Cognitive-Behavioural Intervention for Test Anxiety: Could Teachers Deliver the STEPS Program and What Training would they Require?

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Abstract

High levels of test anxiety have been shown to be damaging for educational achievement, wellbeing, and mental and physical health. Given the relatively high number of adolescent students reporting high levels of test anxiety, there is a profound need for interventions to equip these students with effective test anxiety management skills. In this chapter, we describe one such intervention (STEPS: Strategies to Tackle Examination Pressure and Stress), the evidence for its effectiveness, and recent work to develop an updated version (STEPS 2.0). We discuss whether school staff could be effective in the delivery of interventions for test anxiety. They are in an advantageous position by virtue of their understanding of the school ecology and, with appropriate training, have the potential to considerably broaden access to test anxiety intervention. We finish the chapter with a consideration of the initial training elements required for school staff.

Keywords. Test anxiety, Cognitive-Behavioural Intervention, STEPS, Teacher-Delivered Intervention.

X.0 Introduction

The fears and worries experienced by students before, during, and after testing, referred to hereafter as test anxiety, can be damaging for educational achievement, wellbeing, mental health, and physical health. Effective interventions need to be made widely available to minimise the harmful consequences of test anxiety. In this chapter, we begin by defining test anxiety followed by a brief discussion of its negative impacts, before reviewing the evidence for test anxiety interventions. We describe one intervention specifically designed for adolescents aged 14-19 years, namely STEPS (Strategies to Tackle Examination Pressure and Stress), studies that have evaluated the effectiveness of STEPS, and the development of an updated version (STEPS 2.0). We then review the evidence for teacher-delivered psychological interventions in schools, and conclude the chapter with a consideration of the training elements required for teachers to be able to deliver STEPS 2.0.

X.1 What is Test Anxiety?

Test anxiety refers to affective and physiological responses (“tension”, e.g., panic, feeling dizzy, and heart beating very fast) accompanied with thoughts dwelling on failure (“worry”), and cognitive interference (e.g., 'going blank' during a test), that result from appraising a performance-evaluative situation as highly threatening. The ‘threat’ in question was originally defined by Spielberger (1966) as ‘ego threat’. That is, failure, and its possible consequences, is judged to be damaging to one’s self-esteem, self-image, or self-view (see Leary et al., 2009, for alternative uses of the term ‘ego threat’). Failure could, for example,

damage one's aspirations, one's view of being an 'achiever' or an 'academic person', or result in negative judgements from important others (Banks & Smyth, 2015; Putwain, 2009).

Emotions are widely considered to also include a motivational element (Scherer, 2009), which in the case of anxiety is avoidance of the anxiety-provoking event or object (Clark & Beck, 2010). In test anxiety, avoidance often manifests as behaviours which can protect one's self-esteem against failure (see Covington, 2009). One possibility is effort invested to avoid failure (e.g., Pekrun et al., 2004). However, avoidance behaviours can also include forms of self-sabotage such as procrastinating about test preparation and disengaging from one's studies (a 'strategic' withdrawal of effort). In these circumstances, a ready-made reason for failure ("I didn't try hard enough") has been created that directs attention away from negative judgements about one's competence (De Castella et al., 2013; Jackson, 2017; Martin, 2001, 2003). This may provide a reason for failure that protects self-esteem against being seen as incompetent, but paradoxically increases the likelihood of failure due to missed opportunities to improve one's knowledge and skill, practice test questions, and so on.

X.1 Why is test anxiety an issue of concern?

Test anxiety is an issue of concern for two reasons. First, there is a longstanding body of evidence showing that higher test anxiety is associated with lower academic achievement (for meta-analyses see Hembree, 1988; von der Embse et al., 2018). Importantly, studies have shown the negative correlation between test anxiety and test performance remains after controlling for prior achievement (Pekrun, 1991, 1992; Putwain et al., 2015) and ability (Putwain et al., 2013). It is not simply the case that students with low achievement or ability are more anxious about tests.

Second, test anxiety is related to poor mental health and wellbeing. Highly test anxious students report higher symptoms of emotion disorders (i.e., anxiety disorders and depression) than their low-test anxious counterparts (e.g., Weems et al., 2010) and meet diagnostic thresholds for anxiety disorders (e.g., Herzer et al., 2014; see Pekrun & Loderer, 2020). Highly test anxious persons also show lower subjective wellbeing, comprising positive affect and life satisfaction, after controlling for prior subjective wellbeing (Putwain et al., 2021; Steinmayr et al., 2016). Relatedly, and sadly, an analysis of English Coroner's reports[1] over a sixteen-month period in 2014-15 found that examination pressures were specifically cited as a cause of adolescent suicide in 15% of cases (Rodway et al., 2016). Test anxiety

[1] A Coroner is a court or government official with the responsibility for establishing the cause of death. In England a Coroner is a qualified solicitor or barrister.

should not, therefore, be treated lightly. It can negatively impact achievement, mental health and wellbeing, and physical health, alike (e.g., Conley & Lehmann, 2012; Glaser et al., 1986).

X.3 Test anxiety intervention

Fortunately two meta-analyses have shown that test anxiety is responsive to intervention. The first, comprising 562 studies in total from 1950 to 1986, included 137 intervention studies (Hembree, 1988). Intervention approaches included behavioural, cognitive, cognitive-behavioural, study-skills training (alone or in conjunction with behavioural/cognitive approaches), and test-taking skills training. All intervention approaches were successful in reducing test anxiety compared to participants receiving no intervention. The two most successful approaches for participants in the later stages of secondary education were study-skills training with behavioural intervention or cognitive-behavioural intervention. The second, comprising 56 studies from 1974 to 1998, included the aforementioned approaches as well as stress inoculation training and hypnotherapy (Ergene, 2003). All intervention approaches successfully reduced test anxiety and cognitive approaches combined with study-skills training resulted in the largest reduction of test anxiety. Ergene (2003) noted that relatively few intervention studies were specifically focused on children or adolescents. Of the 56 studies he reviewed, there were only 12 using samples of K-12 students from elementary or secondary school.

However, a narrative review from 2000 to 2010 (von der Embse et al., 2013), and a systematic review from 2011 to 2018 (Soares & Woods, 2020), of test anxiety interventions specifically focused specifically on children and adolescents further underscored the findings of the meta-analyses. Cognitive, behavioural, and cognitive-behavioural, interventions, and study-skills training (often combined with one of the aforementioned approaches), were successful in reducing test anxiety. Emphasising the paucity of intervention evaluation studies focused on children or adolescents, only 10 studies were identified by von der Embse et al. (2013) and a further 11 by Soares and Woods (2020).

The findings summarised in these meta-analyses and reviews offer considerable hope for persons who experience high levels of test anxiety that they can learn skills to help manage their anxiety effectively. In addition, practitioners, and commissioners of interventions, can be confident in the availability of evidenced-based interventions for test anxiety that have undergone rigorous evaluation. It is a concern, however, that there are still relatively few interventions available for K-12 students, and that more high-quality evaluations for test anxiety intervention are needed.

Adolescence, particularly, is a time when many students in secondary school are exposed to high-stakes tests that can have a profound influence on their subsequent life trajectory in education systems throughout the world (see Morris, 2011). Adolescence is also a developmental period characterised by sensitivity in limbic and cortical regions of the brain involved in stress responses. The combination of pressured testing during a period of heightened stress reactivity leaves adolescents vulnerable to heightened test anxiety. Moreover, episodes of anxiety tend to re-occur throughout one's life when first experienced during childhood or adolescence (Garber & Weersing, 2010). It is, therefore, absolutely critical for the positive mental and physical health of adolescents that interventions for test anxiety focused specifically for this population are developed, subjected to rigorous testing, and made widely available to those who need them.

X.4 Strategies to Tackle Examination Pressure and Stress (STEPS)

In response to the relative paucity of evidence-based psychological interventions for test anxiety in school-aged populations, Putwain et al. (2014) developed a brief cognitive behavioural intervention (CBI), namely Strategies to Tackle Examination Pressure and Stress (STEPS). STEPS was designed as a multimodal CBI intervention, based on the principles of the Self-Regulative Executive Function (S-REF) Model (Wells, 1997) adapted to test anxiety by Matthews et al. (1999), and evaluation anxieties more generally, by Zeidner and Matthews (2005). The original version of STEPS comprised six sessions each lasting for approximately 40 minutes. Session 1 was focused on identifying triggers for test anxiety, Session 2 on identifying and challenging cognitive biases, Session 3 on relaxation strategies, Session 4 on study skills, and Session 5 on visualisation. Session 6 was a review of the intervention and a reflection on which strategies were effective, and equally importantly, when and how these strategies could be employed in order to manage test anxiety.

Each session included the following elements. 1) Psychoeducation in order to instruct students about underpinning principles of STEPS. For instance, in Session 1 STEPS participants are presented with a model of test anxiety in order to understand potential triggers. 2) Reflection exercises that allowed STEPS participants to personalise psychoeducational instruction. 3) Short informal quizzes with immediate feedback, and minimum pass requirement, to reinforce psychoeducation. 4) Direct instruction on anxiety management approaches. For instance, in Session 3, participants were instructed how to engage in diaphragmatic breathing. 5) Practice of anxiety management techniques within the session. 6) Short video clips of adolescent students talking about their own experiences of test anxiety and managing test anxiety using the strategies included in STEPS. 7) Follow-up tasks

to practice the anxiety management strategies covered in a particular session. These were specifically not referred to as 'homework' to avoid possible contamination of existing negative views of school homework being transferred to STEPS follow-up tasks.

STEPS was originally envisaged as a self-help tool that students aged 14-19 years could complete on their own. Accordingly, STEPS content was programmed on the presentation software Articulate (Articulate Global Inc.). This allowed for an interactive format, the inclusion of quiz-based reinforcement, the inclusion of text- and visual-based instruction, and the inclusion of video clips with sound, within a single format. This allowed students to proceed through each session at their own pace, and the standardised presentation ensured high fidelity. There was no guarantee, however, that students would deeply engage with that material.

Putwain et al. (2014) conducted an evaluation of STEPS with 3,225 adolescent participants in the final three years of secondary schooling (mean age 14.9 years). Participants were randomly allocated to intervention (to complete STEPS at home or during a designated lesson at school) or inactive control groups. The completion rate was poor. Only 13.7% of intervention group participants completed all six STEPS sessions, and 60% completed none at all, making an intention-to-treat analysis ineffectual. An alternative analytic strategy was to compare participants who did complete STEPS to the control group and to a sample-size matched group randomly drawn from intervention participants who had completed no STEPS sessions.

At pre-intervention, there were no statistically significant differences between intervention group participants who completed STEPS and control group participants, or intervention group participants who did not complete STEPS. At post-intervention highly test anxious participants who completed STEPS reported significantly lower test anxiety scores than control group participants (tension d = -.53; worry d = -.63;) and those in the intervention group who completed no sessions (tension d = -.49; worry d = -.89). Although these results were encouraging, and point to STEPS being an effective CBI for test anxiety, the comparisons are analogous to those used in quasi-experimental designs. That is, the intervention and comparison groups were no longer randomly allocated and results must be interpreted with caution.

Due to the poor completion rate, a likely result of low student motivation and/or self-regulatory skills, we subsequently switched STEPS to a mode of delivery whereby a facilitator (a trained assistant psychologist) led a group of six to eight students through the intervention. Two evaluations of STEPS as a facilitator-led intervention have been conducted

as randomized controlled trials (RCTs). In the first of these studies, 56 highly test anxious participants in the final two years of secondary schooling (mean age 14.7 years) were randomly allocated to intervention or control-list wait groups. Intervention group participants showed statistically significant declines in the tension (d = -1.14) and worry (d = -.76) components of test anxiety after completing STEPS, compared to the wait-list controls whose tension scores showed a negligible decline (d = -.08) and worry scores remained unchanged.

Additional follow-up measures were taken at a third time-point after the wait-list controls had completed STEPS. Participants in the wait-list control group showed similarly sized declines in tension (d = -1.14) and worry (d = -.79) after completing the STEPS sessions. This third time-point of measurement also served as a short-term follow up (≈ 7 weeks after completing STEPS) of participants receiving the intervention first. This group showed small increases in tension (d = .09) and worry (d = .20) and, but importantly scores remained similar to wait-list control group participants who had just completed STEPS.

In the second RCT, 161 highly test anxious participants in the final two years of secondary schooling (mean age 14.1 years) were randomly allocated to intervention or control-list wait groups (Putwain & von der Embse, 2021). After completing STEPS, test anxiety showed a large statistically significant decline in the intervention group participants (d = -.86) compared to a moderate statistically significant decline (d = -.62) in wait-list controls. In addition, participants also completed measures of generalised anxiety disorder (GAD) and panic disorder (PD). After completing STEPS, participants in the intervention group showed statistically significant declines in GAD (d = -.43) and PD (d = -.54) whereas the wait-list control showed no statistically significant changes.

The completion rate for all six sessions was 82% in Putwain and Prescod (2018) and 91% in Putwain and von der Embse (2021), demonstrating the effectiveness of moving from self-help to facilitated intervention delivery. In addition, anonymous post-STEPS feedback has been collected from 102 secondary school students aged 14-16 years, who were not participants in a formal evaluation study, from 2016 to 2019 (Putwain & Symes, 2020). Students reported feeling that they were in a better position to control their test anxiety before and during a test, after completing STEPS, and that they had learnt useful anxiety management skills that could be employed during a test. In combination, the findings of these studies show that STEPS is an effective intervention for test anxiety.

X.5 STEPS 2.0

Over 2020 and 2021 we developed a revised version of the intervention (STEPS 2.0). This revision was largely necessitated by support for Adobe Flash Player (used in the Articulate software to present STEPS) being withdrawn on 31st December 2020, rendering the original version of STEPS obsolete. Many of the elements in STEPS 2.0 remain the same as the original version. Notably, we chose to remain with the Articulate software (more recent versions rely on alternatives to Flash Player) as it allows for a professional presentation of STEPS sessions in a standardised format which can assist intervention fidelity. The order and foci of the six sessions remain largely unchanged and are intended to be completed in approximately 45 to 60 minutes each. This is slightly longer than intended in the original self-help version of STEPS and based on experience of facilitators delivering that version in a face-to-face context with small groups.

The development of STEPS 2.0 provided the opportunity to incorporate feedback from facilitators and students accumulated over an eight-year period. Two substantive presentational changes were made. First, text-based presentation of psychoeducational elements was reduced and replaced with visual modes of presentation accompanied by a group activity. In order to support facilitators in leading group activities, as well as assisting intervention evaluations (Truijens et al., 2019), an accompanying manual was also developed. The manual explains to facilitators the objectives for each of the six sessions, the aims for each slide on the Articulate presentation, and how to lead group activities. Like the original version, STEPS 2.0 includes a student booklet that explains the self-reflection and follow-up tasks, and provides space for students to keep a record of their reflections and experience of the follow-up tasks.

Second, the film clips of the adolescent students talking about their experiences of test anxiety and test anxiety management in the original version of STEPS polarised the opinions of participants. Some found it immensely reassuring to hear peers describing experiencing similar worries and anxieties to themselves. Others found the videos as contrived and unhelpful. Although the film clips used volunteers aged 16-18 years old, and were unscripted, it is likely that the experience was novel for many and may have contributed to the lack of a ‘natural’ feel to the clips. Accordingly, we chose to omit film clips from STEPS 2.0.

The only substantive change to content was in Session 4 where we incorporated insights from research on self-regulation of learning (Zimmerman et al., 2017) into the study skills training. Specifically, in the psychoeducational element of Session 4, we show STEPS participants how the stages of self-regulated learning can be used in test preparation: 1) Setting goals for revision, 2) undertaking the revision, 3) evaluating the effectiveness of

revision through testing oneself, and 4) setting new goals for revision based on the feedback from the third stage. Information is included on how to make each of these stages effective. Students are shown, and asked to reflect on different visual, auditory, and textual forms of revision.

X.6 Teacher-Delivered Interventions in School Settings

Psychological interventions for K-12 students, including CBIs, are typically undertaken in primary healthcare settings by qualified and trained psychologists, therapists, or counsellors. The timing, location, and potential cost, of interventions can be a barrier to children, adolescents, and parents accessing interventions (Barrett & Pahl, 2006). Schools may be an advantageous setting for intervention as they offer unparalleled access to children and adolescents (Masia–Warner et al., 2006) and, therefore, have the potential to substantially increase access to intervention (Masia–Warner et al., 2006; Owens et al., 2014). The available evidence shows that interventions delivered in schools can be effective in reducing anxiety.

A meta-analysis of 49 school-delivered interventions for all types of anxiety disorder, 46 of which used CBI, showed a reduction in symptoms at post-intervention (g = 0.20), 6-month (g = 0.23), 12-month (g = 0.23, and > 12 month (g = 0.13) follow-up, compared to no intervention, waitlist, or school-as-usual controls (Werner-Seidler et al., 2017; g is the standardised mean difference between the intervention and control group). Furthermore, there was no statistically significant difference between interventions delivered by trained school staff (n = 19 studies; g = .18) and those external to the school (n = 30 studies; g = .17). Importantly, teachers have been shown to be as effective as psychologists in the delivery of school-based anxiety interventions (Lowry-Webster et al., 2003) when training includes key implementer characteristics elements (e.g., knowledge of underpinning theoretical models).

These findings show that interventions can be effectively delivered in the school setting. Furthermore, teachers, and other school staff, have the potential to deliver such interventions. However, school systems do not typically work to support the delivery of interventions, and sustainability can be limited through a lack of consideration of how interventions fit with school values and policies (Fixsen et al., 2010). Nevertheless, notwithstanding the already heavy workload of teachers (e.g., Walker et al, 2019), the position of teachers within a school ecology, along with their understanding of school systems and first-hand knowledge of students, may be advantageous in organising the delivery of anxiety interventions in a sustainable fashion.

Insights from implementation science provide informative recommendations for how to navigate barriers to successful and ongoing implementation of interventions in schools. The support and understanding of school leadership is critical, and thus the attitudes, values, and beliefs of administrators, managers, and stakeholders (e.g., school governance) must be addressed (Fixsen et al., 2010). School leadership must be involved in the planning of intervention, and initial training and ongoing implementation support is required for persons delivering the intervention thereafter (Forman et al., 2009). In the final section of this chapter, we consider what initial training teachers, or other school staff without specialist expertise, would require in order to successfully deliver a test anxiety CBI in a school setting.

X.7 Initial Training Required to Deliver CBI for Test Anxiety

In this section we propose a structure for providing the initial training required for teachers, or other school staff, to be able to successfully deliver a CBI for test anxiety. Our proposal is based on the core competencies required to deliver effective CBI for anxiety (Roth & Pilling, 2007). We focus specifically on the STEPS intervention, to demonstrate the link from training elements to specific intervention elements. However, the structure we present could be easily transposed to other test anxiety CBIs. Training is broken down into three areas: 1) The theoretical background to test anxiety, 2) the theoretical background to CBI, and 3) the therapeutic practice skills required to facilitate small group intervention. In common with effective practice-based training, the description of the following areas should be accompanied by learning outcomes, vignettes, self-reflective exercises, and summative assessment of knowledge (Blanchard & Thacker, 2012).

X.7.1 Underpinning theoretical knowledge of test anxiety

Teachers, or other school staff, may have limited theoretical background knowledge of test anxiety, or knowledge largely informed by anecdote. In order to provide a relatively brief, but sufficient, understanding of test anxiety, training should include the following four elements.

X.7.1.1 Differentiating Between Stress and Anxiety

The terms ‘stress’ and ‘anxiety’ can be used interchangeably in everyday parlance. In CBI, however, it is important to be more precise with terminology to avoid conflating the different meanings of the two terms. In appraisal models, stress refers to the balance between perceived demands and resources (e.g., Blascovich, 2008; Lazarus & Folkman, 1984). When resources are perceived to outweigh demands, the resulting challenge state can include positive emotions, greater motivation and effort, and enhanced performance. When demands are perceived to tax or outweigh resources, the resulting threat state can include negative

emotions, avoidant motivation and effort, and lowered performance. A threat state can include, but is not limited to anxiety (see Pekrun's, 2006, 2021, control-value theory for types of emotions that can result when resources do not meet demands). This first element should conclude by presenting the various affective, cognitive, affective, physiological, and motivational signs, or indicators, of test anxiety.

X.7.1.2 Understanding how Students can be Affected by Test Anxiety

In order to provide a context for why CBI for test anxiety is required, it is necessary to show: 1) the typical proportion of students who are experiencing high levels of test anxiety; 2) the impact of test anxiety on learning, achievement, and test performance; and 3) the impact of test anxiety on wellbeing and mental and physical health. Estimates using samples from the United States and England suggest between 10 to 30% of adolescents aged 15-18 years experience high levels of test anxiety (Putwain, 2020; Putwain & Daly, 2014; von der Embse et al., 2014). It would likely be instructive to share these figures along with demographic differences. Training should also show how anxiety can interfere with information processing both before and during tests and could be demonstrated using Stroop or dual processing tasks. This section should conclude by drawing the links between test anxiety and the risks for lower wellbeing and mental and physical health.

X.7.1.3 Understanding Test Anxiety Processes

Various contemporaneous theories and models detail the processes involved in test anxiety. These include the biopsychosocial model (Lowe et al., 2008), control-value theory (Pekrun, 2006), and the cognitive-behavioral model (Segool et al., 2014). The S-REF Model underpinning STEPS represents three interrelated systems (executive processes, self-knowledge beliefs, and maladaptive-situational interactions) that combine to result in elevated state anxiety, distress, and cognitive interference. An understanding of the processes that result in high levels of test anxiety can inform those delivering CBI why certain individuals become highly anxious in tests (and other performance-evaluative situations) and provide insight into how intervention can alter, or disrupt, these processes to manage anxiety more effectively.

X.7.1.4 Understanding that Test Anxiety is Amenable to Intervention

To conclude the first area of training, it is necessary to show that test anxiety is malleable and that highly test anxious persons can acquire the skills to effectively manage anxiety through CBI. A presentation and discussion of the results of CBI evaluation studies for anxiety in general, and test anxiety in particular, can provide a brief introduction to CBI. Understanding that a high level of test anxiety is, although often enduring, not inevitable, will

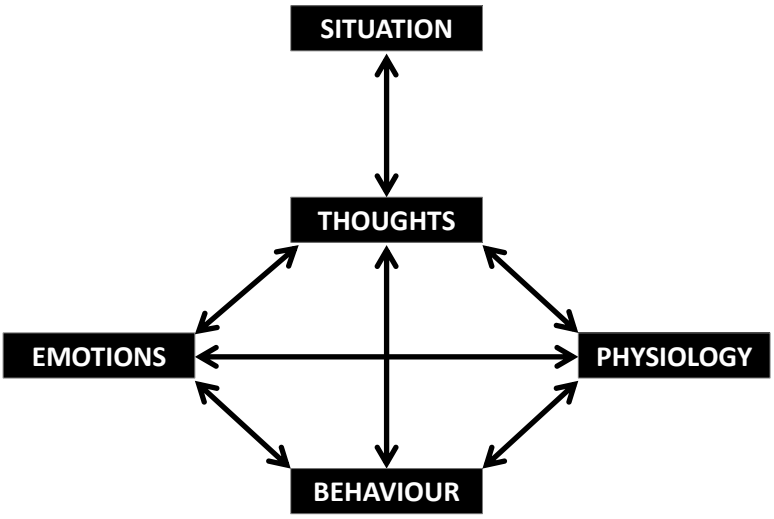
increase confidence in the importance and appeal of CBI. By way of an introduction to STEPS, for instance, results of the aforementioned studies by Putwain et al. (2014), Putwain and Pescod (2018), and Putwain and von der Embse (2021) could be shown and the key elements of intervention (i.e., what is covered in each of the six sessions) highlighted.

X.7.2 Underpinning Theoretical Knowledge of CBI

It is unlikely that teachers, or other school staff, will have a detailed understanding of the underpinning principles of CBI and the associated intervention techniques. Training for test anxiety CBI should, therefore, equip facilitators with the requisite background knowledge and skills to successfully and confidently implement an intervention, based on the following three elements.

X.7.2.1 General Principles of CBI

Figure 1: The Five Areas of Cognitive Behavioural Intervention



To introduce the general principles of CBI a model such as Williams and Chellingsworth's (2010) 'five areas' (see Figure 1) can be presented and explained to show how emotion, cognition, physiology, and avoidance behaviour are mutually and dependently related; that changing any one of these areas will impact on others. This model can also be used to show how situational influences on emotion, physiology, and behaviour, are mediated by cognition. Other important elements of CBI to cover are the use of homework, or follow-up tasks as they are referred to in STEPS, and not avoiding making assumptions about the

underlying reasons for high test anxiety in specific students. It is equally important for the facilitator to avoid pre-judging which intervention elements are likely to be successful. What might have been a successful strategy for themselves, their friends and peers, and other students, will necessarily be successful for students participating in CBI (Clark & Beck, 2010). This element should conclude with how to identify students for CBI and the importance of evaluating CBI.

X.7.2.2 Cognitive Intervention: Theory and Techniques

Cognitive intervention techniques are central to CBI, including STEPS. Training should include background and worked examples of core beliefs, the cognitive triad, negative automatic thoughts, and cognitive biases (see Beck et al., 2005; Clark & Beck, 2010). This should be followed by a discussion of intervention strategies that can be used to challenge negative automatic thoughts. The A-B-C model of events, beliefs, and consequences (see Ellis & Ellis, 2019) would be a useful paradigm to demonstrate how to challenge negative automatic thoughts.

X.7.2.3 Emotional and Behavioural Intervention

STEPS includes relaxation strategies commonly used in CBI, namely progressive muscle relaxation, diaphragmatic breathing, and guided visualisation (Beck, 2011). Teachers, and other school staff, may have prior experience of these techniques as they can be commonly found in self-help books, on the internet, and in yoga classes. What is important is that the person leading the CBI becomes proficient in these techniques if they are to effectively instruct others in their use (Crane et al., 2010). Behavioural intervention is approached in STEPS through study strategies. Teachers may also have experience of instructing students in test preparation strategies, although knowledge of the effectiveness of specific strategies may be limited (e.g., Morehead et al., 2016). Teachers may not, however, be familiar with the principles of self-regulated learning, although we anticipate that an experienced teaching professional would be able to understand and implement these without difficulty.

X.7.3 Therapeutic Practice Skills Required to Facilitate Small Group Intervention

Staff working in school settings, such as teachers, may be highly experienced in working with adolescents and already have pre-existing relationships with students. Experience and pre-existing relationships could be both a help and a hindrance to the effective facilitation of STEPS. For instance, assumptions about the causes of test anxiety arising from previous experience of working with students may be a hindrance and prevent the exploration of alternate reasons. However, if a facilitator had previously built a trusting

and supportive relationship with a student, that could help the development of positive relationships with a STEPS group. In addition, the facilitation of a CBI requires therapeutic skills that teachers may be less familiar with. The following 4 elements, common to all forms of CBI delivery (see Roth & Pilling, 2007), have proven useful to the smooth and effective delivery of STEPS sessions, and should be included within training.

X.7.3.1 The importance of Freely Exercised Choice

Adolescence is a period of development characterised by a growing need for respect and autonomy. Interventions that afford a degree of autonomy, and include respectful interactions with adults, are likely to be more successful (Yeager et al., 2018). Accordingly, it is critical to ensure that students understand that they can choose to freely participate in STEPS, and that STEPS is not something that a student's school requires them to undertake. It is entirely understandable that some students might be unsure whether they want to participate or not. Students can be offered the option to try the first session, or even the first two sessions, before choosing whether to commit to all six sessions. Some students will choose to discontinue, but engagement in STEPS will be higher for those that choose to continue with the remaining sessions.

X.7.3.2 Creating a Safe Psychological Environment

In order to help establish an environment in which students are able to benefit from intervention, it is necessary to establish boundaries at the outset with regards to confidentiality, respect, and being non-judgemental (Waterman & Walker, 2013). STEPS sessions are confidential in that what is discussed in the group is not discussed with anyone else outside of the session. The limits of this confidentiality must be clarified however; that if students disclose anything related to illegal activity, or that might involve a safeguarding issue, the facilitator is required to inform others at school. STEPS sessions are conducted in a respectful manner in that group members listen to what others have to say and do not talk over them. Furthermore, STEPS group members do not judge, criticise, or mock, others in the group. Students are either informed of these boundaries or asked to generate their own, which can encourage greater engagement, but need to be reminded of them at the beginning of each session.

If students become comfortable in a STEPS group, it is possible that they may choose to disclose something unrelated to test anxiety, for instance about bullying, self-harm, eating disorders, or problems at home. It is important that this discussion is closed down as quickly and sensitively as possible. This is partly as facilitators may not have the requisite training, skills, and supervision for these issues, and partly to keep the STEPS sessions focused on test

anxiety. A student could be asked to talk to the facilitator after the session who can continue to support the student if they have the appropriate training, skills, and supervision. If not, the facilitator should refer to the appropriate person for safeguarding at school, as appropriate.

X.7.3.3 Building Rapport and Positive Relationships

The success of STEPS depends as much on the group being able to form positive relationships with each other and the facilitator in a relatively short space of time as on the actual anxiety management skills included in STEPS. Giving students choice and establishing rules helps to set the scene for positive relationships. These can be further developed through the facilitator adopting three key therapeutic skills (Cook-Cottone et al., 2015). First, the facilitator needs to develop and communicate empathy. That is, the facilitator needs to see and imagine the world as the students are seeing it. One way to do this is to verbally summarise student's thoughts or feelings, either individually or for the whole STEPS group, and to do this regularly.

Second, to build rapport, students have to know that they are valued; the facilitator needs to communicate to students that they are liked. There is a possibility for role conflict if teachers are also involved in the assessment of work of students in a STEPS group. Careful thought should be given to matching a facilitator with groups of students; persons with a wellbeing or pastoral role within a school may be best placed to lead STEPS sessions. Initial impressions do count and the facilitator needs to present themselves as a friendly, helpful professional. Third, the facilitator needs to demonstrate credibility. Students need to know that the facilitator is knowledgeable about test anxiety and how it can be managed in order to have confidence in STEPS and the techniques that are being introduced. Credibility is achieved partly through undertaking the type of training described here and partly through gaining practice and in delivering STEPS, and reflecting on one's practice. The facilitator acts as an important role model for the STEPS group, and the students will follow their lead and cue. If the STEPS facilitator can demonstrate empathy, rapport, and credibility to the group, then the students will emulate these. These skills can be practiced in training through role play.

X.7.3.4 Facilitator Style

As much as is possible, within the power dynamics in a school setting, an 'equal footing' approach should be adopted so that the group facilitator and students are seen as equally contributing to a common goal. The style aimed for is called 'collaborative empiricism' (Beck, 2011). That is, the facilitator and students trying things out like a group of experimenters to see what works best. Not everything will work, but the idea is to keep trying

things out until you find out what works best for particular individuals. This is important because it acknowledges that while some elements of STEPS as a multi-modal intervention may work more successfully for some persons than others, it is important for STEPS participants to keep trying.

The facilitator has to develop an unconditional positive regard for students (Cook-Cottone et al., 2015). That is, they should never disapprove or judge the things that students do or say, but to try to understand, and communicate that they understand, the reasons why students may feel or behave in a particular way. Students may have a negative view of themselves, or of their academic ability. Anything that can be done to 'undo' the negative view the student has of themselves is important and communicating unconditional positive regard is one way to achieve this.

X.8 Conclusion

In this chapter we argue that test anxiety among adolescents should not be taken lightly; educational achievement, wellbeing, and mental and physical health can be undermined by high levels of test anxiety. Even when high test anxiety is persistent, CBIs have fortunately shown it is possible for adolescents to acquire skills that can be used to manage test anxiety effectively. One such brief intervention, STEPS, has been shown to reduce test anxiety, and also GAD and PD. It is possible that school staff without prior psychological expertise would be able to deliver STEPS, or other brief CBIs, if provided with the appropriate training. If interventions, and the associated training, were made available to school staff at a reasonable cost, there is great hope of considerably broadening access to intervention for high test anxious adolescents.

X.9 References

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