

Original Research

Incorporating Video Feedback into a Cognitive-Behavioral Intervention for Treating Childhood Anxiety: Initial Findings after Delivering Super Skills for Life

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Abstract

The present study examined the effectiveness of a transdiagnostic intervention programme, Super Skills for Life (SSL), in children with clinical anxiety. SSL, in addition to the principles of cognitive and behavioral therapy, also incorporates video feedback and cognitive preparation as essential components of the treatment. The program was implemented in a clinical population in an NHS community child mental health unit. The sample consisted of 23 Greek-speaking elementary school children diagnosed with at least one Anxiety Disorder (AD). Each session was held once a week for 1 hour. The program consisted of 8 sessions. Children were video-recorded during a 2-min speech task in sessions 1 and 8. All the children completed a large battery of self-reported questionnaires targeting emotional and behavioral difficulties before and after participating in the intervention. There was an immediate improvement in



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participants after the completion of the intervention. Regarding the behavioral indicators of anxiety during the 2-minute speech task, improvements were observed and recorded by both the children themselves and external observer assessments. Thus, behavioral improvement was detected regarding children's social competence and self-concept from pre-treatment to post-treatment. The present study used an open clinical trial design, had a small sample size, and did not provide evidence regarding the long-term sustainability of the program's beneficial effects after the intervention's completion. This study provides preliminary exploratory results regarding the effect of video feedback on the improvement of social anxiety and self-perception of children with pathological anxiety. Additionally, it constitutes a useful therapeutic tool within the framework of applying SSL to this population.

Keywords

Videofeedback; cognitive preparation; childhood anxiety; social anxiety; social self-perception; group interventions

1. Background

Super Skills for Life (SSL) is a transdiagnostic clinical intervention protocol for children targeting mainly emotional but also other comorbid problems (e.g., low self-esteem, aggression, peer problems, psychomotor difficulties, lack of social skills). It was developed by Essau and Ollendick [1]. It can be implemented in different contexts. Several studies so far have reported its immediate and long-term effects in several countries, such as the UK [2, 3], Spain [4-11], Mauritius [12], Malaysia [13], and Greece [14]. SSL includes not only effective cognitive-behavioral techniques, behavioral activation, and social skills training, but also video feedback with cognitive preparation, which constitutes a potentially useful therapeutic tool, especially in children with limited social competence [10]. Children with clinical anxiety have been reported to have poor social skills [15-18]. This results in them having difficulty receiving positive reinforcement through social interactions. On the other hand, as it emerges from studies mainly in adults with social anxiety, they display negative self-images, especially when they observe themselves in social interactions [19].

Video feedback technique involves using video recordings of a child's social interactions to help them update their negative self-perceptions and improve social skills. By watching themselves in social situations, children can identify discrepancies between their self-image and how they actually appear to others, leading to a more realistic and positive self-perception [20, 21]. Video feedback, combined with cognitive preparation, aids in the intervention of the SSL program, especially for children with diminished social competence. Initially, these techniques help correct cognitively distorted perceptions [22, 23]. As mentioned before, socially anxious children often have a distorted perception of their performance in social situations, believing they did worse than they actually did. Therefore, watching their behavior on video allows them to observe their actual performance. This helps them distinguish between how they felt (e.g., "I thought I did terribly") and what really happened (e.g., "I spoke clearly and made eye contact"). In addition, before watching the video, the child is cognitively prepared to focus on specific positive behaviors (e.g., "Let's look for the times you smiled" or "Pay attention to when you spoke with confidence"). This preparation guides their

attention away from negative thoughts and toward the positive aspects of their performance [22]. Cognitive preparation, combined with video feedback, has been studied extensively in the adult population, whereas it has been studied less extensively in the pediatric population [22, 24, 25]. Nevertheless, children find it easy to grasp and engage with the process [2, 8]. In addition, if we examine video feedback together with cognitive preparation as part of a broader protocol, we will find that, in the last decade or so, a plethora of studies have taken place examining the effectiveness of SSL in the area of social competence and skills, demonstrating significant benefits in children [2-4, 6, 7, 11, 26]. In particular, the study by Essau et al. [2] is the foundational study of the SSL protocol, which introduced the 2-minute video speech task. It demonstrated that the intervention had a positive impact on reducing peer problems and improving social behavior, with these results being sustained at the 6-month follow-up. While we refer broadly to the beneficial effect of SSL on a participant's social self-perception, it is noted that two sessions of SSL involve teaching children's skills to enhance their behavior in social situations. For example, this training includes 'how to start a conversation' or 'how to join a group conversation,' techniques to solve social problems, i.e., through role-playing during the sessions, and then practicing them as part of their homework.

Our study aimed to examine the clinical effectiveness of the transdiagnostic SSL program in a sample of children with pathological anxiety, with a specific focus on changes in social performance and self-perception following the delivery of the full intervention, which incorporates video feedback with cognitive preparation as integral components. We hypothesized that the particular intervention would reduce participants' social and performance anxiety by correcting their self-concept and enhancing their social skills. This study is a preliminary part of a broader research project, where a large battery of questionnaires was administered to young participants who were administered SSL before, as well as after the completion of the intervention [14].

2. Materials and Methods

2.1 Implementation of the SSL

The intervention was delivered over a period of two years, between 3/2019-2/2021, and took place at the Mental Health Center of Athens General Hospital for Chest Diseases "Sotiria," targeting children diagnosed with ADs. SSL was delivered by a special education teacher, who facilitated the sessions. The facilitator recruited the children after they were evaluated by a child psychiatrist using the Greek version of a reliable semi-structured interview [27]. Before implementing the intervention, the facilitator had a day-long workshop on the program, conducted by the program's senior authors, that covered topics like Anxiety Disorders (ADs) and its risk factors, prevention principles, program organization, ethics, and group leadership skills. The facilitator was also given a leader's manual with detailed session outlines and met weekly with the senior authors to discuss any issues with the program's content or delivery.

The intervention included instruction in the following competencies: educating participants about emotions and feelings, reframing thoughts (cognitive reappraisal), problem-solving, increasing positive activities (behavior activation), using relaxation techniques, self-monitoring, and developing social competence. These competencies were delivered through a range of formats, including small-group and individual exercises, simulated scenarios (role-plays), activities, and games. To reinforce learning, assignments were issued at the end of each session, requiring the

children to practice the skills they had been taught. Children who completed their assignments were awarded a colorful sticker at the close of every session [1, 3].

2.2 Participants

In total, 23 children (mean age:10.2 ± 1.9 years; range: 6-12 years; 14 boys, 9 girls) participated in this open-label study. Participants were recruited from central Athens. All participants were Greek-born or/and Greek-speaking. The participating children were not receiving concurrent psychological treatment or had not initiated psychopharmacological treatment before the intervention. In this study, the children diagnosed with Intellectual Disability or Pervasive Developmental Disorder were excluded because the program is not designed to address the specific and complex needs associated with these conditions [28]. The inclusion and exclusion criteria for the participants are presented in Table 1.

Table 1 Inclusion and exclusion criteria of the participants.

<i>Inclusion criteria</i>
Children were between 6 and 12 years of age (attending primary school).
Children had at least one diagnosis of an AD, confirmed by a child psychiatrist through a structured diagnostic interview.
Children and caregivers were able to understand, write, and read the Greek language.
Children agreed to attend all sessions and to complete the assigned questionnaires after the 8th session.
<i>Exclusion criteria</i>
Children had a diagnosis of intellectual disability.
Children had a diagnosis of pervasive developmental disorder, the severity of which interferes with program implementation.
Children were concurrently undergoing psychological treatment.
Children had initiated psychopharmacological treatment prior to the intervention.

2.2.1 Procedures

All parents of participants were sent information that described the research project, along with an informed consent form to be completed and returned by their parents. Children’s participation was voluntary; they were informed that their responses to the questionnaires would be kept confidential, and they could withdraw from the research at any time. The SSL was delivered in the afternoon (after morning class). Children participated in the eight sessions of the SSL, with each session lasting for 60 min, once a week. The group size ranged from 6 to 8 children, with an average of 8 per group. All the children completed a large battery of self-reported questionnaires targeting emotional and behavioral difficulties before and after participating in the intervention.

In sessions 1 and 8, children were asked to give a 2-minute speech to the whole group and face a video camera. For the 2-minute speech tasks that were conducted at the first session, the children were asked to introduce themselves; for the 2-minute speech task at session 8 (i.e., post-intervention), children were asked to say something in front of the whole group about what they had learned from participating in SSL and the skills they found to be most helpful. Before showing

the children their video during the 2- min speech tasks, they were once again instructed to pay attention to how they appeared during the speech, not to how they felt.

Therefore, before watching the videos, participants were asked to complete a questionnaire titled: “How I think I look like”, which contained questions as mentioned in Table 2. The questions referred to how much the children believed they exhibited the specific behavior during the speech, while they had three possible answers, specifically: Very much, quite a bit, and not at all.

Table 2 Items of the two Questionnaires: “How I think I look like” and “How do I finally look like”.

Self-reported Scales	
How I think I look like?	How do I finally look like?
My legs were shaking.	How strong and clear was your voice?
My hands were moving nervously.	How friendly did you see?
I was biting my nails.	Did you mix up your words?
My posture was relaxed.	Do you think you looked smart?
I was coughing out of embarrassment.	How much did you look at the camera?
I was laughing constantly.	How good was your speech?
I was pulling on my clothes.	Did you seem nervous?
I was losing my words or stuttering.	
I was biting my lips.	
I was focused on my speech.	

Then, the facilitator invited them to watch their video, and subsequently to answer the items of the “the way I finally look like” questionnaire, which asked how, in their opinion, they ultimately looked on camera, as noted in Table 2 above. Participants were now asked to give four possible answers: very much, quite a bit, a little, not very much.

Therefore, the two questionnaires “How I think I look like in the video” and “The way I finally look like in the video”, were administered in the first (i.e., pre-intervention) and in the last or 8th session (i.e., post-intervention), before and after watching their two-minute videos. In total, the participants completed four questionnaires. The higher the score a child received, the more social anxiety he had and the lower his self-perception. It is important to note that these two questionnaires were not designed as standardized psychometric scales intended to measure a single latent psychological construct. Instead, they serve as task-specific behavioral tracking checklists embedded directly within the SSL video-feedback protocol. They aim to measure distinct, observable somatic and behavioral reactions to situational anxiety during a specific exposure task. Therefore, a 3-point scale was used before watching the video to keep tasks simple for children during high anxiety, while a 4-point scale was used after the video to capture more detailed self-observations. Since the two checklists were analyzed independently, the different scale formats did not affect the statistical analysis.

2.2.2 Results from Qualitative Analysis of Fydrich - Behavioral Assessment of Social Performance

The same favorable results were obtained from the qualitative analysis of the measure Fydrich - Behavioral Assessment of Social Performance-modified. This concerns a behavioral assessment

system designed to measure various key dimensions (gaze, quality of voice, discomfort, speech length, conversational flow) of social competence through video recordings [29].

In particular, the gaze of socially anxious children who score high on this assessment often differs from that of their peers and may display characteristic signs of hesitation or avoidance. Their gaze is often lowered or marked by brief, furtive glances. At times, it may appear frozen or vacant, while at other times they may dart about nervously or convey a sense of alertness and fear [30].

On the other hand, within the context of high social stress, the sympathetic nervous system affects breathing, laryngeal muscle tension, and airflow, causing the voice to reveal the child's emotional state. Consequently, these children often speak softly, almost in a whisper, while at times their voice may sound flat, lacking natural intonation. Occasionally, the voice may crack or tremble slightly, especially at the beginning of speech or when the child addresses a group. In some cases, the child speaks with pauses, searching for the right words or attempting to avoid exposure [31].

Moreover, children with social anxiety often respond with single words or minimally elaborated comments (e.g., "yes", "I don't know", "maybe"). This behavior reduces their speaking time, allowing them to minimize exposure to potential evaluation or criticism. In addition, these children tend to speak hesitantly, with prolonged pauses, and they often avoid initiating spontaneous conversation; when they do, they usually limit themselves to brief utterances, avoiding further elaboration on the topic [32].

Regarding the discomfort exhibited by children with social anxiety, it stems from their fear of social evaluation, heightened self-monitoring, increased psychophysiological arousal, and lack of positive social experiences. At the same time, children with social anxiety often demonstrate limited conversational flow. Specifically, they show reduced initiative to start or engage in conversation, frequent pauses, limited reciprocity, and low spontaneity.

It is worth mentioning that two trained and independent observers rated the videos offline, indicating the frequency and the tension with which the children displayed these behavioural signs of anxiety. Both raters, who held a Master's degree in Psychology, did not participate in the delivery of the SSL, and they were blind to the children's scores on self-report questionnaires. The use of two independent observers enabled the senior researchers to assess how well their ratings agreed, thereby ensuring high inter-rater reliability. The mean score of the two raters was calculated for the analyses. The recording was divided into successive 30-second sample intervals in which the observers recorded whether each of the aforementioned behaviours was present.

2.3 Ethical Approval

Ethical approval to conduct this research was obtained from the Ethical Board of the Sotiria Chest Disease Hospital of Athens, Greece.

2.4 Statistical Analysis

Concerning self-perception assessment, non-parametric tests were selected due to the non-normal distribution of the data, aiming to identify statistically significant changes before and after the SSL intervention. In particular, the Wilcoxon matched-pairs signed-rank test was used to evaluate differences between the baseline and final scores for each questionnaire. A p -value < 0.05 was considered statistically significant. The analysis was performed using STATA 12 software.

3. Results

Following the analysis of participant responses, the data showed that before watching their video, while at the beginning of the intervention the participating children expressed personal inadequacy in performing this task through their answers, as well as a greater expectation that they would appear anxious, at the end of the intervention (session 8), and before watching their video, this social adequacy and expectation was expressed with a statistically significant improvement in their corresponding score.

Furthermore, after participants watched their video recordings, the ratings they gave of their personal adequacy in performing this task also differed statistically significantly between the first and last sessions of the intervention (Table 3). That is, the indicators of anxiety, as rated by the participants themselves, were clearly reduced in the final session compared to the beginning of the intervention. Table 4 presents the scores (raw data) obtained by participants in the pre- and post-intervention questionnaires. For instance, during the first session, individual 1 rated his performance on the task before watching the video as 15. During session 8, also before watching the video, his corresponding score was 12; that is, his social self-perception had improved. On the other hand, after watching the video, individual 1, initially in session 1, rated his performance with 18, compared to the score of 15 assessed post-video in session 8, also demonstrating an improvement in the social competence factor. Furthermore, as shown in the same table, the predominant diagnosis in the sample is Generalized Anxiety Disorder (GAD) in 12 individuals. At the same time, in 6 cases the diagnostic entity of Social Anxiety Disorder (Soc Phob) was found. Clinical depression (De) was also detected in 5 cases of children. Finally, Anxiety Disorder Other Specified/Unspecified (AD OS/U) was found in 5 cases, while Separation Anxiety Disorder (SAD) in only 3 cases. In other words, regarding the comorbid diagnoses of ADs, the most frequent ones concerned De and Learning Disorders, sharing the same percentage of 21.7% (5 individuals in each case).

Table 3 Total scores of pre- and post-video assessment scales of our sample.

Spoken tasks self-ratings	Session 1 (pre-intervention) mean $\pm$ SD	Session 8 (post-intervention) mean $\pm$ SD	<i>p</i> -value
"How do I think I look like (before watching the video)?" (<i>pre-video</i>)	15.7 $\pm$ 0.7 (score A)	11.3 $\pm$ 0.4 (score B)	0.0001
"How do I finally look like (after watching the video)?" (<i>post-video</i>)	20.5 $\pm$ 0.83 (score C)	11.8 $\pm$ 1 (score D)	<0.0000

Abbreviations: N = 23; mean = mean value; SD = Standard Deviation; score A: How I think I look like (Session 1); score B: How I think I look like (Session 8); score C: How I finally look like (Session 1); score D: How I finally look like (Session 8).

Table 4 List of diagnoses, age, gender, and pre- and post-video assessment scales of our sample.

Participants	Gen	Age	Diag 1	Diag 2	Diag 3	<i>Spoken task ratings</i>			
						<i>Pre-Video (expectation)</i>		<i>Post-Video (final assessment)</i>	
						score A (Session 1)	score B (Session 8)	score C (Session 1)	score D (Session 8)
1	F	12	Soc Phob	SAD	GAD	15	12	18	15
2	M	11	GAD	Soc Phob	SAD	16	9	23	10
3	F	12	PD	IAD	N/A	13	10	16	13
4	M	12	Soc Phob	Gen Dysph	N/A	24	11	24	8
5	M	10	SocPhob	De	N/A	13	11	15	10
6	F	12	GAD	De	N/A	17	12	21	19
7	M	9	GAD	N/A	N/A	14	10	19	17
8	F	12	GAD	N/A	N/A	15	12	18	15
9	M	12	Soc Ph	N/A	N/A	14	10	29	15
10	M	08	SAD	LD	N/A	20	11	21	7
11	F	11	GAD	SocPhob	De	12	11	16	14
12	F	12	GAD	N/A	N/A	15	12	18	15
13	M	6	SAD	N/A	N/A	14	11	20	18
14	M	9	GAD	ADHD	LD	17	15	20	7
15	F	8	AD OS/U	ADHD	LD	14	11	19	7
16	M	10	AD OS/U	De	LD	14	14	22	21
17	M	6	GAD	N/A	N/A	15	11	19	13
18	M	12	GAD	N/A	N/A	16	10	24	10
19	M	9	AD OS/U	N/A	N/A	18	12	19	17
20	F	12	GAD	N/A	N/A	12	9	15	12
21	M	9	GAD	N/A	N/A	19	9	25	14
22	M	10	AD OS/U	LD	N/A	13	15	16	12
23	F	10	AD OS/U	De	N/A	14	10	20	7

Abbreviations: score A: How I think I look like (Session 1); score B: How I think I look like (Session 8); score C: How I finally look like (Session 1); score D: How I finally look like (Session 8); M: Male; F: Female; Diag: Diagnoses; Gen: Gender; SocPhob: Social Phobia; PD: Panic Disorder; GAD: Generalized Anxiety Disorder; IAD: Illness Anxiety Disorder; SAD: Separation Anxiety Disorder; De: Depression; AD OS/U: Anxiety Disorder Other Specified/Unidentified; LD: Learning Disability; ADHD: Attention Deficit Hyperactivity Disorder; Gen Dysph: Gender Dysphoria; N/A: (Extra Diagnosis) Not Available.

According to Qualitative analysis of Fydrich, the two observers noted that, during their final video recording at session 8, in comparison with the evaluation of videos at session 1, the children had more consistent and stable eye contact with the facilitator and the camera; their speech had flow, meaning, and liveliness, their voice tone was steady without hesitation, and the duration of their speech was very satisfactory; they were now able to stand comfortably in front of the camera and speak for two full minutes without pauses, interruptions, or signs of discomfort.

4. Discussion

The main objective of the present study was to investigate the effectiveness of the SSL intervention in a clinical sample of children with pathological anxiety, emphasizing the changes in social performance and self-perception following delivery of the full version, which incorporates video feedback with cognitive preparation as integral components. The intervention's results demonstrated a potential overall immediate improvement in participants, in both behavioral indicators of anxiety, social competence and self-perception. These trends were observed both through the children's self-reports and evaluations by independent external observers.

These preliminary findings are consistent with previous research supporting the role of video feedback and cognitive preparation in addressing social anxiety and improving social performance [2, 8, 10, 22, 33]. The use of video recordings allowed the children to observe their actual performance, correcting the cognitively distorted perception they often have of their social performance. This process helped them distinguish between how they felt (e.g., "I thought I did terribly") from what actually happened (e.g., "I spoke clearly and made eye contact"). Therefore, participants probably focused on objective evidence of their performance, rather than on their subjective feelings of anxiety. Additionally, cognitive preparation before video viewing, which guided their attention toward specific positive behaviors, may have helped shift the focus away from negative thoughts.

The improvement in performance assessed on the pre- and post-video questionnaires in favor of the last session over the first suggests that the SSL intervention may have played a key role in fostering an increased sense of competence and more realistic expectations regarding participants' performance. This is further supported by the independent observers' evaluation, which recorded improvements in specific behavioral indicators, such as voice quality, speech flow, and a reduction in discomfort. These initial findings underscore that the improvement was probably not merely subjective but also reflected an objective change in the children's behavior.

Despite these encouraging results, the present study has certain limitations. It used an open clinical trial design with a small sample size drawn from a single community unit, recruited without randomization (N = 23). The open-trial design without a parallel control group precludes firm conclusions regarding causality, as non-specific therapeutic factors, time-related maturation effects, or expectancy biases cannot be fully ruled out. Albeit, it is important to note that the children who participated in the study had strict entry criteria: they could not be receiving any concurrent psychosocial treatment. Moreover, trait-like factors like social competence and social self-perception do not remit spontaneously or evolve rapidly, so the improvement observed in the study may not solely attributable to the passage of time. These speculations reduce the likelihood that the observed improvement is attributable to confounding factors, such as the passage of time or external therapy. On the other hand, the small sample size limits the generalizability of the findings

beyond this context and statistical power. Furthermore, the study did not provide evidence regarding the long-term sustainability of the program's beneficial effects after its completion. This is also a major limitation of our study, since there was no funding for the researchers to cover the long-term maintenance of treatment benefits. At the same time, the sample was largely drawn from the central, low-income suburbs of Athens. It involved economic migrants, i.e. a population that is typically mobile and difficult to re-approach [34]. Additionally, effect size indicators were not used, which limits the estimation of the magnitude of changes beyond statistical significance. Moreover, because the study evaluated the SSL intervention as a whole package without a dismantling design or a comparison group, it is not possible to isolate or attribute the observed improvements exclusively to the video feedback and cognitive preparation components. The outcomes reflect the combined efficacy of all therapeutic elements included in the SSL protocol. Conversely, a key advantage of this particular study was that the diagnosis of participants with pathological anxiety was derived through a reliable semi-structured interview used by an experienced child psychiatrist. Furthermore, the beneficial effects of the intervention were demonstrated in a clinical sample of children.

In conclusion, this open pilot study provides preliminary indications of the feasibility and potential benefits of video feedback and cognitive preparation for children with clinical anxiety. Given the absence of a control group and the small sample size, these findings should be interpreted with caution and require confirmation through larger randomized controlled studies.

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Author Contributions

Anna Tsourдини was the basic researcher of the project. Ioannis Syros wrote the manuscript. Xenia Anastassiou-Hadjicharalambous supervised the project, provided critical feedback, and helped shape the research, analysis, and manuscript. Blossom Fernandes contributed to the statistical analysis.

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Competing Interests

The authors state that there are no conflicts of interest regarding the publication of this paper.

AI-Assisted Technologies Statement

We declare that while working on this manuscript, we employed the assistance of AI tools at various stages to help with fundamental grammar, language enhancement, and English translation of the text. We assert that all scientific content, data analysis, and conclusions were created independently by the author. The authors have meticulously examined and revised the text produced with AI assistance to guarantee its precision and take complete responsibility for the manuscript's content.

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