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CLINICIANS PERSPECTIVES WHEN TREATING ADULTS IN POVERTY LIVING WITH ANXIETY DISORDERS

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LIVING WITH ANXIETY DISORDERS

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A Project

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

Natalie Stout

Paul Henry Maldonado

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Approved by:

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ABSTRACT

The study explored the perceptions of clinical therapists who have conducted treatment on adults who live in poverty with an anxiety related disorder. Previous studies have discussed the relationship between poverty and the development of anxiety related disorders, while others have discussed the negative impacts anxiety can have on physical health, mental health, and social functioning. To improve the efficacy of therapeutic intervention for low income adults with anxiety related disorders, the study explored what clinicians believe are the most effective aspects of therapy to utilize. The study elicited qualitative data, reflecting on the experiences of ten participants who had at least two years of clinical practice with low income adults who suffered from an anxiety disorder. The data was collected through face-to-face interviews, and analyzed the challenges and successes that therapists experienced in their clinical practice. The study found that clinicians viewed cognitive-behavioral approaches as the most effective treatment model when treating this population. The study also revealed that clinical practice experience was perceived to lead to higher rates of positive treatment outcomes. Based on the findings of the study, we recommend that that clinical social workers and agencies continue to utilize and adapt cognitive behavioral approaches when treating low-income adults who suffer from anxiety related disorders.

DEDICATION

From Natalie: First and foremost, I would like to thank my Heavenly Father for giving me strength to complete this journey. Thank you to my mother who has a willing ear to listen and willing shoulder to cry on. You have always been my rock and I will always love you. Thank you to my dad for providing me resources to help me get through grad school and prepare for my future. You've always given so much and I will ever be grateful for that. Thank you to my friend Sarah Allison who gave me weekly advice and encouragement and believed in my abilities. Thank you to Marc Plouffe who saw so much good in me and gave me praise and built me up when I had self-doubt. Lastly, thank you to my Savior Jesus Christ for making it possible to overcome my weaknesses and shortcomings and providing a way for me to progress in life.

From Paul: Getting to this point would not have been possible without the love and support from my family. Thank you dad for being a provider throughout my youth and a mentor throughout my adulthood. Thank you mom for going through the grind first and guiding me through my graduate program. Timothy, thank you for being my emotional support and the best brother that I could ever ask for. Danielle, thank you for being the first sibling to pursue a college degree, and setting a standard for the rest of us. Paloma, thank you for inspiring me, while all of your siblings have grinded through high school and tip toed through college, you have somehow managed to take the most advanced coursed and academically blossom.

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CHAPTER ONE

INTRODUCTION

Problem Statement

   Anxiety is a common feeling that warns people of impending danger and can be a safeguard against harm. Everyone experiences feelings of anxiety throughout their lifetime. For a person with an anxiety disorder, the anxiety does not go away and can get worse over time. The feelings can interfere with daily activities such as job performance, school work, and relationships. "Anxiety disorders share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat" (American Psychiatric Association, 2013, p. 189).

   Anxiety disorders are one of the most common mental disorders experienced by adults in America. According to the National Institute of Mental Health [NIMH], 28.8 % of the adult American population experience an anxiety disorder in their lifetime and 18.1% of the adult American population experience an anxiety disorder for a 12 month period. (2016). Non-Hispanic whites are more likely than other races to experience it and women are more likely than men to experience an anxiety disorder (NIMH, 2016).

   There is a high prevalence of anxiety disorders among adults living in America who live under the poverty line. According to the 2007-2011 US Census Bureau, "14.3% of the US population had income below the poverty level"

(Macartney, Bishaw, & Fontenot, 2013). The highest percentage of people living under the poverty line belongs to minority groups including American Indian and Alaska Native, then black or African American, then Hispanic or Latino. (Macartney, Bishaw, & Fontenot, 2013). Living in poverty is a high risk factor of having an anxiety disorder. Yet, racial and ethnic minorities have less access to mental health services than majority whites. They are less likely to receive the needed care from a mental health facility and when they do, it is more likely to be poor in quality. There is a need for more access to services for people living in poverty and for more effective services and treatment for clients with an anxiety disorder.

In order to provide better clinical treatment for clients with an anxiety disorder living in poverty, more knowledge is needed. There is minimal research that reports the clinicians' perspectives on effective treatment. Clinicians who have more experience providing therapy for adult clients with an anxiety disorder are more likely to know what therapeutic interventions have better client outcomes. By consulting with clinicians about effective aspects of treatment, researchers hope to better establish experienced information in social work practice. This will enable clients to receive a higher level of care and better treatment outcomes.

Policy Context

The treatment and mistreatment of anxiety disorders costs America a lot of money. According to a study commissioned by the Anxiety and Depression

Association of America [ADAA], anxiety disorders cost the U.S. more than $42

billion a year, almost one-third of the country's $148 billion total mental health bill.

More than $22.84 billion of those costs are associated with the repeated use of

health care services. People with an anxiety disorder are three to five times more

likely to go to the doctor and six times more likely to be hospitalized for

psychiatric disorders than those who do not suffer from anxiety disorders. (1999,

p. 1)

A majority of the service populations are of lower economic status and

experience hardships that can lead them to develop symptoms of anxiety.

Therefore, people living in poverty that seek treatment for any illness often use

government funds to do so. Through use of public benefits and government

insurance, adults living in poverty often seek medical and mental health

treatment. Studies have shown that poverty is the leading cause of generalized

anxiety disorder (Tucker, 2012). People with anxiety disorders often seek relief

for symptoms that mimic physical illnesses when mental health treatment would

be more effective.

With all of the information, a policy could be implemented to screen for

mental illness in medical settings to rule out the existence of anxiety disorders. If

an anxiety disorder is present, professionals could refer clients to a mental health

facility for treatment. Through treatment clients could learn to effectively cope

with their triggers and reduce their symptoms. If a mental health disorder is the

primary diagnosis, long-term exposure risks patient's likelihood of recovery. If

clients were screened for mental health symptoms and then referred to the appropriate mental health treatment facilities, then the mental health bill could be more usefully allocated. More programs could be made, therefore serving more of the population in need.

<u>Purpose of the Study</u>

The purpose of the study was to explore the most effective aspects of treatment clinicians employ when working with adult clients with an anxiety disorder living in poverty. Research reports that anxiety disorders are highly treatable and yet only about a third of the amount of people with a disorder receive treatment. Clients who receive treatment generally report positive outcomes resulting in the diminishment of symptoms. Although treatment have expanded from the mental health to the medical field, therapy continues to be an effective long-term treatment for anxiety disorders.

Although there are many therapeutic factors that enhance treatment outcomes, one aspect that rises is the clinical aspects of treatment that enhance client outcomes. For example, some goals of clinicians working with adult clients with an anxiety disorder is to enhance their resiliency, teach effective coping techniques, and help them to function at a normal level again (Panayiotou & Karekla, 2013). Much research has been done on techniques and treatment methods to enhance overall wellness results. By practicing and learning what practices are most effective, clinicians are expert on the subject and have an

educated view. In obtaining experienced clinician's perspectives, the most effective treatment factors can be widely known and used.

Finding and implementing the best intervention is a matter that clients, clinicians, and agencies are concerned with. Clients who struggle with anxiety often have a lot of stress in their life, sometimes due to living circumstances, that prevent them from focusing on treating their anxiety (Panayiotou & Karekla, 2013). This diagnoses can have a tremendous impact on an individual physical and mental health. When a client does seek treatment, they expect the treatment method to be effective and to alleviate their symptoms. If they went to a clinician who wasn't well versed in working with clients with anxiety disorders and therefore didn't know how to treat them, they would lose confidence in being able to seek professional help. This study will provide further evidence of effective treatment techniques that clinicians have implemented in their practice when working with adults with anxiety disorder.

In order to obtain a reliable sample, the method used in this study is a qualitative design. A face-to-face interview will be conducted with 10 clinicians who have over 2 years of experience working with adults with an anxiety disorder living in poverty. The areas to be explored are the clinician's demographics, years of experience with study population, and clinical perspectives on treatment. Availability and snowball sampling was employed in order to obtain the necessary amount of clinicians for the study. Qualitative data analysis will be conducted for the purpose of the study.

<u>Significance of the Study for Social Work</u>

This proposed study intends to contribute to social work practice, policy and research. Findings of the study will benefit the clinicians who work with adult client living in poverty with an anxiety disorder. It will also benefit the clients who receive improved services as a result of the findings. It will provide useful information to clinicians in order to meet the needs of clients now and in the future. Clinicians need to have a good knowledge base of effective methods of treatments in order to competently treat clients and remain employed. In order to provide competent treatment, clinicians need to rely on the strengths and knowledge of others to be effective in their practice. Without this research, clinicians may continue to use methods that don't have the most effective results. Findings of this study will contribute to social work agencies because they want to ensure that their consumers continue to return to their agency. If the clinicians practicing within are unable to successfully treat their clients, the agency loses business and money. Agencies may also lose prestige and go out of business. They must advertise that they have the most current and effective interventions in order to keep their prestige and placement in the community. In order to do that, they must know that the clinicians inside are continuing to educate themselves on the most effective practices in the field.

This study contributes to social work research by adding knowledge on effective treatment aspects that enhance treatment outcomes. This study will contribute to the limited amount of literature already in use. Evidence based

practices continue to enhance the effectiveness of clinician treatment approaches. The more studies that are done on effective treatment methods, the more evidence will be gained and the more the methods will be used by clinicians in treatment. Each clinician may use different approaches and have differing opinions of what is most effective. Having multiple clinicians supporting a few effective intervention ideas provides more concrete evidence.

The findings of this study can change social work practice in general by providing more knowledge of effective treatments for clients living in poverty with an anxiety disorder. If the most effective intervention strategies are known, then clinicians can implement them in their practice. The NASW code of ethics states "Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice" (2008). Research is constantly improving practice methods and if clinicians don't take advantage of the new knowledge, they won't be as effective as they should be. This research will address the clinician's perspective on the most effective elements of treatment for anxiety disorder. In this study, researchers want to find out, according to clinicians, what therapeutic factors are the most effective when working with adult clients in poverty with an anxiety disorder?

CHAPTER TWO

LITERATURE REVIEW

<u>Introduction</u>

This chapter presents literature that relates to clinical factors that affect therapy outcomes when treating anxiety in adults of poverty. The subsections reflect how anxiety impacts the quality of life, the influences of poverty, therapy as an intervention, and. clinical factors influencing efficacy Theories guiding conceptualization are the Ecosystems Theory, Social Learning Theory, and Cognitive Behavioral Theory.

<u>Literature Review</u>

<u>Impacts of Anxiety on Quality of Life</u>. Historically, anxiety symptoms were thought to cause heightened levels of stress that influence satisfaction levels with the quality of life. Through the progression of research, studies have proven that anxiety can diminish the quality of life. This section reviews the impacts anxiety has on mental health, social functioning, and physical health to present the impacts that anxiety has on the quality of life.

<u>Mental Health</u>. In 2005, Rapaport, Clary, Fayyad, & Endicott conducted a study assessing the impacts anxiety had on mental health and the relation it had on the quality of life. To collect data on the perceptions of individuals struggling from anxiety symptoms, the researchers compared two groups (one consisting participants diagnosed with anxiety) using a self-reporting questionnaire. Areas that the questionnaire assessed were perceptions of physical health, mental

health, and social relations. When comparing group scores, the group with diagnosed participants scored lower satisfaction rates of 53% overall compared to the other group that scored 70%. Daily struggles that the data noted were that the diagnosed participants felt more adversity when getting around physically; maintaining mood; family relations; sexual drive, maintaining interests, work, leisure time activities; maintaining economic status; household activities; living/housing situation; and overall sense of well-being". In addition, the diagnosed participants had a higher range of comorbid disorders that were presented in their demographics (major depression, chronic/double depression, panic disorder, PTSD, premenstrual dysphoric disorder, OCD, dysthymia, and social phobia). The study screened and excluded individuals with bipolar disorders, schizophrenia or other psychosis, alcohol or substance abuse or dependence, severe personality disorders, or the presence of significant suicide risk. For participants with mood disorders and PTSD, these individuals showed the most significant impairments across all areas assessed. Participants with social phobia, OCD, and panic disorder showed diminishment in areas of social relationship, family relationship, leisure, and ability to function. Severe impairment varied by disorder: 85% of the subjects with chronic/double major, 63% of the subjects with major depressive disorder, and 59% of the PTSD subjects. Less subjects with panic disorder (20%), social phobia (21%), and OCD (26%) had severe impairments with quality of life. As predicted prior to the data collection, the severity of the symptomatology had a significant impact on the

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quality of life for the participants. However, the study supported that all participants with affective or anxiety disorders had a diminished quality of life in comparison to individuals without a disorder.

Social Function Ability. Exploring the relationship between anxiety disorders and perceived quality of life, further findings indicate that symptoms can have impairments on social functioning. Dryman et al. (2016) wanted to assess how social anxiety disorder SAD impaired social, educational, and occupational abilities of diagnosed individuals. The study consisted of 129 participants recruited by the Adult Anxiety Clinic of Temple University of Philadelphia, who received a primary diagnosis of SAD. About 20% of the participants had a comorbid diagnosis of major depressive disorder (MDD) or dysthymia. Using self-report questionnaires and three scales (Brief Fear of Negative Evaluation Scale (BFNE), the Fear of Positive Evaluation Scale (FPES), and the Quality of Life Inventory (QOLI)) the researchers used responses to assess satisfaction of life quality. Scores indicated a significant variance in the in areas of achievement, personal growth, social functioning, and surroundings. Reflecting on the scores, the participants appeared to have significant difficulty exploring opportunities, relationships, and growth due to fear of being evaluated. Unable to obtain desired social experiences, the participants displayed a diminished satisfaction supporting the researchers' hypothesis of anxiety negatively impacting the quality of life.

Physical Health. In recent studies, anxiety has shown to have negative impacts on mood stabilization. These findings have argued that individuals with anxiety can have a higher risk for health deterioration in the long-term. Iorfino et al. (2016) found that anxiety and mood disorders were significant influences to development of disabilities or even mortality. Assessing the relationship, a review on was conducted on 134 studies to examine impairments anxiety's on young people (ages 12 to 30) and their functional domains. The studies were challenges with clinical syndrome, substance abuse, economic limitations, and self-harmful behaviors that ultimately impacted health outcomes. Participants struggling with clinical syndrome were at higher risk for impairments of cognitive ability, inconsistent sleep, and increased amygdala structure resulting in startled responses. When paired with substance abuse issues in participants showed correlations with impairments in attention, cognition, and reduced function of the frontal/temporal structure. Combined with stressors of economic limitations, participants were at higher risk for hypothalamic-pituitary-adrenal (HPA) dysregulations and poor verbal memory/cognitive flexibility. Participants performing self-harm behaviors had higher correlations of impaired decision making, reduced anterior cingulate cortex function, and HPA dysregulation. Based on the influences of the impaired areas of function, the study demonstrated the impacts of anxiety and mood disorders on physical health.

Influences of Poverty. To enhance the efficacy interventions when treating anxiety in adults of poverty, factors promoting symptomatology and preventing

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positive outcomes must be assessed. In this section, research examining environmental factors that promote onset, prevalence, and diminished social support were assessed.

Assessing how families of the United States react to poverty-related stress, research by Wolf, Santiago, and Wadsworth (2009) found that these circumstances put low income families at risk for developing a range of psychopathology. A sample of 300 individuals (98 families) from community health clinics and Head Start agencies, were assessed for twelve months on their ability to respond and adapt to involuntary circumstances of poverty related stress. Participants lived 150% below the federal poverty line with the mean annual income being $19,386. Data was collected in the form of a questionnaire that was given at the beginning and end of the study, assessing poverty-related stress, involuntary engagement stress response (IESR) levels, and anxiety symptoms and aggression. Results found a significant cross-level interaction between poverty-related stress and IESR levels which indicated that poverty-related stress had a greater impact on the development of anxiety symptoms. Similarly the correlation between poverty-related stress and IESR levels on aggression had a significant effect on older individuals displaying higher levels of aggression. The study's findings indicated that poverty related stress has significant impacts on psychopathology, specifically symptoms of anxiety and aggression regardless of ethnicity. In order to prevent or decrease

symptomatology, the study suggested the increase of interventions at the environmental, psychological, and perhaps even physiological levels.

Palomar-Lever and Victorio-Estrada (2012) found that psychosocial experiences from extreme poverty have significant impacts on emotional stability. Through studying lower economic societies in Mexico, the researchers found that a relationship existed between poverty and the onset of mental health disorders (typically anxiety and depression). Obtaining a sample of 913 participants, 603 from the government social service program opportunities and 310 of their spouses, a survey was used to assess depression, anxiety, optimism, negative self-esteem, stress, loss of control, lack of self-regulation, problem solving, sense of humor, and religiosity impacts on personal well-being. Data took two weeks to collect and was conducted through an interview process at the leisure time of the participants. Results found that 15% of the participants had depression scores of 50 or higher and 10% had anxiety scores above 50. Both cases signified that participants had emotional disturbances with relations to the scores signifying the existence of anxiety or depression. Results also showed that the correlations with gender and self-esteem were important for predicting depression, and stress was the primary factor for anxiety. Overall, Palomar-Lever and Victorio-Estrada found that psychosocial experiences from poverty had significant impacts on the onset of anxiety and depression.

Social support is a tool that is recommended for overcoming the negative impacts anxiety can have on social interactions, mental and physical health. In a

study by Panayiotou, & Karekla (2013) the use of social support was analyzed to see if it could buffer the negative impacts of stress through positive experiences. Recruiting 326 adults who were screened for anxiety disorders and were given a series of questionnaires: Psychiatric Diagnostic Screening Questionnaire (PDSQ), Fear Survey Schedule III (FSS-III), World Health Organization Quality of Life Instrument, Short-Form (WHOQOL-BREF), Perceived Stress Scale (PSS-10), Social Support Questionnaire (SSQ), and Stressful Life Events Scale. Following the first screening, the participants were provided with The Brief-COPE (28-item) to measure of strategies they used to cope with problems and stress. The results showed that participants pursued social support to the degree that they thought it was available. A consistent finding emerged for participants with General Anxiety Disorder demonstrated the lowest scores in QOL, higher scores of perceived stress, experience of stressful life events, depressive symptoms, but the tendency to seek support to cope. However participants with Social Anxiety Disorder less likely to seek social support. Findings indicated that although social support could buffer some effects of anxiety, this was not consistent for those who had negative perceptions of social interactions.

Therapy as an Intervention. Through the years, research has supported the use of CBT as an effective intervention for anxiety. In this section, literature discussing the efficacy CBT to treat anxiety was examined while also assessing how resistance and motivation can also affect treatment outcomes. To enhance the efficacy of clinical interventions, this section also reviews research on the

other studies that discuss alternative factors that have influenced treatment outcomes such as; therapeutic alliance, clinician experience, education, and competency, and clinician burnout. Despite that Cognitive Behavioral Therapy had been proven to be an effective treatment for Generalized Anxiety Disorder (GAD), Leichsenring, Ulrich,Kachele, Kreisch, Ulrich, Winkelback, and Leibing (2009) conducted a study to examine the effectiveness of short term psychodynamic psychotherapy. The study consisted of 56 participants who were diagnosed and screened for any indicators serious mental illness that would exclude them from the study: Schizophrenia, Bipolar, substance dependence, or neurological disorder. Participants were then randomly assigned to one of two groups (CBT or psychodynamic) where they received 30 weekly sessions of treatment with a follow up session (six months later) to assess results. When comparing the measurement results of both groups, neither displayed a significant advantage in treatment efficacy. Measurement tools utilized for anxiety were the Beck Anxiety Inventory and the Hospital Anxiety and Depression Scale anxiety scale and for interpersonal problems were assessed using the (Inventory of Interpersonal Problems). In reflection, no significant differences between the outcomes of the two treatments established short term psychodynamic therapy as an effective treatment for anxiety disorders.

The effectiveness of clinical treatments are based on the prevalence of reducing symptom severity and enhancing long term results. As an individual intervention CBT has been proven to be effective, based on the influence it has

on client's views of their dilemmas. By getting clients to shift of perspective has proven to lead to immediate improvement of symptomatology. To assess the prevalence of sudden improvements, Norton, Klenck, and Barrera (2010) conducted a study to assess the efficacy of Transdiagnostic CBGT with cognitive changes. Their study consisted of two trials, each being assigned a group, and each group being exposed to a transdiagnostic CBGT. There were 130 participants, with 78 placed into one trial and 52 placed in the other. Both trials used the same format of Random/Educational Supportive Treatment. Results showed that 17 clients had sudden improvements, with three of them having two indications of improvements. As expected, clients who had sudden improvements had better outcomes at the end of treatment than those who did not have a sudden improvement.

Resistance to Treatment. Despite that numerous studies have proven CBT to be an effective intervention, client motivation and resistance can ultimately prevent positive outcomes. Research by Hara et al. (2015) assessed the difference in treatment outcomes when integrating motivational interviewing to CBT. The researchers divided two groups and exposed one to the integrated form of CBT. The researchers assessed the anxiety levels of the participants (pre/post) by using the Penn State Worry Questionnaire (PSWQ) and the resistance of clients based on homework compliance and working alliance. When comparing scores, the participants who presented less resistance scored lower on their post PSWQ scores than participants who were less compliant. In

conclusion, the study emphasized "the need to enhance therapists' proficiency in identifying important and often covert in-session clinical phenomena such as the cues reflecting resistance and non-collaboration" (Hara et al., 2015, p 162).

Historically, the therapeutic alliance between the client and clinician has been perceived as an essential influence to the outcomes of treatment. However, previous research does not fully assess what clinical factors strengthen or weaken the alliance which begs for the increase of research in this area. Research by Nissen-Lie et al. (2015) focused on assessing perceptions of the client and therapist using the Work Alliance Inventory (WAI) which rated the clinician's work involvement styles, difficulties in practice, and in session feelings. Though Nissen-Lie et al. (2015) did not find what enhanced therapeutic alliances, they found a correlation between' negative experiences of clients based on the clinician's presentation of stress and anxiety. In conclusion, the researchers found that the clinicians' appearance of stress were mistaken as judgement, and therefore prevented clients from feeling secure their sessions.

To assess the different perspectives of alliance, Zandberg, Laura, and Chu (2015) conducted a study on treating youth with anxiety. The experiment consisted of 62 participants who received 12 Cognitive Behavioral Therapy sessions under 23 psychology doctoral students. The participants were divided into two groups (Ages 13 and older vs Below age 13). After every fourth session, both the clinicians and participants were asked to rate their perspectives on the alliance of their therapeutic relationships. Comparing scores between the age

groups, the younger group showed higher levels of positive alliance scores by the fourth session in comparison to the older group that raised perspective scores by the eighth session. Clinicians perspectives presented lowers scores than the clients of either group. The study concluded that perspectives of alliance are rarely mutual between client and clinician, yet the researchers could not find these differences had on the outcomes of treatment.

As clinical treatments have developed higher efficacy rates, there are questions about what makes each approach more effective than the other. In a study by Mason, Grey, and Veale (2016), the hypothesis was challenged on whether clinical experience as a therapist enhanced the effectiveness of clinical outcomes. The study consisted of 282 participants who were divided into two groups (CBT trained interns and Clinical Psychologists) and all clients were treated with CBT (12 sessions). On a weekly basis, clients were assessed with the Generalized Anxiety Questionnaire (GAD-7) and the Patient Health Questionnaire (PHQ-9). Upon completion of the twelfth session, 216 participants (82.3%) had finished the treatment. neither group had significantly better results in comparison. Hence experience did not play a significant outcome in the effectiveness of treatment outcomes.

In this study, Parker and Waller (2015) postulate that clinicians often overestimate their abilities as more superior than other clinicians. Clinicians tend to have certain biases in regards to their abilities compared to others. This is partially due to an over emphasis of ones abilities while overlooking the abilities

of others. In this study, close to one thousand clinicians where asked to participate in this survey from online databases and workshops. Altogether, they received about 200 responses. The results demonstrated that clinicians typically have unrealistic expectations about how many clients will improve from treatment. In the study by Parker & Waller, (2015) clinicians reported high rates of improvement (58%) from CBT practices for clients who have an anxiety disorder. However, the study demonstrated that "clinicians appear to engage in substantial overestimation of their own and their teams' abilities and have unrealistic beliefs regarding client response to therapy" (Parker & Waller, 2015, p. 663).This is the case regardless of who the clinicians are serving. We expect to find the same kind of over exaggeration in our own study and will recognize that the results will be subjective to the clinician's point of view.

Theories Guiding Conceptualization

Theories guiding conceptualization of the study are the Social Learning Theory and Cognitive Behavioral Theory. In utilization of these theories, a foundation is provided that assists in recognizing and understanding factors that promote/prevent treatment efficacy, promote/and prevent onset of mental health problems, and potentially raise awareness for the need of research.

The Social Learning Theory demonstrates that learning is a cognitive process that takes place in a social context and can occur purely through observation or direct instruction, even in the absence of motor reproduction or direct reinforcement (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2013). In

layman's terms, individuals learn from others. Not only are adult clients with an anxiety disorder learning from the clinician or others in a group therapy sessions, but clinicians learn effective techniques of practice from other expert clinicians. One type of learning that will be used the most is observational learning. This is learning behavior by imitating the actions of one or more other people. As clients imitate clinicians, and clinicians imitate other clinicians, effective treatment will take place.

Reflecting on the Cognitive Behavioral Theory, the use of treatment models, especially psychotherapy and CBT, clients can adapt perspective to change behaviors that can decrease symptoms and promote long-term health. As symptoms lessen, clients are more able to pursue alternative goals that enhance their quality of life and social function ability. In order to have an effect on the client's behavioral change, a systemic approach that cognitive behavioral theory provides is essential (Turner, 2011). By enhancing the knowledge of clinical factors that promote positive treatment outcomes, clinicians can provide treatments that are effective, efficient, and evidence based.

Summary

Studies indicate that poverty places individuals at risk for developing anxiety or symptomatology. Untreated anxiety can lead to impairments of mental health, social functioning, and physical health. However, studies support therapy as an effective intervention for managing symptoms and preventing long-term impairments. Establishing the theories of conceptualization, the study has a

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foundation that assists in recognizing and understanding factors that affect

treatment efficacy, onset of mental health problems, and potentially raise

awareness for the progression of research.

CHAPTER THREE

METHODS

Introduction

       This chapter will discuss the research methods employed in this study. The main sections that will be pressed upon are the study design, sampling methods, data collection and instruments, procedures, protection of human subjects, and qualitative data analysis.

Study Design

       The purpose of this study is to evaluate clinicians' perspectives on the most effective aspects of treatment they employ when engaging in therapy with adult clients with anxiety. It describes what therapeutic factors currently enhance treatment outcomes and explains why they are effective. This study uses a qualitative design for collecting data. In doing so, face-to-face interviews were conducted with ten clinicians with at least two years of experience working with adults diagnosed with an anxiety disorder living in poverty. This design is more effective due to the use of open-ended questions which elicits participant's responses freely and spontaneously. Since data is collected from a smaller sampling population, its findings can't be generalized to a larger population. However, it can be transferable to another setting. The limitations of this study include the possible influence in the outcome of data due to personal biases of researchers. Also, researcher's presence during data gathering can affect the clinician's responses. In doing this study, researchers explore, according to

clinicians, what therapeutic factors are the most effective when working with adult clients in poverty with an anxiety disorder?

<u>Sampling</u>

The study utilized availability and snowball sampling. Due to closeness in proximity to the researchers, participants were recruited within the southern Californian region of San Bernardino county. The researchers recruited subjects from among their professional acquaintances. The sample population consisted of 10 clinicians who provided mental health therapy with clients of poverty with an anxiety disorder. Clinicians in this study were expected to have at least 2 years of clinical experience working with this population. In assessing the clinician's experience, the researchers assessed if there was a relationship between experience and positive treatment outcomes. It is assumed that the longer a clinician has worked with a particular population, the more insight they have into using methods and skills that enhance treatment outcomes.

<u>Data Collection and Instruments</u>

Data was collected through self-administered questionnaires and in person interviews. Information that was intended to be collected were the participant demographics and the open-ended responses regarding the clinical factors. Demographics were obtained through a self-administered questionnaire and included information such as: gender, age, licensure status, field experience, and years of experience with the population. The clinicians' perceptions and experiences were collected using an interview guide constructed by the

researchers. The interview guide contained eleven open-ended questions that were intended to explore clinicians' perspectives on what clinical factors assisted in producing desired outcomes when treating adult clients with anxiety. The interview questions assessed areas such as client traits, clinician traits, rapport components, therapy models, types of resistance, coping methods, and significance of experience. Interview sessions were audio recorded so that data could be transcribed.

Procedures

The study consisted of a recruitment phase, an interview, and a follow up phase. In the recruitment phase, the participants were contacted via text or phone call to determine the location and time to conduct a face to face interview. If participants were not able to meet due to time constraints, a telephonic interview was later scheduled. During the scheduling phase the participants were provided information regarding the nature of the study, the process, purpose of their participation, and the contact information of the researchers and faculty advisor. Upon meeting, the researchers provided informed consent in written form, requested permission to record the session, and documented consent. Interviews were later transcribed for data analysis. Informed consent was collected with the participant signing an "X" for anonymity purposes. The interviews lasted between 20 to 30 minutes and were conducted in places of the participants' choice (private offices, coffee shops, restaurants, etc). Interviews and data collection were conducted, between January 1, 2017 and March 31,

2017. Data was maintained in a password protected computer throughout the study. In conclusion to each interview, the researchers offered the participants the invitation to receive the data results prior to being published. For the participants who were interested in assessing the data results, a follow phase was conducted to deliver the information via email or phone call. In conclusion to the study, all recordings and transcripts were destroyed.

Protection of Human Subjects

Promoting the rights and well-being of the participants was considered at each phase of the study. Questionnaires and interview questions were formulated to respect all cultures and the anonymity of the participants. Demographic questions did not ask for any personal information that risk revealing the identity of the participants (e.g. name, residence, county of employment, or ethnicity). Interview questions did not ask participants for information that may challenge the ethics of their professional duties (e.g. previous employments, personal client information, etc.) and all participants used a pseudo-name to protect their identity during interview audio recordings. Upon first contact, participants were informed about the nature of the study, the purpose of their participation. Prior to data collection, informed consent was provided informing participants of the procedures used to maintain their anonymity, the duration of the interview process, and the lack of risks involved with participating. Participation was regarded as voluntary, and subjects were permitted to terminate at any time with no consequences. Upon the conclusion of

interviews, participants received the contact information of the researchers and the faculty advisors so that any potential concerns can be addressed. Lastly, a follow up phase was be conducted to assess the wellbeing of the participants and reveal data prior to publishing. Lastly, all audio recordings will be destroyed upon conclusion of the study

Data Analysis

The data gathered in this study was analyzed using qualitative methods. All interview sessions were transcribed verbatim from audio tapes. Descriptive statistics were used in order to summarize the data sets. The study used descriptive statistics in order to report descriptive numbers including the mean, median, mode, variance and standard deviation of the data sets. The data was prepared in transcript form with an established plan of analysis. It was then assigned codes and entered into SPSS software. Assessing the differences between participant responses, themes were highlighted in order to interpret theories. Lastly, researchers assessed findings to ensure consistency, control biases, as well as preconceptions in order to establish credibility.

Summary

The research method utilized in the study is a qualitative survey design that is used to assess clinicians' perceptions for clinical factors that enhance treatment outcomes when providing therapy for adults of poverty living with an anxiety disorder. Participants for this study were be recruited within the southern Californian region of San Bernardino County to closeness in proximity to the

researchers. The sample consisted of 10 clinicians who have a minimum of 2 years of clinical practice experience. The participants varied in gender, age, licensure status, field experience, and clinical experience with population. Interview questions focused on areas that enhance treatment outcomes such as client traits, clinician traits, rapport components, therapy models, types of resistance, coping methods, and significance of experience.

CHAPTER FOUR

RESULTS

<u>Introduction</u>

In this chapter, the major findings included the average duration of treatment, client characteristics that predict outcomes, clients coping mechanisms employed, resistance encountered, skills to build a therapeutic alliance, therapeutic models used, theories utilized, significance of clinician's experience, and trainings that enhance clinician's efficacy. Demographics of the participants interviewed in the study will be presented.

<u>Presentation of the Findings</u>

<u>Demographics.</u> The sample population consisted of ten clinicians who had a minimum of experience of two years conducting therapy with adult clients struggling from poverty and an anxiety disorder. Half of the clinicians interviewed were male and half were female. (Age Range). Eight out of ten had their masters of social work degree and the other two were licensed marriage and family therapists. (Licensure). Most of the clinicians had 10-15 years of field experience in general. One clinician had 25 years of experience and one clinician had two years of experience. The average time in the field amongst all of the clinicians was 11.6 years. (Experience with Population)

<u>Approximate Number of Clients and Duration of Treatment.</u> The clinicians had a challenging time estimating how many clients that they served in their career. A couple clinicians ended up not giving a number. One of them reported,

"It's hard to put a specific number to it." The numbers ranged from 50 all the way up to 4000. The most common answer was around 100 clients. The numbers varied depending on the number of years the clinicians worked with this client population.

When asked about the average duration of treatment, the clinicians gave split responses. Four of the ten clinicians reported seeing improvements around six months, for example, one participant stated,

> "To see improvement, each client varied. For the ones who were on the severe spectrum, like PTSD and sometimes possibly generalized anxiety disorder I would say anywhere between six months to about a year; if not that a little bit longer. For those who were on the moderate to mild side of the spectrum, I would say between two to four months to get some relief" (I2, personal interview, February 2017).

On the other hand, three of the ten clinicians reported seeing improvements around a month of treatment. One participant shared,

> "We were supposed to do a dozen sessions, if I had to say an average or a median number, that would be around six (sessions/weeks). Some people drop out, some people completely finished, and some people get slightly better and feel like they were cured then they stopped (treatment)" (I5, personal interview, March 2017).

Three of the other clinician's felt treatment would last about a year or longer. One participant indicated, "In the setting I'm in now, I would say one to three years

should be substantial. In the policy, it states 26 sessions should be enough to implement coping skills for that person to manage independently" (I1, personal interview, February 2017).

Methods for Building Rapport. The clinicians had a lot of insight on methods to build rapport with clients. Although there was a lot of variation, some answers were similar. Many clinicians agreed that there is great importance in normalizing the client's experiences and symptoms, using effective listening skills, get to know the individual, use language that the clients understand, being nonjudgmental, being authentic and genuine with clients, and letting them share their story. Some other answers that were given by at least one of the clinicians include: psychoeducation, being self-aware, being culturally competent, motivational interviewing, ask open ended questions, check on client's emotions, making the clients comfortable by creating a safe comfortable environment. In general, clinicians discussed that there is great importance of establishing rapport with clients with an anxiety disorder in order to effectively conduct therapy.

Characteristics for Predicting Treatment Outcomes. When the clinicians were asked about the client characteristics that predicted treatment outcomes, themes that emerged from their responses were physical health (deterioration vs healthy), insight (knowledge of self, triggers, and emotional awareness), treatment motivation (attendance, use of skills, engagement in sessions, etc.), and resistance (to treatment). Out of the ten participants, six reported motivation

being a significant characteristic for determining treatment outcomes. For example, one participant stated, "Part of their success was due to motivation for treatment and the other part was their openness to talk about their problems" (I2, personal interview, February 2017). Another significant characteristic that emerged was insight (four of ten participant). One participant reported,

> "Having good insights and being able to talk about what's going on, what the anxiety is like, where you are feeling it, and what it feels like when it comes. What seems to make it better, what seems it makes it worse, seems to be what most helpful on getting better" (I1, personal interview, February 2017).

Other characteristics discussed were resistance (two out of ten participants) and physical health (one out of ten participants).

Most Effective Coping Mechanisms. When giving answers about effective coping techniques that clients use, clinician had many different answers. A common theme was relaxation techniques including mindfulness skills, grounding techniques, 5 senses exercises, deep breathing exercises, meditation, guided imagery, and progressive muscle relaxation. Another common theme was self-care activities including being involved in hobbies, listen to uplifting music, being active, meet their basic needs, communicate their needs and engaging in community activities. Some of the varying answers include utilizing their strengths, the serenity prayer, finding replacement behaviors, cognitive restructuring, group therapy, reframing, give clients homework, write journals,

seeking safety, refer to additional services, avoid negative coping mechanisms, recognize riggers, and prepare them for the end of treatment from the beginning.

Resistance and Challenges within Treatment. In asking the participants about resistance and challenges encountered while treating low-income adults with an anxiety disorder, themes of barriers that emerged were distrust, cultural differences, a lack of education, dual relationships, and potentially substance abuse. Though the clinicians' responses were split, majority (seven out of ten) reported that cultural differences between them and their clients seemed to be a significant factor to the occurrence of resistance, "the culture of poverty has a lot of stigma about mental health, not just therapy but medication as well. The stigma is driven from the (client's) desire to not seem crazy (I2, personal interview, February 2017). The three remaining participants gave split responses, one participant felt that lacking of education played a significant factor in resistance, another felt that the dual relationship with their clients (being a case manager and clinician) had a significant impact on resistance, and another felt that substance abuse was also a contributing factor.

Building a Therapeutic Alliance with Clients. To build a therapeutic alliance with clients, clinicians reported utilizing many skills and techniques. Among the list of clinician's answers, none seemed to be the same. The first clinician said to understand their own internal anxiety, utilize their own coping skills, and understand yourself as a person. The next participant discussed utilizing listening skills, repeating back what client says in their terms (reflect feeling, reflect

meaning, set a plan with the clients, using visualization tools. Another clinician

said using case examples to give them examples of what has worked for others.

Another participant added using humor to connect, using basic language,

use cultural competency skills, and providing psychoeducation. Another clinician

discussed having a sense of awareness of the environment that they work in,

and the background and environment that the client comes from. Another

clinician reviews client's chart before sessions and knows as much as they can

about them. Another clinician makes use of personal stories, culturally

awareness. Another clinician emphasized being on the side of the client, meeting

client where they are at, modeling language and behavior. The last clinician

pointed out the use of active listening skills, paying attention to cues amongst

conversation, being authentic, and giving them something to think about at home.

Therapeutic Models. Therapeutic models that the clinicians reported using

in treatment were cognitive behavioral therapy (CBT), dialectical behavioral

therapy (DBT), solutions focused therapy (SFT), narrative therapy (NT),

psychoeducation (PE), and psychodynamic. Majority of clinicians (eight out of

ten) reported significant success using CBT, however, most of the them

additionally incorporated some of the other theories mentioned,

> "My primary modality was to first obtain the client's story by using narrative
>
> therapy. My technique to doing this was by sharing one of my own
>
> personal stories. Then I would use modalities that gave immediate relief
>
> such as CBT and Solutions Focused Therapy. As the client developed

relief of their symptoms I would sometimes then use psychodynamic

(within groups and individual sessions) in order to help the client process

events and feelings" (I3, personal interview, February 2017).

Out of the participants that did not use CBT, one of them utilized SFT while the

other used DBT, "People with depression and anxiety work best DBT not CBT.

CBT gets too much into people's heads and I like to have people become more

in tune with their bodies" (I4, personal interview, February 2017).

Theories Utilized. Many of the clinician's interviewed were not very familiar

with theories and didn't consider them when providing therapy. Many of the

answers they gave were more models of intervention and not theories. Their

answers are theoretically based and therefore valid. Answers included Maslow's

hierarchy of needs, Cognitive theory, Here and now (Present), use of case

examples, Bowen including the use of family tree and timeline, psychodynamic,

Humanistic, Carl Rogers including the use of active listening and client centered

approach, Narrative theory, strengths-based approach, family systems, DBT,

Motivational interviewing, seeking safety, Modular treatment, cognitive behavior,

and solution focused.

Significance of Clinical Practice Experience. When the participants were

asked about how experience has influenced their clinical practice with the

population, the responses they reported were confidence, cultural competence,

and clinical competence (knowledge of interventions and therapy models).

Majority of the clinicians (nine out of ten) reported clinical competence being their

primary area of growth and a significant aid in their ability to serve clients. Half of the clinicians also reported having enhanced feelings of confidence. For example, one participant stated, "spending more time in the field and being exposed to different types of clients, different outcomes, I feel a little more able to modify things" (I3, personal interview, February 2017). Three of the participants reported feeling more culturally competent about their population.

Trainings that Enhance the Efficacy of the Clinicians. In general, the clinicians interviewed highly encouraged taking advantage of any and all trainings available to improve practice skills. The clinicians seemed to mostly name of trainings that they had been to in general and said that they would be effective when working with this population. The trainings that they included were "Why Try" training, DBT training, "seeking safety", CBT training, psychodynamic training, law and ethics training, trainings on theory, training for working with LGBTQ community, cultural competency training, anger management training, domestic violence training, and substance abuse training.

Summary

In summary, this chapter presented the demographics, characteristics, and major findings, regarding the average duration of treatment, client characteristics that predict treatment outcomes, coping mechanisms employed, types of encountered resistance, skills utilized to build a therapeutic alliance, therapeutic models used by clinicians, theories utilized, significance of clinical practice experience, and trainings that enhance clinician's efficacy. All

information was gathered through ten face to face interviews, collecting the

opinions and thoughts, to demonstrate the findings that surfaced.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the major findings presented in chapter 4. The chapter also reflects on the limitations of the study, recommendations for social work practice, policy, and research. The chapter concludes with a summary of findings and what they imply for the Social Work practice.

Discussion

The participants of the study were diverse in terms of gender, age, educational background, field experience, licensure status, and clinical practice experience. The study found that cognitive behavioral therapy (CBT) as a primary therapeutic model was effective when working with adult clients who live in poverty with an anxiety disorder. This finding was consistent with DiMauro, Domingues, Fernandez, and Tolin's study (2013) finding that CBT is an effective therapy model when treating anxiety related disorders. The study focused on exploring the short and long-term gains CBT had on adults suffering from anxiety related disorders. The study consisted of 231 participants who received three or more sessions of CBT. The participants' improvements were measured by using pre and post-tests upon entering treatment, exiting, and a year after completing treatment. The results showed that majority of the participants showed significant improvements ratings and decreased in symptom severity when comparing pre

37

and post test scores. When following up a year later, majority of the participants maintained their post test scores. The study demonstrated that CBT had short and long-term effectiveness when treating adults with anxiety.

The results of the study found that clinical practice experience led to improvements in treatment outcomes due to therapist's development of clinical competence. This finding was consistent with a study finding by Brown, Craske, Glenn, Stein, Sullivan, Sherbourne, and Rose (2013). Their study explored the relationship between CBT outcomes and the developed competence of novice therapists. The study recruited 14 therapists who had not provided psychotherapy before. The therapists were then responsible for providing CBT to recruited participants (n=176) who were suffering from depression and/or anxiety related disorders. Results were gathered by assessing therapist's competence throughout the experiment and measuring the progress of the clients. As the experiment progressed, the therapists demonstrated consistent growth in their competence of CBT. To compare the clients' results, their symptom severity was collected prior to treatment, at the mid phase, and post treatment. As their treatment progressed, the clients demonstrated a decrease in their symptom severity. In conclusion, the researchers found that the more competent the therapists became, the more effective their practice became.

Another significant finding of the study was client characteristics that predict treatment outcome. In this study, the clinicians believed that clients who were motivated and less resistant to treatment were a lot more likely to have

positive treatment outcomes. These findings are consistent with the research by Hera, Westra, Avriam, Button, Constanino and Anthony (2015). Their study assessed the difference in treatment outcomes when integrating motivational interviewing to CBT. The researchers divided two groups and exposed one to the integrated form of CBT. The researchers assessed the anxiety levels of the participants (pre/post) by using the Penn State Worry Questionnaire (PSWQ) and the resistance of clients based on homework compliance and working alliance. When comparing scores, the participants who presented less resistance scored lower on their post PSWQ scores than participants who were less compliant. In conclusion the study emphasized "the need to enhance therapists' proficiency in identifying important and often covert in-session clinical phenomena such as the cues reflecting resistance and non-collaboration" (Hara et al., 2015, p 162).

Another important finding was the importance of building a therapeutic alliance. Historically, the therapeutic alliance between clinician and client was perceived as an essential aspect of treatment. In a study done by Nissen-Lie, Havik, Hogeland, Ronnestad and Monsen (2015) they focused on assessing perceptions of the client and therapist using the Work Alliance Inventory (WAI) which rated the clinician's work involvement styles, difficulties in practice, and in session feelings. They found that if the client felt judged by clinicians and didn't build a secure alliance, then clients felt less secure during sessions and had more negative treatment outcomes.

<u>Limitations</u>

Limitations of the study include the small sample size of ten clinicians who conducted therapy in specific agencies within the Riverside and San Bernardino County regions, which may not be consistent with perceptions of clinicians from other counties or agencies. Another limitation that may have affected the study was the lack of diversity in the educational backgrounds of the participants. With most of the participants having a masters in social work, the study was limited to the effective aspects that clinicians with a social work background utilize. Lastly, the time restraints between the researchers and the participants may also had an effect on the findings. Most of the clinicians had to meet the researchers after their work hours. Due to the rush of the interview process, most of the clinicians had little time to reflect on their clinical practice prior to the interview.

<u>Recommendations for Social Work Practice, Policy, and Research</u>

Reflecting on the findings, CBT is an effective therapy model for treating adults with an anxiety related disorder. Though clinical practice is something that develops with time, clinicians can make up for this by receiving training and developing their knowledge of CBT interventions. To promote this on a micro level, it important for future clinical social workers to utilize supervision, literature, and practice to refine their competence of CBT when providing therapeutic interventions with this population. To promote this recommendation on a macro level, mental health agencies that provide services to low income adults should strive to provide additional training and education for their clinical staff.

Another recommendation for micro social work is emphasizing the importance of building a therapeutic alliance with the client. In order to ensure that this is enacted, trainings and policies can be created and utilized to ensure that the clinicians are giving enough time and attention to this aspect of treatment. Since it is known how important building a therapeutic alliance is, more research should be done on the most effective methods of building a therapeutic alliance with clients from this population. By building a therapeutic alliance between clinicians and client's, clients are more likely to have positive treatment outcomes and more likely to show up for therapy.

Conclusions

The study examined the most effective treatment model clinician's use when treating this population, how clinical practice experience led to improvements in treatment outcomes, client characteristics that lead to positive treatment outcomes, and the importance of building a therapeutic alliance. This chapter discussed the limitations of the study including a small sample size, lack of clinical diversity, and time constraints in the interview process. This chapter discussed the recommendations for social work practice, policy and research including more use of Cognitive behavioral therapy to treat adult clients living in poverty with an anxiety disorder and emphasizes the importance of building a therapeutic alliance when working with this population.

APPENDIX A

INFORMED CONSENT

College of Social and Behavioral Sciences
School of Social Work

INFORMED CONSENT

The study in which you are asked to participate is designed to explore the most effective aspects of treatment clinicians employ while conducting therapy with adult clients with an anxiety disorder living in poverty. The study is being conducted by Natalie Stout and Paul Maldonado, MSW students, under the supervision of Dr. Janet Chang, Professor in the School of Social Work, California State University, San Bernardino. The study has been approved by the Institutional Review Board Social Work Sub-committee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to explore aspects of treatment clinicians employ when conducting therapy with adult clients with an anxiety disorder living in poverty.

DESCRIPTION: Participants will be asked questions about their perspectives on effective treatment and some demographic variables.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY OR ANONYMITY: Your responses will remain anonymous and data will be reported in group form only.

DURATION: It will take 30 to 45 minutes to complete the interview.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There will not be any direct benefits to the participants.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Janet Chang at 909-537-5184.

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks (http://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after December 2017.

This is to certify that I read the above and I am 18 years or older.

_____   _____
Place an X mark here   Date

I consent to having the interview audio tape recorded   _____   _____
                                                                            Yes   No

APPENDIX B

QUESTIONNAIRE

QUESTIONNAIRE

1) What is the average duration of treatment when working with a client who has an anxiety disorder living in poverty?

2) What methods are effective when building rapport with clients with an anxiety disorder living in poverty?

3) What client characteristics are important in predicting outcomes in treatment?

4) What coping mechanisms did your clients find most effective? Were there any modifications that you personally added to engage them?

5) What types of resistance have you encountered when treating adults of poverty? Which provided the most challenge?

6) What traits, skills, or methods helped you as a clinician when building a therapeutic alliance with clients of this population?

7) What therapeutic models did you typically formulate your treatment around? Or what combination of theories did utilize and why do you think they were effective?

8) What significance does experience have in your clinical practice with this population?

9) Are there any types of trainings that can enhance the efficacy of new clinicians who work with this population?

Developed by Natalie Stout and Paul Henry Maldonado

APPENDIX C

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

This study you have just completed was designed to explore the most effective

aspects of treatment clinicians employ when conducting therapy with adult clients

with an anxiety disorder living in poverty. We are interested in your perspective

and wanted to inform you that no deception is involved in this study.

Thank you for your participation. If you have any questions about the study,

please feel free to contact Dr. Janet Chang at 909-537-5184. If you would like to

obtain a copy of the group results of this study, please contact Dr. Janet Chang

(email: jchang@csusb.edu) after December 2017.

APPENDIX D

DEMOGRAPHICS

DEMOGRAPHICS

Gender

( ) Female   ( ) Male

2) Age

( ) 20-25   ( ) 26-30   ( ) 31 to 35

( ) 36 to 40   ( ) 41 to 45   ( ) 46 and above

3) Educational Background

( ) Master of Social Work   ( ) Marriage and Family Therapist

( ) Psychologist   ( ) Professional Clinical Counselor

( ) Other: Specify_____

4) Licensure Status

( ) Licensed   ( ) Pre-License

5) Field experience _____ years

6) Years of experience conducting therapy with adult

clients living in poverty with an anxiety disorder? _____ years. (Must be at

least 2)

Developed by Natalie Stout and Paul Henry Maldonado

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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

   Team Effort: Natalie Stout and Paul Maldonado

2. Data Entry and Analysis:

   Team Effort: Natalie Stout and Paul Maldonado

3. Writing Report and Presentation of Findings:

   a. Introduction and Literature

      Team Effort: Natalie Stout and Paul Maldonado

   b. Methods

      Team Effort: Natalie Stout and Paul Maldonado

   c. Results

      Team Effort: Natalie Stout and Paul Maldonado

   d. Discussion

      Team Effort: Natalie Stout and Paul Maldonado