Incorporating Video Feedback into a Cognitive-Behavioral Intervention for Treating Childhood Anxiety: Initial findings after delivering Super Skills for Life.

1. Background

Super Skills for Life (SSL) is a transdiagnostic prevention 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 [2013]. It can be implemented in different contexts. Several studies so far have reported its immediate and long-term effects in several countries such as in the UK [Essau et al., 2014; 2019], Spain [Diego et al., 2023; Fernández-Martínez et al., 2019, 2020; Melero et al., 2021a; Melero et al., 2021b; Orgiles et al., 2019; 2020a; 2020b], Mauritius [Ramdhonee-Dowlot et al., 2021], Malaysia [Yoga-Ratnam et al., 2022], and Greece [Tsourdini et al., 2019]. SSL includes not only effective cognitive-behavioural techniques, behavioural activation, and social skills training, but also video-feedback with cognitive preparation, which constitutes an essential therapeutic tool, especially in children with limited social competence (Orgiles et al., 2020). Children with clinical anxiety have been reported to have poor social skills (Coplan et al., 2004; Ginsburg et al., 1998; Schneider, 2009; Spence et al., 1999). 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 (Wilson & Rapee, 2005).

Video feedback 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. (Rapee & Hayman, 1996; Warnock-Parkes et al., 2017). This technique, although not established in the clinical practice of treating childhood anxiety, however, children find this easy to grasp and has shown an understanding of this process (Essau et al., 2014; Melero et al., 2021a).

Video feedback, combined with cognitive preparation, aids in the intervention of the Super Skills for Life (SSL) program, especially for children with diminished social competence. Initially, these techniques contribute to correcting cognitive distorted perception (Harve et al., 2000; Rodebaugh, 2004). 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 (Harve et al., 2000). Cognitive preparation, combined with video feedback, has been studied extensively in the adult population, in contrast to the pediatric population (Harve et al., 2000; Hodson et al., 1995; Rodebaugh et al., 2010).

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 skills to enhance their behavior in social situations, such as 'how to start a conversation,' '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 investigate the beneficial effect of the video-feedback technique in a selective sample of children with pathological anxiety following the SSL programme. We hypothesize that the particular intervention would lessen the social and performance anxiety of participants through correcting the perception of 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 (Syros et al., 2025).

2. Material and Methods

2.1. Implementation of the SSL

The intervention was delivered over the 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. Before implementing the intervention, the facilitator had a day-long workshop on the program, which was

conducted by the program's senior authors, and covered topics like Anxiety Disorders (AD) 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 featured instruction in the following competencies: educating participants on emotions and feelings, reframing thoughts (cognitive reappraisal), solving problems, increasing positive activities (behaviour activation), using relaxation techniques, monitoring oneself, and developing social competence. These competencies were delivered through a range of formats, including exercises in small groups and individually, 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 (Essau et al., 2013; 2019).

2.2. Participants

In total, twenty-three children (mean age:10.2; 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 (Tsourdini et al., 2019).

2.3.1. Procedures

All parents of participants were sent information that described the research project, together 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 range of group size was six to eight children, with an average size per group being 8 children. 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 in front of the whole group and facing 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 the way in which they appeared during the speech and 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 1.** 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.

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 contained questions about how, in their opinion, they ultimately looked on camera, as noted in **Table 1** below. 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.

Table 1: 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.	

2.3.2. Results from Qualitative analysis of Fydrich - Behavioral Assessment of Social Performance

The same favorable results were derived 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 (Fydrich et al., 1998).

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 others, the eyes may dart about nervously or convey a sense of alertness and fear (Kleberg et al., 2021).

On the other hand, within the context of high social stress, the sympathetic nervous system affects breathing, laryngeal muscle tension, and airflow, causing the quality of 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 (Jones & Mark, 2011).

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 (Rapee & Lim, 1992).

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 allowed the senior researchers to calculate how well their ratings agree with each other, thus 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 or not each of the aforementioned behaviours was present.

2.4. Ethical Approval

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

2.5. Statistical Analysis

The Wilcoxon matched-pairs signed-rank test was applied in order to investigate the differences between the first and the last total score in each questionnaire. Data was not parametric in effect. P-value <0.05 was considered statistically significant. The analysis was performed by 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 the participants watched their video recording, it was found that the ratings they gave for how they evaluated their personal adequacy in performing this task also differed statistically significantly between the first and last sessions of the intervention (**Table 2**). 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 3** presents the scores obtained by participants in the pre- and post-intervention questionnaires. The predominant diagnosis in the sample is Generalized Anxiety Disorder (GAD) in 12 individuals, while 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.

Table 2. Total scores of pre- and post-video assessment scales of our sample.

Self-reported scales	Session 1 (pre-intervention)	Session 8 (post-intervention)	p-value
"How do I think I look like (before watching the video)?"	**15.7±0.7**	**11.3±0.4**	**.0001**
"How do I finally look like (after watching the video)?"	**20.5±0.83**	**11.8±1**	**< .0000**

Table 3. List of diagnoses, age, gender and pre- and post - video assessment scales of our sample.

						Self-reported Scales Score			
Participants	**Gen**	**Age**	**Diag1**	**Diag 2**	**Diag3**	**How I think look like (session 1)**	**How I think look like (session 8)**	**How I finally look like (session 1)**	**How I finally look like (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		13	10	16	13
4	M	12	Soc Phob	Gen Dysph		24	11	24	08
5	M	10	Soc Phob	De		13	11	15	10
6	F	12	GAD	De		17	12	21	19
7	M	9	GAD			14	10	19	17
8	F	12	GAD			15	12	18	15
9	M	12	Soc Ph			14	10	29	15
10	M	08	SAD	LD		20	11	21	07

11	F	11	GAD	SocPhob	De	12	11	16	14
12	F	12	GAD			15	12	18	15
13	M	6	SAD			14	11	20	18
14	M	9	GAD	ADHD	LD	17	15	20	07
15	F	8	AD OS / U	ADHD	LD	14	11	19	07
16	M	10	AD OS / U	De	LD	14 1	14	22	21
17	M	6	GAD			15	11	19	13
18	M	12	GAD			16	10	24	10
19	M	9	AD OS / U			18	12	19	17
20	F	12	GAD			12	09	15	12

21	M	9	GAD			19	09	25	14
22	M	10	AD OS / U	LD		13	15	16	12
23	F	10	AD OS / U	De		14	10	20	07

Abbreviations: 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

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

This study's primary objective was to investigate the effectiveness of the video feedback technique in a clinical sample of children with pathological anxiety. The intervention's

results demonstrated an overall immediate improvement in participants, concerning both behavioral indicators of anxiety and their social competence and self-perception. This improvement was recorded by the children's self-reports and by the assessments of 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 (Eskiyurt et al., 2023; Essau et al., 2014; Harve et al., 2000; Melero et al., 2021a; Orgiles et al., 2020). 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 differentiate 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 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, proved to be critical, shifting 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 led to an increased sense of competence and a more realistic expectation of their performance. This is further supported by the independent observers' evaluation, which recorded a clear improvement in specific behavioral indicators, such as voice quality, speech flow, and a reduction in discomfort. These initial findings underscore that the improvement was 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 recruited without randomization (N=23), and it did not provide evidence regarding the long-term sustainability of the program's beneficial effects after the intervention's completion. Therefore, future research could use larger samples, include control groups, and incorporate follow-up assessments to confirm the sustainability of the results. On the other hand, the strength 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 study provides preliminary empirical support for the effectiveness of video feedback in improving social anxiety and self-perception in children with pathological anxiety. It constitutes a useful therapeutic tool within the framework of applying the SSL program to this population.

Abbreviations

AD	**Anxiety Disorder**
AD OS / U	**Anxiety Disorder Other Specified / Unspecified**
ABC	**Antecedent - Beliefs - Consequences**
CBT	**Cognitive Behavior Therapy**
DSM	**Diagnostic Manual of the American Psychiatric Association**

AD	**Anxiety Disorder**
AD OS / U	**Anxiety Disorder Other Specified / Unspecified**
ABC	**Antecedent - Beliefs - Consequences**
SSL	**Super Skills for Life**

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