Child Adolesc Soc Work J (2009) 26:259–273
DOI 10.1007/s10560-009-0173-1

Overcoming Barriers to Using Empirically Supported Therapies to Treat Childhood Anxiety Disorders in Social Work Practice

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Published online: 8 May 2009

Abstract Anxiety disorders are among the most common psychiatric disorders in children and adolescents. Most empirically supported treatments (ESTs) for pediatric anxiety disorders include various cognitive-behavioral methods. Although demonstrated efficacious in controlled and clinic settings, there are barriers to implementing these types of therapies in social work settings due to beliefs about the usefulness of ESTs in community settings; limitations of treatment manuals; time constraints of implementing ESTs; fidelity and flexibility of implementing ESTs; and limited training opportunities. This article provides an overview of ESTs for childhood anxiety disorders, highlighting options for overcoming common barriers to implementing ESTs. Collaborative multi-method approaches to advance implementation of ESTs in social work practice are suggested.

Keywords Anxiety · Children and adolescents · Empirically supported treatments · Evidence-based practice · Implementation

As one of the most common psychiatric disorders in youth, anxiety disorders affect approximately 10.5–17.5% of children and adolescents (Anderson et al. 1987; Benjamin et al. 1990; Pine 1994). Even though fear and anxiety are a normal part of development, research suggests that elevated levels of anxiety in childhood are

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associated with negative family (Ginsburg et al. 2004), social (Chansky and Kendall 1997), and academic outcomes (King and Ollendick 1989). If untreated, symptoms of anxiety are often unremitting (Woodward and Fergusson 2001) and may intensify into adulthood (Kendall 1992). Thus, in addition to impairing the psychosocial functioning of children, untreated anxiety symptoms can have a profound effect on later functioning and elevate individuals' risk for experiencing occupational impairments and developing co-occurring mood or substance abuse disorders (e.g., Kendall et al. 2004). Recent advances in research on interventions with children and adolescents with anxiety disorders have led to the availability of empirically supported treatments (ESTs) for childhood anxiety disorders. However, real barriers to implementing these treatments in social work practice remain. This article provides an overview of types of childhood anxiety disorders and ESTs and discusses barriers and potential solutions to overcoming these barriers to implementation.

Childhood Anxiety Disorders

Common childhood anxiety disorders include separation anxiety disorder, generalized anxiety disorder, specific phobias (e.g., blood phobia, vomit phobia), social phobia, panic disorder, post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD). Children with separation anxiety experience overwhelming anxiety from being separated from attachment figures (either permanently or temporarily) and these children often display a variety of avoidant behaviors to remain in proximity to attachment figures (Bell-Dolan and Brazeal 1993). Children with generalized anxiety disorder experience excessive and uncontrolled worrying about a variety of events and activities. These children often worry about general life concerns, experience distressing self-defeating cognitions, and may anticipate negative future outcomes (e.g., having one's parents killed in a car accident). Specific phobias in children and adolescents are characterized by persistent fears associated with circumscribed stimuli (e.g., animals, blood, vomit) or situations (e.g., elevators, flying) and these children tend to engage in avoidant behavior to limit their exposure to phobic stimuli. Youth with social phobia experience excessive fear of being evaluated negatively in social or performance situations (e.g., reading in class, attending parties) and may limit their exposure to being evaluated by others. Panic disorder is characterized by the presence of panic attacks that occur 'out of the blue' and persistent fears associated with experiencing future panic attacks. Youth with this disorder may avoid places (e.g., stores, streets) or situations that become associated with episodes of panic. PTSD is characterized by a constellation of cognitive (i.e., recurrent thoughts about the trauma, flashbacks, nightmares), behavioral (i.e., avoidance of situations that are associated with the trauma), and physiological (i.e., difficulty falling asleep, hypervigilance) symptoms that are experienced following exposure to a traumatic event. Youth affected by pediatric OCD experience recurrent obsessions and/or compulsions that cause significant distress and/or impairment in their daily functioning. By nature, the clinical presentation of OCD is heterogeneous with individuals often presenting with a variety of obsessions (e.g., contamination, aggressive/violent) and/or compulsions (e.g., washing, checking).

Considering the high prevalence rates of childhood anxiety disorders, the heterogeneity of these disorders, the functional impairment in youth with elevated anxiety levels, and the social costs resulting from the chronic nature of untreated anxiety symptoms, it is clear that effective interventions are needed to treat childhood anxiety disorders. To better establish the efficacy of treatments, mental health consumers and providers are now emphasizing the importance of using interventions with empirical support for treating specific disorders (Kendall and Suveg 2006; Ollendick and King 1998). Indeed, with the increasing demand for evidence-based practice, consumers and providers must consider what ESTs are available for implementation with their client population.

Empirically Supported Treatments for Childhood Anxiety Disorders

According to The Task Force on Promotion and Dissemination of Psychological Procedures (1995), ESTs must be: (1) more effective than a control treatment (i.e., a placebo or no treatment) or equally effective to an established treatment, as determined in randomized clinical trials conducted by independent researchers; (2) must employ a standardized treatment manual in all treatment efficacy studies; and (3) must clearly report the characteristics of the studied participants in all corroborating research investigations (Chambless and Hollon 1998). If a psychotherapy meets all these criteria, the therapy is eligible to receive "well-established" (or empirically supported) status; if some (but not all) of the criteria are met, "probably efficacious" or "experimental" status is considered. Receiving "well-established" status is analogous to a psychotherapy being a "gold standard" or "first-line treatment" for a specific mental health condition.

A variety of behavioral and cognitive-behavioral therapies (CBT) for childhood anxiety disorders have received "well-established" or "probably efficacious" EST status (Albano and Kendall 2002; Kazdin and Weisz 1998; Ollendick and King 1998; Silverman et al. 2008a, b). Although included to varying degrees in each treatment protocol, components of these therapies include psychoeducation on anxiety and its effects, exposure therapy, cognitive restructuring, relaxation training, diaphragmatic breathing, systematic desensitization, contingent reinforcement, and modeling (Kendall and Suveg 2006). Table 1 provides a summary of the components from "well-established" or "probably efficacious" treatments for childhood phobias (Chambless and Ollendick 2001; Ollendick and King 1998), panic disorder (Ollendick 1995; Wade, Treat and Stuart 1998), generalized anxiety disorder, separation anxiety disorder, social phobia (Barrett et al. 1996; Kendall et al. 1997), PTSD (Amaya-Jackson and DeRosa 2007), and pediatric OCD (Abramowitz et al. 2005).

The Use of Empirically Supported Therapies for Childhood Anxiety in Social Work

Compared to applied psychology graduate students and psychiatric residents, masters in social work (MSW) students tend to receive less clinical supervision and

Table 1 Childhood anxiety disorders, main symptoms and CBT components

Disorders	Main symptoms	CBT components
Specific phobia	Marked and persistent fear of specific things or situations (i.e., dogs, thunderstorms, injections); avoidance of feared thing or situation; responses of intense anxiety (including crying, tantrums, clinging, freezing) when faced with feared thing or situation.	Gradual and systematic exposure to feared stimuli; systematic desensitization; modeling
Panic disorder	Unexpected panic attacks with intense fear and somatic and/or cognitive symptoms (such as dizziness, heart pounding, sweating, fear of going crazy or losing control). Persistent worrying about having another attack (persistent worrying must last at least 1 month).	Psychoeducation; interoceptive and naturalistic exposure techniques; cognitive restructuring; diaphragmatic breathing
Generalized anxiety disorder	Excessive and uncontrolled worry about a variety of events and activities (occuring more days than not for at least 6 months). Anxiety and worry are associated with 3 of the following symptoms (only 1 symptom is needed in children) restless, irritable, difficulty sleeping or concentrating, tense muscles, fatigue.	Recognize anxious feelings and somatic reactions; reframe negative attributions and unrealistic expectations; teach adaptive coping skills such as diaphragmatic breathing; evaluate the success of the coping strategies; assist the family with strategies to respond to the child's anxiety; behavioral experiments; exposure
Separation anxiety disorder	Overwhelming anxiety from being separated from home or attachment figure (for at least 4 weeks and must begin before age 18). Recurrent excessive distress when separations occur; excessive worry about events that may lead to losing or harm to attachment figure; excessive fear of being away from attachment figure; nightmares with themes of separation; complaints of physical symptoms when separated or when there is fear of separation.	Exposure to feared stimuli; recognize anxious feelings and somatic reactions; reframe negative attributions and unrealistic expectations; teach adaptive coping skills such as diaphragmatic breathing; evaluate the success of the coping strategies; assist the family with strategies to respond to the child's anxiety
Social phobia	Excessive fear of being evaluated negatively in social or performance situations and may limit their exposure of being evaluated by others (duration 6 months). Anxiety (which may be expressed by crying, freezing, tantrums) occurs upon exposure to feared situation.	Exposure to feared stimuli; recognize anxious feelings and somatic reactions; reframe negative attributions and unrealistic expectations; teach adaptive coping skills such as diaphragmatic breathing; evaluate the success of the coping strategies; assist the family with strategies to respond to the child's anxiety
Obsessive compulsive disorder	Recurrent obsessions and/or compulsions that cause significant distress and/or impairment in daily functioning.	Psychoeducation; exposure and ritual prevention; cognitive restructuring

Table 1 continued

Disorders	Main symptoms	CBT components
Posttraumatic stress disorder	Persistently reexperiencing traumatic event; avoidance of trauma reminders; increased arousal (disturbances last more than 1 month).	Psychoeducation; teach management of anxiety and trauma reminders; create trauma narrative; cognitive and affective processing; exposure to trauma reminders; support developmental competencies; address grief and loss issues; address safety and positive relationships; provide parenting skills and behavior management, as needed

Many ESTs for pediatric anxiety include a variety of CBT components. The components listed for each disorder are the ones that are most often used to address the symptoms and have been tested in CBT pediatric anxiety treatment trials

didactic experience in using empirically supported therapies (Weissman et al. 2006). One recent study by Bledsoe et al. (2007) found that 61.7% of social work training programs did not use didactic and clinical supervision in any ESTs with 54.6% of psychotherapy training being in non-evidence-based forms of social work counseling. However, given the existence of validated treatments and an emphasis by managed care organizations to fund short-term, cost-effective therapies with demonstrated success at treating specific disorders (Sanderson 2003), it is critically important for treatment providers to add ESTs to their treatment repertoire (Cournoyer and Powers 2002). Furthermore, the ethical obligations of social workers is to "fully use evaluation and research evidence in their professional practice" (National Association of Social Workers 1999) to maximize their clients' well-being.

Implementing ESTs for Childhood Anxiety Disorders: Barriers and Responses

As practitioners become aware of ESTs for childhood anxiety disorders through dissemination efforts, the next step is implementing these methods in practice. There are many barriers to implementing ESTs and more research is needed to understand the best ways to implement these treatments in daily community practice (Mullen et al. 2008). As part of this effort, it is important to identify potential challenges to EST implementation and possible solutions. After reviewing literature about implementing ESTs (e.g., Addis 2002; Aarons and Palinkas 2007; Addis and Krasnow 2000; Addis et al. 1999; Baumann et al. 2006; Galinsky et al. 2006; Howard et al. 2003; Kendall and Beidas 2007; Nelson et al. 2006; Rosen 2003; Weissman et al. 2006), we have identified five common barriers to implementation. Furthermore, we also suggest possible measures that may help guide the implementation of ESTs. Our responses are not meant to minimize the challenges, but rather to discuss potential options for overcoming EST implementation barriers.

Barrier: Belief that ESTs will not Work in the "Real World" of Social Work Practice

Skepticism about the generalizability of treatments tested in controlled environments (referred to as efficacy studies, often conducted at university clinics) is a potential barrier to implementing empirically supported childhood anxiety interventions. If treatments for childhood anxiety disorders have only been tested with homogeneous groups in controlled settings, the concerns of social workers, who treat children with comorbid conditions from diverse populations and in diverse settings, are quite valid. However, the assumption that a treatment based on efficacy studies will not work denies the child the opportunity to be provided with treatment based on the best available evidence. Commitment to serving the client's best interest requires social workers working toward approaches to implementing ESTs (Rosen 2003).

Response

Options to address this barrier include utilizing an EST as a first line of treatment, testing ESTs in real world settings, adapting ESTs to meet the unique needs of clients, and evaluating results. Since there is evidence supporting "well-established" or "probably efficacious" treatments for childhood anxiety disorders (Ollendick and King 1998; Silverman et al. 2008a, b), social workers are encouraged to use ESTs as the first line of treatment. ESTs for pediatric anxiety are specific empirically tested treatment techniques, methods or components, such as the ones listed in Table 1 or available at the websites listed in Table 2 that are to guide the treatment with the child and family. If an EST for childhood anxiety has only been tested in a controlled setting, social workers have a unique opportunity to evaluate the treatment in a real world social work practice setting (referred to as effectiveness studies). The assumption that a specific treatment developed in tightly controlled clinical trials is not effective in "real world" practice needs to be tested. For agency settings that do not have the capacity or funding to conduct an effectiveness study, partnerships between agencies and schools of social work or other mental health college and university departments can provide a means to evaluate ESTs in real world settings (Reghr et al. 2007). If efficacy studies do not translate to effective practice in community settings, then social workers are encouraged to adapt and tailor the empirically tested anxiety treatment to meet the needs of the clients. When adaptations to ESTs are made to tailor the intervention to clients' preferences, challenges and conditions, a systematic evaluation to track individual client outcomes (i.e., single subject design) should be conducted (Howard et al. 2003). Learning about the effectiveness of ESTs and adaptations with diverse populations within different settings and with complex conditions will help expand the knowledge base of ESTs that are relevant to social work practice.

To address the belief that ESTs will not work in the real world, it may be beneficial to report up-to-date results from treatment outcome studies and how interventions have been implemented in studies. While more studies are needed on

Table 2 Web-based sources of information about childhood anxiety disorders

1. Anxiety disorders association of America, children and teens
   http://www.adaa.org/GettingHelp/FocusOn/Children&Adolescents.asp
2. American psychology association, division 12, society of clinical psychology, empirically supported treatments, anxiety disorders and stress
   http://www.apa.org/divisions/div12/rev_est/anxiety.html
3. National institute of mental health, anxiety disorders education program
   http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml
4. Obsessive compulsive foundation
   http://www.ocfoundation.org/
5. National association of social workers, research web page, see anxiety disorders
   http://www.socialworkers.org/research/default.asp
6. National center for childhood traumatic stress, national child traumatic stress network
   http://www.nctsnet.org/nccts/nav.do?pid=hom_main
   http://tfcbt.musc.edu/ (free web-based training in TF-CBT)
7. Cochrane collaboration (www.Cochrane.org). See reviews of pediatric anxiety treatment studies. Examples include:
   http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004856/frame.htm
   http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD005170/frame.htm
   http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004690/frame.htm
8. National registry of evidence-based programs and practices (NREPP), a service of the substance abuse and mental health services administration (SAMHSA).
   http://nrepp.samhsa.gov/

the transportability of anxiety efficacy studies to community settings, there is evidence that outcomes similar to those found in structured efficacy studies conducted in university settings can be achieved by practitioners providing treatment within community-based practice settings (e.g., Valderhaug et al. 2007; Wade et al. 1998). Also, not all pediatric anxiety disorder efficacy studies have been conducted under tightly controlled conditions with homogeneous samples. In fact, some studies include participant characteristics that are common in community clinic populations. For example, children with comorbid conditions such as ADHD, oppositional defiant disorder, depression, and conduct disorder were included in randomized clinical trials of youth with an anxiety disorder (Kendall et al. 1997) and OCD (Storch et al. 2007). In both these studies, robust treatment gains were found at post-treatment and short-term follow-up. In addition, a few efficacy studies with children with anxiety disorders (Ferrell et al. 2004; Pina et al. 2003) and a few effectiveness studies with children with PTSD (Salloum and Overstreet 2008; Stein et al. 2003) have included substantial minority samples (African American and Latino children). However, despite these efforts, more research is needed on the generalizability of empirically supported anxiety treatments with ethnic minority children, children from low-income families and/or children who present with complex clinical challenges (Silverman et al. 2008a, b).

Barrier: Belief that Therapeutic Relationships or Rapport Could be Damaged by Using Manualized Treatments

Practitioners have a wide range of opinions about the advantages and disadvantages of manualized treatment. Perhaps extreme perspectives on manuals can be summed up as intuitive practice versus standardized practice. Practitioners opposed to using manuals believe that practice should be more intuitive with clinical judgment and process guiding treatment. Practitioners in favor of manualized treatment believe that systematic empirical evidence outlined in the manual should guide the treatment (Galinsky et al. 2006). Some perceived advantages of manualized treatment may include the belief that manuals provide motivation, structure, and resources for practitioners, and improve practitioners' skills. Some perceived disadvantages include the belief that manualized treatment is overly mechanical, not useful for attending to individual needs, and may limit therapeutic creativity and authenticity (Addis and Krasnow 2000; Baumann et al. 2006). Included in this list of disadvantages is the commonly held belief that manualized treatments are "cookie cutter" approaches that devalue the therapeutic relationship between practitioners and clients (Addis et al. 1999; Addis and Krasnow 2000; Baumann et al. 2006).

Response

Within the structure provided by manualized treatments, many manuals recognize the importance of the clinician-client relationship and therapeutic processes. Practitioners are still encouraged to develop a healthy therapeutic relationship and strong rapport while using manualized treatments for children with anxiety disorders. In fact, many treatment manuals incorporate methods that directly promote strong therapeutic relationships. For example, in the Coping Cat Cognitive-Behavioral Therapy for Anxious Children manual, Kendall and Hedtke (2006) state that the first task is to build rapport: "Rapport between the anxious child and the therapist is critical to the success of therapy, and it is certainly worthwhile to devote ample time to the establishment of a trusting relationship between the child and therapist" (p. 2). Rapport building strategies include beginning with playing a game to learn more about the child; providing an overview of the structure, rationale and goals of the treatment; encouraging questions and communication; explaining the role of the therapist as one of a coach; and emphasizing a team approach.

Manuals often include alliance-building activities that many practitioners use, but that are not always written explicitly. These include clarifying the practitioner's role as both coach and collaborator; discussing practitioner and client expectations of treatment; discussing concerns about treatment processes and outcome; and reviewing progress at the end of each session and obtaining client feedback (Addis et al. 1999). However, prior to the implementation of a manual-based treatment, a trusting relationship can be facilitated by discussing with the parent and child (when appropriate) ways in which ESTs are known to be effective in treating childhood anxiety. Indeed, collaborative practice decisions where both the social worker and client are informed about best available evidence and manualized treatment choices may be the starting point for building rapport (Howard et al. 2003).

Barrier: Belief that Caseloads are Too Heavy to Implement ESTs

Social workers in private practice and community-based mental health agencies often struggle to maintain a balance between caseload size and effective practice. In a fee-for-service reimbursement atmosphere, clinical social workers may be expected to sustain high caseloads (Addis 2002). In a qualitative study of practitioner attitudes toward ESTs, Nelson et al. (2006) found that most participants cited the impractical length and number of treatment sessions required by some ESTs and the lack of cost-effectiveness or reimbursement by third party payers as common reasons for avoiding use of such interventions. ESTs are often cited as impractical in managed care settings because they may require 8–20 weekly treatment sessions (Addis 2002; Kendall and Beidas 2007). In addition, practitioners note that substantial caseloads often require over 40 hours per week of client contact and documentation, making it challenging to find additional time to become proficient in the implementation of ESTs. Citing fatigue from high caseloads, practitioners also express a lack of energy or desire to read evidence-based research and treatment manuals or to complete required training on ESTs (Nelson et al. 2006).

Response

The predetermined number of sessions specified in many treatment manuals can afford children with anxiety disorders and their families a timeline for the interventions and can increase hope that change is possible. It may also serve as a benefit when negotiating with insurance companies that require such specifics prior to the onset of treatment (Sanderson 2003). Currently, most childhood anxiety disorder outcome studies are based on 12 sessions, although the number of sessions may range from 1 to 50 (Silverman et al. 2008a, b), and alternative options are being studied (e.g., intensive CBT; Ollendick et al. 2005; Storch et al. 2007). With the healthcare system changing and managed care organizations demanding efficacious and time-limited treatments, social workers must demonstrate effective clinical outcomes to satisfy the needs of both clients and payers. Failure to adhere to these trends will most likely have legal and ethical implications for practitioners (Sanderson 2003).

Once ESTs are learned and practitioners are competent in implementing ESTs, these systematic and efficacious approaches may actually assist social workers in managing heavy caseloads. For example, in a study of service provider perspectives after implementing a new EST in the child welfare system, many caseworkers perceived the structure of the EST as a positive treatment aspect and the manualized format as being helpful. The structure provided by the EST was viewed by some staff as a way to improve efficiency, and increased time management during sessions (Aarons and Palinkas 2007). Therefore, rather than being viewed as a hindrance or aggravation when providing services, ESTs should be seen by social workers as a cost-effective and essential tool to navigate the current healthcare system.

Barrier: Belief that it is Too Difficult to Adapt Practice to Implement ESTs with Fidelity

The concept of fidelity in EST refers to how strictly a prescribed and written intervention is followed by a practitioner and provided to a client in a treatment setting (Kendall and Beidas 2007). Many social workers share the view that integrating ESTs with a high degree of fidelity is unfulfilling and limits their creativity and innovation in the therapeutic process (Addis 2002). Nelson et al. (2006) found that flexibility when employing manualized treatment was an essential component for practitioners due to the complexity of individual client situations and needs. However, even when flexibility is encouraged, other factors such as practitioner comfort level and skill in implementing specific procedures may be a barrier to maintaining fidelity.

Response

Even in clinical trials for children with anxiety disorders, treatment manuals are used in a flexible manner where fidelity to treatment principles are maintained while individualized care is provided (e.g., Kendall et al. 1997). For example, in a recent open trial of CBT with children with OCD conducted in a community clinic, the treatment manual included this statement, "It is emphasized that the manual should be used as a guide and in a flexible way, where consideration is paid to the child's age and developmental level and to individual variations in problems and themes that need to be addressed" (Valderhaug et al. 2007, p. 582).

Along these lines, most ESTs allow for and encourage flexibility in implementation. It is imperative that practitioners utilize their own clinical experience and creativity in the implementation of ESTs to ensure client success (Kendall and Beidas 2007). As discussed, social workers may modify and evaluate an EST when they have concerns about whether there is a "goodness of fit" between the intervention and the individual client's circumstance or need, although modifications may limit or alter the effectiveness of the intervention (Proctor and Rosen 2008, p. 289). Even when implemented with a degree of flexibility that may limit overall efficacy, social workers must recognize that utilizing ESTs is preferable to utilizing treatments lacking empirical support (Kazdin and Weisz 1998).

Insuring fidelity to a prescribed treatment can be complex. In fact, even if a treatment was delivered as it was prescribed, the issue of level of skill, or degree of competence with which it was delivered may be a factor that influences fidelity. Methods to ensure fidelity can range from simple checklists of completion of tasks outlined in treatment manuals, to intensive clinical supervision and training, to even more labor intensive strategies such as having independent evaluators review taped sessions (Tucker and Blythe 2008). Having some method to check fidelity is imperative as social workers who claim to be providing a specific EST may not in fact be providing the content as it was intended and tested.

Barrier: There are not Enough Training Opportunities to Learn ESTs, Especially with Respect to CBT and Behavioral Exposures

Lack of training opportunities (i.e., workshops, conferences, web-based information, on-going supervision) is a barrier to implementing ESTs. Even when training is available, other barriers such as lack of interest and cost are present (Weissman et al. 2006). Additionally, though a discussion of organizational barriers to implementing ESTs is beyond the scope of this article, it is important to recognize that training barriers may be confounded by factors within the organizational and community context such as resources, constraints, mandates, and availability of trained supervisors for on-going supervision (Reghr et al. 2007).

In the treatment of pediatric anxiety disorders, there is ample research to support the efficacy of using cognitive-behavioral therapy that incorporates exposure therapy (Kazdin and Weisz 1998). However, exposure, whether carried out in vivo or via imagination, is often a source of intimidation and concern among practitioners who have not yet employed such interventions due to fears of client reactions, personal beliefs about causing temporary anxiety in their clients, and lack of understanding about anxiety habituation. In a study examining the treatment practice patterns of licensed mental health practitioners, it was found that while 29.2% of practitioners identified cognitive-behavioral therapy as their endorsed treatment approach when working with clients who have experienced trauma, those surveyed rarely identified exposure therapy or techniques as a preferred treatment method (Sprang et al. 2008). Such apprehension or lack of training in facilitating therapeutic exposures may contribute to the overall avoidance of EST utilization for childhood anxiety disorders.

Response

As schools of social work prepare social workers to search, select, implement and evaluate the best available evidence for services for specific client populations (Howard et al. 2003), and as more agency field placements encourage and provide support for ESTs, training needs may diminish. However, since many clinical social workers have not been trained on specific ESTs (Bledsoe et al. 2007; Weissman et al. 2006), training needs are considerable and are a current barrier to implementing ESTs. Furthermore, even for practitioners who have obtained training in ESTs, learning and continuing education is an on-going process.

To address the barrier of social workers needing more training opportunities to learn ESTs graduate schools of social work need to increase the instructional opportunities and practical experience using ESTs to treat mental health conditions such as anxiety disorders (Bledsoe et al. 2007). Since there is growing evidence for CBT for childhood anxiety disorders, didactic training and clinical supervision on this approach needs to be provided in clinical social work graduate programs. Second, there are several websites that provide information about childhood anxiety disorders, including research summaries and upcoming conferences (see Table 2). For example, The National Center for Childhood Traumatic Stress provides monthly web-based training opportunities. On this website, there is a course for Trauma-

Focused CBT, (TF-CBT) which is a "well-established" EST for PTSD, as well as a new implementation manual for TF-CBT that describes how this EST may be implemented in a social work setting.

Third, recent articles in social work and other mental health journals provide summaries on childhood anxiety disorder treatment research (e.g., Abramowitz et al. 2001; Moon 2002; Silverman et al. 2008a, b). In addition to other journals that publish articles on childhood anxiety, there are also three journals specifically about anxiety that provide up-to-date research (e.g., *Anxiety, Stress and Coping: An International Journal; Journal of Anxiety Disorders; Depression and Anxiety*). Lastly, while it is best to attend trainings prior to implementing a specific EST and to have sufficient supervision, manuals and workbooks can provide practical clinical information on 'how-to" conduct treatment. For example, the therapist manual for a "well-established" EST called the Coping Cat Cognitive-Behavioral Therapy for Anxious Children Program (Kendall and Hedtke 2006) and a CBT computer-based training program (CBT4CBT; Kendall and Khanna 2008) are easily accessible (see http://www.workbookpublishing.com/). There is also a recent article that reviews several books about childhood anxiety disorders for professionals and parents (see Weems 2005) as well as a child anxiety network that lists books for professionals and parents (www.childanxiety.net). For social workers with less training and experience in treating children with anxiety disorders or in using CBT techniques, these training opportunities may be only the first step toward implementation. Opportunities that provide more in-depth training and on-going clinical supervision from experts or through collaborative consultations that address daily implementation may be needed. In addition, research on implementation strategies to advance ESTs in real world social work practice settings is needed.

Future Directions

With the prevalence of pediatric anxiety disorders, it is quite likely that social workers will encounter children and adolescents with these disorders in their practices. Ethical and competent social work practice mandates that social workers stay up-to-date on empirically supported practices and utilize such practices. While ESTs for childhood anxiety disorders are available and have shown preliminary effectiveness in 'real world' settings, social workers lag in training and research on implementation. Thus, practitioners and researchers must engage in collaborative efforts to overcome barriers and create relevant practice knowledge. Indeed, "social work must redouble efforts to empirically address the many critical issues related to practitioner use and implementation of knowledge in actual practice" (Proctor and Rosen 2008, p. 290).

Overcoming barriers to using ESTs to treat childhood anxiety disorders in social work practice will require collaborative multi-method approaches. Future research and practice must include the following: 1) Field placements that provide mental health treatments for children and social work graduate program training that supports and trains practitioners in ESTs including cognitive-behavioral therapy; 2) Interdisciplinary university-agency partnerships to advance the field by conducting

effectiveness studies that use randomized clinical trials to compare treatment as usual versus ESTs. Understanding client preferences in terms of service delivery of ESTs is an important component of implementation research; 3) Social work practitioners and researchers need to work together to refine and expand manuals so that they are easy-to-use, flexible and address complex clinical challenges; 4) Practitioners and researchers should work collaboratively to develop companion manuals that provide practical information about ways to implement ESTs in diverse settings and systems and with diverse populations; and finally, 5) Researchers and practitioners must learn from each other what works with different populations in diverse settings and what are effective strategies for implementing ESTs in community settings.

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