Interventions for Childhood Anxiety Disorders – What Works Best from a Child’s Perspective: A Qualitative Study

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ABSTRACT

Background: Anxiety spectrum disorders are the most prevalent psychopathology among children and adolescents. Qualitative research in childhood anxiety disorders can provide valuable insights regarding interventions. The objectives of this study were to examine the child’s perspectives on the subjective experience of concerns, the impact of the symptoms on socioacademic functioning, and the process of recovery with interventions. Methods: Children and adolescents aged 6–16 years, presenting with any subtype of anxiety spectrum disorder as per International Classification of Diseases and Related Health problems, 10th Revision (ICD-10) Diagnostic Criteria for Research, were included. Convenience sampling was used, and 30 children fulfilling inclusion and exclusion criteria were selected. An interview guide with simple questions to facilitate response was used, at the baseline and 12th week of follow-up, to generate a written narrative account of the experience of concerns, the impact of symptoms, and the treatment process. Children received treatment as usual, which included a workbook-based cognitive behavioral intervention. Results: Content analysis was done using 30 baseline and 20 follow-up narratives. Clustering of themes were done. Themes related to the recovery process reflected perceived improvement in academic performance and competence, apart from the improvement in symptoms. There were more themes in favor of cognitive interventions. Conclusion: Children’s narratives highlight the importance of cognitive interventions for anxiety disorders.

Key words: Anxiety disorder, child, interventions, qualitative study

Key messages: This qualitative study elicited children’s perspectives on illness experience and treatment impact in our sociocultural setting. Children’s narratives highlighted the importance of cognitive interventions in childhood anxiety disorders.

Anxiety disorders are considered the gateway disorders for many of the adult psychiatric disorders.[1] Childhood anxiety disorders, if untreated, can lead to chronic...
An epidemiological study conducted in Bangalore found a prevalence of 4% for anxiety disorders in children age 4–16 years.[3] The anxiety disorders among adolescents study had reported the prevalence of anxiety disorder to be 14.4% (4.8% in boys and 9.6% in girls) as per Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR).[4] This study documented the prevalence, pattern, comorbidities, and relationship with depression, associated suicidal phenomenon, and school phobia.[5] The prevalence of anxiety disorder among children in the clinic population at a tertiary care center was reported to be 20%.[6]

Interventional studies in the Indian context are limited, and we mostly rely on research information from the west. Qualitative research is scarce in child psychiatry, but research has highlighted the need for qualitative research to enhance our understanding of the children’s experience and to provide them better care models. This study aimed at examining the child’s perspectives on the subjective experience of concerns, the impact of the symptoms on the socioacademic functioning, and the process of recovery with interventions.

METHODS

The study was conducted at a child and adolescent psychiatry clinic at a tertiary care academic institute, after obtaining the Institutional Ethics Committee approval. Informed consent from parents and assent from the child was obtained for participation in the study. Children and adolescents with a diagnosis of separation anxiety disorder of childhood, phobic anxiety disorder of childhood, social anxiety disorder of childhood, generalized anxiety disorder of childhood, social phobia, specific phobia, panic disorder, obsessive-compulsive disorder, or posttraumatic stress disorder as per International Classification of Diseases and Related Health problems, 10th Revision (ICD-10) Diagnostic Criteria for Research were included. Screen for Child Anxiety Related Emotional Disorders (SCARED) was used for the initial screening, and Mini International Neuropsychiatric Interview for children and adolescents was used to establish the diagnosis. The first author made the diagnosis, and it was concurred by the second author. Convenience sampling was used, and 30 children fulfilling the inclusion and exclusion criteria participated in the study.

A workbook for cognitive-behavioral therapy (CBT) was used to standardize the interventions received by all the study participants in addition to the standard care. The components of the workbook were reviewed and approved by all authors and were delivered by the first author. It included training in labeling and monitoring anxiety, mind–body relationship, relaxation strategies, thought diary, problem-solving, coping strategies, challenging negative thoughts, and teaching a friend to overcome anxiety. This was delivered over four to eight sessions as per the needs of the child.

The following interview guide was used to generate a response. Children and adolescents gave a written narrative account at baseline and at 12 weeks of follow-up.

At baseline:
1. What is the nature of your concerns (problems)?
   What is your current experience of these concerns and how significant are they?
2. What impact do these symptoms have on you and the activities you perform at home, school, and other situations? How do they affect your well-being? How do they affect your efficacy (competence)?
3. What do you feel is the cause/reason for these problems (symptoms)?
4. How hopeful do you feel about improvement/recovery? In what way do you want the treating team to assist you in the process of recovery?

At follow-up:
1. What is the nature of your current concerns (problems)? What change have you experienced in the past 3 months?
2. What impact do these symptoms have on you and the activities you perform at home, school, and other situations? How do they affect your well-being? How do they affect your efficacy (competence)?
3. What is your current thinking about the cause/reason for these problems (symptoms)?
4. How hopeful do you feel now about improvement/recovery? In what way did the treating team assist you? What have you learned and mastered in the past few months? What do you feel helped you?

RESULTS

The qualitative analysis was done using 30 written narratives at baseline and 20 written narratives at follow-up. There were 16 boys and 14 girls. Children who had completed at least four sessions of CBT \((n = 20)\) gave the follow-up narrative at the end of 12 weeks. There were 15 narratives by children age 6–12 years and 15 by adolescents in the age range of 13–16 years. There was no significant difference in gender or age group among those who provided the follow-up narratives.
The most common diagnosis was social anxiety disorder \( (n = 19) \), followed by generalized anxiety disorder \( (n = 11) \), obsessive-compulsive disorder \( (n = 7) \), and separation anxiety disorder \( (n = 4) \). Around 56\% \( (n = 16) \) had two or more anxiety disorders.

Most children were school-going and able to give a written narrative account. A few younger children \( (n = 3) \) required assistance in understanding the questions and writing down their thoughts. Adolescents’ narratives were more detailed than those by younger children. The illness experience and illness impact were analyzed using the baseline narratives; and the treatment impact and the subjective experience of change using the follow-up narratives.

Content analysis was done manually by examining core statements made in response to the interview guide. Thematic analysis was done, commonalities and differences were examined, and repetitive themes were identified. A few predetermined themes were used during the analysis to assess the change process with the intervention \( (e.g., \) internalization of interventions). Data interpretation was examined independently by the third author to establish the validity of the findings.

Repetitive themes emerged in the areas of achievement, interpersonal difficulties, self-esteem, and self-efficacy. Impact on academic and nonacademic achievement, as well as interpersonal difficulties in family, peer, and social setting, emerged during analysis \([Table 1]\). A few examples are provided below:

1. Illness experience:
a. Terms used to describe anxious affect

For example, anxious \( (n = 5) \) > scared/tensed/shy \( (n = 4) \) > nervous/afraid \( (n = 2) \)
b. The most common responses for the question on the perceived cause of the illness were internal \( (n = 12) \) or external \( (n = 10) \), and a few had a disease model \( (n = 5) \). External causes included life events.

“The reason for this problem is tension and worry.”

2. Illness impact:

For example, “Stress about studies. I always think more about the future.”

A majority of responses on illness impact reflected the impact on performance in academic activities \( (n = 18) \), play \( (n = 16) \), and other age-appropriate activities \( (n = 5) \). Responses on the impact on relationships showed perceived impairment in peer relationship \( (n = 16) \), family relationship \( (n = 6) \), and interaction with school authorities \( (n = 2) \).

For example, “Cannot complete the day.”

“I never go out to play or for anything else.”

3. Treatment impact:

For the interview guide on treatment impact, there were more responses to nonpharmacological intervention as against pharmacological interventions. Cognitive components \( (n = 14) \) such as problem-solving, positive self-talk, challenging negative thoughts, and process-based approach were more common among the responses than behavioral interventions \( (n = 6) \) such as relaxation strategies, graded exposure, and exposure and response prevention. A few children \( (n = 4) \) also reported parental interventions such as psychoeducation and addressing parental anxiety as having helped them. Children’s responses to treatment impact reflected their perceived improvement in academic performance and competence, apart from the improvement in the symptoms.

For example, “Return to school.”

“Giving exams without fear.”

“Performing better.”

Two samples are given below to enable comparison of the child’s subjective experience at baseline and at follow-up, which highlight the impact of the treatment.

Sample 1:

**Baseline:**

“I’m afraid, and I feel anxious for silly things. Whenever I am pointed out to answer or something else, my whole body starts shivering, and I sweat a lot. I thought of myself a waste-bin.”

“These symptoms made me feel I am good for nothing. I can’t face any problem and this has been my behavior throughout my life. I’m going to be someone who can’t face things.”
“All this problem is because I want myself to be the best person in the world and I started stressing myself for that.”

**Follow-up:**

“All I want to do now is to understand my problems and why I’m suffering like this. I’m able to overcome things and to suggest myself solutions for these problems. Before, I used to depend on parents now I can do it myself. Whenever the symptoms occur, I’m able to manage them.”

“All also want myself to be the best, but I don’t stress myself like before. The therapy sessions helped me to get back to my studies and my dreams. They made me think and act and changed me a lot. I don’t worry about the results. I can feel the change in me, and the people around me can also see the change in me.”

**Sample 2:**

**Baseline:**

“My problems are somehow related to people around me. Right now, I’m scared—very scared of my school and exams. I don’t want to go to school. These problems are making me feel irritated, angry, frustrated and depressed, which in turn ruins my relationship with other people. I’m getting panic attacks. My fear of exams is leading to this.”

**Follow-up:**

“My problems are about relationship issue, indecision, low self-confidence, and self-esteem. These make me panicky, irritating, and angry too. Depression is also there (but I can’t realize it). I become nervous; as a result, I’m not able to do anything properly. I start daydreaming, and I’ve mood swings.”

“I’ve grown up a lot in this past one and a half months. I’m more sure of myself now and have started realizing my mistakes. I now have more faith in myself. I’ve learned to relax and not to take life so seriously. I’ve learned to let go. I’ve learned to praise myself, and my mood is more balanced … I think, the one thing that helped me besides medicines is talks with my doctor and parents.”

**DISCUSSION**

This qualitative study was an attempt to collect the opinions children with anxiety disorders have regarding the illness experience and treatment process. It elicited the impact the symptoms had on the child’s achievement, interpersonal functioning, and self-esteem, the depth of which other clinical measures and rating scales often fail to capture.

Follow-up narratives reflected a perceived improvement in self-efficacy and competence with the interventions; themes reflected internalization of cognitive interventions.

The study answers a few critical questions that a clinician often encounters while handling young children with anxiety: To what extent the improvement made is part of the natural course of development or the effect of treatment? Do cognitive behavioral interventions help the children in our cultural setting? If so, which component? The study adds clinical value and relevance to the already existing quantitative data.

It was interesting to note that only a few children perceived that the medications helped them \( (n = 4) \). Most responses of the children \( (n = 30) \) mentioned the cognitive, behavioral, and other psychosocial interventions as having helped them. Although there is a larger focus on behavioral interventions for childhood anxiety disorders such as relaxation strategies and graded exposure, it was interesting to note that many responses reflected that cognitive interventions helped them most.

The use of workbook-based CBT seems viable in our sociocultural setting and feasible for delivery to school-going children. However, challenges were encountered in retaining the children for multiple sessions. Attrition was high: one-third of them had dropped out by the 12th week of follow-up.

There has been a move toward research with children engaging them as active participants. This study has reiterated the fact that systematic and rigorous qualitative research has much to offer child and adolescent psychiatry. Studies with more rigorous methodology are required.

**Limitation**

The sample was heterogeneous and included children with different anxiety disorders, with a wider age range of 6–16 years. This might explain the differences in the reported experiences.

**CONCLUSION**

This qualitative study was an attempt to elicit children’s perspective on illness experience and treatment process. Children’s narratives highlighted the importance of cognitive interventions. Further studies examining the efficacy of workbook-based cognitive-behavioral interventions are needed to address the current lack
of trained professionals to deliver cognitive-behavioral interventions.

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Conflicts of interest
There are no conflicts of interest.

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