PROGRAM EVALUATION OF THE COPING CAT PROGRAM
WITH GIFTED, ELEMENTARY STUDENTS

by

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ABSTRACT

This study is an evaluation of the Brief Coping Cat anxiety reduction psychoeducational curriculum within a gifted elementary school population. The goal of the Brief Coping Cat intervention is to decrease students’ self-reported feelings of anxiety by teaching them a variety of strategies designed to help them recognize, understand, and manage emotions and physical reactions to anxiety. The primary evaluation question of this program evaluation focuses on students’ perception of their experience in the intervention, as measured by mixed methods. Pre-treatment and post-treatment data show decreased anxiety and global psychological distress as evidenced by the decrease of mean scores. Students also reported satisfaction and favorable impressions of their experiences. Implications for the use of this intervention with gifted populations are discussed.

The form and content of this abstract are approved. I recommend its publication.

Approved by: Franci Crepeau-Hobson
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CHAPTER I
INTRODUCTION

Out of approximately 50 million American school children, about one in ten experiences the negative consequences of anxiety (Blaas, 2014). Sometimes, the presence of anxiety can serve positive purposes, including problem solving and motivation towards goal-oriented behavior (Peterson, 2015). However, chronic, maladaptive anxiety often has a negative impact with disruptions and interference in one’s daily life (Cross & Cross, 2014). According to the fifth edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-V; American Psychological Association [APA], 2013), clinically significant generalized anxiety is characterized by uncontrollable, excessive worry that causes functional impairment. The DSM-V also outlines various physiological struggles attributable to anxiety, including restlessness, fatigue, irritability, muscle tension and the disturbance of sleep. Furthermore, anxiety can lead to trouble with concentration and emotional regulation (APA, 2013). When anxiety’s negative effects are experienced within a school setting, a student’s academic performance and functioning can be impeded. This may obstruct the full expression of one’s true abilities, and/or the promotion of maladaptive coping strategies, including avoidance and internalization (Stornelli, Flett & Hewitt, 2009).

Previous research indicates that the gifted student population is particularly susceptible to maladaptive levels of anxiety (Gaesser, 2014). Gifted individuals, who comprise approximately 3% to 5% of the student population, are characterized as having well above average abilities in areas such as intelligence and academic achievement (National Association for Gifted Children, 2013). However, the theory of asynchronous development suggests gifted students’ cognitive and academic strengths tend to mature at a faster rate than their socioemotional abilities (Lamont, 2012).
While some research suggests that gifted students possess increased levels of intensity and resiliency that act as protective factors, other studies indicate they often demonstrate above average levels of anxiety in the forms of oversensitivity, negative perfectionism, failure-avoidance, and social isolation (Gaesser, 2014; Blaas, 2014). They also tend to experience intense fears and worries at an earlier age and higher magnitude when compared to same-aged nongifted peers (Harrison & Van Haneghan, 2011). Gifted, anxious students may also have difficulty with mental uneasiness and internal reconciliation of their strengths and weaknesses (Gaesser, 2017). Although gifted students often identify similar concerns as their nongifted peers, (e.g., the dark, injury, kidnapping, failure in school, imaginary creatures), gifted youths’ advanced comprehension abilities tend to exacerbate the feelings of nervousness and apprehension, often at an earlier time than peers and with more intensity (Tippey & Burnham, 2009).

If these thought processes become maladaptive, distorted, and chronic, they can result in clinical levels of physical and psychological distress (Gaesser, 2017). However, in an effort to maintain social status, gifted students are often hesitant to ask for outside support, resulting in silent struggles (Jen, 2017). Although schools are becoming more attuned to successful instructional strategies for the gifted population, historically, there has been less emphasis on combating gifted students’ socioemotional struggles.

Furthermore, few studies have been published regarding the reduction of anxiety’s negative consequences in gifted youth (Eckhart & Robins, 2017). As such, there is likely a large proportion of gifted youth with unmet anxiety needs. Without proper intervention, these students may be more likely to experience a range of negative consequences, including later
psychopathology, academic underachievement, and poor socioemotional wellbeing (Gaesser, 2017).

Due to the extensive time children spend in school on a daily basis, the school setting is a natural context for tackling mental health concerns and fostering socioemotional competencies. School psychologists are charged with providing appropriate, high quality mental health services to both general and special education students who demonstrate varying levels of need (National Association of School Psychologists; NASP, 2015). Furthermore, federal laws, including the Every Child Succeeds Act (2015) and the Individuals with Disabilities Education Improvement Act (2004), extend these mandates.

The empirical base of school-based affective psychoeducational interventions has grown tremendously thanks to a number of research studies (Joyce-Beaulieu & Sulkowski, 2015). Within a school setting, counseling grounded in cognitive-behavioral therapy has assisted gifted students in managing anxiety and promoting significant positive change by modifying thoughts, behaviors, and emotions to solve various problems (Peterson, 2015). Group counseling featuring small group discussion amongst same-aged gifted peers has been shown to be effective in increasing students’ meaningful socioemotional engagement and development (Peterson, Betts & Bradley, 2009). Although individual counseling also has robust research support, a group format is often lauded for being more time- and cost-efficient; furthermore, it is ideal for facilitating activities like role playing with peers to build interpersonal skills (Flannery-Schroeder, Choudhury & Kendall, 2005). Particularly, school-based CBT group counseling within elementary contexts has also shown promising results (Sanchez et al., 2018).

Intervention studies have provided evidence of the effectiveness of therapeutic interventions in decreasing symptoms of anxiety (Joyce-Beaulieu & Sulkowski, 2015) and such
school-based interventions have been studied with gifted adolescents (Jen, 2017). However, as of 2017, there have been no published outcome studies that included an elementary-aged gifted population (Wellisch & Brown, 2012; Jen, 2017). Research shows the evidence that early intervention efforts can mitigate socioemotional concerns, and particularly, school-based anxiety prevention and early intervention efforts have been considered both feasible and efficacious (Neil & Christensen, 2009). Thus, it is important to evaluate the use of anxiety reduction interventions with anxious, gifted elementary students. Such early intervention may help to foster the realization of these students’ optimal potential and reduce the risk for future negative outcomes.
CHAPTER II
LITERATURE REVIEW

Giftedness

The term “giftedness” is defined and interpreted variably by scholars, educators, and laypeople. Most often, gifted students are identified as such via scores on various standardized intelligence tests, measures of academic performance (i.e., report cards, aptitude scales), and referrals from educators (McClain & Pfeiffer, 2012). In addition, students who exhibit high achievement and ability in the areas of creativity, leadership, visual or performing arts, psychomotor ability, as well as those with varied talents and multiple intelligences have also been included in the gifted student population. These students are often enrolled in alternative programming with the intention of helping to actualize gifted students’ potential (Martin, Burns & Schonlau, 2010).

Due to the variety of definitions and identification criteria, a heterogeneous population of gifted individuals exist, with differences both within group and between gifted and nongifted populations (Martin, Burns & Schonlau, 2010; Peterson, 2009). This further clouds the understanding of what constitutes giftedness, which is evident when it is a topic of discussion in school districts, individual schools and between educators. There is a general consensus that the gifted population constitutes the top 3% to 5% of the population in at least one domain, most commonly established via an IQ test score, but misidentification and disproportionate enrollment within school-identified gifted programs are likely (Borland, 2009; Warne & Price, 2016).

Advantages and Disadvantages of Giftedness.

The idea of giftedness has been conceptualized as either a blessing or a curse, or both (Martin, Burns & Schonlau, 2010). The work of various scholars, including a groundbreaking longitudinal study of gifted individuals by Terman (1925, 1935, 1947, 1959, as cited in Sears,
1984), have often suggested advanced skills and giftedness can be considered “a key protective factor against the potentially harmful effects of stressful life events” (Martin et al., 2010, p. 31). However, other research suggests that giftedness can conversely be considered a risk factor for psychological distress (Gaesser, 2017).

Dabrowski (1966) suggested people who are gifted exhibit “overexcitabilities” more often than their nongifted peers in one or more of the following domains: psychomotor, intellect, sensations, emotions and imagination (Harrison & Van Haneghan, 2011). In his theory of positive disintegration, Dabrowski proposed that in order for gifted individuals to maximize their strengths, “positive maladjustment” often occurred via emotional turmoil and conflicts within and between one’s psyche and society (Dabrowski, 1966). Furthermore, according to the theory of asynchronous development, gifted children’s psychological capacities often mature at an uneven rate, as cognitive strengths are typically more evident and stronger than one’s socioemotional abilities (Lamont, 2012).

According to Dabrowski (1966), some common traits of the gifted population, including increased excitability, intensity and sensitivity, can be considered either advantageous or deleterious, depending on contexts and circumstances. Most research suggests gifted individuals can have subjectively different experiences than their peers when faced with normal challenges of childhood and adolescence (Peterson, 2009). Furthermore, perfectionism, a common trait amongst gifted individuals, can both positively motivate a student to complete thorough work, while also crippling their ability to manage time and energy effectively (Lamont, 2012). The combination of these complex skills often contributes to variable emotional or behavioral reactions that may deviate from the norm (Peterson, 2009).
A gifted student’s wellbeing, which broadly includes his or her self-concept, self-perception, and abilities to regulate behavior and emotions, can be influenced by a range of factors (Blaas, 2014; Neihart, 1999). Wellbeing is often a function of his or her expression of giftedness (i.e. intellect, creativity) and the degree of giftedness, which is often notated as moderate or high, albeit often arbitrarily defined. The fit of a gifted student within a school, as dictated by the accessibility to proper services, as well as one’s genetic propensities and environmental influences, can also impact one’s functioning in academic and nonacademic tasks (Blaas, 2014). Also, personality characteristics, as theorized by Dabrowski and other scholars, often play a role into how much success a gifted student demonstrates and feels (Karaduman, 2013; Peterson & Lorimer, 2011).

**Mental Health Challenges of Gifted Students**

Many have assumed the socioemotional skills of gifted youth are at least equally well-developed as their advanced talents in academia or other fields (Peterson, 2009). However, much of the current literature base has alluded to the contrary. Gifted individuals often struggle significantly with socioemotional functioning; some common difficulties include social alienation, rigid dispositions that lead to frequent arguments and power struggles, as well as the avoidance of activities that may elicit rejection or failure (Blaas, 2014). In addition, Trail (2010), as well as Lovett and Sparks (2010), suggest between 2% and 7% of gifted individuals have been labeled as twice-exceptional, as they possess a co-occurring learning disability (as cited in McCallum et al., 2013). This parallel circumstance often frustrates students who may be lauded for strengths they exhibit in one or more areas, while struggling to keep up with grade-level peers in another (Missett, 2013; Peterson, 2009).
Martin, Burns and Schonlau (2010) note, “One might hypothesize... that the prevalence of mental health problems would be higher among gifted children who have not been identified or who are not well-served, as a presence of a mental health disorder may mask their identification.” (p. 38). Poor socioemotional wellbeing has been associated with a multitude of negative outcomes, including maladaptive coping strategies, suicidal ideation, mood dysregulation, and sleep and eating concerns (Martin et al., 2010; Peterson, 2009; Peterson & Lorimer, 2011). In addition, if a student does exhibit impairment in his or her socioemotional functioning, it often diminishes the expression of one’s strengths (Blaas, 2014).

Some gifted students struggle with internalizing concerns, like depression and anxiety, that are often hard to pinpoint through overt behavior observation (Blaas, 2014). Others demonstrate emotional and behavioral disturbances externally via opposition to authority, aggression, and attention problems (Peterson, 2009). The identification of children for gifted education can be precluded by the negative attitude educators have about students’ emotional or behavioral difficulties and manifestations, especially those challenges characterized as externalizing (Missett, 2013; Peterson, 2009). As such, gifted students who present with these challenges may not be included in accelerated learning or enrichment opportunities.

**Anxiety within the Gifted Population**

Gifted students often struggle with high levels of anxiety and possess fears and worries to an amplified degree (Harrison & Van Haneghan, 2011). Tippy & Burnham (2009) note that although many identified concerns of gifted students (i.e., the dark, injury, kidnapping, failure in school, imaginary creatures) are very similar to their nongifted peers, gifted youths’ advanced comprehension abilities tend to exacerbate the feelings of nervousness and apprehension, often at an earlier time than peers and with more intensity. Gifted individuals may also struggle more
with existential questions regarding the meaning of life and death or imagine the worst possible situations after assessing the magnitude and potential of dangerous circumstances. These angsts often result in apparent insomnia, as well as fear of the unknown and of the future (Lamont, 2012).

Studies investigating the relationship between anxiety and gifted students have been scant and yielded inconsistent results. Aljughaiman and Tan (2009) discovered statistically significant, above-average ratings of anxiety amongst gifted female students in Saudi Arabia. A study by Tong and Yewchuk (1996) revealed similar results when comparing a group of Canadian male and female gifted students to a control group of nongifted students. Conversely, other studies by Beer (1991) and Merrell, Gill, McFarland and McFarland (1996) showed gifted students experienced typical levels of anxiety.

Maladaptive internalizing behaviors often include elements of concealment, dissociation, and resistance (Aljughaiman & Tan, 2009). Such issues are common among gifted students as they are less likely to express the need for outside assistance when they are distressed, often fearing negative social repercussions. As such, gifted students may not get the support they need to address symptoms of anxiety which have the potential to impair academic performance and socioemotional wellbeing (Jen, 2017).

School-Based Interventions for Elementary Students Who Are Anxious and/or Gifted

The support of gifted students’ socioemotional functioning has unfortunately been overshadowed by education’s focus on academic rigor, despite evidence of a strong correlation between adaptive socioemotional functioning and advanced academic performance (Blaas, 2014). Although there are conflicting reports regarding the cause and effect relationship of socioemotional impairment and academic underachievement, deliberate facilitation of the
development of gifted youth’s socioemotional functioning within the school setting has been largely neglected (Blaas, 2014; Jen, 2017). Schools often struggle to meet the unique, complex socioemotional needs of gifted students who may experience extreme and varied discomfort and distress but are ill-equipped or embarrassed to seek out guidance. Thus, exclusive focus on gifted students’ academic endeavors has the potential to stunt socioemotional asset growth by not preparing students for the various nonacademic challenges they may face during childhood and adolescence (Barnette, 1989; Peterson, 2009).

School-based mental health interventions commonly take place in a multi-tiered system of support framework for both academic and behavioral concerns. Typically, universal supports, including quality instruction and screening efforts, sufficiently meet the needs of about 80% of the student body, while 5% of the population are served through intensive services like individual counseling and behavior intervention plans. The remaining 15% of students are often considered “at risk” for future complications and receive more targeted supports, including group counseling sessions (Messina, Kolbert, Hyatt-Burkhart & Crothers, 2015). Along with other interventions, group counseling is delivered directly by mental health providers in schools, including school psychologists, social workers, and counselors. Referral reasons often include academic, developmental, emotional, and social concerns, all of which may be related to anxiety (Flanagan, Allen & Levine, 2014).

Within a school, counseling efforts are often grounded in cognitive-behavioral therapy (CBT), which considered the gold standard for the treatment of many mental disorders (Santesteban-Echarri et al., 2018). CBT focuses on the dynamic interaction between one’s thoughts, behaviors, and emotions. For treating anxiety, CBT-based counseling efforts aim to "replace maladaptive thoughts and cognitive distortions by promoting coping responses, such as
thought stopping" (Joyce-Beaulieu & Sulkowski, 2015, p. 50). Other CBT techniques, like relaxation training, may also be employed to reduce anxiety and teach applicable coping strategies (Joyce-Beaulieu & Sulkowski, 2015). As a theoretical perspective, CBT is also commonly utilized with gifted students, including when addressing perfectionism and its associated cognitions, feelings, and responses (Kennedy & Farley, 2017). Due to its flexible approach, the provision of school-based CBT has also been shown to be especially effective for elementary populations (Chiu et al., 2013).

Despite the widespread use of psychoeducational and therapeutic interventions in the school setting, there is a dearth of research in this area in regard to gifted populations, with only seventeen empirical studies published between the years of 1984 and 2015 (Jen, 2017). Some valuable information has been gleaned from this small sample of studies, including the usefulness of sharing and exploring internalizing concerns within school-based psychoeducational groups (Peterson, 2008; Peterson & Lorimer, 2011). Direct, rather than indirect affective approaches have been most effective with gifted students, which may be related to the routines of typical American schooling. Students, including those who are gifted, are typically familiar with receiving academic skill instruction in a straightforward, explicit and clear manner; thus, they often feel comfortable articulating socioemotional concerns via psychoeducational group counseling and small group discussion modalities (Peterson, 2009; Jen, 2017). This finding is consistent with prior literature that emphasizes the practicality and positive impact of psychoeducational group work in school settings (DeLucia-Waack, 2000). Gifted students also have favored homogenous groupings with other high-ability students (Jen, 2017). Thus, differentiated teaching of both academic and nonacademic concepts have been well-received by the gifted student population (Peterson, 2009).
Despite these insights, there has been limited study of the implementation of CBT-based interventions with gifted populations in elementary schools. None of the seventeen empirical studies explored by Jen (2017) targeted an elementary-aged gifted student population, despite robust evidence of the effectiveness of early prevention and intervention efforts in mitigating emotional and behavioral problems (Wellisch & Brown, 2012). Furthermore, younger children may be more open to intervention than older students. The one intervention outcome study that included somewhat younger children indicated that gifted fifth graders were more receptive to school-based, small-group affective curriculum than gifted students in the 6th through 8th middle school grades (Peterson and Lorimer, 2011).

Considering the data showing the prevalence of anxiety within elementary schools and the gifted population, further exploration into the use of specific interventions with gifted populations is a worthwhile cause (Jen, 2014). Research shows positive effects of CBT-based counseling with both gifted students and elementary students; yet to date, there has been no evaluation of an empirically-based program implemented with students who possess both of these characteristics concurrently. The present evaluation aims to address this gap in the literature through the evaluation of an empirically-backed psychoeducational program implemented with elementary students who are both anxious and gifted. The rationale behind the program evaluation, based in the work of Maher (1978, 1979), is to inform future decision-making and allocate mental health resources to appropriate student populations and individuals in the school setting.
CHAPTER III
METHOD

Design

The research design for this program evaluation was a mixed method, quasi-experimental, pretest/posttest single case design. Each individual served as its own control through the use of pre-treatment and post-treatment data and no separate comparison group was included. This type of design allows for clearer determination of intervention’s effectiveness on the target population (Cozby & Bates, 2012). The following research question guided this evaluation: “How do the gifted, talented participants of the Brief Coping Cat program perceive their experience in the intervention, and how do they think it influenced their ability to cope with anxiety?”

The rationale behind a mixed method approach is guided by a philosophy of pragmatism, or in the words of Howe (1998), “what works”. Some believe mixed method research offsets the weaknesses of quantitative and qualitative research, as it provides a more complete, thorough explanation of an evaluation. Furthermore, it is suggested that an evaluation’s validity increases when quantitative and qualitative data corroborate. If corroboration does not occur, a mixed method approach encourages the generation of novel hypotheses and instruments (Onwuegbuzie & Johnson, 2006).

Setting & Sample

The setting of the evaluation was an elementary school in a metropolitan area of the western United States. It serves approximately 500 preschool to fifth grade students, and its entire student population identified as 43% white, 28% Latino and 15% African-American. The remaining students identified as Native American, Asian or Multiracial. Approximately 10% of students enrolled at this elementary school qualify for services as English Language Learners.
(ELL) and 15% were considered learning disabled. Forty-four percent of students received free or reduced lunch.

The subjects of focus were four elementary students who were enrolled in the gifted and talented intervention program. The students in the sample ranged from ages 9 to 10. Of the four students, one identified as male, while three identified as female. Two of the four students identified as Asian-American, while the remaining two participants identified as African-American and mixed race, respectively. Written parental consent for participation in the assessments and intervention was received for each student, as well as assent from each participant (see Appendices A and B).

Prior to the start of this evaluation, these students had been previously identified as gifted and talented. Based on a team’s analysis of each individual student’s body of evidence inclusive of qualitative and quantitative data, they were each categorized as gifted and talented within at least one of the state’s designated domains (intellectual, academic, artistic, creative and/or leadership). For about two hours per week, these students participated in a gifted and talented “pull-out” class taught by the gifted and talented teacher. This gifted and talented class was held during the school day but outside the regular classroom setting. This model of a continuum of services is supported by the standards released by the National Association for Gifted Children (1998), along with a gifted teaching model endorsed by the state’s department of education.

The students were referred by their gifted and talented teacher to participate in the intervention. This teacher possessed a title of Gifted Education Specialist, per the state department of education’s endorsement qualifications. At the start of the evaluation, she had been employed in the role at this school for 12 years, and due to the nature of her specialist
position, she had all four students as her pupils for more than two consecutive years. Thus, she had cultivated relationships with her students of multiple years, as well as their families.

The teacher’s reasons for referrals were based on student and parent reports of impairing levels of anxiety, both at school and at home. She also considered anecdotes from the four participants’ current and past general educational teachers about students’ academic functioning being impaired by anxiety. The gifted and talented teacher shared that according to her own impressions, as well as those of parents and students themselves, these students demonstrated profoundly impairing levels of anxiety, particularly around their performance in academic and social settings.

To the teacher’s knowledge, the students had no medical diagnoses (of anxiety disorders or otherwise). Given the privacy safeguards ensured by the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), parents reserve the right to withhold medical diagnoses from their child’s educational records (Bergren, 2004). Thus, it is unknown if any of the students had a formal diagnosis of an anxiety disorder, but the descriptions of the students’ negative effects of anxiety were consistent with some symptomatology of diagnosable anxiety disorders (APA, 2013).

Measures

Progress monitoring measures: Child Outcome Rating Scale (CORS) and the Child Session Rating Scale (CSRS).

The Child Outcome Rating Scale (CORS) and the Child Session Rating Scale (CSRS) client feedback scales, components of the systematic feedback platform Partners for Change Outcome Management System (Duncan, Miller & Sparks, 2003, 2006; Miller et al., 2005) were used to monitor progress. The CORS measures child-reported global psychological distress and
the CSRS measures the child’s impression of the therapeutic relationship. Through its use of child-friendly language and images (i.e., frowning and smiling faces), these inventories take approximately one minute to complete.

The CORS and CSRS have been listed in the National Registry of Evidence-Based Programs and Practices of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and both have adequate psychometric properties (SAMHSA, 2012; Duncan, Sparks, Miller, Bohanske, & Claud, 2006; Cooper, Stewart, Sparks & Bunting, 2013). Research shows that implementing feedback-informed progress monitoring practices reduces deterioration and advises the mental health professional to refine service provision appropriately for students in an effort to meet individual needs (Astramovich & Coker, 2007; Lambert et al., 2003, as reported in Nielson, 2015).

For this evaluation, the frowning and smiling faces from the CORS and CSRS were placed on a 0 to 10 point Likert scale. A point value of 0 was associated with the CORS and CSRS frowning faces, and a point value of 10 was associated with the CORS and CSRS smiling faces. Options between these two extreme ratings were offered in one-point increments. Thus, for each progress monitoring instance, students chose any whole number between zero and ten directly corresponding to the range linking the CORS and CSRS frowning and smiling faces. This was assumed to depict their perception of their own psychological distress (on the CORS) and their impression of the therapeutic relationship (on the CSRS). Lower scores on the CORS and CSRS indicate more psychological distress or a less favorable perception of the therapeutic relationship, while higher scores on the CORS and CSRS suggest less psychological distress and a more favorable perception of the therapeutic relationship.
Outcome measure: Revised Children’s Manifest Anxiety Scale, 2nd Edition (RCMAS-2)

Self-reported levels of anxiety were assessed pre- and post-intervention via the Total Anxiety score on the Revised Children’s Manifest Anxiety Scale, 2nd edition (RCMAS-2), “one of the most widely-used measures in children’s anxiety research” (Reynolds & Reynolds, 2008, p. 3). The RCMAS-2 is a 49-item child self-report inventory assessing the level and nature of anxiety in children from 6 to 19 years old. The measure can be administered in individual or group formats, and children respond to questions with a “yes” or a “no”.

The RCMAS-2 provides an indication of three factors of anxiety. The Physiological Anxiety scale consists of questions about anxiety’s physiological expression, including nausea, headaches or sleep difficulties. The Worry scale asks about obsessive concerns related to nervousness, obsessions and fears. The Social Anxiety scale includes questions about one’s anxiety in social or performance settings. Together, these scales yield a Total Anxiety score. An indication of the validity of the responses is also provided through the Inconsistent Responding Index and Defensiveness scale.

Various reliability and validity studies, including those with ethnically and gender diverse populations, show the RCMAS-2 is psychometrically sound. On the RCMAS-2, T-scores at or below 60 are within the normal range. T-scores between 61 and 70 are considered to be within the moderate/at risk range, while T-scores above 71 are considered as clinically significant. The manual notes that the measure is not meant to be diagnostic, but instead, it should gauge individual’s general anxiety levels for informed placement in appropriate interventions and services (Reynolds & Richmond, 2008).

Outcome measure: Experience of Services Questionnaire (ESQ)
The Experience of Services Questionnaire (ESQ; Attride-Stirling, 2003) is a freely available, short satisfaction measure (see Appendix A). It is designed for use in child healthcare, including mental health care. The ESQ was developed in the United Kingdom, and it is commonly utilized there, as well as in Scandinavia (Brown, Ford, Deighton & Wolpert, 2014). The ESQ has three forms with consistent content; for this evaluation, only the child version for children aged 9-11 was utilized. The ESQ uses pictorial response options (smiling or frowning faces) with direct question that ask respondents’ level of agreement with various statements. Raters note their level of agreement with each of twelve multiple-choice questions with a strong affirmative, weak affirmative or negative response option with score values of 1, 0 and -1, respectively. Any questions answered with a neutral “I don’t know” response are not scored. Thus, total scores on the 12-question ESQ range from 12, indicating strong satisfaction of services, to -12, suggesting strong dissatisfaction of services (Barber, Tischler & Healy, 2006).

In addition to the twelve multiple-choice questions, the ESQ also features three short-answer questions, encouraging students to, in their own words, elaborate upon their likes and dislikes with the service they received. One of the short-answer questions also allowed students to share any other details about the service they received (Brown et al., 2014).

The ESQ is regarded as an instrument that subjectively measures respondents’ satisfaction within two constructs: care (i.e. interactions with service provider, communication, competence, consistency) and environment (i.e. appointment times, location). Investigation into the ESQ’s psychometric properties showed good precision with the items measuring the satisfaction of care construct, while items measuring the satisfaction of environment construct demonstrated less precision (Brown et al., 2014). While further work is needed to explore the
psychometric properties of the ESQ, it shows promise as a “powerful service evaluation tool” (Brown et al., 2014, p. 444).

Given the ESQ is designed for a traditional healthcare setting, rather than a school, the wording of three questions of the ESQ was slightly altered by the independent, unaffiliated assessor prior to the administration of the questionnaire (Brown et al., 2014). For each individual, the assessor handed out the ESQ. Before the student completed it independently, the assessor reference three of the questions and orally told students to consider the words “facilities” and “appointments” as “classroom” and “sessions”, respectively. Even with this tweak in administration, the essence of the ESQ remained unchanged, and all ESQs were administered anonymously and in individual settings. They were also blindly scored by an independent, unaffiliated assessor.

**Qualitative outcome measure: semi-structured child interview**

Upon completion of the program, a semi-structured interview was also conducted with each student individually by the program facilitator. The interview protocol that was used originated from a study with gifted students by Jen, Gentry & Moon (2017) (see Appendix B). Questions adhered to the wording of this protocol and probes or queries were utilized if deemed necessary by the interviewer.

With interviews, respondent bias can be attributed to interviewees providing desirable but inaccurate answers to interview questions in an effort to curry good favor with the interviewer; this could especially be the case if the interviewer was also the service provider. Furthermore, there is an inherent power differential between adults and children, which may be amplified in a therapeutic relationship (Eder & Fingerson, 2002). Thus, this qualitative data should be
interpreted with caution, as it may be somewhat invalid and biased due to the nature of the interviews.

**Procedure**

Before the intervention was implemented, a RCMAS-2 was administered to all students individually. This occurred in order to establish baseline levels of self-reported anxiety before exposure to the intervention. The RCMAS-2s were deidentified and then scored by two, unaffiliated, trained, blind independent assessors in order to lessen bias of the program administrator and to confirm scoring. According to a review by a nationally certified school psychologist unaffiliated with the sample, no elevations on the validity scales were noted. Therefore, it appeared that the RCMAS-2 appeared to be valid reflections of students’ self-reported anxiety symptoms.

Next, participants took part in the intervention facilitated by the school psychology intern, who was a fourth year doctoral student studying school psychology. Before treatment began, the site’s school psychology intern had received training via coursework and field experience in CBT intervention implementation and analysis. Throughout the implementation, the intern received two hours of individual supervision each week with the site’s nationally certified school psychologist, where they reviewed the intervention’s curriculum and discussed progress monitoring. Random observations for treatment integrity were also conducted by the site’s school psychologist, and adherence to the treatment manual averaged 90 to 95%. Student progress was monitored on six instances using the Child Outcome Rating Scale (CORS) and the Child Session Rating Scale (CSRS) (Duncan, Miller & Sparks, 2003, 2006; Miller, Duncan, Sorrell & Brown, 2005).
Upon completion of the 8-week program, students were readministered the RCMAS-2 in order to collect post-treatment information. Again, two, unaffiliated, trained, blind independent assessors scored each protocol in order to lessen bias of the program facilitator and to confirm scoring. The RCMAS-2 scoring was then reviewed and deemed accurate by a nationally certified school psychologist unaffiliated with the sample.

In addition, four weeks after the program had ended, the students completed the Experience of Services Questionnaire (ESQ; Attride-Stirling, 2003) individually and anonymously. Each student also met with the program facilitator individually for a feedback interview to discuss their perception of and satisfaction with the BCC program. Deidentified data linking each individual’s pretreatment and post-treatment data was stored in encrypted formats on a password-protected computer.

**Intervention**

The Brief Coping Cat (BCC) program is a brief Cognitive-Behavioral Therapy (CBT) based therapy for the treatment of childhood anxiety disorders in children ages 7 to 13 (Kendall, Crawley, Benjamin & Mauro, 2013). It is an abbreviated program, derived from Coping Cat (CC), which has demonstrated favorable results (Kendall et al., 2013; Flannery-Schroeder, Choudhury & Kendall, 2015).

Given constraints of real-world practice, the 8-week BCC program was chosen for this evaluation, rather than the 16-week CC program from which it is derived (Kendall & Hedtke, 2006a, 2006b). Various barriers to care, most notably time and few trained providers, often hinder individuals from receiving treatment for their anxiety. Both the BCC and CC programs are designed for implementation within a school; however, abbreviated group programs, such as BCC, allow for mental health providers to render services to more individuals in a shorter period.
of time (Santesteban-Echarri et al., 2018; Kendall et al., 2013). Counseling in small groups also allows the mental health provider to deliver services with both fidelity and flexibility, tailoring service delivery to individual student needs; this approach is explicitly and frequently encouraged in the BCC therapist manual (Ferris, 2017; Harn, Parisi & Stoolmiller, 2013). All student activities were performed as prescribed by the BCC therapist manual (Kendall, Crawley, Benjamin & Mauro, 2013) and student workbook (Kendall, Beidas & Mauro, 2013). The BCC therapist manual also includes two parent meetings, at the start and end of the intervention (Kendall et al., 2013). However, this evaluation did not include the two parent meetings, due to limited parental communication, despite multiple attempts from the program facilitator.

Similar to the 16-week Coping Cat program by Kendall & Hegtke (2006a, 2006b), the BCC program uses the four-step FEAR acronym (Feeling frightened; Expecting bad things to happen; Actions and attitudes that can help, Results and rewards) as an instructional framework (Podell, Mychilyszyn, Edmunds, Puleo & Kendall, 2015). The program consists of eight sessions that integrate behaviors (i.e., exposure tasks, role play activities, practice and reward) and cognitive information-processing factors inherent in associated anxieties (i.e., emotional distress, anticipatory dread) (Kendall & Hegtke, 2006). Emotional understanding and management skills, as well as the impact of social forces, including peers and families, are inherent (Kendall & Hegtke, 2006).

In both the abbreviated BCC and original CC programs, instruction follows a general sequence, although the 8-week program introduces some elements at an accelerated pace (Kendall et al., 2013). Instruction begins with teaching students how to identify feelings and physiological states they experience during anxious situations. Next, the students become aware of their thoughts and beliefs that impact their aroused state. Then sessions integrate exposure
tasks, where anxious self-talk is identified, challenged and modified. Lastly, employed coping efforts are self-evaluated for their efficacy, and students reinforce helpful, adaptive strategies (Kendall & Hedtke, 2006; Podell et al., 2015).

The original 16-week CC intervention has been supported by research, albeit inconsistently. When compared to control groups, students in two studies exposed to the CC treatment self-reported "better outcomes for anxiety measures, fear, perceived ability to cope with most-dreaded situations, frequency of negative thoughts during the past week and depression" (Kendall, 1994, as cited in Promising Practices Network, 2006; Kendall et al., 1997). A later study by Flannery-Schroeder & Kendall (2000) investigated CC in both individual and group program delivery formats, which showed some positive outcomes, including a significant reduction of self-reported trait anxiety. However, no significant differences between the individual and group participants were observed, suggesting a superior program delivery modality does not exist (Flannery-Schroeder & Kendall, 2000). Studies have shown post-treatment gains have been maintained more than 7 years (Kendall, Safford, Flannery-Schoreder & Webb, 2004). The CC program has also earned endorsement from the federal SAMHSA National Registry of Evidence-Based Programs and Practices (2006, 2017).

Although research supporting the 8-week BCC program (Kendall et al., 2013) is less abundant than the original 16-week CC program, favorable results have been observed. The BCC program has been lauded for its more practical application to the school setting, given its shorter duration and opportunities for multiple exposures within the natural context of a school (Crawley et al., 2013). Furthermore, the BCC program still contains what are considered essential, effective therapeutic change mechanisms (i.e. psychoeducation, cognitive restructuring, exposures), while excluding those considered to be less vital, such as relaxation training.
(Hudson, 2005; Crawley et al., 2013). Therapists, as well as participants and their parents, have also favorably reviewed the BCC program, noting its sufficiency and promise (Crawley et al., 2013). The most recent study corroborated these encouraging findings. The study by Santesteban-Echarri et al. (2018) adapted the BCC program to a group setting in the Spanish mental health system. Findings suggested the BCC program is “associated with beneficial treatment outcomes [and] was acceptable and feasible for children with anxiety” (p. 3330).

**Data analysis**

Descriptive statistics of the participants’ self-reported scores on qualitative outcome measures (RCMAS-2 and ESQ) were calculated using the computerized statistical program SPSS. Progress monitoring data of the CORS and CSRS feedback inventories was analyzed and graphed using Microsoft Excel in order to monitor students’ needs and impressions and alter treatment plans as appropriate. Interview data was analyzed via thematic analysis (Braun & Clark, 2006). All four students participated in the intervention in its entirety.
CHAPTER IV

RESULTS

Progress Monitoring: CORS and CSRS

As the intervention progressed, participants reported decreased psychological distress as measured by the CORS (see Figure 1). Lower scores on the CORS indicate more psychological distress, and higher scores on the CORS suggest less psychological distress. As the intervention progressed, the average rating of the CORS increased steadily, from a rating of 8.66 to 9.75 points, out of a possible 10 points.

In addition, participants reported generally favorable impressions of the therapeutic relationship as the intervention progressed, as measured by the CSRS (see Figure 1). Lower scores on the CSRS indicate less favorable impressions of the therapeutic relationship, and higher scores on the CSRS suggest more favorable impressions of the therapeutic relationship. The scores ranged from 7.75 to 9.75 points during the evaluation, out of a possible 10 points.
Figure 1. Mean Child Outcome Rating Scale (CORS) and Child Session Rating Scale (CSRS) ratings by progress monitoring instance.

**Outcome measure: RCMAS-2**

Before and after the intervention, the four participants were each administered the RCMAS-2 by a trained, unaffiliated, independent examiner. Table 1 outlines the results. Notably, only one student’s pre-intervention TOT scale score (T-score = 60) on the RCMAS-2 fell within the at-risk range (T-score between 61 and 70), while no scores recorded were within the clinically significant range.

Table 1

*Descriptive Statistics on the RCMAS-2 Total Anxiety (TOT) scale T-scores as a Function of Participation in the Brief Coping Cat (BCC) program (n=4)*
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Minimum</th>
<th>maximum</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before BCC</td>
<td>38</td>
<td>60</td>
<td>50.75</td>
<td>9.91</td>
</tr>
<tr>
<td>After BCC</td>
<td>37</td>
<td>48</td>
<td>42.25</td>
<td>4.50</td>
</tr>
</tbody>
</table>

*Note: On the RCMAS-2, T-scores of 61-70 are considered at-risk, while T-scores of 70 or more are considered clinically significant.*

As depicted in Table 1, findings yielded a lower mean RCMAS-2 TOT scale T-score after participation in the program, indicating a decrease in raters’ self-reported levels of anxiety on this measure. Furthermore, the maximum score pre-intervention was within the at-risk range, while all RCMAS-2 TOT T-scores were within normal limits. Due to the small sample size which resulted in inadequate statistical power, other statistical analyses were not utilized (Slavin, 2008). However, in this particular case, findings suggest participation in the program may have contributed to a decrease in the RCMAS-2 TOT scale T-scores.

**Outcome measure: ESQ**

At the conclusion of the program, all four students completed the Experience of Services Questionnaire (ESQ; Attride-Stirling, 2003) individually and anonymously. The questionnaires were scored by a trained, independent, unaffiliated evaluator. Scores on the ESQ range from -12 (indicating a very low satisfaction with services) to +12 (indicating a very high satisfaction with services). The mean ESQ score was an 11, indicating an average very high level of satisfaction with the services provided.

**Outcome measure: Semi-structured Interviews**
Students were also individually interviewed by the program facilitator four weeks after 8-week session program ended. Qualitative data was gathered from documented field notes during the interviews, as well as students’ written short-answer, open-response questions on the ESQ, which were completed individually and anonymously. Due to its accessible and flexible application, as well as proper alignment with a pragmatic evaluation approach, thematic analysis of the qualitative data was conducted (Braun & Clark, 2006). The field notes and written responses were coded by the interviewer then categorized within preliminary themes. The following results reflect a series of emerging themes that succinctly represent patterns and commonalities across the corpus of data (Braun & Clark, 2006).

Generally, the participants viewed their participation in the BCC program as encouraging and worthwhile. Not surprisingly, they experienced nervousness about initial participation in the program with an unfamiliar leader; one student said, “I did not know who I would be working with or when or how… my parents just told me someone was going to help me worry less.” However, the worries were coupled with an element of excitement about, as one student shared, “doing something not about reading or math but about me, instead.”

All students reported their anticipatory anxiety quickly subsided once the group started, as they realized that all group members were familiar with one another from previous school years. One student voiced appreciation for “being in a group with other ‘GT’ [gifted and talented] kids, not having to be in the group with strangers… or younger kids who get nervous about things I don’t.” Another noted, “I like that I didn’t have to do it alone, and I could practice with other kids instead of with just a grownup.” When asked how interactions outside of the therapy session changed amongst the group members, students shared that the experience grew and expanded their relationships with one another. It appears that a unique social bond between
these students was enhanced by being in the BCC group together, eliciting a sense of camaraderie.

As for the content of the group, the students shared it was helpful to think about the physiological sensations that can occur before, during or after times of extreme anxiety (e.g., rapid heart rate, sweaty palms, shortness of breath). One student succinctly shared, “I learned more about the clues my body gives me when I worry.” Using physical symptoms to bring attention to corresponding thoughts, students expressed that becoming aware of and changing cognitive self-talk was “a challenge”, but they felt like they had improved in this area since the start of the program. Tapping into the whole-body effects of anxiety seemed to be most identified through the guided or more explicit instruction.

According to the participants, the feature of the BCC program that appeared to resonate the most was the 4-step FEAR plan. Two of the four students expressed relief to have a sequence of steps to follow during times of anxiety, with one participant sharing, “I don’t have to get mad or cry every time I am nervous. I know what I can do to help the bad feelings and thoughts go away.” Another student thought the FEAR plan “was easy to remember, even when I get upset.” Students shared that they felt like the FEAR plan could apply to the many sources of anxiety they currently were experiencing, including academic endeavors (i.e., raising a hand in class), as well as social situation (i.e., getting picked for teams at recess). They also articulated that the combination of role-playing and modeling helped them comprehend the plan better. The ability to easily pull from a mnemonic device like the FEAR plan appeared to be a key tool for thwarting the cycles of anxiety.

The exposures of the BCC program, which constitute the last four weeks, were slightly less favorably received by participants. Rather than using the prompts provided in the workbook
and therapist manual, the students preferred generating their own individualized, hypothetical anxiety-provoking situations. Although the students shared their reactions to different situations, they came to the realization that they were not “the only one who would get super worried.” Furthermore, the students admitted to not liking “homework” (“Show That I Can” tasks); instead, they preferred in-session behavioral rehearsals and exposures. It appears that personal experiences, rather than fabricated, hypothetical scenarios, were most meaningful to these students, as it helped normalize some of these common anxieties.

As the idea of coping with anxiety in day-to-day life became normalized, increased levels of confidence emerged. One student thought behavioral rehearsal with low-level anxiety-provoking situations was “too easy.” Also, student feedback about the structure of the lessons was variable. One student reported the pace of the presented exposure tasks was slower than they would have liked. Yet another student shared appreciation for the pace, noting, “We did not go too fast or too slow… we took everything step-by-step and took our time.”

Logistically, the students shared some disdain for the paper-and-pencil progress monitoring tools that were utilized, with two students suggesting computerized administration. They also shared frustration with the yes/no format of the RCMAS-2 questionnaires, requesting a wider variety of response options. One student suggested having the participants “vote” on the time and day of the sessions, as all were involved in at least one extracurricular activity that occurred outside of the classroom during the school day (i.e., library assistant, technology expert). One student reported, “Sometimes we did not end right on time, which would make me late for my meeting.” This stresses the idea that the facilitator must be conscientious of much more than delivery of content, considering contextually what other factors throughout the process may create anxiety, rather than reduce it.
When asked about their least favorite aspect of the program and what they would change, all students expressed interest in a longer program. One student expressed, “We did not have enough weeks together… we could have practiced more.” When asked the optimal number of weeks, students’ answers ranged from 10 to 18 weeks. This desire for more group sessions reinforces the sense of community and increases in confidence the students gained as a group participant.

Compared to their feelings before the group, students also shared they felt better after the completion of the BCC program. Three students shared that since joining the group, they gained more confidence in social situations, which one hypothesized to be from both listening to and sharing with group members “about feelings, instead of about school stuff.” This suggests that the students placed value upon their participation in the affective intervention, viewing it as a worthwhile, yet meaningful, change of pace. Furthermore, the recognition that others feel the same way reinforced the normalization of anxiety, which promoted the use of the newly acquired skills. Others shared improved stress management and emotional regulation. Two students described “the new tools in their toolbox” helped them demonstrate what they had learned, by applying the FEAR plan when anxiety manifested.

Notably, the students shared they were less anxious after they participated in the group. Students alluded to feeling more empowered and less hindered by their anxiety. When asked to elaborate, one student shared they used FEAR plan strategies when they sensed anxiety manifesting; this made the student feel like they could deal with future anxiety-provoking situations that could have been paralyzing in the past. Furthermore, three students shared they would recommend a friend struggling with anxiety to participate in a BCC group.
CHAPTER V
DISCUSSION

Gifted students show evidence of high potential within the school setting, but their unique socioemotional profiles can include dysregulated emotions, which can negatively overshadow their strengths. Many gifted students experience negative aspects of anxiety, including excessive worry, intense emotionality and irritability (Harrison & Van Haneghan, 2011). While schools have worked to align curriculum to best suit gifted students’ academic endeavors, teaching gifted students to cope with anxiety in healthy ways is a less emphasized practice. This lack of support, coupled with gifted students’ common reluctance to ask for assistance, can cause gifted students to struggle with their anxiety silently and face the possibility of adverse life and academic outcomes (Missett, 2013).

Recent research, albeit scarce, has solely focused on secondary gifted students’ levels of anxiety. While research suggests anxiety is fairly common in a pre-adolescent population, a gap in literature exists in regard to reducing anxiety in elementary, gifted students (Cartwright-Hatton, McNicol & Doubleday, 2006; Jen, 2017). Given the effectiveness of early intervention programs for anxiety, application within an elementary, gifted population is warranted.

This evaluation evaluated the effectiveness of the Brief Coping Cat (BCC), an empirically-based anxiety reduction curriculum with a population of gifted, elementary students. In addition to assessing pre- and post-intervention self-reported levels of anxiety and global psychological distress, the evaluation also examined participants’ impressions of the therapeutic relationship and their satisfaction with the intervention. Some insight and practical implications can be gleaned from this study, but many limitations and future directions are also evident.
Notably, the sample lacked clinically significant levels of anxiety from the start. Thus, the assumption that gifted students possess typical levels of anxiety is corroborated by the work of Beer (1991) and Merrell et al. (1996) and contrary to the findings of Aljughaiman & Tan (2009), as well as Tong & Yewchuk (1996). Regardless, study findings from multiple measures yielded favorable results. After participation in the intervention, students’ self-reported Total Anxiety score as measured by the *Revised Children’s Manifest Anxiety Scale, 2nd Edition* (RCMAS-2; Reynolds & Richmond, 2008) was lower than before the intervention.

Initial progress monitoring suggested rather low levels of global psychological distress and high levels of therapeutic relationship satisfaction. However, continuing progress monitoring data suggests that as the intervention occurred, participants’ reported levels of psychological distress decreased while their impressions of the therapeutic relationship increased. After the intervention concluded, students reported great satisfaction with the services received, as measured by the Experience of Services Questionnaire. This child-reported satisfaction is consistent with the BCC program implementation by Crawley et al. (2012).

In addition, student interviews indicated a positive response to participation in the intervention. Initial excitement and nervousness evolved into engagement, camaraderie, and the deepening of existing friendships. The grouping of gifted individuals together appeared to be positively received, which is consistent with the findings of Jen (2017). Based on the qualitative data, the acquisition of skills (as guided by the FEAR plan), as well as the opportunities to practice their newfound skills, empowered the students to confidently utilize what they had learned. Group members were generally compliant and appeared to be motivated by the content of the program, as well as positive social interactions with the service provider and fellow group members. While some logistical changes were suggested, the participants’ overall impression of
the program showed they desired a deeper, longer, group investigation into anxiety and how to cope with its manifestations.

**Limitations**

When considering the findings of this evaluation, the following limitations should be considered. MoFirst, the small sample size and its subsequent inadequate statistical power, as well as the lack of random assignment and a control group, prevents the results of this evaluation to be extrapolated (Slavin, 2012). However, this evaluation still holds merit due to its primary research objective: to study the effectiveness and outcomes of a single intervention with a unique population (Smith, 2012; Kratochwill & Levin, 2010). Further, as Jen (2017) noted, from 1984 until 2015, no previous studies about affective interventions with gifted populations have occurred within an elementary setting. Therefore, small-N evaluations, such as this one, promote “examinations of phenomena in real-life contexts, shedding light on the underlying mechanisms and providing a rich basis for practitioner knowledge” (Gouvea, 2017, p. 1).

The small sample size is also impacted by the innerworkings of the setting and sample. The gifted and talented program at the site currently serves about 40 students and smaller samples rarely mimic the wealth of characteristics of populations. Given gifted individuals make up a very small subset of the population, it would be difficult to find a plethora of gifted, elementary students with clinical levels of anxiety within a typical public school setting. Additionally, each school experiences its own idiosyncrasies that could have varying levels of effect on program evaluations such as this. These idiosyncrasies include but are not limited to: the protocol for identifying and treating anxiety, methods of qualification for mental health intervention and/or gifted education, underfunding, limited trained personnel and time
constraints. Legal mandates are often left purposefully ambiguous to allow for individualization of student services. However, this ambiguity can also lead to multiple legal interpretations that can further confuse those involved (Sulkowski, Joyce & Storch, 2012).

Although they were referred and consented to the evaluation due to perceived high levels of anxiety, the students who participated in this evaluation presented with subclinical Total Anxiety scale scores on the RCMAS-2, both pre- and post-intervention. Medical diagnoses of anxiety disorder were also unknown. Thus, they did not constitute a sample of students with disordered levels of anxiety. It is possible that their self-reported reduction in anxiety occurred simply due to the passage of time, or their self-reported anxiety was mitigated by psychoeducation alone, rather than modeling, exposures or other program components. Furthermore, gifted students with anxiety concerns often commonly have comorbidities, such as social skill deficits, depression and difficulties with attention, which were not addressed in this evaluation (Beidas, Benjamin, Puleo, Edmunds, & Kendall, 2010).

While the intervention was implemented with hopes of treatment integrity, as with any school-based activity, an approach characterized by “fidelity with flexibility and fit” emerged (Harn, Parisi & Stoolmiller, 2013). Some efforts were made to maintain treatment integrity, but the constraints of real-life practice limited the number of observations and observers. Furthermore, some differentiation in service delivery occurred based on individual student needs, as encouraged by the treatment manual (Ferris, 2013; Kendall et al., 2013). While this approach is aligned with best practices, it also allows for finesse in program implementation; therefore, it is unclear how the variations inherent in differentiated direct instruction affected outcomes. Additionally, this evaluation’s results were very likely impacted by excluding the parent meetings as prescribed by the BCC program. Parental involvement has been shown to increase
interventions’ efficacy and generalizability (Ginsburg, Silverman & Kurtines, 1995, as cited in Beidas et al., 2013). The influence of parent, family and environmental factors can both provoke and reduce feelings of anxiety. Without parental communication, students’ exposure opportunities and/or skill demonstrations in their homes remains unknown.

In addition, using the RCMAS-2 as an outcome measure may have restricted the evaluation’s scope. While it prevents neutrality, the forced-choice format of the RCMAS-2 also does not allow for response distortion based on circumstances, which may be valuable data when determining the manifestations and/or nature of one’s anxiety (Anguiano-Carrasco, MacCann, Geiger, Seybert & Roberts, 2015). Additionally, the RCMAS-2 does not have parent or teacher forms, resulting in limited multirater and interpretive reporting. Also, a second parallel form of the RCMAS-2 does not exist; thus, with only eight weeks between administrations, some testing bias is likely.

Furthermore, the decision to have the students interviewed by the program facilitator was based on student requests, which appeared to be a real-life example of their anxiety at play. Both individually and collectively, each student rejected the idea of being interviewed by an unaffiliated interrogator, citing discomfort with unfamiliar people and the desire for more face time with the service provider, with whom a relationship had grown. However, the qualitative information gleaned from interviews is considered especially illuminating, as individuals can give detailed information about their feelings and opinions in a way that is sometimes imperceptible to quantitative measures (Alshenqeeti, 2014). Thus, the students consented to being interviewed by the service provider with the encouragement to provide both negative and positive feedback, with no repercussions, but the validity of the students’ interview responses may contain some elements of invalidity and/or extrapolation, given the interviewer.
Future Directions

By focusing on a gifted population within an elementary setting, this evaluation paves the way for various future endeavors. Increasing the sample size would increase statistical power and make the results more generalizable. Conducting the evaluation at gifted and talented schools may increase numbers of potential participants who have clinical levels of anxiety, as the setting with other high-achieving students may exacerbate one’s existing anxiety. In addition, evaluating the BCC program with only gifted, elementary students with clinically significant pre-intervention anxiety scores could more clearly explain potential correlations between treatment and outcomes. Furthermore, future evaluations including random sampling, a control group or hybrid grouping (featuring both gifted and nongifted peers) may show significant differences within or between gifted students.

Implementation and evaluation of the 16-week Coping Cat (CC) program with this population, rather than the abbreviated 8-week BCC program could determine if more service time is of greater benefit. Although the present evaluation indicated that participants found the BCC program to be worthwhile and enriching, all mentioned interest in participating in a longer program. This elicits the question whether or not an abbreviated program is appropriate for gifted students who tend to engage in deep thinking and comprehension. The results of a future program evaluation of the 16-week CC program could be an interesting point of comparison. Similarly, Sulkowski, Joyce & Storch (2012) suggest “curtailing the length of… sessions to accommodate a regular school schedule” (p. 924) to determine effects, if any, on outcomes.

Rather than assessing participants’ pre-intervention and post-intervention Total Anxiety scores on the RCMAS-2, looking at the individual factors of anxiety (i.e., physiology, worry, social impact) may allow for a more focused approach to intervention implementation and
evaluation. Furthermore, random assignment of samples may help mitigate the restrictions present due to a single form of the RCMAS-2. In addition, using other outcome measures with both self- and parent-report forms, such as the Multidimensional Anxiety Scale for Children, 2nd Edition (MASC-2; March, 2012), may provide more insight via multirater reports and integrative interpretation (March, Parker, Sullivan, Stallings & Conners, 1997).

The inclusion of other feedback measures may be beneficial in the future (Crawley et al., 2013). While the ESQ rated student satisfaction with the services delivered, it is typically used in healthcare settings; thus, the creation or implementation of a school-based service satisfaction questionnaire should be considered in the future. Furthermore, the supervision of the service provider could be expanded; for instance, videotaping sessions for more than one experienced practitioner to view and discern adherence to treatment manuals may be a worthwhile practice to ensure treatment integrity (Shortt, Barrett & Fox, 2001).

The BCC and CC programs are two examples of empirically-sound, school-based brief cognitive-behavioral intervention designed to reduce anxiety. A detailed, comparative evaluation of these and other programs may elucidate optimal circumstances for each program’s implementation. Herzig-Anderson, Colognori, Fox, Stewart & Warner (2012) report promising results of two school-based programs with elementary-aged students: Cool Kids school version (Misfud & Rapee, 2005) and Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, Langley & Hoover, 2018). Results from these programs’ implementation with gifted, elementary students could expound upon the results of this evaluation.

In addition to holding the prescribed parent meetings, more communication with parents would clarify students’ generalization of skills to the home setting. Parents could collaborate and consult with the service provider in an effort to reinforce the program’s key messages. Also,
future program evaluations could also include meetings with teachers in order to strengthen the connection between home and school. When compared to middle or high school, elementary students typically spend most of their school day with one teacher; thus, classroom teachers are both valuable data sources and influential collaborators in school-based mental health interventions.

Lastly, evaluating the responsivity of affective interventions such as the BCC and CC programs with unique populations is imperative. Gifted students who are also members of ethnic minority groups may present with unique manifestations of anxiety, as they commonly face additional risk factors for underachievement, such as social strains with peers or families, as well as a loss of cultural identity (Blaas, 2014). Results from Crawley et al. (2013) featured a predominantly White sample; other evaluations featuring a large, culturally diverse sample may yield unique findings. Gifted students also commonly possess comorbidities (i.e., social skills or communication deficits, difficulties with attention, depressive behaviors) that play a role in students’ compliance with interventions and the associated outcomes (Beidas et al., 2010). Similarly, gifted students who are considered to be twice-exceptional are also at a higher risk for underachievement and poor socioemotional wellbeing (Blaas, 2014). As evidenced by Santesteban-Echarri et al. (2018), the application of BCC to other cultures appears to be successful (as cited in Piedra & Byoun, 2012). Further investigation is needed to determine how best to intervene with these and other unique subsets of the gifted, elementary population.

Conclusion

The Brief Coping Cat program is considered to be a feasible, effective program for anxiety reduction with gifted, elementary students, as evidenced by the quantitative and qualitative data of this program evaluation. The findings from this evaluation suggest there is
perceived benefit in addressing gifted students’ socioemotional issues through affective interventions, especially when the aim is to decrease one’s level of anxiety and increase one’s confidence in adaptively coping with anxiety. Participants reported that the activities in the program were encouraging and insightful and noted that learning a sequenced coping strategy and practicing it within a safe space was empowering and confidence-building.

Similarly, to the differentiation that is common in gifted classrooms, socioemotional learning programs should be multi-tiered for appropriate implementation with gifted students; Neihart, Reis, Robinson & Moon (2002) offer resources for strategically planning for the implementation of various socioemotional programs, including those centered around anxiety reduction. Furthermore, informing educators about the importance of socioemotional intervention for gifted students is imperative, and even more so in the critical elementary years. While professional development in schools is often focused on gifted students’ academic achievement, the combination of students’ giftedness and socioemotional struggles can lead to underachievement. Therefore, additional program evaluations similar to this one will help fill the literature gap and potentially improve the overall socioemotional wellbeing of the gifted, elementary student population. In conclusion, the results of this evaluation serve as an integral first step towards the implementation of affective intervention with gifted, elementary students who struggle with anxiety.
REFERENCES


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APPENDIX A

Experience of Services Questionnaire (ESQ): Child Version (ages 9-11)

(Brown, Ford, Deighton & Wolpert, 2014)

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the people who saw you listen to you?</td>
<td>Yes, Only a little, Not really, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>Was it easy to talk to the people who saw you?</td>
<td>Yes, Only a little, Not really, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>How were you treated by the people who saw you?</td>
<td>Very well, Ok, Not very well, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>Were your views and worries were taken seriously?</td>
<td>Yes, Only a little, Not really, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>Do you feel that the people here know how to help you?</td>
<td>Yes, A little, Not really, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>Were you given enough explanation about the help available here?</td>
<td>Yes, Only a little, Not really, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>Do you feel that the people here are working together to help you?</td>
<td>Yes, Only a little, Not really, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>The facilities here (like the waiting area) are</td>
<td>Comfortable, Ok, Uncomfortable, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>The time of my appointments was</td>
<td>Convenient, Ok, Not convenient, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>The place where I had my appointments was</td>
<td>Easy to get to, Ok to get to, Hard to get to, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>If a friend needed this sort of help, do you think they should come here?</td>
<td>Yes, Maybe, Not really, Don’t Know</td>
<td></td>
</tr>
<tr>
<td>Has the help you got here been good?</td>
<td>Yes, Only a little, Not really, Don’t Know</td>
<td></td>
</tr>
</tbody>
</table>
What was really good about your care?

Was there anything you didn’t like or anything that needs improving?

Is there anything else you want to tell us about the service you received?
APPENDIX B

Student Interview Protocol

(Jen, Gentry & Moon, 2017)

1. Please tell me about your experiences in the small group discussion.
   Probes: Please describe your experience. How did you feel about being in a small group at the beginning of camp? At the end?

2. Please tell me about your counselor. How would you describe your counselor? Describe him/her as a group leader.
   Probes: What did she/he do when your small group had a discussion? When nobody said anything? When someone dominated the conversation? When someone shared something unique? When someone shared something personal?

3. How would you describe the other students in your small-group discussions?

4. How did your experiences in the small-group discussion influence how you related to the group members outside of the group discussions?
   Probes: (e.g., during activity time, lunch time, challenge-points activities)?

5. What is your opinion about the topics discussed in the small group?
   Probe: How much do they seem to connect (how relevant) to your life?

6. What was a moment in your small group that you will probably remember for a long time?
   Probe: Why?

7. What did you like least about your small-group discussion?
   Probes: What about X did you like the least? What could your counselors have done to make it better?

8. If anything, what did you learn in your small-group discussions?
   Probes: If at all, how might you apply what you learned and experienced to your life? At home? At school? In the future?

9. What do you recommend that we change about the small-group meetings next year?
   Probes: Meeting times? Specific topics?