



## Research report

# Integrating video-feedback and cognitive preparation, social skills training and behavioural activation in a cognitive behavioural therapy in the treatment of childhood anxiety



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## ABSTRACT

**Background:** The present study examined the effectiveness of a transdiagnostic prevention programme, Super Skills for Life (SSL), in children with anxiety problems. SSL is based on the principles of cognitive-behaviour therapy (CBT), behavioural activation, social skills training, and uses video-feedback and cognitive preparation as part of the treatment.

**Methods:** Participants were 61 primary school children, aged 8–10 years, who were referred by their teachers as having significant anxiety problems. Children were video-recorded during a 2-min speech task in sessions 1 and 8, and during a social interaction task. All the children completed measures of anxiety symptoms, social skills, and self-esteem before and after participating in the 8-week SSL and at the 6-months follow-up assessment.

**Results:** Anxiety symptoms were significantly reduced at post-test and follow-up assessments. SSL also had a positive effect on hyperactivity, conduct, and peer problems although it took longer for these effects to occur. Behavioural indicators of anxiety during the 2-min speech task decreased, indicating that the independent raters observed behavioural change in the children from pre-treatment to follow-up. Boys had higher overall behavioural anxiety during the 2-min speech task at all three assessment periods, specifically showing higher lip contortions and leg movement than girls.

**Limitations:** The present study used an open clinical trial design, had small sample size, and did not use structured diagnostic interview schedules to assess anxiety disorders.

**Conclusions:** This study provides preliminary empirical support for the effectiveness of SSL in children with anxiety problems.

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## 1. Introduction

Approximately 15–31.9% of children and adolescents in the general population are affected by anxiety disorders (Essau et al., 2000; Lewinsohn et al., 1993; Merikangas et al., 2010). Anxiety disorders cause significant distress and impairment in major life domains, including educational underachievement (Essau et al., 2000; Feehan et al., 1993; Woodward & Fergusson, 2001). If left untreated, anxiety disorders that begin early in life tend to have a negative course and may serve as a risk factor for several other

psychiatric disorders in adulthood (Essau et al., 2014; Kessler et al., 1994).

Cognitive behaviour therapy (CBT) is the treatment of choice for childhood anxiety, with 50 to 70% of children with an anxiety disorder responding positively to CBT (Barrett et al., 1996; Barrett et al., 2001; Essau et al., 2012; Kendall et al., 1997; Seligman and Ollendick, 2011; Stallard et al., 2007). These moderate remission rates might be attributed to the fact that these studies have been based on interventions that are specifically designed for anxiety disorders despite strong evidence of the high comorbidity between anxiety and other internalising (e.g., depression) (Essau, 2005) and externalising disorders (e.g., conduct disorder). In fact, children and adolescents who had comorbid depressive symptoms or disorders and received treatment for their anxiety disorders had a poorer outcome than those who did not (Brent et al., 1998;

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O'Neil and Kendall, 2012). Furthermore, there has been discussion whether younger children could understand the basic concepts of CBT (e.g., the association between thoughts, feelings and behaviour) due to their cognitive development. For example, children have been reported to have difficulty in understanding a major component of CBT (i.e., cognitive restructuring), resulting in low compliance rate in completing their homework in this area.

Due to limitations of CBT (e.g., requiring patients to learn high-level skills) (Rhodes et al., 2014), a recent trend has been the implementation of behavioural activation in the treatment of anxiety disorders (e.g., Chen et al., 2013) as its rationale is easier to understand and operationalise for both patients and mental health professionals (Rhodes et al., 2014). Behavioural activation was originally designed to alleviate depression by targeting avoidance of normal activities which preclude individuals from experiencing positive reinforcement opportunities from their environment (Lewinsohn et al., 1985). By targeting avoidance, behavioural activation helps to disrupt the cycle of avoidance, decrease activity, and anxious/low mood through repeated exposure to goal oriented behaviour (Rhodes et al., 2014). The efficacy of behavioural activation in the treatment of anxiety disorders has recently been reported in adults (Chen et al., 2013), but not in children.

Children with high anxiety have been reported to have poor social skills (Coplan et al., 2004; Ginsburg et al., 1998; Schneider, 2009; Spence et al., 1999) and low quality friendships which in turn put them at risk for victimization (La Greca and Lopez, 1998). These findings emphasise the importance of teaching children the skills that help them experience successful outcomes from social interactions, including non-verbal responses (e.g., appropriate use of eye contact and facial expression), and verbal skills (e.g., tone, rate and volume of speech) (Spence, 2003).

Studies among adults with anxiety disorders, particularly those with social anxiety, tend to show that these adults have negative images of themselves, especially when they observe themselves in social interactions (Clark and Wells, 1995; Rapee and Heimberg, 1997). Since negative self-processing diverts individual's attention from external social information which could help change their negative beliefs, Rapee and Hayman (1996) have suggested using cognitive preparation prior to viewing themselves as a method to modify such beliefs. In line with this suggestion, studies among adults have shown that cognitive preparation before viewing videos of the self have proven effective in correcting the distorted self-perception and in reducing anxiety (Harvey et al., 2000; Kim et al., 2002; Rodebaugh, 2004). Although video-feedback with cognitive preparation (Clark and Wells, 1995; Harvey et al., 2000) is effective in the treatment of anxiety disorders in adults, this strategy has not been implemented heretofore with children. Studies have also reported that anxiety disorders tend to run in a family. According to a recent study by Schreier and Heinrichs (2010) the mechanism by which anxiety may be transmitted from mothers to children was maternal report of negative child evaluation (FNCE). It was argued that parents not only extend their own interpretational bias towards their child but also extend their fear of negative evaluation to a more general fear of negative evaluation such as fear of negative evaluation related to their child. It is however unknown if parental FNCE mediated the association between child anxiety and treatment outcome.

Drawing from the above research, a transdiagnostic treatment protocol (called "Super Skills for Life"; SSL, Essau and Ollendick, 2013) was developed for children with internalising problems (i.e., both anxiety and depression). SSL has five core principles: (1) it is based on a transdiagnostic approach by targeting common core risk factors (e.g., low self-esteem, lack of social skills) of comorbid disorders, and as such it should be more time efficient and cost-effective (Rohde, 2012); (2) it is based on the principles of CBT to

help children develop skills to cope with anxiety-provoking situations; (3) it uses video feedback with cognitive preparation to help children enhance their self-perception (Harvey et al., 2000; Rodebaugh, 2004). Children are exposed to social situation by asking them to give three 2-min speeches in front of the whole group facing a video camera during the intervention period (first and last sessions) and at follow-up session, as well as being asked to role play a social interaction in front of the class and being video-taped. Furthermore, two sessions of the SSL involve teaching children skills to enhance their behaviour in social situation such as "when to start conversations", "when to join a group conversation", techniques to solve any social problems, and to role play these skills during the sessions, and to practise them as part of their homework; (4) it uses the principle of behavioural activation by having children increase their activity levels and participate in positive and rewarding activities, which in turn can help to improve their mood and overall self-esteem; (5) finally, it teaches children basic skills to use during social interactions to help increase their experience of successful outcomes from the interactions.

The aim of the present study was to evaluate the effectiveness of SSL. Its specific aims were to examine: (1) the effects of the SSL on children's anxiety and depressive symptoms, social skills, and self-esteem; and (2) the mediating factors that predict the treatment outcome. The hypotheses to be tested were: (a) there will be a decrease in the principal problem (i.e., anxiety) and a decrease in the symptoms of other disorders (e.g., depression, conduct problems) at post-test and at follow-up as compared to pre-treatment levels. (b) parental fear of negative child evaluation (as reported by the child) and self-esteem will mediate the treatment outcome.

## 2. Method

### 2.1. Participants

A total of 61 children, aged between 8 and 10 years ( $M=8.84$  years and  $SD=0.73$ ) participated. Of these, 43 were boys (70.49%) and 18 were girls (29.51%). The participants were from low socioeconomic status and from diverse cultural backgrounds (38.33% were White; 23.33% were Black; 16.67% were mixed; 15.00% were Asian; 6.67% were Middle Eastern).

All the children were selected by their teachers from four primary schools in North and South-West London; these children were known by their teachers as showing significant anxiety problems. Although the teachers did not use any objective measures of anxiety severity to make their referral, anxiety of the study cohort is as severe as those in numerous RCT cohorts (e.g., Stallard et al., 2007) and the anxiety scores were in the clinical range as measured using the SCAS. Other inclusion criteria were that the children (a) were in years 5 and 6 in school; (b) no signs of self-harm were evident; and (c) the children were not currently undergoing psychological or pharmacological treatment for their anxiety problems.

### 2.2. Implementation of the SSL

The delivery of the SSL was conducted by facilitators, all with a Masters degree in Psychology (major in Child Psychopathology). Before implementing the SSL, the facilitators received an intensive one-day workshop by the senior author (CAE). The workshop covered topics related to anxiety disorders and their risk factors, principles of prevention, organisation and ethical issues in running the programme with a group of children, as well as group leader and group process skills. Each session of the SSL was reviewed through dialogue, role play, and exercises. All the facilitators were

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