identified about the social worker's role in empowering the open systems (parents, educators, and pediatricians) in a child's life to be better able to provide protective factors to offset childhood anxiety.

Summary

Although there are a limited number of school-based prevention programs involving educating parents and teachers and teaching children emotional regulation and cognitive processing, no follow-up investigations have been identified in literature involving experiences, beliefs, and attitudes of those involved in these programs. By exploring attitudes and beliefs of parents, teachers, and pediatricians regarding their roles in terms of addressing protective factors which mitigate against childhood anxiety, social workers can further understand these roles, particularly in communities that do not have any school- or healthcare-based childhood anxiety prevention programs such as Rochester/Rochester Hills, MI, a suburb of Detroit. This information can help inform

both school- and healthcare-based programs that empower parents, teachers, and pediatricians to comfortably address protective factors for the prevention of childhood anxiety.

Chapter 3: Research Method

Untreated childhood anxiety can lead to children and adolescents of all racial and socioeconomic backgrounds being at risk of academic failure, social difficulties, and conflicted family relationships (Higa-McMillan et al., 2016). According to the NIMH (2018), childhood anxiety is known to affect 32% of adolescents in the United States. Additionally, 33.8% of all adults have been diagnosed with an anxiety disorder at some point in their lifetime, and currently 7.1% of all children are diagnosed with an anxiety disorder (CDC, 2019). Despite this, many children and adolescents with anxiety disorders never receive interventions (Ginsburg et al., 2014). Criminal activity, school dropout rates, unemployment, and substance abuse problems can result from untreated childhood mental health challenges involving childhood anxiety (Weir, 2017). Juvenile delinquency, academic failure, substance abuse, and chronic mental illness may be prevented by addressing protective factors for at risk school-aged children (Ginsburg et al., 2014). Mitigating factors against childhood anxiety can be addressed via wellinformed prevention programs within school and public health systems.

The purpose of this generic qualitative study was to explore beliefs and attitudes of parents, teachers, and pediatricians regarding their roles in terms of providing addressing factors which mitigate against the onset of childhood anxiety for school-aged children in Rochester/Rochester Hills, MI. Parental factors which have been found to have a negative impact on childhood anxiety are attachment issues, parental

psychological problems, conflicts in the home, or lack of childhood development knowledge (Alyanak et al., 2013). Teachers have a difficult time identifying children who are exhibiting early symptoms of anxiety (Neil & Smith, 2017). In addition, family practitioners feel ill-prepared to identify, manage, and make appropriate referrals regarding childhood anxiety (O'Brien et al., 2017). Parents, educators, and pediatric healthcare providers must be prepared to identify, manage, and possibly prevent childhood anxiety.

Chapter 3 includes methods used to answer the following research question: What are the beliefs and attitudes of parents, educators, and pediatric healthcare providers regarding their roles in terms of addressing protective factors which mitigate against childhood anxiety? I explain the rationale for using a generic qualitative research design and explore this research question. Chapter 3 also includes a description of how I used the biopsychosocial and social work systems theories as lenses to explore the research topic, recruit participants, and gather and analyze information and data. Chapter 3 includes explanations of sampling methods, recruitment strategies, methods of gathering information, and data analysis methods. It looks at steps taken to ensure confidentiality and ethical considerations, including anonymity, informed consent, doing no harm, voluntary participation, dignity and respect for participants, research bias, safety in data collection and retrieval, storage, and disposal of participant information. Lastly, I discuss trustworthiness of qualitative research as it pertains to this study by addressing rigor, credibility, transferability, dependability, and confirmability in addition to ethical considerations.

Research Design and Rationale

The qualitative research design was appropriate to address my problem because there were not any predetermined variables to measure or hypotheses to test. The qualitative research design was effective in identifying emerging themes regarding roles of parents, educators, and pediatric healthcare providers in terms of addressing protective factors which mitigate against childhood anxiety.

There was no research to date involving beliefs and attitudes of parents, educators, and pediatric healthcare providers regarding their roles in terms of addressing protective factors which mitigate against childhood anxiety. Exploring themes that emerged via this study added to knowledge regarding this topic and might lead to theory development. The topic was explored via the tenets of constructivism, which involves assuming reality is an interpretive process. Qualitative research involves exploring a topic of interest within real-world parameters, with well-grounded and rich descriptions of thoughts, beliefs, attitudes, and behaviors of those within unique settings (Babbie, 2017). Studying beliefs and attitudes of parents, educators, and pediatric healthcare providers in Rochester/Rochester Hills, MI might yield different results compared to those in the city of Detroit or a rural area such as Mt. Pleasant.

It is the inductive and constructivist nature of qualitative research that made it suitable to address my research question. The research question was explored with the assumption that reality is constructed based on individual interpretations of those

involved. This design gave parents, educators, and pediatric healthcare providers the opportunity to share their thoughts, beliefs, experiences, and attitudes regarding their roles in terms of addressing protective factors which mitigate against childhood anxiety. I had no preconceived notions about these factors. There was no hypothesis because the research question had not been previously studied and I found no measurable variables to measure. The holistic nature of childhood anxiety made qualitative research appropriate because it allowed me to explore a variety of social systems instead of just one factor. Next, I discuss the specific qualitative method which was used to explore my research question.

Methodology

Each qualitative methodology has its unique focus which involves exploring different interpretations of realities. The grounded theory design involves meanings through which participants construct realities; this results in new theory development (McLeod, 2001). Phenomenology involves deep meanings associated with personal lived experiences. Its purpose is to address descriptions, interpretations, and critical reflections of experiences (McLeod, 2001). Ethnography involves perceptions, knowledge, and worldviews based on culture, language, ritual, and social practice (McLeod, 2001). Case studies involve investigating and analyzing a single or collective case that is intended to represent the complexity of what is being studied (McLeod, 2001). These qualitative methods differ in terms of ways of interpreting information. The generic qualitative research method involves interviewing participants and generating descriptions or emerging themes, in a way that does not require any preset knowledge or specific angle to

explore (McLeod, 2001). The generic qualitative inquiry involves seeking to discover what is rather than looking for what should be.

This study involved exploring thoughts, attitudes, beliefs and experiences of parents, educators, and pediatric healthcare providers regarding their roles in terms of addressing protective factors which mitigate against childhood anxiety for school-aged children in Rochester/Rochester Hills, MI. A generic qualitative method of inquiry was appropriate for my research question as it involved exploring themes that emerged from an open-minded, unbiased, and in-depth perspective by interviewing participants in an open-ended and semi-structured format, either virtually, face-to-face, or via phone conversations.

Reflexivity

Reflexivity ensures rigor and quality in qualitative research and serves as the highest standard for determining trustworthiness (Teh & Lek, 2018). Reflexivity is a practice that challenges researchers to deeply understand our role in the research, and in creating new knowledge. Researchers do this by understanding and describing intersecting relationships between participants and ourselves (Berger, 2015). Researchers also practice active reflection via reflective journaling and with open conversations with our mentors so that we, the researchers, can better understand our self-knowledge, our sensitivities, and our biases and how these might impact our research (Berger, 2015). The goal in reflexivity is to take the necessary steps in self-monitoring, self-awareness

and accountability towards participants, our mentors, and our readers to not allow the research findings to be overly influenced, in this case, by me as the researcher (Teh & Lek, 2018). The steps I took practice of reflexivity are described below and began by understanding my role as the researcher.

Role of the Researcher

My first role as a researcher was that of being the data collection instrument. One thing that differentiates quantitative research from qualitative research is that the instrument is the researcher herself versus a survey (Rubin & Rubin, 2012). As the researcher, I was present to ask questions, observe body language, emotional responses, tones, and moods. I recorded the interviews and journaled after each interview. I took notes as needed during the interviews to obtain as rich and detailed of information as possible.

I have over 20 years of work experience within the area of childhood mental health and over 10 years of founding and developing the Anxiety Wellness Program which aspires to promote education, advocacy, representation, and treatment to children and young adults who suffer with anxiety disorders. I realize this experience could have bred bias and took every step possible to ensure that it did not, which I will describe next.

Another role of the researcher is the added responsibility of being aware, accepting of, and therefore managing past personal and work experiences which could breed biases and prejudices (Cresswell & Cresswell, 2018, Patton, 2015, Ravitch & Carl, 2016). Factors such as culture, social economic status, gender and ethnic identities, past personal traumas, and experiences all will contribute to researcher biases. In addition to

my 20 plus years of work experience within the childhood mental health field, and having founded the Anxiety Wellness Program, I also have the added bias of being a parent, although my children are no longer school-aged. In addition, I live and work in the community where I was recruiting participants and gathering data. Steps I took to manage researcher bias was first ensuring that I did not accept any participants into the study that I knew personally or professionally. Rochester/Rochester Hills, MI is a large suburb of Detroit with many different schools and healthcare facilities. Therefore, I was confident I would recruit enough participants that did not know me personally or professionally. I also managed researcher bias by maintaining awareness via reflective journaling (Ortlipp, 2008), a strategy that can help ensure the reflexivity process by making note of personal assumptions, biases, goals, belief systems, and subjectivities and clarifying ways of not allowing these to interfere with the qualitative research process (Ahern as cited in Russell & Kelly, 2002, p. 2). I also had my committee members provide constant feedback to ensure rigor of the entire study (Rubin & Rubin, 2012). I also had participants review transcriptions and results, and I used the interview guide to ensure all questions asked were open-ended, not leading in any way, being respectful of the participants, and engaging the reflexivity process (Berger, 2015).

The philosophical world view that I brought to this research process is defined by my epistemological assumptions (beliefs about the nature of knowledge) which are greatly influenced by beliefs about the nature of the world and of existence, our

ontological positions (Cresswell & Cresswell, 2018). Our epistemological assumptions and our ontological positions combined, create our unique way of looking at the world, finding out about the world, and making sense of the world. Since our epistemological assumptions determine how to understand the nature of knowledge, how we acquire knowledge, and how we communicate knowledge with others, they will determine how we carry out research (Cresswell & Cresswell, 2018).

I adhere to the worldview of constructivism which states that individuals give meaning to and interpret their experiences within the context of their own personal history and culture and relationships. Essentially, in my world view and as a researcher, I reject the positivist and objectivist traditions which hold that objectivity and evidence is unaffected by the researcher, and that meaning already resides in all things, separate from consciousness or interpretations (Burkholder & Burbanks, 2016). The positivist and objectivist position assumes that truth is static, waiting to be discovered (Burkholder & Burbanks, 2016). Instead, in my worldview and in my research, I adhere to the ontological tradition of constructivism with the epistemological assumptions of interpretivism (Creswell & Creswell, 2018). Constructivism and interpretivism hold knowledge of the world to be based on how we perceive situations and how we interpret our perceptions (Burkholder & Burbanks, 2016, Creswell & Creswell, 2018). Knowledge is produced by exploring and understanding (not discovering). As it pertains to my research, I explored participants' attitudes and beliefs to further understand their roles in providing protective factors against childhood anxiety within a particular social context for each participant.

Having discussed my role as a researcher in detail, including my personal history and my work history with the population I studied and in the community which I studied, I am using the research strategy of reflexivity to ensure that I took steps against my unique experiences creating bias in my research.

Data Collection

Participants

All participants live, have children who attend school at, or work within the Rochester/Rochester Hills, MI community. The following information was obtained from the US Census Bureau, with approximations for 2019. Rochester and Rochester Hills, MI are two adjoining suburbs of Detroit which make up one large community. Combined they have a population of over 97,000 people. Eighty-five percent of the population is white, and almost 13% of the population is Asian. The median household income is $95,000. The median price of a home between both suburbs in $330,000. More than 97% of adults in the community have completed high school, and at least 58% have a bachelor's degree. Overall, the community of Rochester/Rochester Hills, MI is an affluent suburb 20 miles north of Detroit, with a predominantly white population.

The criteria for the educator group of participants includes being a teacher, principle, or specialist educator, working with elementary or middle-school aged children within in the Rochester/Rochester Hills, MI school district and not knowing me personally or professionally. The criteria for the pediatric healthcare provider group of

participants includes being a practicing pediatric, or family practice MD, DO, NP, or PA within the Rochester/Rochester Hills, MI practice area, treating elementary and junior high school aged children, and not knowing me personally or professionally. The criteria for the parent group of participants includes having a personal history of anxiety, as this is the predominant risk-factor of having children who also have symptoms of anxiety. A second criteria for inclusion for parents are having an elementary or junior high schoolaged child within the Rochester/Rochester Hills, MI school district. The last criteria for the parent participants is not knowing me personally or professionally.

Sampling

I recruited a non-probability sample via a purposive method of recruitment. Purposive because the sample was a mixture of a few predefined groups: educators, parents, and pediatric health care providers from the Rochester/Rochester Hills, Michigan school district or area of practice (Creswell, 2014 and Creswell & Poth, 2018). Once I identified the first few participants by sending out recruitment emails, postings, and flyers, I used the snowball method of recruitment to expand my pool of volunteers. I aimed for 6 participants in each category, or approximately 12-18 participants overall (Young and Casey, 2019), and base the collective number of participants on overall saturation, meaning when no new information was emerging (Creswell, 2014). I believed it was important to explore the beliefs and attitudes of more than one system in a child's life and chose the primary 3 systems that were indicated in the literature: parents, educators, and pediatric healthcare providers. I believed that due to the particularly homogenous make-up of the population, aiming to interview six participants from each

category, or an approximate total of 12-18 overall participants, would yield valuable results about the beliefs and attitudes of parents, educators, and pediatric healthcare providers regarding their roles in providing protective factors against childhood anxiety. Although, the goal of the study was not to compare themes between categories of participants, if some differences do emerge, those will be noted. Saturation between categories of participants was also sought but was secondary to the primary goal of overall saturation within the whole group of participants.

I recruited parent participants via local on-line parenting groups and on-line community groups. I recruited the health care providers by sending letters of inquiry to all local pediatric providers, through their publicly available addresses. I recruited educators, first by posting a letter of inquiry on local on-line educator groups, and then by using the snowball effect. For each possible educator participant that I talked to, I asked that they have anyone they know who met the criteria to please contact me at their discretion to possibly participate as well (see Creswell, 2014). Last of all, I recruited participants from each group by making a flyer with my contact information that was shared via social media, requesting that it be forwarded to people who did not know me personally or professionally, who then in turn contacted me at their discretion if they wished to participate.

Instrument

Twelve in-depth, open-ended interview questions were created that could potentially give some insight regarding the research question: what are the beliefs and attitudes of parents, educators, and pediatric healthcare providers regarding their roles in providing protective factors against childhood anxiety? These twelve questions were based on my current knowledge of childhood anxiety, risk factors, and the current literature regarding protective factors (see Appendix A).

1. What are your experiences in treating/teaching/parenting a child who struggles with anxiety?
2. What are your thoughts about preventing childhood anxiety from developing?
3. What do you believe your role is in the prevention of childhood anxiety for children that you treat/teach/parent?
4. What do you know about protective factors that can help prevent childhood anxiety?
5. What do you know about risk factors that can contribute to childhood anxiety?
6. What methods do you use to assess for the possibility of anxiety developing in a child?
7. What methods do you use to identify early signs or pre-cursors for childhood anxiety?
8. Which protective factors are you currently providing as a parent/teacher/pediatrician?
9. What are some barriers to providing these protective factors?

10. What are some ways of overcoming these barriers?
11. What are your thoughts or feelings about having a responsibility to provide protective factors to school-aged children against anxiety?
12. Is there anything else about this topic that you would like to elaborate on?

Procedures

Participants were invited to participate via the recruitment procedures discussed above, and those who met criteria and expressed interest were sent an introductory e-mail with information about the study, informed consent, and a background and demographics questionnaire.

The data was collected by recording face-to-face virtual conversations with participants using my phone recorder, or phone conversations using a call recording app called rev.com. Due to the COVID 19 pandemic no in-person interviews were conducted. We reviewed the consent forms each participant had read and received via email or USPS mail. The initial part of the interview included an overall orientation to the project and process and went over privacy and their rights as participants. After the interviews, the recordings were transcribed, and the transcription was forwarded to each participant who were given the opportunity to verify that their statements were accurate.

Data Analysis

After collecting the data, recording it, having a service do the transcribing, reading each transcription while listening to the recording to ensure accuracy and having

participants audit it also to ensure accuracy, I conducted a content thematic analysis via coding and categorizing (Creswell & Miller, 2000). Content analysis is the most effective way to discover themes in qualitative research by organizing, categorizing, and tagging codes, then identifying relationships between codes that might illuminate important themes in the data (Creswell & Miller, 2000).

Coding was done in stages, starting with pre-coding by highlighting quotes, words, or brief statements that stood out as relevant to the research questions (Saldana, 2009). I only used manual processing. I documented all highlights and identified codes which were then recorded in an excel spreadsheet which I used as a code book. The coding I used to explore for categories and emerging themes was open coding, not preset, nor deductive (QSR International, 2020). The excel spreadsheet code book was created during the coding process, not prior to coding. I started the coding from scratch, all codes came directly from the questionnaire responses, and were created from the data set (QSR International, 2020). The final level of coding and analyzing was to find meaning, patterns, and connections between the identified codes so as to identify themes (Saldana, 2009).

Trustworthiness

Trustworthiness was achieved by ensuring rigor in this qualitative research design by communicating effectively with my committee members the concepts and methods of this study. I was diligent about maintaining alignment between my research question, theoretical framework, literature review, methodology and analysis by communicating with my committee team.

Credibility

Communicating with my committee also lent the study credibility (as seen in Patton, 2015). Credibility ensures that the study and results are believable and honest from the perspective of the participant in the research (Rubin & Rubin, 2012). This can also be achieved with prolonged interactions with participants, persistent observations, triangulating, or by using separate researchers to collect the same data, by debriefing with both participants and peers, and by utilizing the research reflexivity (as seen in Rubin & Rubin, 2012). This addressed credibility by gathering data in an open-minded way from different participants (Rubin & Rubin, 2012). Additionally, I engaged in note taking during the interviews and reflexive journaling immediately after each interview. Multiple levels of coding and being aware of my own biases when transcribing and coding also helped keep the research credible (as seen in Rubin & Rubin, 2012).

Transferability

Transferability means that results can transfer to similar situations regarding the same topic. This, however, was difficult to guarantee in this case because the nature of qualitative research makes it impossible to evaluate if findings can be true in other contexts unless studies can be conducted in those other contexts (as seen in Rubin & Rubin, 2012). However, I planned on interviewing participants until saturation was achieved to help increase the transferability of the results.

Dependability

Dependability involves evaluating the quality of the data collection, data analysis and the theory generation process. It looks to see that any changes in the conditions of the setting, and in the design of the study are captured, making the study consistent and making the findings possible to replicate. This study addressed the issue of dependability by using a step-by-step interview guide which was replicated in each interview and can be replicated in future studies (Rubin & Rubin, 2012). Engaging in multiple levels of coding and recoding throughout each step of the data analysis process ensured dependability (Rubin & Rubin, 2012).

Confirmability

The study addressed confirmability by adhering to best practices in transcribing and coding the data and by documenting everything in the process of both collecting the data and analyzing it. Adhering to peer or mentor debriefing, and the reflexivity process, creating transparency in the entire research process also ensure confirmability (Rubin & Rubin, 2012).

I used a call recording app called Rev which also provides transcription services for a fee. I found during practice interviews with friends and family that responses are much longer than I had anticipated, so I had practiced using the transcribing service. The service takes about 2 hours to complete each transcription. For the 2 mock interviews I did, I listened to each recording and read each transcription to assess its effectiveness and found the transcription to be accurate. I also did this for each transcription in the study.

Ethical Considerations

In addition to following IRB (Internal Review Board) protocol and adhering to all of their criteria for ethically sound research, social work research must also be informed by the professions' values. This starts by demonstrating sensitivity to vulnerable populations, issues of social justice, respect for dignity and privacy, and non-maleficence (do no harm). In regard to social work research, the social work scholar must hold true to their code of ethics, by ensuring that our research topic, methodology and use of results will be congruent with social works core values of competence, integrity, respect for human dignity, striving for social justice, recognizing the importance of human relationships, valuing a participant's self-determination, and focus on empowering service users (NASW, 2018).

Informed Consent

The first step, after a research topic and research method has been formulated in an ethically responsible way, is to ensure a participant's voluntary and fully informed participation via the informed consent process. The informed consent process involves obtaining voluntary and written informed consent from participants, "without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity" (NASW, 2018, paragraph 5.02(e)). Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks

and benefits of participation in the research (NASW, 2018). During the informed consent process, researchers also inform the participants of their right to withdraw from the research without any penalty (NASW, 2018).

Confidentiality

To ensure confidentiality of participants I will discuss collected information only for the purpose of this study and only with my committee members until publication (NASW, 2018). I informed participants of any limits of confidentiality, the measures that were taken to ensure confidentiality, and when and how any records containing research data will be destroyed (NASW, 2018). Furthermore, research results will protect participants' confidentiality by omitting all identifying information during the writing and publication process (NASW, 2018). Another ethical dilemma is ensuring privacy of the participants when using snowball sampling. To ensure privacy when recruiting via snowball sampling I had interested participants contact me at their discretion. I did not have their contact information. Participants asked other potential participants if they were interested in my study and gave them my contact information. Once people contacted me and agreed to participate gathered their demographic information. I discussed the issues of privacy and confidentiality during the informed consent process.

Doing No Harm

In social work research, the notion of "do no harm" is not as straight forward as in traditional medical research and therefore requires us to look at not only physical harm and possible psychological harm but also social and economic harm (Sobocom, Bertotti, and Stromgottfried, 2018). A better way to think of it is to do no harm and cause no

discomfort (Sobocom et al., 2018). Many possible negative consequences can fall under the auspices of harm and discomfort, such as invasion of privacy, social exclusion, emotional discomfort if certain topics are brought up during the research process, even psychological trauma, and disruption to their daily lives or infringement of rights (Sobocom et al., 2018). To ensure that I did no harm during this research process I informed participants of their right to withdraw from the research at any time without penalty (NASW, 2018). I informed participants of access to appropriate supportive services if any emotional distress should arise as a result of research participation (NASW, 2018). Lastly, to protect participants, and to ensure the integrity of the research, I avoided conflicts of interest and dual relationships with participants, by informing participants when a real or potential conflict of interest arose, which only one did, when a local PHP that I did not know personally or professionally really felt she needed my clinical services for her child, and therefore she did not participate in the study. If any other conflicts of interest had arisen, I would have taken steps to resolve the issue in a manner that made participants' interests primary (NASW, 2018). I took this a step further by ensuring that I did not recruit participants which I know personally or professionally, this also eliminated the possible limitation of researcher bias because of possible deliberate choices I might have made regarding the participants (Creswell, 2014).

All my research material is stored in my computer which needs a password to open. Printed out versions of my study, notes and my reflexive journaling are kept in the

locked portion of my desk, and only I have access to the key. My spouse is aware of my study, and written instructions are a part of my living will in the event of my unforeseen death. Both electronic material and hard copy material pertaining to this study will be destroyed after 5 years via shredding, and deleting as per Walden University's policy (Walden, 2020).

Conclusion

Chapter 3 included methods used to answer my research question. I explained the rationale for using a generic qualitative research design to study and explore this research question. This chapter also included explanations of the biopsychosocial and social work systems theories as lenses through which I explored the research topic, recruited participants, gathered information and data, and analyzed data. Chapter 3 includes detailed explanations of sampling methods, recruitment strategies, methods of gathering information, and analysis methods. This chapter included steps that were taken to ensure confidentiality and ethical considerations, including anonymity, informed consent, doing no harm, voluntary participation, dignity and respect for participants, research bias, safety in data collection and retrieval, storage, and disposal of participant information. Lastly, I discussed trustworthiness issues involved with qualitative research as they pertained to this study by discussing rigor, credibility, transferability, dependability, and confirmability, in addition to ethical considerations. This chapter included a full outline of what I proposed to do and then did in this study.

Chapter 4 includes results of the study and any changes to what was proposed in this chapter. I also outline the data collection and data analysis processes.

Chapter 4: Results

Introduction

The purpose of this generic qualitative study was to explore beliefs and attitudes of parents, educators, and pediatricians regarding their roles in terms of addressing protective factors which mitigate against the onset of childhood anxiety for school-aged children in Rochester/Rochester Hills, MI. Mitigating factors against childhood anxiety include secure attachment, low-conflict home environments, and proper management of caregivers' mental health issues. Educators' and pediatricians' roles in terms of providing protection against childhood anxiety include knowing how to identify children who are at risk of developing childhood anxiety disorders, knowing how to recognize precursors or early signs of anxiety, and making appropriate referrals to prevention programs and community resources.

Educators and pediatricians can also provide psychoeducation to parents regarding child development and parenting skills as well as teach children how to problem solve, resolve conflicts, be mindful, and model non-fear-based cognition. Pediatricians can also help identify problems with attachment early on and provide education to parents regarding secure attachment at the time of birth as well as during early wellness visits. This qualitative study was based on the following research question: What are the beliefs and attitudes of parents, educators, and pediatricians regarding their roles in terms of addressing protective factors which mitigate against childhood anxiety for school-aged children in Rochester/Rochester Hills, MI?

Chapter 4 includes an outline of the data collection process as well as setting and demographic information about participants, including the number and categories of participants, location, duration of interviews, and recording methods. This chapter also includes a discussion the inductive coding process that was used. Emerging themes and codes are discussed and illustrated. Any disparate cases are also discussed. Any issues of trustworthiness are addressed, and results are applied to the research question.

Data Collection

After receiving approval on May 29, 2021, from the Walden IRB (approval #0520-21-0754200), I started recruiting parents, educators, and pediatric healthcare providers of school-aged children within the Rochester/Rochester Hills, MI community. I completed the recruiting process via local online parenting and community groups, social media posts, and recruitment ads, as well as mailing out recruitment flyers to publicly posted mailing addresses. I also verbally recruited participants via telephone calls with publicly listed phone numbers of local pediatric health providers and dropping off recruitment flyers at local healthcare offices.

Solicitation of Participants

I solicited participants via online posts and flyers. Beginning on May 29, 2021, I recruited healthcare providers by sending letters of inquiry to all local pediatric providers through publicly available email addresses, LinkedIn messages, and mailing or dropping off recruitment flyers at their offices. I recruited educators first by posting letters of

inquiry to local online educator groups, and then by using snowball sampling. For each educator participant I talked to, I asked they ask anyone they know who met criteria to please contact me at their discretion to possibly participate as well (see Creswell, 2014). Lastly, I recruited participants from each group by posting flyers on social media with my contact information. I requested flyers to be forwarded to people who did not know me personally or professionally or could have contacted me at their discretion if they wished to participate.

Recruitment of educators took less than 2 weeks. Recruitment of parent participants took 3 months, and recruitment of pediatric providers took 5 months. There was a lack of interest among pediatric providers, but enough interviews were conducted to obtain valuable information involving emerging themes as well as apparent saturation, although I cannot with confidence say that saturation was achieved with this category of participants. Lack of interest from pediatric health care provider participants was a limitation in this study and will be discussed further in Chapter 5. The sample included six parents who had histories of symptoms of anxiety and a school-aged child within the Rochester/Rochester Hills community and school district. The sample also included six educators of elementary, junior high, and high school aged students within the Rochester/Rochester Hills community, and four pediatric health care providers.

Screening and Selection of Participants

Participants reached out in a variety of ways. Once participants reached out to me via email, LinkedIn, Facebook, text, or phone calls indicting interest and requesting an informed consent form, I emailed the informed consent form to them. Three participants

preferred I mail it to them. I was able to screen all educator and pediatric health care provider participants with their Internet work profiles, which verified their professions and places of employment. I screened parent participants by asking via a screening questionnaire if they had histories of anxiety and if their child attended a school in the Rochester/Rochester Hills school district and community. I also filled out a basic screening demographics questionnaire prior to each interview for each participant to doublecheck that each participant met criteria. Each participant emailed me back their consent form after reviewing the IRB consent form, except for three who mailed it in. These were the three participants who preferred to complete phone interviews. They were also most concerned about confidentiality. Eventually, 13 participants were screened out. Two reasons for this are that they knew me personally or professionally, or they did not have a previous history of their own anxiety. A third reason was that they lived near the Rochester/Rochester Hills, MI community but not in the community. Once I received each participant's consent form via email or by mail, I communicated with them via their preferred method of communication to schedule Zoom or phone interviews. Once each interview was scheduled, I emailed them a Zoom link (see Table 1).

Table 1

Recruitment Efforts

Location	Attempts	# Reached vs. # of Participants
Facebook Groups	10 (posted 2X)	Approx. 15,000/8
Facebook Ads	2	Approx. 150,000/4
Facebook Posts	2	Approx. 550/0

Instagram Posts	2	Approx. 110/0 Approx.
Linked In Posts	2	500/1
Linked In Private Messages	25 (messaged 2X)	25/1
Facebook Pages		20/1
Private Messages	20 (messaged 2X)	35/1
USPS mailed Flyers	35	83/0
Verbal Recruiting	83	
Total	181	166,323/16

Table 2

Participant Response Rates and Screening

Interested Participants	Screened Out	Offered Interviews	Completed Interviews
33	13	20	16

Table 1 indicates that from May 29, 2021, until September 29, 2021, there were 181 discrete recruitment efforts where I reached out to approximately 166,323 possible participants in the Rochester/Rochester Hills area, sometimes twice; this resulted in 33 interested participants. Thirteen of the 33 interested participants were screened out due to three reasons: knowing me personally or professionally, being a parent but not having their own history of anxiety, or not living or working in the Rochester/Rochester Hills community. Twenty participants were offered interviews, and 16 followed through by emailing or mailing their consent forms, scheduling, and participating in interviews.

Data Collection

I started conducting interviews on June 2, 2021. Zoom interviews ranged in time from 20 to 45 minutes and took place during the months of June 2021 through September 2021. I completed all the interviews from my home office or my office at my work setting. The participants joined the Zoom interviews from home, work offices, even from their cars. This ensured both privacy and confidentiality during the interview process. We reviewed the consent form they had already read and signed by replying via email with "I consent" or by signing the printed consent form and mailing it via USPS. The initial part of the interview, prior to audio recording, included an overall orientation to the study and process and went over privacy and their rights as participants.

A few participants chose phone interviews instead of Zoom as that was given as an option as well. All participants met the participation criteria for their categories. I used a semi-structured interview guide that consisted of 12 open-ended questions. I

observed the participants' verbal and nonverbal cues and responses throughout the Zoom interviews and took notes during the interviews of any observations I made. The audio portion of the interviews were recorded with my phone recorder so as not to accidentally record the video part of the interview. Upon completion of each interview, the audio files were uploaded to Rev.com for transcription, and the transcriptions were downloaded to my computer as Microsoft Word documents. I ensured accurate transcription by comparing the transcription to the audio recording. I began the broad coding process by highlighting words and phrases throughout the transcript that were significant or meaningful, and then forwarded the highlighted transcript to each corresponding participant to ensure that they agreed with the transcription of their interviews, and with information I found most significant. None of the participants responded with any changes to their interviews. Two participants had accents which Rev.com did not translate well and they corrected for any mistakes from the transcription.

Analysis

After collecting data and recording, transcribing, reading through transcriptions, highlighting significant data, sharing it with participants, and finding no mistakes, I did a thematic content analysis via coding and categorizing. Content analysis is the most effective way to discover themes in qualitative research by organizing, categorizing, and tagging codes. I identified relationships between codes that illuminated important themes in the data.

Coding was done in stages, starting with pre-coding by highlighting quotes, words, or brief statements that stood out as relevant to the research questions (Saldana, 2009). I only used manual processing. I documented all highlights and identified codes which were then recorded in an excel spreadsheet which I used as a code book. The coding I used to explore for categories and emerging themes was open coding, not preset, nor deductive (QSR International, 2020). The excel spreadsheet code book was created during the coding process, not prior to coding. I started the coding from scratch, all codes came directly from the questionnaire responses, and were created from the data set (QSR International, 2020). In the final level of coding, thematic analysis was to find meaning, patterns, and connections between the identified codes so as to identify themes (Saldana, 2009).

The analysis generated 482 distinct highlights, 40 codes, 10 categories, and 5 themes (see Figures 1-6).

Figure 1

Categories and Themes

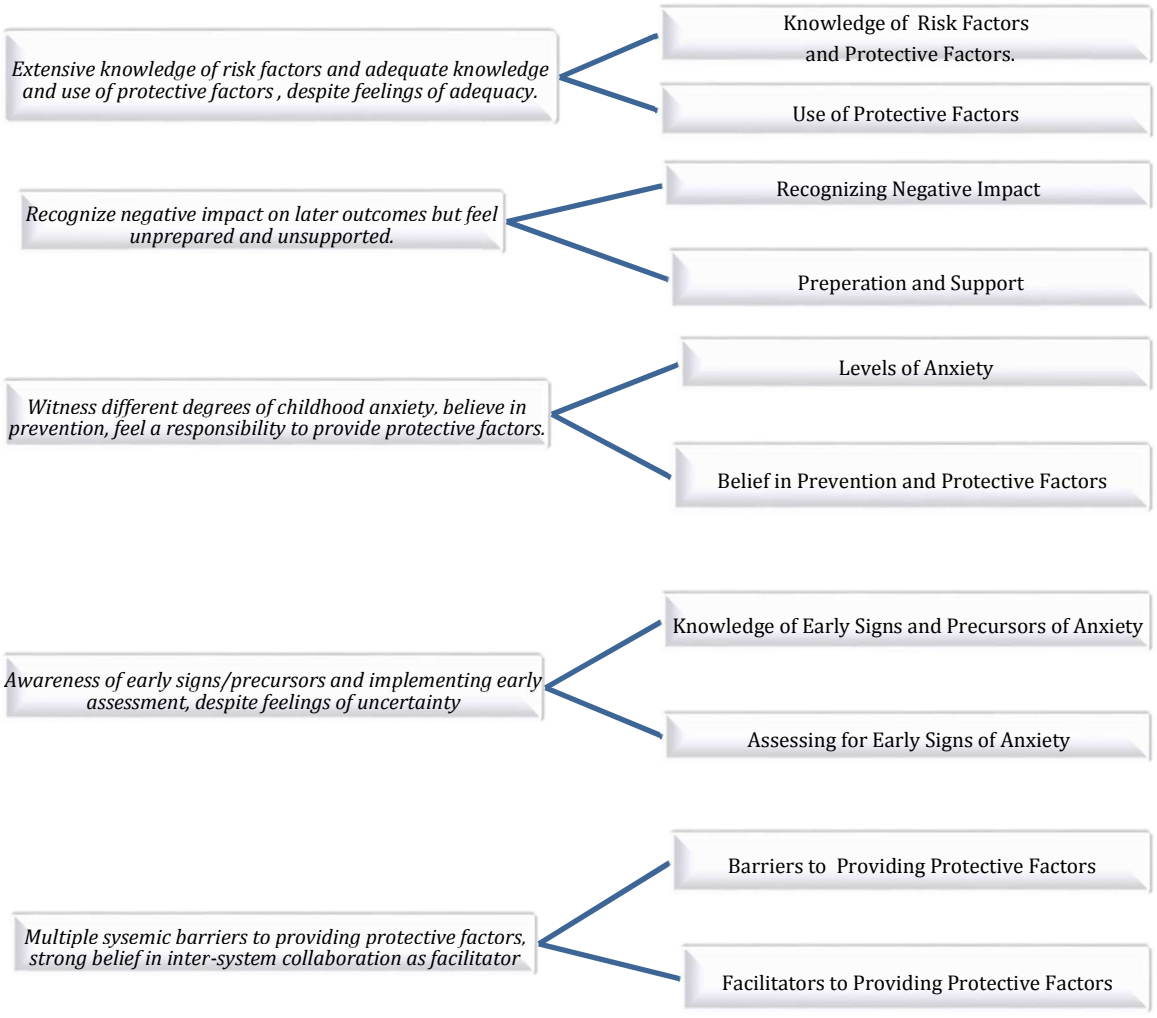


Figure 2

Theme 1 Codes

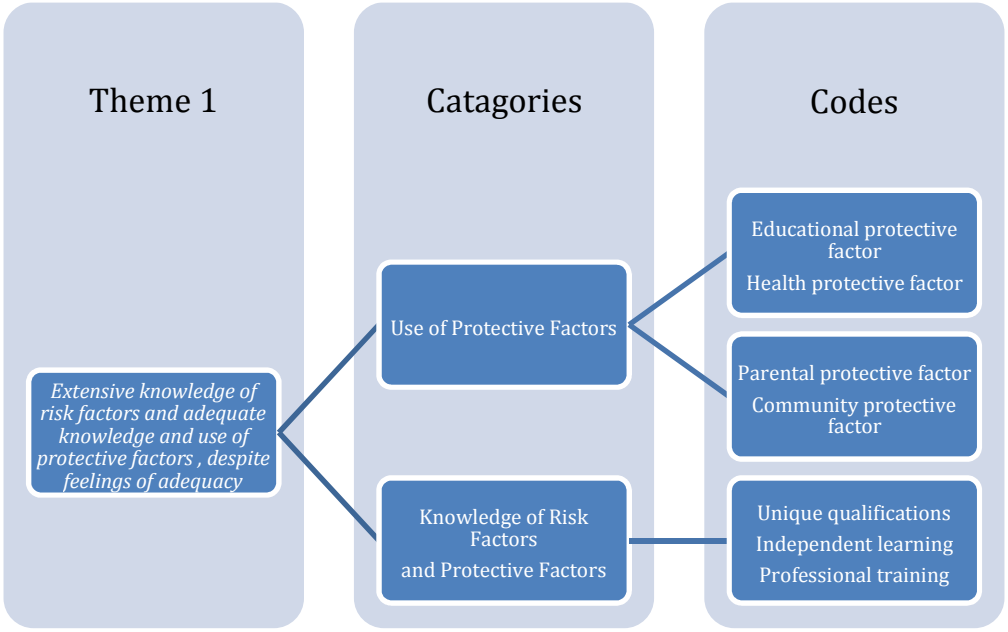


Figure 3:

Theme 2 Codes

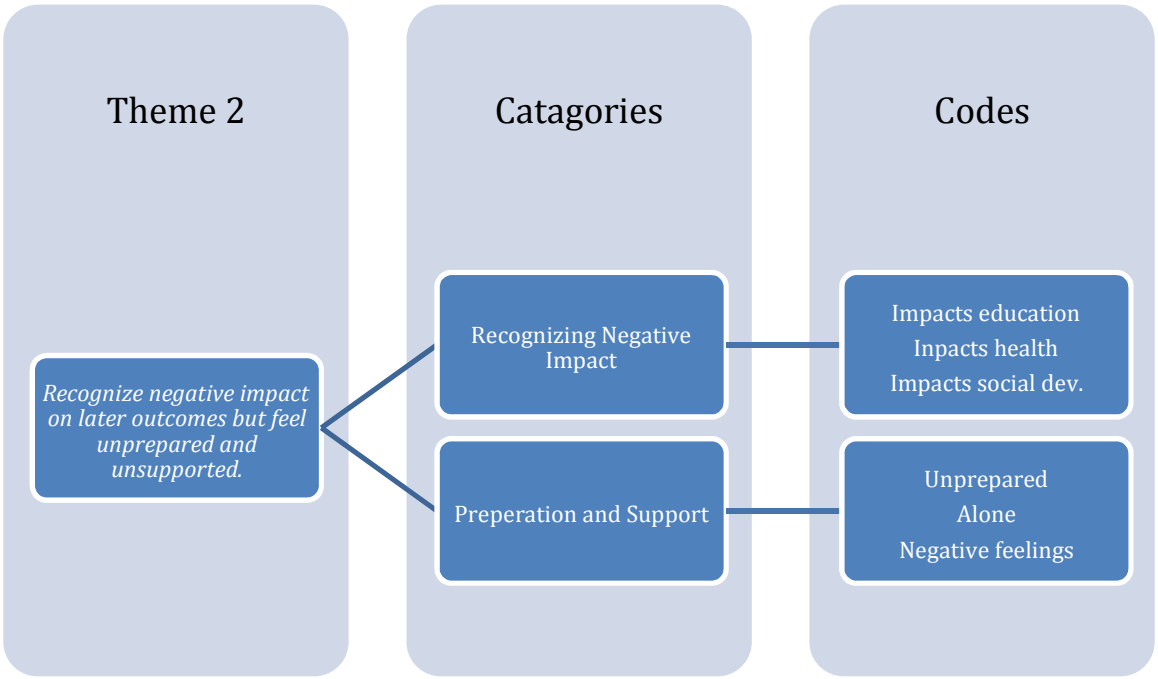


Figure 4:

Theme 3 Codes

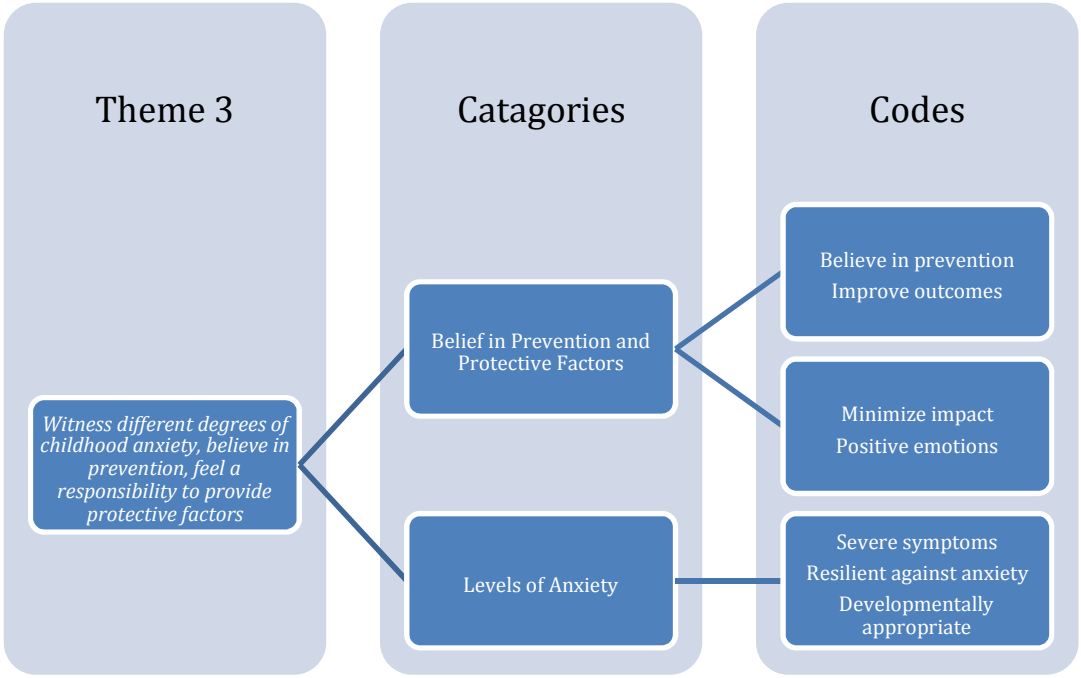


Figure 5:

Theme 4 Codes

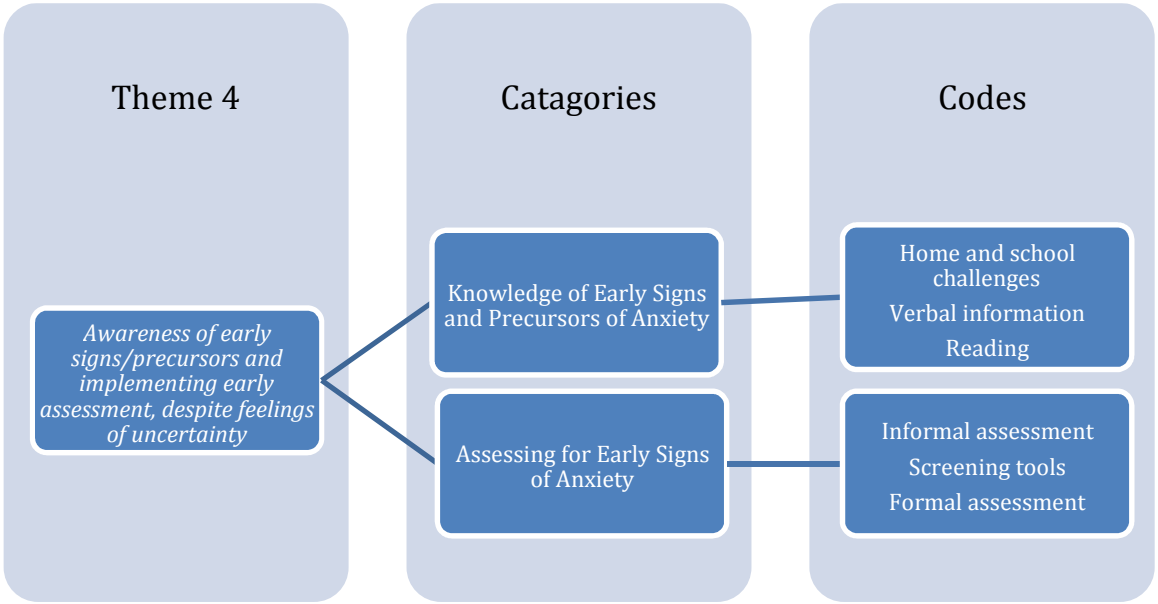
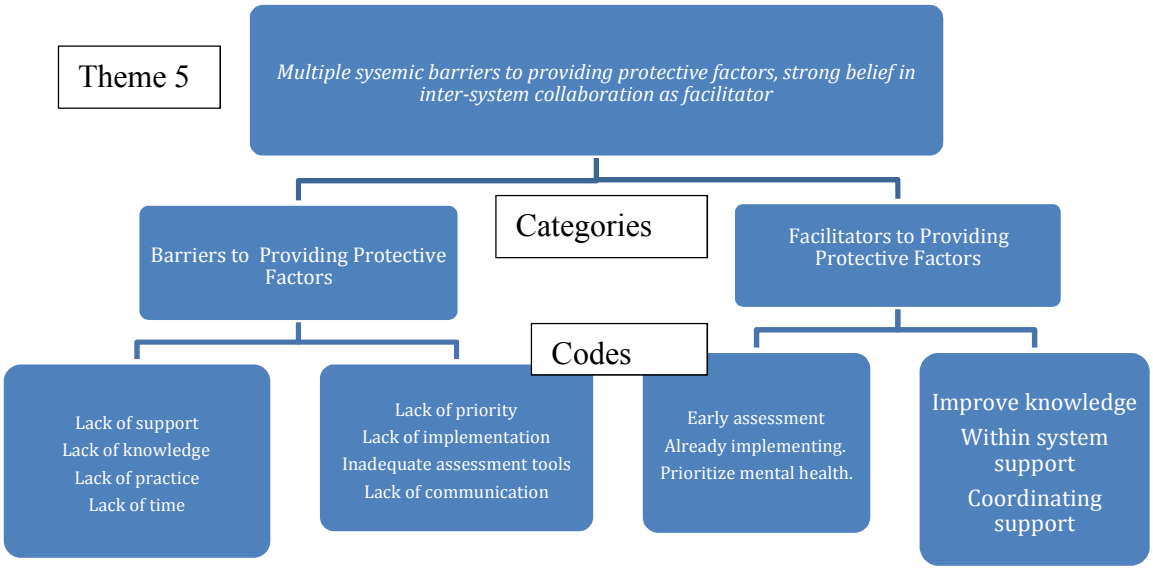


Figure 6:

Theme 5 Codes



Results

In-depth information and data obtained from 16 participants was extensive and detailed. My research question was: What are the beliefs and attitudes of parents, educators, and pediatricians regarding their roles in providing protective factors against childhood anxiety for school-aged children in a suburb of Detroit?

Theme 1

Parents, educators, and pediatric healthcare providers witness different degrees of childhood anxiety daily in children's lives and believe they have a responsibility to provide protective factors and to help prevent childhood anxiety. Educators state that anxiety is "very present in the school setting." They see kids having anxiety attacks, or feeling ill due to anxiety, acting up in class due to anxiety, or withdrawing and not participating. P1, a pre-school teacher said:

> It is obviously normal for a few weeks, even a few months for preschoolers to show some separation anxiety, but for it to persist or get worse, that prevents the child from learning and socializing. Or when it's less severe, I see the child reluctant to join the group, they stay by the wayside.

This participant shared a story of one pre-k student whose separation anxiety was so bad, she would take almost an hour to stop crying months after the beginning of school, and the rest of the day she refused to talk. This educator requested social work services for the child and had her assessed for an Individualized Education Plan (IEP) and they ended up provided special services.

Participant 2, an educator saw so much anxiety in the classroom, and felt ill prepared to help her students, she decided to become a school counselor. Now as a school counselor, she deals with anxiety in her students every day. P 2said, "Like today I helped a girl who was having a panic attack."

According to another school counselor, Participant 3 said "50-60%" of her caseload involves children struggling with anxiety. Another educator, Participant 4 stated that most kids that struggle academically have some sort of anxiety.

Pediatric healthcare providers see anxiety in their practices presenting as physical symptoms such as stomachaches, digestion issues, headaches, children being under

weight or overweight, as well as more obvious forms of anxiety such as kids having panic attacks, tics, and compulsions, and struggling at school. One nurse practitioner, Participant 5 discussed the difficulties in knowing if a child is struggling with anxiety, "You must ask the right questions because a parent won't volunteer the information." This PHP believes the parents are not withholding mental health information purposefully, they just don't know it is relevant. Some of the clues this PHP picks up on are things like kids having difficulties at school, or a child just throwing a big tantrum each time she sees them in the exam room, or a child that won't look at her or say hello or talk at all.

Another PHP, Participant 12, a Physician Assistant admits that her experience in childhood anxiety is about treatment not prevention. She shares, "Parents bring kids into the office already at a breaking point really. The parents seek help when it is already affecting the child's life, sometimes even their health. At that point it's treatment or referral."

Parent participants witnessed the full spectrum of anxiety in children starting at a young age. Some children of parents who themselves struggle with anxiety have no symptoms of anxiety. They exhibit characteristics such as being outgoing, confident, assuming the best in people and thinking everyone loves them, being flexible and able to "go with the flow" or "roll with it." These temperament characteristics tend to serve as protectors against childhood anxiety (Hudson et al, 2019). Parents who suffered with anxiety also had children who struggle with anxiety, as evidenced by them having frequent worry thoughts about their school or social abilities, frequently expecting bad

things to happen, doing poorly in school, feeling judged or inadequate. These parents have other children who only exhibit developmentally appropriate levels of anxiety, such as feeling nervous in new settings or with new authority figures. For example, one parent, Participant 6, has 3 children ranging in age from 7 to 13, all girls. This mom admits that one of her daughters has no anxiety. Her daughter is outgoing, flexible, always ready for a new challenge, she thinks everyone wants to be her friend, and only expects good things to happen every day. She automatically assumes the best in other people. This mom feels it is a delight to see her child interact in social settings and states, "The truth with her is by the end of the day everyone IS her best friend."

Another one of her daughters is mostly confident and social and can redirect to positive thinking when faced with challenges. This mom, Participant 6, shares that her daughter with developmentally appropriate levels of anxiety might be upset for a minute but can always find a way to rethink or adjusts well. She occasionally will show signs of anxiety if she gets nervous about going to a new place, or spending time with new people, especially authority figures. She will hesitate to ask a cashier for help or place her own order at the restaurant. Or she will be visibly nervous before a test. But she redirects easily. This mom states about this daughter, "I just tell her 'Oh, you are fine, it's OK, you got this' and she'll believe me"

Her third daughter, the eldest, has high anxiety ranging from compulsions to constant worry about things turning out bad and doubts about her abilities. This same

mom, Participant 6, states, "There is almost never a day that anxiety doesn't creep in and wreck her day. Parenting her has been a challenge."

This range of different levels of anxiety in children whose parent suffers with anxiety indicates that the risk factor of having a genetic predisposition is only that, a predisposition, not a predestiny (Drake & Ginsburg, 2012 and Arnold & Tallerful, 2011).

Each of the parents that participated have a history of symptoms of anxiety themselves, and this history has been a part of their current knowledge and awareness of childhood anxiety and how they communicate about it. One mom, Participant 7, shares that she is very open with her family about her own anxiety. They know that it exists, it is not something that she tries to hide. This mom believes that her transparency about her struggles with anxiety has taught one of her daughters to express when she is having a nervous day. And she notices that on days that she feels overanxious, the kids they rally around her and provide encouragement.

One mom, Participant 8, believes that societal expectations can have a big effect on childhood anxiety in the Rochester/Rochester Hills community. She believes the social constructs of the Rochester/Rochester Hills, MI community drives it. She states:

> We are so nervous about doing something wrong, or saying something wrong, or of being perceived the wrong way. Then we as parents instill those same fears in our kids. Sometimes I don't even notice I did it, then I have to undo it. The most important thing is not passing on those traits to our kids, let kids be and let them do what comes naturally to them, so long as they are safe and happy.

Another parent, Participant 9, shared that he deeply wants his children to not suffer with the anxiety he has struggled with. He admits that he catches himself in nervous situations and modeling anxiety behaviors to his son and then forces himself to get it together. This parent states, "I suppose that is the joy of parenting, you must reflect on yourself, figure out what works and what doesn't work. You work to improve so that you and your kids become better in the process."

All the parents that were interviewed believed that preventing childhood anxiety from developing is important and possible. Additionally, all the parents that participated were insightful about their own anxiety and had made attempts to treat it. This might not be the case in general, and one of the considerations for future studies will be to address the issue of who chooses to participate versus who does not. How does this impact the results? Like most parent participants, Participant 8, shares she has been in therapy to overcome her own anxiety, and reads anxiety self-help books, and parenting books. This mom states, "Therapy and all the books I have read reflect me. So, for me prevention of childhood anxiety is about that innate desire for my children to take on the best characteristics that I have and for them to become better people than I am."

Educators also reiterated their belief in the prevention of childhood anxiety and shared ways they feel they already have a small role in providing protective factors. One educator, Participant 4, a high school teacher, believes the best prevention is being proactive and open about mental health. She believes her high school does a good job of

being proactive and open about mental health both in the counseling department, and in the classroom, "We make mental health a normal topic of conversation. We also teach our students self-care like meditation, and relaxation techniques."

Another educator, Participant 1, an early elementary school teacher, believes it is important to give students skills early on. In her classroom they do this by teaching children to manage feelings by recognizing them and labeling them. They read books about feelings and talk about feelings constantly. If a child is struggling with a feeling that they don't have words for, they help them find the words, "It looks like you are nervous about joining group."

Regarding their role in the prevention of childhood anxiety, pediatric healthcare providers, had the least amount of hands-on experiences to share. All four of them agreed that the prevention of childhood anxiety would benefit a child's health overall and their social, emotional, and academic functioning, but they verbalized doubt about their ability to provide protective factors for that prevention. One pediatric nurse practitioner, Participant 11, stated, "As far as prevention, I don't know, I'm sorry, by the time I become aware of it, it is time to treat it." However, as she answered more of the questions in the interview, she added:

> Adding screenings would give us a little more insight into warning signs to know which kids to monitor more closely, such as 'oh look this kid hasn't slept through the night in a few months.' Also, more knowledge. We see patients for all kinds of reasons, and I think parents also don't know the warning signs, but if we as practitioners knew that the first complaints or early symptoms are X, Y and Z,

then we can keep monitoring and we can get them help sooner. It would only mean a few added checkmarks in our template.

Another PHP, Participant 13, a pediatrician, believes that if the pediatric health profession could help prevent anxiety from developing, the child would do better in school, have better social relationships, even family relationships, and would have better overall health. This pediatrician also acknowledged that prevention would require a lot of insight from the parents, and some changes in the healthcare model. She shares that the current pediatric healthcare model targets the child as the patient, and prevention would mean targeting the parent and doing parent type of interventions, early on from the first newborn visit. These parent type interventions would include knowing more about the parents' mental health history to assess for the child's risk, and provide regular interventions at well-child visits, such as education about attachment, and child development, and assessing for parent depression and anxiety.

This PHP believes that currently pediatric health care providers do not have a significant role in the prevention of childhood anxiety, "right now, it is more about identifying, not preventing, but I definitely believe we should have a role in preventing childhood anxiety." Another PHP, Participant 12, a Physician Assistant, also shares that she and other PHPs in her office do not currently have a role in preventing childhood anxiety, but believes it would be possible to do so by giving parents information about warning signs and early symptoms to look for, "red flags" children who are at risk of

developing anxiety might exhibit. This PHP also believes that asking each parent about their mental health history, and any family history of anxiety, which are not current questions on their patient history forms. Participant 12 said, "If there is parental or family history of mental health issues, we can easily provide information to parents about protective factors to help mitigate for this." She did not know what those protective factors would be but believes the information is readily available.

Despite feeling the least involved in the prevention of childhood anxiety from all three categories of participants, PHPs believe that prevention is possible, and that it could become a part of their routine responsibility in their primary role of managing the healthcare of children.

Theme 2

All three categories of participants recognize the negative impact that anxiety has on later outcomes of childhood development, however, parents, educators, and PHPs do not feel adequately prepared or supported in providing protective factors against childhood anxiety. PHPs noticed the negative impact anxiety has on a child's physical health, and parents recognize the negative impact anxiety has on social and emotional outcomes and all three categories recognize that anxiety impacts a child's education. One educator stated she often witnessed challenging behaviors in the classroom which she knew were being caused by a child's anxiety. This educator, Participant 4, a teacher stated, "as a teacher, I often do not know what to do about kids' acting out behaviors that are caused by performance or social anxiety."

One nurse practitioner, Participant 11, mentioned that she often sees kids for anxiety because of struggles they are having at school, "They either refuse to go to school, or are always feeling sick at school." One dad, Participant 9, shared the struggle of helping his son succeed academically because of anxiety:

> His whole demeanor changes when it's time for homework, he gets angry and will avoid doing his work. If we let him not do his homework, it affects his grades and that makes it even harder for him to stay motivated and encouraged.

PHPs also mention health related issues that present because of anxiety, "School aged kids present with new onset bedwetting or bowel movement retention, stomach aches, headaches, and hives." One Physician Assistant, Participant 12, shared a story of a child who had to undergo different kinds of cardiac testing because of chest pain and palpitations that resulted in numerous trips to the ER. The child was put on a betablocker, and after a year of these episodes, she was referred to a child therapist who was able to diagnose and treat the child for panic disorder, which resulted in all the physical symptoms going away. The PA stated, "When a kid comes in with physical problems, we have to rule out medical conditions, the thing is anxiety creates all kinds of medical conditions."

Parents acknowledge the social and emotional struggles their kids face when they struggle with anxiety, and that these struggles can impact the whole family. One mom of

a boy who struggles with anxiety, Participant 15, states that when he is "triggered" by insecurities a mean streak in him flares-up. "He will start using profanity and just aim to hurt your feelings, it doesn't matter who it is, me, his dad, his siblings, even cousins and friends." This mom feels that her son's anxious behaviors affect his social skills, his relationships, and his self-concept. "He ends up feeling really bad about himself, his selfconfidence drops, and it triggers more insecurities. It's a vicious cycle."

Despite the recognition of the negative impact anxiety has on childhood development, all three categories of participants feel alone in their responsibility to provide protective factors. Some teachers shared that they have had no training in recognizing or managing anxiety in the classroom and no mental health experience, other than their own life experiences. Teachers also believe they lack support from school social workers, school counselors and administration due to their lack of availability. One educator said that funding was recently cut, and counselors were taken out of the elementary schools in the district. This educator, Participant 4, a teacher stated: If we have a child in the classroom that is showing behavior problems, and I know the behavior is not because he is a bad kid, it's coming from a place of anxiety, I can't stop everything to help her process that anxiety. I have 29 other kids to teach, but there is no one else, our school does not have a school counselor, the social worker comes around maybe once a week, and the principle might or might not be in the building.

Most of the educators interviewed had the same concern that social workers only work part time and principles are not always available to help manage situations.

One pre-school teacher, Participant 1, talked about a lack of support from parents as well. She felt that the only tool for assessment that educators in her district have is observable behaviors in the classroom unless parents give them a heads up about anxious behaviors that their child might present with. Participant 1 believes that if parents were to inform the school at the beginning of each school year of any behaviors that their children exhibit at home that might impede a child's education, this would help educators set up a plan.

Parents felt alone in identifying anxiety in their children and in managing it. One dad, Participant 9, talked about his son's anxiety which was mostly triggered around school performance. This father shared that if teachers would stick to the plan of preparing his son for what will happen that afternoon or the next day and if they would hand maybe 2 or 3 assignments at a time instead of 20 for the week all at once, his would be less overwhelmed and better able to manage his anxiety. Participant 9 believes that though it is talked about it a lot and it's in his son's IEP, it does not always get done, so then they have to help him break things down at home, and by that time, sometimes he is already shut down.

Parents talked about feeling frustration in coordinating with school staff about a child's anxiety. One dad, Participant 9, stated that there is limited social work support for helping to manage his son's anxiety flare-ups at school and admits to often feeling alone in supporting his son.

PHPs do not feel confident in assessing for childhood anxiety or in having adequate outside support for this assessment. One pediatric nurse practitioner, Participant 5, stated that it is difficult to know if or when a child is struggling with anxiety. She states, "You have to ask the right questions because usually a parent won't volunteer mental health information." The biggest lack of support that PHPs notice is from their own profession ranging from a lack of assessment tools regarding mental health approved for use, or mandated for use, to a lack of education regarding anxiety. One PHP, Participant 13, a pediatrician, states that starting in infancy they monitor for other behavioral issues, but not for anxiety, "We assess for autism, ADHD, and behavior problems. At age 11 we start to monitor for depression, but anxiety was left out of the assessment protocols that we use, which is ironic because it's what we see the most of."

Although all three categories of participants verbalized feeling a lack of support from other key stake holders, they each mentioned ways in which they can be more supportive to each other. One educator, Participant 3, a school counselor, shared that the district used to provide a program for kids in elementary school, it included in-class presentations, small groups for at-risk kids, and parent groups. The program was to educate kids and their parents about childhood mental health issues, teach strategies such as mindfulness, emotional regulation, and rescripting. It provided special groups for kids that the counselor referred to for more intense support, so this was a big way that we were able to provide support for parents in mitigating childhood anxiety, but when funding was cut, the program was also cut. This educator believes one way she can personally as an educator continue to support parents and the community is to organize more assemblies

and find community resources for funding. She believes she can print out educational material to make available to all students and parents, especially if I notice a kid who is showing early signs of anxiety.

One PHP, Participant 11, a nurse practitioner, feels that even though it is challenging for her to break down a wall she encounters sometimes from parents regarding mental health, parents need to know that if they have anxiety themselves, it needs to be controlled sooner rather than later, because children learn from that. She feels that one this PHPs need to do if they notice anxiety in the family, is to start that conversation with parents early in infancy. Participant 11 states, "We need to start giving parents resources, and not in subtle ways, but in direct appropriate ways, letting them know it can impact their child's well-being."

This PHP participant added an extra layer of valuable information to the study. She interviewed as a pediatric health care provider, but also could not help but interject as a parent, and as someone who struggles with anxiety herself. She shared that from her own experience, not just as a practitioner, but as a parent, the sooner parents have a clear understanding of the full impact of their own anxiety on their children, the sooner they will jump into action. Participant 11 shared:

> I didn't even realize how anxious I was until I started taking medication. I just felt something go away, it gave me an extra pause where I could make a choice about how to react. I didn't realize there was a different way to feel when I had

> felt a certain way for so long. It is so insidious that you don't realize as a parent what is happening and how it impacts the kids, because they are watching, and they are listening, and obviously they have the same genetic predisposition. If someone had told me 'Hey this can impact your kids, here's some ways to mitigate for that' that would have been helpful.

One parent, Participant 7, mentioned ways she encourages other parents to advocate for their kids who struggle with anxiety with the education system:

> In my experience, educators are more than willing to partner with me to help my kid succeed, so I make sure at the beginning of each school year to touch base with the teachers and mention any struggles my kid has. I have one daughter with an IEP, so I make sure especially with her that the teacher is 1000% aware of what her accommodations are. I have a friend that has a child with medical issues that contribute to his anxiety, and I suggest to her that she provide all the information she can to the school about his medical condition. I feel it is our job to educate the educators about the individual needs of each of our children, and that is the best support we can provide for them as they educate our kids.

Another parent, Participant 6, admitted that she had never considered asking about mental health concerns during her daughter's well-child visits until her daughter started struggling with anxiety. This parent admits that in hindsight she had every opportunity to ask her pediatrician for information about certain behavior issues she had noticed. She admits she could have volunteered mental health family history information once she noticed that no one had asked her for this during the intake process. Participant

6 said, “I know now, and at every check-up, I bring up any questions about mental health. My nurse practitioner has been very helpful, recommends books, and workbooks, and strategies, even offered a therapy referral.”

Theme 3

All three categories of participants mentioned extensive knowledge of protective factors (and ways in which they implement these) against childhood anxiety, despite feeling they do not provide adequate protective factors, and believing they have no knowledge of them. Pediatric healthcare providers believe they have a lack of knowledge regarding protective factors but felt confident in their knowledge regarding risk factors. Every participant identified genetics as the primary risk factor, in accordance with current literature (Voltas et al, 2017). One mom, Participant 15, stated:

> Genetics is the primary risk-factor. My dad has anxiety, and so do I and my sisters. Then struggling with anxiety, if you aren’t careful, can set you up for bad parenting or anxious parenting, which would be the second risk-factor.

All 16 participants mentioned risk-factors for childhood anxiety: unhealthy parenting practices, lack of necessities, lack of healthy relationships, not feeling loved, not feeling secure, parents’ anxiety, parents’ worry, exposure to violence. One parent, Participant 6, stated that risk-factors are the opposite of protective factors. Participants felt some risk factors were unique to living in the Rochester/Rochester Hills community, including pressure to perform, fear of failure, fear of letting family down, fear of letting

sports team down, parents' expectations, high achieving culture, not finding balance, and being overscheduled (Tam et al, 2018). One parent, Participant 8, described the unique risk-factors of living in Rochester, MI by sharing that on the one hand it is great to live in a community with so much privilege, where parents are not worried about necessities and survival so they can focus on trying to help their kids be better equipped at life than they were. She shares that everything is very competitive in the Rochester/Rochester Hills, MI community; academics, athletics, who has what and who doesn't. This participant states:

> If kids fail at something here, that can create a lot of stress and trigger anxiety. Also, the social norms here, for example, my son hasn't wanted to cut his hair in 2 years, and sometimes he likes to paint his nails. So far, he doesn't care about people mistaking him for a girl sometimes, but it might create stress for him later. And people do ask about it with obvious disapproval, even our own family members.

One educator, Participant 2, also mentioned the unique risk-factors of living in the Rochester/Rochester Hills community:

> Fear is a big risk-factor in this community. Fear of failing, students get very scared about disappointing their parents, themselves, and their teammates. They stress a lot about their grade point average, as if any drop in it will close every door of opportunity for their future. We do have a big push to help them change their mind about what failure means and being resilient to that. Kids, especially

at this school do have very high expectations for themselves, and parents have even higher expectations for their kids.

All four PHPs felt they did not know much about protective factors, that they had never researched the topic, had no training in it, or "not much experience in identifying anxiety, not much at all." One PHP, Participant 11, believes not many healthcare providers know much about childhood anxiety or protective factors. And that whatever they do know comes from their own experiences with anxiety or experiences that their family has had. PHPs believe that though some providers take a special interest in anxiety and have sought out extra training none of them remember learning about anxiety in school, other than basic things in psych rotations, and none of them remember learning about protective factors specific to childhood anxiety.

All three categories of participants had a high level of knowledge regarding protective factors, although they did not believe themselves to be knowledgeable in this area. All three categories of participants believe what knowledge they do have has been gained through life experiences vs. training or education (O'Brien et al, 2019). One PHP, Participant 12, a physician assistant, shares that she does clinically assess for anxiety in her patients by observing behaviors in the child or in the parent. If she notices anxious behaviors, she tries to provide support for parents like education about child development, or ways to mitigate for anxiety during transitions for kids, even basic ways for parents to interact with babies and toddlers to promote healthy attachment. With

older children she will ask about their feelings, and normalize all emotions, and will sometimes suggest therapy, or family therapy. According to this PHP she provides these interventions, which she does not recognize as protective factors, because she is sensitive to anxiety due to family members that struggle with anxiety and from information she has learned outside of her medical training.

One PHP, Participant 5, a nurse practitioner, mentioned an array of basic protective factors that apply to overall health which she believes also apply to mental health:

> Healthy parenting strategies, structure and routine, adequate sleep, adequate nutrition, getting enough exercise, limiting screen time, having a healthy parent/child relationship, these are all protective factors for health in general, although I haven't read if they relate to anxiety, I feel that they do.

Parents, educators, and pediatric healthcare providers do not believe they are currently providing adequate protective factors against childhood anxiety; however, the data indicates that all three categories of participants provide some degree of the protective factors mentioned in the literature review daily. For example, some of the data that formed the code of 'protective factors being provided' include; using encouragement, normalizing anxiety, listening, reflecting feelings and values, help child identify triggers, connect with, build a relationship with, being supportive and accepting, using a calming voice, working together vs. controlling, not being critical, helping kids process thoughts and feelings, teaching coping skills, practicing coping skills, open communication, and

early referral to mental health specialists. These are all biopsychosocial factors that can protect against the onset of childhood anxiety (Lam et al, 2019 & Alyanak et al, 2013).

Parents verbalized awareness and insight regarding their primary role in providing protective factors against childhood anxiety. Most parents acknowledged information found in the literature review, such as treating their own anxiety, and being mindful of not modeling anxious thoughts and behaviors (Lam et al, 2019). One mom, Participant 2, stated:

> Everything starts at home, treating my own anxiety sooner rather than later, checking-in with my kids every day, making sure I don't miss any indicators, making sure my kids always consider me the safe place to share their feelings. All these things go a long way in preventing anxiety, or at least in minimizing its negative impact.

One dad, Participant 9, talked about the importance of letting kids fail as a protective factor:

> You never want to see them get down on themselves or be upset, but again, that's a part of life. I can't always be making sure that everything goes right for him, so sometimes we practice failing here at home, where it's a little safer, and then we can practice strategies for failing. For example, if he is building a complicated Lego set and getting frustrated, then he destroys it, pointing out how that was a bit of a failure, but no need to worry because he can keep trying until he gets it right.

All three categories of participants recognize that the bulk of protective factors originate at home, such as a stable and supportive home environment, a trusting relationship with parent, routine, consistency, family time, a parent treating their own anxiety, modeling non-anxious thinking and behaviors, advocating for a child in the school and health setting, having knowledge about the child's development and particular issues, being well informed about the child's specific needs, not exposing child to high levels of conflict or trauma and teaching children coping skills and strategies (Alyanak et al, 2013).

Educators and PHPs acknowledge their unique opportunity to support parents by helping to teach children these skills and by providing parents with resources and information vs. referring them out. Parents recognize their need to engage outside support. One parent, Participant 7, stated she needs to ask more questions about child development and mental health concerns during her well-child visits. Another parent, Participant 15, recognized the need to coordinate with educators regarding any possible accommodations her child might need.

One educator, Participant 2, was able to provide a unique layer of information as she started out as a teacher and after 3 years became a school counselor because of the struggles with anxiety she encountered in the classroom and feeling ill prepared. This educator felt that as a teacher she did not have the mental health training to really know what to do, but she would encourage students by telling them it was okay to feel nervous and reassure them by telling them it would be okay, that they would be okay. Now, as a counselor, she feels better prepared with the skills to listen to them, reflect their feelings

back to them, reflect their values, and to try and find a deeper meaning as to where the anxiety is coming from. This participant admits that what she lacks is time. She has a caseload of 400 children, so she cannot do individual therapy with them. She does solution focused interventions and refers them to outside therapy if she believes it is an anxiety disorder. Another intervention she provides is help students differentiate between a bad day, and an anxiety disorder or depression. She states:

> A lot of kids now come into my office having self-diagnosed with depression or anxiety, when really, it's just a situation we have to sort through. So as a teacher my role was to send them to the counselor. My role now is to identify if it is short-term, situational, or if it is something more chronic. My role is also to provide solution-focused interventions, some psychoeducation, and to find resources for the more chronic cases.

Another educator, Participant 14, believes that teachers need to be mindful that bad behavior in the classroom is usually rooted in anxiety. She feels it is unfortunate that teachers were never trained on how to manage anxiety in the classroom. She agrees with the other educator participants that the biggest protective factor she can provide is partnering with the parent and coming up with a plan for those kids that are already struggling. She also shared some valuable information about differentiating protective factors against childhood anxiety for children of different ages:

> I think in general, for those kids that don't struggle yet, it is different at every age. I feel with the younger kids, when I taught elementary, teaching them basic things like recognizing emotions, labeling them, encouraging conflict resolution, teaching the whole class calm down strategies, breathing techniques and mindfulness. In junior high, I encourage and teach organizational skills, communication skills by modeling appropriate communication when I hear inappropriate communication, and sometimes even emotional regulation when kids get frustrated in class.

One educator, Participant 10, had a unique perspective, not only is he an educator, but he is also a parent of a school-aged child in Rochester, MI. This educator stated, "Developing a meaningful relationship with my students and encouraging them to have a say in their educational journey I think helps with anxiety. Also believing in them and letting them know that I believe in them, this also helps." This educator talked from the perspective of a parent as well:

> I wish more educators would really take the time to research each IEP and really understand the unique needs of each student, and talking to parents early on, if they notice anything that indicates anxiety, let parents know, and develop a plan for appropriate accommodations in the classroom.

This parent/educator- who interviewed as an educator but inadvertently also shared from his parenting perspective at times- believes that the most important consideration for his own kids, and for students, is instilling in them that anxiety and mental health concerns are not anything to be ashamed of. This parent/educator

participant believes that sharing of information needs to be transparent in both directions, educators need to be educated on identifying and managing anxiety, but also on the specific needs of a child. He states:

> Parents need to know that educators, at least the ones I know, are extremely open to helping. We just need to know. That is the most important thing, don't hide it, don't think it will just go away. I mean it can go away but only with the right support and help. So, in my experience both as an educator and as a parent, partnering up with each other to best support our kids, that is the best protective factor.

Theme 4

All three categories of participants mentioned awareness of early signs of anxiety and precursors, and things they do to assess and mitigate for this, despite feeling they do not provide adequate protective factors. Educators and pediatric healthcare providers stated they have limited formal assessment tools such as anxiety scales, social work questionnaires, intake questions, and the patient health questionnaire available to them, and feel that the ones that are available are inadequate in identifying anxiety or early signs of anxiety. PHPs felt confident in identifying precursors or early signs of anxiety in children using visual observations such as kids chewing on their shirts, no eye contact, bed wetting, or bowel movement problems, not gaining weight due to picky eating, visible separation anxiety or stranger anxiety. One pediatric nurse practitioner,

Participant 11, stated that she identifies anxiety when a child does not deal well with transitions or has temper tantrums in the exam room. These are informal ways of assessing for anxiety or precursors that does not involve standardized tools. One PHP, Participant 13, a pediatrician, believes that identifying early signs of anxiety is itself a protective factor. And that the biggest protective factor she can provide is during the well-child visits by asking about any behavior problems and then based on those answers assessing for anxiety. Also, by noticing anxiety in the exam room such as a child not being able to have eye-contact, chewing on their shirt, hiding behind mom, and small tics like hair pulling and mentioning it to the parent and getting help for the child.

However, a different PHP, Participant 11, stated that despite noticing some anxious behaviors in the exam room, unless a parent brings up mental health or anxiety directly, she will not bring it up herself, and she did question her own reluctance to talk about observed anxiety in a child.

Educators and PHPs also feel stress about having to use standardized tools due to a lack of training. One teacher, Participant 4, stated that filling out the forms was one more thing to do without any clear benefit to it. One pediatric health care provider, Participant 12, a PA, stated that the formal assessment tools they use only look at depression, ADHD, and autism, but not directly at anxiety. With further probing regarding the standardized tools used in her office she stated, "In early childhood we are mandated to assess for behavior problems and starting at age 11 we are mandated to do formal assessments for depression. We use the forms we need to meet requirements." She talked about the difficulties of fitting in everything that is mandated into the time that they have with each patient.

Despite the challenges described by educator and PHP participants in using formal assessment tools, all three categories of participants had organic ways of assessing for anxiety. For example, several educators stated, "I can see their anxiety." Evidence they used to identify anxiety was child being slumped down, no eye contact, fidgety, unhappy, verbalizing worry thoughts and acting out behaviors. One PHP, a pediatrician, stated:

> The patient health questionnaires only glimpse at how the child is feeling that day. It doesn't assess previous or even recent history. Getting an idea of how a child is living, what his interests are, how things are going at home, the dynamics between the parent and the child, these are all telling things if I suspect anxiety.

Another PHP, Participant 11, a nurse practitioner, stated, "We don't have much time outside of sticking to the template, but if tantrums, or acting out, or moodiness comes up my first guess is anxiety."

Parents also felt they could identify anxiety by facial expressions, persistence of questions, child closing off, behaviors being out of character, child's moods, if they isolate, and personality changes. One mom, Participant 6, describes how she can tell when one of her daughters is feeling anxiety:

> You can just see it in their face. Luckily, they wear their emotions on their faces. When we check-in in the evening I will let them know that I notice they feel sad or

> worried, and usually they will open-up, but not always. My daughter that struggles most with anxiety, I can tell when her questions become more and more persistent. The more closed off she gets, the more anxious she is feeling.

One mom, Participant 16, whose child has not shown any signs of excessive anxiety, believes that due to her own struggle with anxiety, and her child going back and forth each week between her home and his dad's home, she has always known to be on the look-out for signs of stress or anxiety. She makes sure he is transitioning from each home fine, and so far, he does. She watches for little things in general, his demeanor, his outlook, his appetite, how is he doing in school and with friends. Participant 16, along with most parent participants mentioned many early sings of anxiety observable in their children, such as being clingy, being very quiet, hiding in his room, or being very irritable, which her son has shown none of these signs.

One PHP, Participant 5, a nurse practitioner discussed ways she can detect early signs of possible childhood anxiety, she shares that even in infancy early signs are present such as babies that can't be soothed by mom, very picky eaters, babies that are upset by new situations frequently instead of curious or excited, and infants and toddlers that are extremely reactive to new stimuli. This PHP participant stated, "I would say, though I know this is controversial, that toddlers and preschoolers that still can't sleep separate from mom, this might be an early sign of anxiety."

One parent, Participant 6, discussed the early childhood differences between her daughters that do not struggle with anxiety and the one that does, she confirmed that there were early signs of anxiety with her eldest daughter:

> As a baby, she was difficult. She cried so much, I could not put her down, she would not sleep in her crib. She slept in our bed until she was three or four, then in a toddler bed in our room. She was a fussy eater, but also a clingy eater. She was and still is very sensitive to clothing. As an infant her socks bothered her, or tags on clothes. As a toddler and preschooler certain shoes and clothes, so much so she often wore the same outfit for days. In preschool she cried every day at drop off time, all year long. She cried with babysitters, even her grandparents. Many times, we were told it was a stage and different things to try to make things better. In retrospect, from the experiences of my other two girls, I think it was early signs of anxiety. Maybe it was anxiety already.

Educators also mentioned early signs of anxiety, including not interacting in class, not participating in groups, reactive to day-to-day classroom situations, frequent fear or apprehension about new activities, and excessive worry.

Theme 5

All three categories of participants mentioned multiple barriers in being able to provide these protective factors against childhood anxiety and shared a multitude of ideas of ways to overcome these barriers. Some of these barriers included funding issues for programs to support parents, transportation, and childcare difficulties for parents to attend these programs, lack of openness of parents to believe in anxiety and its negative impact,

or to believe in prevention and protective factors. One PHP, Participant 11, admitted to her reluctance to bring up symptoms of anxiety she might notice in the office setting:

> Sometimes parents don't want to hear about mental health issues. It's not that I turn a blind eye, but unless they directly ask for advice about it, they will just shut me out regarding anxiety. I think it is getting a little better this past year, like everyone has anxiety because of the pandemic, so it's okay to talk about it in general terms.

All three categories of participants identified their own stress about their role in providing protective factors as a barrier. One mom, Participant 7, feels that it is stressful knowing it is up to her to make sure she does not miss anything with her kids while making sure she has her own anxiety under control. "And that I don't get too busy with work or life that I forget to check-in with them, or that I keep them so busy they don't have time to process their emotions, it's a lot to think about," she states.

Other codes for barriers included lack of knowledge, lack of team communication, not working as a team, lack of interest from the child, lack of time, lack of information, parents using urgent care as their home provider, missing signs, missing symptoms, not prioritizing mental health.

One PHP, Participant 5, stated there is so many other things to monitor for during healthcare visits "many other requirements that if you miss those there could be real health consequences." She later reconsidered and said that missing mental health indicators also has dire consequences and felt shocked at herself for not having recognized that before.

A resource room educator feels that the biggest obstacle to providing protective factors is a lack of shared information regarding each child. “Resource room teachers”, states Participant 14, “along with other ‘specials’ educators, do not have access to all of the information that the primary teacher, social worker, and school counselor has, yet this is where the student comes when she is in crisis or needs extra support.” She believes it would be helpful to have the whole story and that there is a confidence barrier, she states, “I must share all the information I get from the student, but none gets shared with me. I get it, there is this over all need for confidentiality for each student, but if they included us as part of the education team, then we could all always be on the same page.”

Despite the long list of barriers to providing protective factors, all three categories of participants had many ideas about ways to overcome these barriers. Some of these ideas included parenting based on child development knowledge learned vs. based on other people’s interferences, time management, self-honesty about own anxiety, allowing for downtime to process emotions, allowing kids to practice challenging situations at home, learning more about protective factors, providing resources directly with information sheets or pamphlets, parent groups, and skills groups for children, providing mental health care managers which insurance covers, improved user friendly screening tools, a few added checks on the template, more questions at registration, better access to a child’s background and family history, normalizing talking about mental health, provide education about mental health, using community resources for funding, volunteers for

programs, and volunteers to help with parent transportation and childcare. All three categories of participants feel hopeful and optimistic about the possibility of providing protective factors against childhood anxiety. They feel encouraged about improved support in the community and feel motivated and challenged to also provide that support.

One parent, Participant 8, stated, "Childhood anxiety will never go away 100%, but it will only get better with access to support and resources and everyone working together." One educator, Participant 10, stated, "I feel hopeful as this topic is becoming more open and accessible it helps take away the shame for kids, and shame only ever makes anxiety worse." One PHP, Participant 13, stated:

> Providing protective factors needs to become a part of daily care in our practices because decreasing the prevalence of childhood anxiety, now that I think about it, will also decrease the prevalence of a lot of other health and social issues that come as a consequence of suffering with anxiety.

Every single participant felt that providing protective factors against childhood anxiety is a responsibility that falls on them, and they each felt ready for the challenge. They also did not believe they had been providing enough protective factors thus far, when in fact, they have been providing some, as outlined under Theme 4. Some participants also acknowledged a shift in recent years regarding childhood mental health, a greater openness in the community to talk about it. One mom, Participant 15, believes one of the things that is helping is that it has become more acceptable for people to talk anxiety and mental health awareness. She feels the community is making these conversations more normal not just for children but for parents too. More people are

being more intentional about being in therapy, reading, and doing self-help things. This mom shares that she feels perfectly comfortable talking to long-term friends, or parents of other kids that her son goes to school with, or to random people she meets about mental health topics. She feels optimistic that attitudes about anxiety are shifting in the community and that things are getting better regarding mental health stigma. "Maybe not better but the more that we talk about it to each other the more we learn and grow, and anxiety becomes something normal that can be managed," she states.

One PHP, Participant 13, believes that the health profession focuses so much on depression, and any behavior that is out of the norm, they immediately start to rule out autism or ADHD, when really the first screening should be for anxiety. She states, "Protective factors should really be established in everyday care and should definitely be our responsibility, not just to screen for it, but to provide basic protective factors."

One educator, Participant 14, stated, "The role of providing protective factors does not stress me out, it feels like an opportunity to really model this better world that I see for the next generation, I feel hopeful for them." Another educator, Participant 10, stated:

> Protective factors and prevention of childhood anxiety should fall under the umbrella of education. Anything that impacts education, really. Working with kids to learn coping skills, and with parents to model coping skills. It all starts

> with parents, if we can support parents so they can model coping skills and strategies and partner with parents so that we are all providing the right resources for each child, I think that can reduce the negative impact that anxiety has on student's learning.

In conclusion to this section, the RQ is: What are the beliefs and attitudes of parents, educators, and pediatric healthcare providers regarding their roles in providing protective factors against the childhood of anxiety in a suburb of Detroit? The answer emerged from the extensive information obtained from 16 individual interviews with parent, educator and PHP participants from Rochester/Rochester Hills, MI. The interviews, and notes taken during the interviews, and reflexive journaling, provided hundreds of data points that resulted in 40 codes, 10 categories and 5 codes that emerged as the answer to this research question. In summary, the final themes are written in paragraph form here for a shortened answer to the research question: Parents, educators, and pediatric health care providers (PHPs) witness different degrees of childhood anxiety daily in children's lives and believe they have a responsibility to provide protective factors and to help prevent childhood anxiety from developing. All three categories of participants recognize the negative impact that anxiety has on later outcomes of childhood development, however, parents, educators, and PHPs do not feel adequately prepared or supported in providing protective factors against childhood anxiety. All three categories of participants mentioned significant knowledge of protective factors (and ways in which they implement these) against childhood anxiety, despite feeling they do not provide protective factors, and feeling they do not have adequate knowledge of them.

All three categories of participants mentioned awareness of early signs of anxiety and precursors, and the steps they take to assess and mitigate for this, despite feeling they do not provide protective factors. All three categories of participants mentioned multiple barriers in being able to provide these protective factors against childhood anxiety and shared multiple ideas of ways to overcome these barriers, including feeling hopeful and optimistic about having the responsibility of providing protective factors, plus ways of being more supportive towards each other in providing protective factors against childhood anxiety.

Trustworthiness and Credibility

Trustworthiness can be achieved by ensuring rigor in the qualitative research design and by communicating effectively with others that you have done so, this lends the study credibility (Patton, 2015). Credibility can also be achieved with prolonged interactions with participants, persistent observations, triangulating, or by using separate researchers to collect the same data, by debriefing and by utilizing the research reflexivity (Rubin & Rubin, 2012).

This study addressed credibility by gathering data in an open-ended way from 16 different participants, using two different data collection methods, by debriefing with a peer, and committee members (Rubin & Rubin, 2012). Engaging in journaling and note taking immediately after each interview, multiple levels of coding, and being aware of

my own biases when transcribing and coding also helped to keep the research credible (Rubin & Rubin, 2012).

Transferability means that results can transfer to similar situations regarding the same topic. This, however, is difficult to guarantee in this case because the nature of qualitative research makes it impossible to evaluate if findings can be true in other contexts unless studies can be conducted in those other contexts (Rubin & Rubin, 2012). However, having achieved saturation in this context helped to ensure transferability.

Dependability evaluates the quality of the data collection, data analysis and the theory generation process. It looks to see that any changes in the conditions of the setting, and in the design of the study are captured, making the study consistent and making the findings possible to replicate. This study addressed the issue of dependability by using a step-by-step interview guide which can be replicated in each interview and in future studies. (Rubin & Rubin, 2012). Engaging in multiple levels of coding and recoding throughout each step of the data analysis process ensures dependability (Rubin & Rubin, 2012).

I addressed confirmability by adhering to best practices involving transcribing and coding data and documenting the process of collecting and analyzing data. Peer debriefing and reflexivity create transparency during the research process, which ensures confirmability (Rubin & Rubin, 2012).

Summary

This chapter included descriptions of research methods, adherence to the proposed study, the interviewing process, and a detailed data analysis which involved multiple

layers of coding, categorizing, and identifying emerging themes and then a discussion of results obtained from thematic analysis. Data obtained from 16 in-depth interviews provided valuable information about thoughts, perceptions, feeling, and attitudes regarding addressing protective factors which mitigate against anxiety among school-aged children in Rochester/Rochester Hills, MI.

Results showed that despite feeling ill-prepared to meet the responsibility of addressing protective factors which mitigate against childhood anxiety, participants value that role and embrace it as important. They recognized negative consequences which result from anxiety. Parents, educators, and pediatric health care providers do not believe they are currently addressing protective factors which mitigate against childhood anxiety, when in fact they are providing them daily. They do not believe they have knowledge and believe they lack training, when in fact they have much knowledge regarding childhood anxiety, risk factors, protective factors, and early signs of anxiety and precursors. that Their knowledge was gained via life experiences as opposed to training or education. Results indicate a perceived lack of support from other key stakeholders. For example, parents felt a lack of coordination with educators, and educators felt a lack of communication from parents. Participants mentioned a desire to have more coordinated efforts in order to address protective factors, which they believed to be the most likely way to help decrease the prevalence of childhood anxiety.

Chapter 5 includes interpretations of findings. I discuss how results relate to information found in Chapter 2. I explore similarities or differences compared with current literature, and any new knowledge that might have emerged. I also analyze and interpret findings in the context of the biopsychosocial and social work systems theories.

Chapter 5: Discussion

Introduction

The purpose of this generic qualitative study was to explore beliefs and attitudes of parents, educators, and pediatricians regarding their roles in terms of addressing protective factors mitigating against the onset of childhood anxiety for school-aged children in Rochester/Rochester Hills, MI. Mitigating factors against childhood anxiety include parental conditions such as secure attachment, low-conflict home environments, and proper management of caregivers' own mental health issues. Educators' and pediatricians' roles in terms of providing protection against childhood anxiety include knowing how to identify children who are at risk of developing childhood anxiety disorders, knowing how to recognize precursors or early signs of anxiety, and making appropriate referrals to prevention programs and community resources. Educators and pediatricians can also provide psychoeducation to parents regarding child development and parenting skills, including teaching children how to problem solve, resolve conflicts, be mindful, and model non-fear-based cognition. Pediatricians can also help identify problems with attachment early on and provide education to parents regarding secure attachment at the time of birth.

The purpose of conducting this study was to address the significant gap in literature regarding the role of parents, educators, and pediatric healthcare providers in terms of addressing protective factors for the prevention of childhood anxiety. Targeted prevention programs which include protective factors that involve home, healthcare, and school can be most effective at preventing childhood anxiety and other childhood mental health problems (Kozina, 2020; Twum-Antwi et al, 2020). Considering this information, further research was needed to explore parents, educators, and pediatric health care providers are prepared to assume the role of addressing protective factors which mitigate against childhood anxiety, if they know how, and if they want to. By exploring attitudes and beliefs of these groups regarding this topic, social workers can better understand how to help empower all of the people in the open systems of a child's life to be able to fill of providing protective factors against childhood anxiety.

I conducted 16 in-depth interviews with parents, educators, and PHPs over the course of 4 months, and findings indicate these groups witness different degrees of childhood anxiety daily in their children's lives, and believe they have a responsibility to address protective factors and help prevent childhood anxiety from developing. All participants recognized the negative impact that anxiety had on later outcomes of childhood development; however, they did not feel adequately prepared or supported in terms of addressing protective factors which mitigate against childhood anxiety. All categories of participants mentioned extensive knowledge of protective factors against

childhood anxiety and ways to implement them, despite feeling they do not address them feel they had adequate knowledge of them. They mentioned awareness of early signs of anxiety and precursors, and steps they took to assess and mitigate for this, despite feeling they did not address protective factors. They mentioned multiple barriers involving being able to address these protective factors which mitigate against childhood anxiety and shared ways to overcome these barriers, including feeling hopeful and optimistic about having the responsibility of addressing protective factors, plus ways of being more supportive with each other when addressing protective factors which mitigate against childhood anxiety.

Interpretation of Findings

Risk and Protective Factors

Parents, educators, and pediatric health care providers all shared information about the negative impact childhood anxiety has had on children in their lives. They discussed biological, psychological, and social risk factors that influence outcomes of child wellbeing, such as genetic predisposition, temperament (as either a risk or protective factor), neuroscience of anxiety, and physical manifestations and symptoms. They also shared psychological factors that impact outcomes of child emotional development, such as attachment as discussed by Bowlby and Ainsworth, psychological sensitivities, cognition, and emotional regulation, which are all factors that can create vulnerabilities involving development of anxiety in children. Participants also discussed social factors they observed have created risk-factors for children in Rochester/Rochester Hills, MI involving community expectations, high-achieving culture, nonconformity with

society, social comparisons, bullying, and lack of time due to overscheduling. Everything that participants shared regarding risk and protective factors was identified in current literature. Additionally, participants discussed their awareness of roles involved with mitigating these risk factors. The three main risk factors for negative outcomes involve family, health, and education.

Role of Educators Impacted by Current Policy

Educator participants acknowledged their obligation and desire to provide equitable education to children with anxiety and mentioned ways to make accommodations for these children, as is mandated by the 1986 IDEA P.L. (Public Law) 101-119. They also acknowledged that this mandate falls short in terms of providing for the prevention of childhood anxiety, and there were no guidelines in terms of what protective factors to include in classroom settings for children who are not yet identified as having mental health disabilities. One social policy that participants said interfered with providing adequate protective factors for children was the 2010 patient bill of rights component of the ACA, which mandates complete confidentiality involving children's health records. Some participants said since anything having to do with anxiety symptoms in education records is considered a health record, not everyone in the education team had access to this information. They felt this did not allow for everyone working with children to know the same information.

Role of PHPs Impacted by Current Policy

PHP participants acknowledged that due to a lack of knowledge and mandates, prevention has not a been a part of their role thus far in terms childhood anxiety. They stated they did follow protocols in terms of ensuring all children had access to mental health treatment via proper referrals, and treatment and referral has traditionally been their role. Regarding prevention, they also meet requirements of current protocol and mandates which involve behavior assessments at well-child visits as well as depression and substance abuse assessments for children who are 12 and over with an instrument of their choice. Six states mandate that pediatricians do depression screenings for caregivers during well-child visits since caregiver mental health problems are risk factors for anxiety and poor attachment. If depression is identified in a mother or caregiver, the pediatrician can refer them for treatment. Caregivers treating their depression ensures a higher likelihood of secure attachment between caregivers and children, which is a protective factor against childhood anxiety (Bowlby, 1958). This is why depression screenings for caregivers would be helpful. However, MI does not require these caregiver depression screenings, and no PHP participants mentioned doing these assessments routinely. Also, these participants expressed that current checklist templates to meet state and federal mandates were not enough to identify early signs of anxiety in children.

Educators' and PHPs' experiences regarding prevention of childhood anxiety appear to be aligned with current policy, in that there is no federal or state policy and therefore no school or clinic policy in place that mandates prevention programs in schools in this community. Many educators and healthcare providers do make attempts at addressing

mitigating factors against anxiety of their own accord, but without guidance and support of their institutions or federal or state policy, and there is no uniform way of implementing protective factors, measuring outcomes, and ensuring success.

Other Factors Impacting Roles of Educators and PHPs

The findings of this study indicate that despite there being numerous assessment tools recommended in the literature that are effective at identifying early signs or precursors of anxiety, such as the Pediatric Symptoms Checklist for pediatricians, and the Anxiety Sensitivity Index for educators, none of these standardized methods are currently being used by educators or pediatric healthcare providers in the Rochester/Rochester Hills, MI community. Screening for at-risk children is not mandated, and it is not protocol. Both Educators and PHPs expressed stress and reluctance regarding administering formal screening for precursors of anxiety, and none mentioned knowing that these screenings have been found to be effective at identifying early signs of anxiety (Martinez et al, 2015). Both Educators and PHPs do however use more organic ways of clinically assessing for anxiety, and for precursors of anxiety, such as a child's behavior, their demeanor, eye contact, participation, physical symptoms, moods and thinking patterns.

Contrary to what one past study found that teachers do not show sensitivity to the different levels of anxiety a child exhibits in the classroom (Goulet, 2013), the educators I interviewed for this study were in-tune to children experiencing different degrees of

anxiety and the impact this has on education. However, once early signs of anxiety are identified, educators do not feel they are knowledgeable as to what to do next.

Educators interviewed for this study expressed uncertainty about providing protective factors against childhood anxiety, believing they do not have the knowledge or training to do so. However, they also shared many of the supports they provide to children every day that are in fact protective factors found in the literature, such as providing a nurturing environment, being supportive, developing meaningful relationships with each child, ensuring school engagement for each child, and normalizing anxiety (Twum-Antwi et al, 2020). One protective factor found in the literature that none of the educators mentioned was rewards for brave behaviors (TwumAntwi et al, 2020). This omission might be because positive reinforcement is such a big part of education that they did not consider it a protective factor specific to childhood anxiety. Educators also expressed awareness of risk-factors they might contribute as educators, such as being overly critical, and having conflicted relationships with children (Twum-Antwi et al, 2020). Educators felt strongly, some from past experiences with prevention programs, that prevention in the school setting is possible, effective, and important. They mentioned past programs in the Rochester/Rochester Hills, MI school district that identified at-risk kids and provided support for them and their parents. The teachers identified the at-risk children via informal methods and referred them to school counselors for formal screenings. They described this program to be much like the

FRIENDS for Life Program which has been endorsed by the World Health Organization (Kozina, 2020). Educators taught students via small groups coping skills, emotional regulation, conflict resolution, mindfulness, relaxation skills and social skills. Educators also conducted parenting support and psychoeducation groups. Due to funding the program was cut, along with school counselor and social work support, despite parents, students, and teachers finding it helpful.

One aspect that each educator in this study made mention of which was not identified in the literature review was a perceived lack of support from other task-force members, both in their own open system and from other open systems in a child's life. Educators often felt alone regarding identifying and managing anxiety in the classroom. They felt a lack of support from their administration, and from school counselors and social workers, due to a lack of availability. Due to cuts in funding the number of hours worked for counselors and social workers is minimal. Some educators who are not the main teacher felt a lack of support due to a lack of shared information regarding each child's needs. Educators felt a lack of support from parents in terms of communication about their child's anxiety.

PHPs confirmed results of recent studies by expressing uncertainty identifying anxiety in children. They each stated they did not know much about protective factors, were more knowledgeable about risk-factors, and felt their role was to identify, treat and refer out. Some of the PHPs mentioned informal assessments they do based on clinical

observations, but that once anxiety is identified, they refer the child for specialized treatment due to a lack of adequate training. This confirms previous finding that only 13% of PHPs feel comfortable in managing childhood anxiety in the primary care setting (O'Brien et al, 2019). Despite believing they do not provide protective factors, like educators, PHPs mentioned many supports they provide every day to their patients that have been found to be protective factors such as early referral to mental health services, encouraging healthy parent-child relationships, structure, routine, proper nutrition, and exercise, normalizing all feelings, healthy sleep schedule and limited screen time (O'Brien et al, 2019).

PHPs believe that barriers to providing protective factors include a lack of time, a lack of knowledge and training, and the fact that the medical model focuses on treating the child, and prevention is more about working with the parents. This last barrier was not previously identified in the current literature. The PHPs that felt more comfortable identifying early signs of anxiety believed it was due to personal experience with anxiety vs. training, which confirms finding from O'Brien et al (2019). Despite their uncertainty and discomfort, and perceived lack of knowledge and practice in providing protective factors against childhood anxiety, the PHPs interviewed for this study believed that prevention is possible, that providing protective factors such as early identification of precursors, and education about attachment, and assessment of caregiver anxiety or depression should be a part of their role and should be a component of primary care. They all recognized the impact anxiety has on health, education, and social functioning, and believe that assuming that role in a child's life is important to ensure positive

outcomes. Although most of the PHPs I interviewed agreed with recent findings that parents should be the primary system responsible for sharing information with the providers about anxiety symptoms (O'Brien et al, 2019), they recognized that parents may simply not know about anxiety symptoms, and therefore it would fall on them as medical professionals to educate parents about prevention.

Role of Parents

Each parent I interviewed for this study was cognizant of the fact that the bulk of responsibility for the prevention of childhood anxiety falls on them, based on current literature (Dabkowska & Dabkowska-Mika, 2015). They expressed some stress, and feeling overwhelmed by this, but also felt an urgency to ensure that their children would not suffer from anxiety. Parents mentioned the negative impact that anxiety has especially on education, but also on health and social-emotional development in a child's life. They were all aware of genetics as the predominant factor of their children possibly developing anxiety (Alyanak et al 2013, Drake & Ginsburg, 2012). They all also shared the same experiences discussed in one study (Tom et al, 2018), which found that extreme demands for excellence put on children is a risk-factor for childhood anxiety. One thing some parents shared which was not found in the literature review is the balancing act they try to perfect between having high expectations for their children and teaching children the importance of failure.

Parents were aware that temperament in their child also played a part in determining outcome regarding childhood anxiety, and they recognized the different temperaments in their own children and the different outcomes regarding anxiety. All parents shared that they actively engage in helping their children to re-think their worries and to focus on productive responses based on optimism and gratitude which confirms findings in recent studies regarding protective factors (Tam et al, 2018).

Between all parent participants, each protective factor included in the Delphi Consensus Study (Yap et al, 2015) was mentioned, including: establishing and maintaining a good parent/child relationship, encouraging, and supporting a gradual increase in autonomy, encouraging other supportive relationships for the child, establishing family rules and consequences, encouraging good health habits, and minimizing conflict in the home. Other protective factors parents mentioned that were not included in the Delphi Consensus Study was parents treating their own anxiety, not modeling anxious reactions or thoughts, communicating with the child's education team, and learning about child development. None of the parents directly mentioned secure attachment as a protective factor they provide, probably because they do not know the language for this concept. They did mention providing many factors which constitute a secure attachment, including: a safe and secure relationship, open communication, predictability in their reactions and being in the moment with their child (Lam et al, 2019).

Parents, like educators, expressed feeling alone in their role of providing protective factors for the prevention of childhood anxiety. This sentiment from parents

was not identified in previous literature. Most parents said they learned about ways to mitigate for the genetic predisposition their children have from their own experiences with anxiety, not from community resources. They learned from their own reading and research, as opposed to from their prenatal doctors, their pediatricians, the school system, or community resources. They also feel a lack of support from both the educational and health systems, in identifying early signs of anxiety and in managing their child's anxiety. Parents do acknowledge they share a part in the lack of support from outside systems, in that they do not communicate with the education system and the health system directly about mild childhood anxiety. They admit to having a responsibility to advocate for their children for accommodations and to believing they could better communicate with educators regarding their child's specific needs. Parents also feel they could ask pediatric health care providers for more information regarding socio-emotional child development and for support in terms of mental health issues. All parents believed that with an increase in coordination to better access support from outside resources, the prevention of childhood anxiety is possible and necessary. They feel the stress and magnitude at being the primary support system responsible for providing protective factors, but also feel hopeful and optimistic about being able to meet the challenge. The emphasis each category of participants put on lacking support from other open systems and wanting to provide support to other open systems regarding providing protective factors against childhood anxiety points to the ecological nature of both risk factors and

protective factors in childhood anxiety. This indicates that we must continue to look at the social work systems theories that address the different levels of a child's social system; individual, family, educational, health, community, and societal factors (Tomb and Hunter, 2004). The results from this study indicate that childhood anxiety does not happen in isolation. The study confirms the hallmark implications of systems theories that a holistic approach to prevent and manage childhood anxiety will require the continued active participation of all members of a child's primary open system including parents, educators, and primary caregivers (Gitterman and Germain, 1976, Meyer and Matainee, 1998, & Lathorpe, 1969). This study indicated that cooperation between these three levels of support in a child's life might be missing and might improve outcomes. Lastly, this study indicated the high impact of social policy on outcome. Some of the protective factors are not being provided in a uniform, standardized, measurable way due to a lack of mandate and protocol, both at a federal and state level, but also at an organizational level.

Limitations of the Study

The limitations to this study had been previously predicted. The sample size was going to be small to begin with each category of participants because I felt it was important to include information from the three primary open systems in a child's life. Timing would not allow for more than possibly six participants in each category. In addition to this previously predicted limitation, we had the added complication of the COVID 19 global pandemic, which I believe was a factor in recruiting pediatric health care providers. I was only able to recruit four PHPs and noticed a significant disinterest

in this category. The limitation is not knowing if the disinterest was due to the pandemic, as the health profession has been overwhelmed with changes to their practice, and with a big increase in their patient load, or if the lack of interest was due to PHPs feeling a lack of relatability towards this topic. I had also predicted a limitation in the homogenous pool of participants I would probably recruit but had opted for a deeper context by allowing for this limitation. One thing I had not predicted was the possibility of participant characteristics being a possible limitation. In addition to the demographic homogenesis of the group, they all also had a high degree of experience with childhood anxiety, they all had a personal vested interest in the topic of childhood anxiety. Most of the parents had been in treatment for their own anxiety, they read self-help books and belonged to online forums for support. Educators were acutely aware of the impact of childhood anxiety in a child's education and developmental outcomes. The PHPs that were interested all seemed to have a unique interest in the topic of childhood anxiety due to personal experiences or as a parent of a school aged child. This limitation leaves us to wonder if the results would have differed if the parents who chose to participate lacked insight regarding their own anxiety. Additionally, I am not sure if this participant characteristic is a limitation or simply a reality due to the fact of the high incidence of anxiety in the general community.

Recommendations for Future Research

The first recommendation for future research would be to expand on this research effort in the community of Rochester/Rochester Hills, MI by including more pediatric health care providers to the current sample and adding those results to the see if different codes and themes emerged. I would also recommend adding a focus group that included members from all 3 categories of participants to the same study. The current participants all expressed concerns about support from the other open systems and a desire to further support those systems, therefore bringing them together to discuss these issues might bring meaningful information to the table. Second, I would recommend a quantitative study that addresses the same research question in more quantifiable ways. For example, using the codes and themes that emerged from this study to create a Linkert Scale Survey to ask the same question: What are the beliefs and attitudes of parents, educators, and PHPs regarding their roles in providing protective factors against childhood anxiety? This survey could be e-mailed out to a much larger sample within the community and the results could be more generalizable at least in this community. I would also recommend conducting the same study in a rural community in Michigan, and one in an urban community, as I am certain the results would greatly differ, therefore our methods of supporting these different communities as social workers would also greatly differ. I would recommend starting both research studies with the same qualitative in-depth interviews that would generate codes and themes from which to later expand the study into Linkert Style Questionnaire to make the results more generalizable within those communities.

Implications

Implications for Practice

Knowing that parents, educators, and pediatric healthcare providers all see the negative impact of childhood anxiety on social, health, educational and psychological outcomes, and want to intervene to help prevent the trajectory of children fully developing anxiety disorders, social workers can help them coordinate with each other to be able to do this as effectively as possible. I recommend starting with advocating for social policy changes, even at the local level. This might help make some of the recommendations made by the participants into protocol to be implemented. For example, requiring more information regarding family history of anxiety, and child's history of anxiety both in the school record and the medical record would ensure that educators and PHPs are aware of which children are at-risk of developing anxiety. Additionally, providing teacher trainings so that educators could have knowledge and a system for informal assessments of early signs of anxiety. Also, requiring Anxiety Sensitivity formal screenings for children that teachers refer based on their informal assessments. These anxiety screenings will further inform the school system as to which kids need more in-depth interventions. I recommend that each school have enough counseling and social work staff to run prevention programs for children and parents, who are identified as at-risk of developing anxiety. Additionally, I recommend that general protective factors be provided to all children in the classroom. Social workers

can provide teacher trainings on what these protective factors are and provide handouts and activities to empower teachers.

For pediatric health care providers, the first recommendation also begins at the social policy level requiring prenatal screening, so that starting pre-birth children at-risk of developing anxiety are identified and parents are given information on risk-factors to avoid and mitigating factors to practice in their parenting (Fox et al, 2008). Learning about childhood anxiety, early signs, symptoms, precursors, and management strategies should be a component of every medical educational program. Further research is indicated to see if learning about childhood anxiety is required in medical training programs, which PHPs in past studies and this study missed or forgot about. I recommend and advocate for federal and state policy that mandates for a specific Anxiety Sensitivity Scale to be administered to all children at well-child visits. I also recommend guidelines for protective factors to be provided to all pediatric health care providers for each developmental stage that can be incorporated into daily primary care.

My recommendations are based on current literature, the results of my study, and recommendations that came directly from the participants of my study.

Implications for Social Change

By empowering those with the primary roles of providing protective factors against childhood anxiety to be able, prepared, and willing to do so, then perhaps we can help decrease the prevalence of childhood anxiety disorders. This exploration has provided a further understanding of protective factors in childhood anxiety by obtaining in-depth information from the front-line task force: parents, teachers, and pediatric

healthcare providers. This new knowledge will assist in effectively communicating with the school community, the primary care community and with parents about the pressing social issue that untreated, unidentified, or improperly managed childhood anxiety continues to create for many children and their families in this community. Providing protective factors to prevent childhood anxiety, or greatly decrease its prevalence and its impact on developmental outcomes is possible. Having identified some of the beliefs and attitudes of parents, educators, and PHPs regarding their roles in providing protective factors including barriers and facilitators they have identified, we can inform home-based, community-based, healthcare based and school-based prevention programs. These prevention programs can help alleviate many of the known social issues that are directly related to untreated childhood anxiety, such as substance abuse, school drop-out rates, unemployment, juvenile delinquency, and more chronic forms of adult mental illness. (Alyonok et al, 2013, Higa-McMillan et al, 2016). This in turn can create long lasting social change for children and families in our community.

Conclusion

This study confirms the biopsychosocial nature of the development of childhood anxiety, and the ecological nature of both risk-factors and protective factors. It has provided valuable in-depth information to begin to fill in a gap in the literature regarding the beliefs and attitudes of parents, educators, and pediatric healthcare providers in providing protective factors against childhood anxiety. There did not appear to be any

information in the current body of literature as to whether parents, educators, and PHPs knew how to assume the role of providing protective factors to children to possibly prevent childhood anxiety, nor if they wanted to assume that role, or were prepared to assume that role. The results of this study indicate that all three categories of participants do not feel knowledgeable or prepared to assume the role of providing protective factors, but they do want to provide this role. In fact, parent, educators, and PHPs do have some knowledge regarding childhood anxiety, risk factors, protective factors, early signs of anxiety and precursors. Not only do they want to provide this role of providing protective factors, but they also want to be supportive of each other in doing so. Despite feeling ill-prepared to meet the responsibility of providing protective factors against childhood anxiety, they value that role and embrace it as important. The three primary support systems in a child's life recognize the negative consequences to all areas of a child's life if they suffer with anxiety and feel a responsibility to prevent this from happening.

Results indicate a perceived lack of support from other key stakeholders in a child's life, meaning a lack of support from each other in providing protective factors against childhood anxiety. All participants mentioned a desire to have a more coordinated effort in providing protective factors, which they believe to be the most likely way to help decrease the prevalence of childhood anxiety. There is a clear indication that parents, educators, and pediatric healthcare providers in the Rochester/Rochester Hills, MI community are motivated, optimistic, and hopeful about being able to support each other in providing protective factors against childhood anxiety.

With proper training, and a straightforward, mandated method of providing protective factors, all open systems in a child's life can work together to greatly decrease the negative impact that anxiety has on the successful outcomes of our children.

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Appendix A: Interview Guide

Introductory Statement:

Let me share a little about myself personally and professionally. I live in this area and work in the Rochester Hills community, and both of my kids attended school here. They are both grown now. I have been married 30 years. I have been working with children who suffer with anxiety for a long time, and I am very interested in better understanding how we as a community can provide our kids protective factors so that they never develop anxiety. At least 32% of school-aged kids suffer with anxiety at some point in their school experience. These questions and this interview are to better understand the roles of parents, educators, and pediatric healthcare providers in providing protective factors to possibly prevent childhood anxiety. So, let's begin:

Research Question: **What are the beliefs and attitudes of parents, teachers, and pediatricians regarding their role in providing protective factors against childhood anxiety for school-aged children in a suburb of Detroit?**

Interview Questions:

What are your experiences in treating/teaching/parenting a child who struggles with anxiety?

What are your thoughts about preventing childhood anxiety from developing?

What do you believe your role is in the prevention of childhood anxiety for children that you treat/teach/parent?

What do you know about protective factors that can help prevent childhood anxiety?

What do you know about risk factors that can contribute to childhood anxiety?

What methods do you use to assess for the possibility of anxiety developing in a child?

What methods do you use to identify early signs or pre-cursors for childhood anxiety?

Which protective factors are you currently providing as a parent/teacher/pediatrician?

What are some barriers to providing these protective factors?

What are some ways of overcoming these barriers?

What are your thoughts or feelings about having a responsibility to provide protective factors to school-aged children against anxiety?

Is there anything else about this topic that you would like to elaborate on?

Prompts:

-Can you give me an example of what you mean?

-Please tell me more about that. What has that been like in the past?

-How to hope to have it be in the future?...

Closing Statement:

-Is there anything about this topic of childhood anxiety and your role in providing protective factors that I did not ask, that you would like to share more about?

-Do you have any questions for me, or anything else to say?

-This is my contact information, if you need to be in touch with me, or if you think of anything else that I didn't ask (Jacob & Ferguson, 2012).

-I will be in touch with you once I have the transcript of our interview so that you can review it before it goes through the coding process.

-Thank you so much for participating in this interview.

Appendix B: Participation Criteria Questionnaire

Researcher to fill this out prior to each participant interview.

Interview Date: _____

Participant Name:

_____

Preferred Method of Communication:

_____

Mailing Address:

_____

Category of Participation:

_____

For Educators/Healthcare Providers Participants:

Method of confirming profession and place of employment:

_____

For Parent Participants: ***(confirm these questions during contact prior to interview, and re-confirm right before interview)***

Do you have a child who is a student in the Rochester/Rochester Hills, MI community? ___

Do you have a history of symptoms of anxiety?

_____