

The Development of an Anxiety Prevention Intervention for School-Aged Urban Adolescents using Participatory Methods

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Abstract

Youth of color, particularly in urban communities, face disproportionate anxiety levels due to systemic inequities, including exposure to violence, economic instability, and neighborhood disadvantage. Despite increased need, these communities often lack accessible, culturally relevant mental health interventions. This study presents a protocol for a community-driven anxiety prevention intervention tailored to urban youth of color using community-based participatory research (CBPR) methods. The intervention, co-developed with community partners and youth includes five structured weekly sessions on psychoeducation, coping skills, and role-playing exercises. Facilitators trained in social work or psychology will deliver the intervention, with at least one facilitator from the target community ensuring cultural relevance. Recruitment will occur through collaboration with a local high school, with counselors identifying high-risk youth. Data from pilot interventional trial will be collected at baseline, post-intervention, and a three-month follow-up using validated measures such as the Generalized Anxiety Disorder-7 (GAD-7) scale. This study highlights community-based participatory research approach in addressing mental health disparities among urban youth. By incorporating community perspectives, the intervention ensures cultural alignment. Findings will inform future adaptations of community centered anxiety interventions and contribute to knowledge on improving mental health accessibility for marginalized youth. If effective, this model could be expanded to support youth in other under-resourced communities.

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Original Manuscript

The Development of an Anxiety Prevention Intervention for School-Aged Urban Adolescents using Participatory Methods

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Abstract

Youth of color, particularly in urban communities, face disproportionate anxiety levels due to systemic inequities, including exposure to violence, economic instability, and neighborhood disadvantage. Despite increased need, these communities often lack accessible, culturally relevant mental health interventions. This study presents a protocol for a community-driven anxiety prevention intervention tailored to urban youth of color using community-based participatory research (CBPR) methods. The intervention, co-developed with community partners and youth includes five structured weekly sessions on psychoeducation, coping skills, and role-playing exercises. Facilitators trained in social work or psychology will deliver the intervention, with at least one facilitator from the target community ensuring cultural relevance. Recruitment will occur through collaboration with a local high school, with counselors identifying high-risk youth. Data from pilot interventional trial will be collected at baseline, post-intervention, and a three-month follow-up using validated measures such as the Generalized Anxiety Disorder-7 (GAD-7) scale. This study highlights community-based participatory research approach in addressing mental health disparities among urban youth. By incorporating community perspectives, the intervention ensures cultural alignment. Findings will inform future adaptations of community centered anxiety interventions and contribute to knowledge on improving mental health accessibility for marginalized youth. If effective, this model could be expanded to support youth in other under-resourced communities.

Keywords: Mental Health, Urban, Prevention, Community

Background

In the U.S., anxiety among youth has continued to steadily rise over the past few years (1). Findings from the National Survey of Children's Health showed a 27% increase in anxiety from

2016 to 2019 and by 2020, 5.6 million children had been diagnosed with anxiety problems (1). Increased anxiety among youth of color have also been observed over the past few years (2; 3). For example, in a longitudinal study conducted by Louie and Wheaton (2018), three distinct birth cohorts were used to assess for black-white differences in mental disorders across cohorts (2). Findings from this study revealed that the lifetime prevalence of anxiety disorders doubled from the oldest cohort (adults born between 1957-1969) to the youngest cohort (adolescents born between 1983-1991), increasing from 16.3% to 33.4% (2). Additionally, the size of the increase in anxiety disorders among blacks overall exceeded the rate seen for whites over the same period (17.1% for blacks vs. 4.5% for whites) (2). Moreover, data from the National Comorbidity Survey, which assessed for lifetime prevalence of mood/anxiety disorders among English-speaking households, revealed that Hispanic/Latinx youth were at the highest risk for mood/anxiety disorders compared to non-Hispanic White adolescents (3). Besides disparities across racial/ethnic groups, adolescents from low-income households are at higher risk for anxiety compared to their peers from high-income households. (4, 5)

Various social determinants of health may explain why anxiety is one of the most common mental health problems among low-income youth and youth of color. These factors may include systemic racism, discrimination, and limited access to adequate housing (4, 6). However, while there may be many factors that play a role in the development of anxiety symptoms among adolescents, research has shown that increased rates of mental health issues, specifically among urban youth are significantly related to the environment in which they live in and neighborhood disadvantage (7). Characteristics of the urban environment, such as community violence, gang activity, substance use, and poverty, disproportionately affect urban youth of color and increase their exposure to potentially traumatic events such as incidents related to community-level violence (6). This type of trauma exposure has been linked to the development of depression, anxiety, and early age substance use. Similarly, neighborhood disadvantage consisting of limited resources, lack of safety, sub-par

housing, and unemployment have also been associated with anxiety among urban youth (5,7). As evidenced, due to the amount of stressors youth of color are exposed to in urban communities, anxiety among this population is a significant public health problem and the lack of resources in these communities exacerbates these issues. Under-resourced urban communities are in dire need of service and programs that can improve school climates and the overall mental health of the youth living in these communities. As youth spend approximately one-third of their early developmental years within an academic setting, schools have been identified as effective sites for the implementation of mental health programming (8, 9). Due to being such key places for youth, school-based interventions have the opportunity of reaching youth who may have been previously unidentified or untreated (10). Compared to community-based mental health clinics and primary care settings, delivering interventions in school settings addresses some of the many barriers faced by urban youth in under-resourced communities such as removing the need for travel, unfamiliarity, cost, and time (11).

Therefore, the purpose of this school-based community-specific anxiety intervention program was to co-create an anxiety intervention program for urban youth of color with help of the community leaders who have had experience in working directly with youth from this community. More specifically, the primary aims of this intervention are to: 1) Increase participants' knowledge and understanding of anxiety, including its causes, symptoms, and physiological effects; 2) Reduce stigma by normalizing conversations around anxiety and seeking different levels of help (e.g., peer support, spiritual support, talking to a trusted adult, therapy); 3) Increase participant's confidence in managing their anxiety by equipping them with practical coping skills to navigate stressors in their daily lives.

Community-Based Participatory Research (CBPR) can be utilized as a critical approach in the development and implementation of mental health interventions, particularly in urban communities as it is essential that these programs and interventions incorporate the voices of those

living in these communities (12). Researchers agree that the insight that is gained from receiving direct feedback from community members enhances the researchers' understanding about the problems affecting the community, while also building on the strengths of the community. CBPR engages community members as equal partners throughout the research process, ensuring that interventions are culturally relevant, contextually appropriate, and responsive to the specific needs of the population (12). This collaborative methodology has proven effective in addressing systemic issues that contribute to mental health disparities, such as poverty, exposure to violence, and inadequate access to healthcare services (13). Furthermore, CBPR fosters trust between academic researchers and historically marginalized communities, promoting the sustainability of mental health programs and enhancing their real-world impact (14).

Several studies have demonstrated the success of participatory approaches in mental health interventions, particularly those addressing anxiety and other common mental disorders. One such example is the Friendship Bench intervention in Zimbabwe, which trained community health workers—locally known as "grandmothers"—to provide structured problem-solving therapy to individuals with common mental disorders (15). A randomized controlled trial found significant improvements in mental health outcomes, highlighting the efficacy of culturally embedded, community-led interventions. By leveraging local expertise and fostering collaborative partnerships, CBPR enables the development of sustainable, culturally responsive, and impactful solutions to mental health challenges, particularly among populations with limited access to traditional healthcare services. Expanding the use of CBPR in mental health research and practice is essential for addressing the multifaceted nature of anxiety and other mental health disorders in urban communities.

Youth advisory boards, composed of young individuals with diverse perspectives, play a pivotal role in ensuring that interventions are youth-centered, engaging, and accessible. In recent years, research has shown the importance of including youth feedback in the development of mental

health interventions for youth (16). It has been shown that the use of youth advisory boards helps to ensure that youth voices are heard within systems and helps to identify youth priorities related to mental health needs and issues (17). Research also demonstrates that the use of youth participatory methods is helpful in obtaining meaningful insight from youth, engages them in the research process, and therefore empowers youth to be co-participants in problem solving (18). On a larger scale, including youth participation in research can also lead to more effective community-level policies that directly improve health outcomes and quality of life of this population (19). By actively participating in the co-design process, youth advisory board members provide valuable insights into the language, delivery methods, and intervention components that resonate with their peers. Their involvement fosters a sense of ownership and empowerment, increasing the likelihood of program uptake and success.

Pertaining to youth mental health outcomes, engaging community members and youth advisory boards is crucial in developing effective interventions for young people, particularly in addressing mental health challenges such as anxiety. Community members offer invaluable insights into local needs, cultural dynamics, and systemic barriers that can influence the implementation and sustainability of interventions (19). Their lived experiences help shape programs that are contextually relevant and responsive to the specific challenges faced by youth in their communities.

Purpose of study

We present a protocol for a pilot feasibility trial of a community-based anxiety psychoeducational intervention designed to alleviate anxiety symptoms among Paterson youth living in an urban environment. This curriculum was developed through a collaborative partnership with a licensed clinical social worker who was born and raised in Paterson, ensuring that the intervention is both culturally relevant and grounded in the lived experiences of the community. Recognizing the unique stressors faced by youth in urban settings, including exposure to community violence, economic instability, and limited access to mental health resources, this program integrates evidence-

based anxiety prevention strategies with community knowledge and strengths. The curriculum is designed to be interactive, incorporating cognitive-behavioral techniques, mindfulness practices, and resilience-building exercises tailored to the realities of young people in Paterson. By centering local expertise and youth voices, this intervention seeks to empower participants with the tools needed to manage stress, build emotional resilience, and improve overall mental well-being, while fostering a sense of community support and engagement.

3. Methods

Study Overview

Theoretical Framework. The intervention is grounded in the principles of Cognitive Behavioral Therapy (CBT), a well-established evidence-based approach that targets maladaptive thoughts and behaviors to improve mental health outcomes (20). Given the unique needs of urban youth, adaptations of how CBT will be delivered have been developed to enhance its cultural relevance and effectiveness. Research has demonstrated that culturally tailored CBT interventions for urban youth populations incorporate contextual stressors such as systemic inequities, racial discrimination, and community violence, making the approach more applicable and impactful for these communities (21). Additionally, our intervention integrates principles from Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which has been shown to be effective in addressing trauma-related symptoms among youth who have experienced adversity (22). By incorporating such frameworks alongside trauma-informed strategies, our approach aims to provide a comprehensive and culturally responsive intervention for urban youth facing multiple forms of psychosocial stressors.

The curriculum consists of five, weekly group, one-hour sessions to teach practical skills to help adolescents manage anxiety. The intervention leverages core Cognitive Behavioral Therapy (CBT) principles aimed at increasing psychoeducation, and altering maladaptive emotional responses by changing youth's thought, behaviors or both (20). Using a CBT framework, our intervention

strategies underscore that fact that once an individual is aware that they are experiencing anxiety, they can take the next steps toward managing it effectively. This may involve problem solving, cognitive structuring, practicing coping skills, exploring new strategies, or, if necessary, seeking professional support when alternative strategies are unsuccessful.

The intervention will be facilitated by licensed clinical social worker, a license-eligible social worker and license-eligible clinical psychologist trained in delivery of the treatment protocols. While there are no control conditions, as the intervention will run over multiple iterations, a staggered start design will be used to account for potential difference in groups. A staggered start design is a phased implementation approach that allows for iterative assessment and refinement of an intervention before full-scale delivery. In our study, this design involves initiating the intervention with two initial cohorts, each consisting of 8–10 youth stratified by gender (male and female). These first cohorts will complete sessions 1–5 while facilitators document process implementation using fidelity assessment tools. This approach enables real-time evaluation of intervention delivery, facilitator adherence, and participant engagement, allowing for any necessary refinements before subsequent cohorts are enrolled. Following the completion of the initial cohorts, an additional two cohorts will be recruited, with this process continuing until we reach our target enrollment of 30–50 youth.

Supervision will be provided by a licensed clinical social worker who is deeply familiar with the community and was instrumental in the development of the intervention. External review of fidelity and intervention outcomes will be reviewed by the study PI and a licensed child psychiatrist who is on the study team. In addition to clinical outcomes fidelity to curriculum sessions will be recorded for future quality improvement.

Study Setting

The study will be conducted in Paterson, New Jersey, is an urban community with a population of approximately 157,864 residents, with children and youth under 18 years old comprising about 27% of the population. The city faces significant socioeconomic challenges,

including a poverty rate of 23.5%, more than double the state average of 9.7%. These economic hardships contribute to increased mental health concerns among residents, particularly youth, highlighting the urgent need for targeted mental health interventions. The study's Principal Investigator has worked with the community for almost a decade and leads multiple NIH funded studies centered in this community, including a five-year NIH funded grant, The Paterson Prevention Project, which examines the impact of neighborhoods on youth substance use and mental health in the city (23). Using, previous published research from work conducted in the target community (24), and using a community-based participatory approach, the study has identified anxiety as a critical concern among Paterson's youth. Addressing anxiety through targeted interventions has emerged as a crucial step in improving mental health access and outcomes in this underserved community.

Development of the intervention and co-design with community partners

The development of the intervention was a collaborative and community-engaged process that underscores the importance of co-designing with trusted community partners to enhance feasibility, cultural relevance, and sustainability. The initial intervention framework was developed by C.P., a licensed clinical social worker and a longstanding, trusted partner of The Paterson Prevention Project. Through her active participation in research activities, including data collection and engagement with youth, C.P. identified a critical need for anxiety prevention resources and independently initiated an informal intervention at a local high school.

Recognizing the potential impact of this work, C.P. partnered with The Paterson Prevention Project Principal Investigator (IO) and research team to refine and formalize the intervention. This collaboration ensured that the intervention was not only informed by community insights but also grounded in evidence-based strategies. By integrating research-driven methodologies with the lived experiences and firsthand observations of a community-based practitioner, the intervention was strengthened in its feasibility, acceptability, and potential for scalability.

Co-designing interventions with community partners like C.P. facilitates the integration of

scientific rigor with practical, real-world application, increasing the likelihood of successful implementation and long-term sustainability. This approach aligns with participatory research principles, which emphasize the value of local expertise in shaping interventions that are responsive to community needs. Through this iterative process, the intervention was refined to balance evidence-based strategies with culturally and contextually relevant components, ensuring it could be effectively scaled and sustained within the community.

The intervention materials for the curriculum were developed by CP, BDB and IO in collaboration with youth advisory board members of The Paterson Prevention Project. Research staff was instrumental in the development of graphics and curriculum structure (SJ, CM, HV), accuracy of session topics and strategies were reviewed for accuracy by a licensed child psychiatrist on the team (KA) and psychologists in training (PT, RR). In addition, the Paterson Prevention Project youth advisory board which consists of 8 teens and young adults that all live in Paterson, were instrumental in reviewing materials with research staff during biweekly meetings over the course of two years. All research activities including the development of sessions and evaluation materials were supervised and approved by the principal investigator (IO). Focus groups and individual interviews were also conducted with youth led by the study team to aid the development of the program.

Theater Testing

Theater testing is a critical step in the development and refinement of an intervention, allowing facilitators to practice the delivery of the curriculum with a small group before full-scale implementation. This process helps identify strengths, areas for improvement, and any logistical or content-related challenges that may arise. By running the intervention in a controlled environment with a representative sample, facilitators can assess whether the activities, discussions, and pacing are engaging and effective for participants. Research supports the use of pilot or feasibility testing in intervention development, as it provides essential feedback to refine content, delivery style, and overall structure, ensuring that the program is both evidence-based and practical for real-world

application (25). Additionally, theater testing allows facilitators to become more comfortable with the material, enhancing their ability to deliver sessions with confidence and consistency (26).

In February 2025, the study team conducted a theater test of the intervention with five members of our Youth Advisory Board during an eight-hour session in Paterson, New Jersey. The facilitators led participants through the full intervention while a designated study team member took notes on participant engagement, clarity of instructions, and areas needing improvement. After completing the session, the study team convened to discuss feedback and make necessary revisions to the curriculum. Additionally, a follow-up meeting was held with the Principal Investigator to review the final adjustments before moving forward with pilot testing. This iterative process ensures that the intervention is responsive to the needs of the target population, aligns with best practices in youth mental health programming, and is optimized for successful implementation.

Intervention

The intervention consists of a series of five structured sessions designed to enhance participants' understanding of anxiety, its impact, and effective management strategies. Beginning with an introduction to anxiety and its role in stress response, participants engage in discussions and activities that promote awareness and recognition of anxiety symptoms. Subsequent sessions focus on identifying patterns of anxiety, differentiating between adaptive and maladaptive responses, and introducing evidence-based coping strategies, including mindfulness techniques, cognitive reframing, and behavioral interventions. Interactive exercises, such as role-playing, provide opportunities to apply learned skills in real-life scenarios, reinforcing confidence in anxiety management. The program concludes with a review of key concepts, discussions on next steps, and participant feedback through surveys and focus groups, ensuring continuous refinement and responsiveness to youth needs.

Study Procedures

Recruitment, Selection and Consent process

This study is approved by Institutional Review Board Yale University. The recruitment plan for this intervention will involve a collaborative partnership with a local high school, working closely with the principal and lead school counselors to identify youth who may benefit from participation. School counselors and teachers will play a key role in identifying students who exhibit signs of heightened anxiety or have been classified as high-risk based on behavioral observations, academic performance, and self-reported concerns. To ensure a targeted and effective approach, recruitment will prioritize students who have been flagged for increased anxiety symptoms, difficulty managing stress, or other related mental health challenges. Once identified, eligible students will be invited to participate, with parental consent waived as per IRB approval. The intervention cohorts will be divided by gender to foster a comfortable and supportive group dynamic, allowing for tailored discussions and activities that align with the unique experiences and stressors faced by male and female students. This structured recruitment approach ensures that the intervention reaches those in greatest need while maintaining a supportive and inclusive environment for all participants. After referral to the intervention, the relevant information of the study will be provided to all participants in detail, and they will be given sufficient time to consider whether to participate in the study. If the participants agree to participate in the intervention, they will sign an informed assent form. Parent consent will be waived; however, all parents of youth participants will receive an information sheet indicating that their child is participating in an intervention. No blinding or randomization will occur in this phase of pilot testing. Due to participants being classed as a vulnerable population, they will also be notified of mandated reporter requirements.

Each intervention group will consist of five to ten participants, with a preferred group size of eight with total sample of fifty participants. Youth will be separated by sex/gender. Males and females will be assigned to their corresponding groups to enhance comfort and relatability, allowing participants to engage more openly and effectively with peers of the same gender.

Intervention Facilitators

The facilitators of this intervention will consist of professionals trained in social work or psychology, ensuring that participants receive guidance from individuals with expertise in mental health and youth development. Each session will be led by at least one facilitator who is a member of the target community, ensuring that the intervention remains culturally relevant and resonates with the lived experiences of the youth. Having facilitators from the community is crucial, as research indicates that community-based mentors and professionals foster stronger connections with participants, enhance engagement, and improve intervention outcomes (25, 26). These facilitators bring an intrinsic understanding of local stressors, social dynamics, and cultural nuances that external professionals may not fully grasp. Their presence helps to build trust and relatability, making youth feel more comfortable discussing their experiences and applying coping strategies. Additionally, incorporating local facilitators into the program fosters sustainability, as they can continue to serve as mental health advocates within their community beyond the duration of the intervention (25, 26). This approach ensures that the program is not only evidence-based but also deeply rooted in the strengths and needs of the community it serves.

Study Measures

Baseline and post-tests

The study will be conducted over five weeks with multiple assessment points depending on measure. Outcome measures will be collected at the first session which will be considered baseline (T1); post-treatment (T2) (4 weeks from baseline assessment); and 3-month follow-up (T3) (3 months from start of the intervention).

Primary Outcomes

The primary outcome is the mean change in anxiety scores on the Generalized Anxiety Disorder Questionnaire for Adolescents (GAD-7) between baseline and post-treatment (T2). The questionnaire has 7 items, each with a 4-point scale, with scores between 0 and 21 points. Scores are considered as follows: 0–4 (minimal), 5–9 (mild), 10–14 (moderate), and 15–21 (severe) symptoms.

The GAD-7 has demonstrated excellent psychometric properties (27,28). The items inquire about the degree to which the patient has been bothered by feeling nervous, anxious or on edge, not being able to stop or control worrying, worrying too much about different things, having trouble relaxing, being so restless that it is hard to sit still, becoming easily annoyed or irritable and feeling afraid as if something might happen.

Secondary Outcomes

Secondary outcomes will include: the Coping Self-Efficacy Scale (CSES), a validated instrument assessing individuals' confidence in using adaptive coping strategies to manage stressors (29). Additionally, we will develop a study-specific measure to assess participants' knowledge of anxiety, triggers, and effective coping strategies, ensuring that we capture cognitive and behavioral shifts resulting from the intervention. Lastly, depression symptoms will be assessed using a validated measure such as the Patient Health Questionnaire-9 (PHQ-9) (30), which will allow us to explore whether reductions in depressive symptoms contribute to improvements in other targeted outcomes. By integrating these measures, we aim to comprehensively evaluate the intervention's impact and identify key mechanisms driving behavioral change.

Planned analyses

The planned analyses will include both descriptive and inferential statistics to assess the intervention's effectiveness. We will examine changes in Generalized Anxiety Disorder-7 (GAD-7) scores between baseline and post-treatment assessments, hypothesizing that post-treatment mean scores will be significantly lower than baseline scores. Baseline demographic characteristics, including age, gender, race, and socioeconomic status, will be reported. A repeated measures ANOVA within a within-subjects design will be used to test this hypothesis, with Shapiro-Wilk tests assessing normality assumptions. We assume that the distribution of difference scores will be normal and will also explore whether changes in GAD-7 scores differ by gender.

Additionally, logistic regression models will estimate the likelihood of clinically significant

improvements in mental health and behavioral outcomes based on key predictors, including baseline symptom severity, intervention dosage, and demographic factors. Given the longitudinal nature of our data, we will employ linear mixed-effects models to account for within-subject correlations and evaluate changes over multiple follow-up points. These models will help determine whether intervention effects are sustained and whether specific subgroups (e.g., gender-based cohorts) exhibit differential responses.

Sample size and power justification

This study was powered based on the primary aims of assessing the feasibility of the newly developed intervention. Sample sizes ranging from 24 to 50 have been recommended for feasibility studies (31, 32). With a sample size of 50, we expect to retain at least 80% of participants at 3 months post intervention. For primary and secondary aims, we will estimate effect sizes from means and standard deviations which will be used to determine power needed for a future RCT.

Fidelity to intervention

To monitor fidelity to the intervention, a fidelity form created by the study team will be utilized. Each facilitator will complete the fidelity form after each session. The form will track the main activities engaged in, skills covered, deviations from protocol, and adverse events that emerge during each session.

Data management and Monitoring

To safeguard the confidentiality of the participants and to ensure proper handling of all data, processing of all data reporting complies with CITI recommendations and is in accordance with established guidelines on ethical conduct in human research. Participants will provide written informed consent. All participant data will be allocated a deidentified code so that confidentiality is maintained during the study, and when the data are stored. Deidentified data will be stored in password protected secure online data storage repositories at Yale University. Only principal investigators, interventionists, the statistician, the project manager, and research assistants will have

access to this deidentified data for: 1) assessment of participants acute mental health; 2) Quality improvement of intervention; and 3) publication of findings. Any adverse events or clinical complications that arise as result of the intervention will be reported by interventions to supervisor and principal investigator after session and during regular project supervision. All adverse events will be documented.

Ethical and safety considerations

Due to participants being classed as a vulnerable population, they will also be notified of mandated reporter requirements during the assent process and at the beginning of each session. Considering that youth may share vulnerable personal information, students will be reminded of the importance of confidentiality at the beginning of each session. As participation will take place on school grounds, measures will also be taken to not reveal students' participation in the group to non-participating peers. While students will be provided with resources at the end of each session, should a participant express high, acute, mental health needs outside of the scope of the intervention, they will be referred to the school's psychologist/social worker.

Discussion

The significant psychosocial burden of anxiety and persistent resource accessibility gaps necessitates continued efforts to blend best-practices in CBT with the unique needs faced by under resourced urban youth. One major strength of our intervention design is that the conceptualization of this intervention has had significant input from the population it aims to support: urban youth as well as tackles some of the frequent situations and target maladaptive cognitions youth identified. While individual and group CBT-based anxiety interventions have been considered the gold standard for childhood anxiety (33, 34), there is less research on utilizing such interventions within a community-level participatory framework. The current study will be testing out hypotheses around the application of CBT skills in addressing the underlying mechanisms that create and maintain anxiety for urban youth. That is, participants will be encouraged to actively identify and challenge unhelpful

or unrealistic cognitions related to salient experiences (exams, class presentations) and difficult interpersonal interactions. This process is complemented by behavioral activation to encourage broader engagement in coping skills and support seeking. Participants will also be encouraged to practice graded exposure to reduce avoidance of participant identified stressful situations, as well as problem solving barriers to effectively engaging in helpful coping (e.g., seeking support when current coping skills are no longer effective).

Conclusion

This pilot study will provide a basis for the efficacy of a Community Based Participatory Research-guided, Cognitive Behavioral Therapy-informed anxiety intervention for anxiety in school-aged urban adolescents. Outcomes from this study will provide evidence for the feasibility of incorporating this framework within urban schools for multiply minoritized youth as well as enhancing wellbeing in this age group, and thereby directly contributing to better social, mental, and educational outcome.

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