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# Insights into the Feelings, Thoughts, and Behaviors of Children with Visual Impairments: A Focus Group Study Prior to Adapting a Cognitive Behavior Therapy–Based Anxiety Intervention

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**Structured abstract:** *Introduction:* Anxiety is the most common psychological problem reported among children with visual impairments. Although cognitive behavior therapy interventions have proven successful in treating childhood anxiety, it is unclear whether they are suitable and accessible for children who have visual impairments. This study aimed to determine if and how traditional cognitive behavior therapy–based interventions could be adapted for use with this specific population by interviewing children with visual impairments themselves. *Methods:* A qualitative research design was used. Sixteen children with visual impairments (aged 9 to 13 years) participated in two focus group interviews. Participants attended two special schools in the Western Cape, South Africa. Interviews were audio-recorded and transcribed verbatim, and content analysis was undertaken. *Results:* Three primary themes emerged from the focus group data: (1) difficulties encountered by children with visual impairments; (2) existing coping strategies; and (3) insight into the concepts of feelings, thoughts and behaviors (central to cognitive behavior therapy). *Discussion:* The emergent themes and their implications for the adaptation of a cognitive behavior therapy–based anxiety intervention are discussed. *Implications for practitioners:* Results provide practitioners with guidelines to consider when using or adapting therapeutic techniques such as cognitive behavior therapy for children with visual impairments.

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Anxiety is one of the most common forms of psychological distress reported by children and adolescents (Barrett & Sonderegger, 2005; Cartwright-Hatton, McNicol, & Doubleday, 2006; Dadds, Spence, Holland, Barrett, & Laurens,

1997). It has been suggested that children who have visual impairments are at an increased risk of developing psychological difficulties including anxiety when compared to their sighted peers (Gullone, 1996; Li & Morris, 2006, 2007; Li &

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Prevatt, 2007; Margalit & Raviv, 1984; Ollendick, Matson, & Helsel, 1985). Given this increased risk, it is important to equip children who have visual impairments with the necessary skills and strategies to manage their anxiety (Visagie, Loxton, Ollendick, & Steel, 2013).

Cognitive behavioral therapy is a well-established, evidence-based treatment and is considered the gold standard for treating and preventing anxiety in children and adults (Silverman, Pina, & Viswesvaran, 2008; Walkup et al., 2008). To date it has primarily been used to reduce anxiety in children without disabilities. Researchers have begun to adapt it for children with developmental and learning disabilities, and modified cognitive behavior therapy techniques have been implemented in these populations with positive results (Chalfant, Rapee, & Carroll, 2007; Reaven, Blakeley-Smith, Culhane-Shelburne, & Hepburn, 2012;

Reaven, Blakeley-Smith, Leuthe, Moody, & Hepburn, 2012; Sung et al., 2011; White, Ollendick, Scahill, Oswald, & Albano, 2009; Wood et al., 2009). We could identify only one study that reported the use of cognitive behavior therapy in the rehabilitation of adults with visual impairments (Radnitz & Oronson, 2000). Given the scarcity in the literature, we conducted two qualitative focus group interviews with South African children who have visual impairments in order to identify their views about cognitive behavior therapy. The aim was to identify how acceptable traditional cognitive behavior therapy-based intervention programs are to this specific population and what adaptations may be required.

## Methods

### DESIGN

This focus group study was exploratory in nature, and it formed part of the evaluation of a broader cognitive behavior therapy-based anxiety intervention program (for more information pertaining to the program evaluation, see Visagie, Loxton, & Silverman, 2015). A qualitative approach involving two focus groups with a convenience sample of 16 assenting children with visual impairments from two special schools in the Western Cape, South Africa, was undertaken.

### PROCEDURE

Ethical approval from Stellenbosch University Research Ethics Committee: Human Research was obtained: (Humaniora) (HS888/2013) (Institutional Review Board Number: IRB0005239). Thereafter permission was obtained from the Western Cape Education Department in South Africa to conduct this study (reference: 20130507-10635). The school principals

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and school psychologists of the two special schools for children with visual impairments were informed about the project, and agreement to participate was obtained. Thereafter, the first author visited both of the schools and met with the principals and school psychologists to provide them with additional information pertaining to the project (the envisaged research plan, duration of the study, and how the school and children would be involved). Assistance from the school psychologists and the department heads at both schools was given to contact children's parents or guardians and to help coordinate the logistics of the project.

All parents whose children were between 9 and 13 years of age were informed of the project and were asked to return a signed consent form if they agreed that their child participate. After receiving written informed consent from the children's parents or guardians, the school psychologists at the two schools were asked to identify children who would be available to participate in a focus group interview on the specified day. School psychologists informed the children that the focus groups would be taking place and children attended the groups voluntarily.

One focus group was conducted at each school, and children who gave their written consent were included based on their availability. At the first school, 11 parents or guardians consented for their children to participate, and 6 children were available at the school on the specified day and time. At the second school, 48 parents or guardians consented for their children to take part, and 11 children were available at the school on the specified day and time. The reason that such a limited num-

ber of children were able to participate in the focus groups at the second school was that almost 50% ( $n = 20$ ) of the children whose parents gave their consent did not reside in the school hostel or dormitory and, therefore, were not available to participate in the focus group interviews scheduled in the afternoon. The groups were scheduled to take place in the afternoon after school so that they did not interfere with the children's curricular activities. Focus group interviews were scheduled for approximately 45 to 60 minutes, in line with the recommended time that school-aged children are said to be able to stay focused in a group discussion (Kennedy, Kools, & Krueger, 2001). Both focus group interviews were conducted by the first author (who is also a registered psychologist), with a group facilitator present. The interviews were conducted in either English or Afrikaans (depending on the language of schooling at the particular school, Afrikaans at the first school and English at the second school or a choice of the participants) and in a child-friendly way (Visagie & Loxton, 2014).

Since the first author is also visually impaired, it was important to ensure that the size of groups were manageably small, since it was important to enable her to direct the participants' taking turns without the use of visual cues (Khadka, Ryan, Margrain, Woodhouse, & Davies, 2012). The group facilitator was also present during both of the focus group interviews, and she assisted in identifying and reacting to visual cues that the interviewer might have missed. Before commencement of the focus group interviews, the interviewer introduced herself and the group facilitator; provided

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children with a verbal explanation regarding the purpose and nature of the focus group interviews and the overall study; and said what the children's contribution would be. Children were given the opportunity to ask questions. Assent forms were read aloud by the group facilitator. Large print versions of the forms were provided to the students with low vision. Unfortunately, braille versions of the forms were unavailable. For the children who read braille, however, the researcher made sure that she read the assent form clearly and explained it thoroughly. Students with low vision signed the large print forms, and participants who used braille indicated their consent by writing their agreement in braille. It was also explained to children that participation in the focus group interview was voluntary and that they could withdraw at any time. Since outside disclosure (confidentiality outside of the group) can possibly be a problem in focus group interviews (Dowling, 2014; Horner, 2000), participants were asked to agree not to share any private information shared during the group with people outside it. Children understood that "what is said in the group stays in the group."

The focus group interview guide was semistructured; it included a list of topics and possible questions to be discussed. The focus group interviews obtained critical information in five areas:

- The format of program activities—Children with visual impairments' visual difficulties may limit their ability to access traditional cognitive behavior therapy-based interventions, since most of the existing programs rely heavily on visual media (cartoons, coloring-in pictures, and picture-based workbook activ-

ities) to convey information and concepts, and as such are not accessible for children with visual impairments. As a result, we wanted to explore different ways in which the learnings and activities of the adapted cognitive behavior therapy program could be presented.

- The specific program content—Children with visual impairments interact with and perceive their environment in unique ways and, as such, may have different challenges than sighted children. As noted, because research relating to anxiety experienced by children with visual impairments is limited, it was important for us to gain greater insight into the specific content of these children's worries.
- The concepts central to the program—Another important first step in the development of the tailored cognitive behavior therapy anxiety intervention was to gain insight into children with visual impairments' own understanding of cognitive behavior therapy concepts, how they perceive these concepts, and how they cope with them in their everyday lives. The main idea underlying cognitive behavior therapy is that the way individuals think influences or determines feelings and behaviors. To explain this link to children, it is important that they understand the concepts of feelings and thoughts. Many of the existing cognitive behavior therapy-based programs explain these concepts to children in a pictorial manner such as by using drawings of facial expressions and emotions, and cartoons with thought bubbles (Barrett, 2005; Kendall, 1990; Rapee & Lyneham, 2006; Silverman & Kurtines, 1996; Stallard, 2003; Van Starrenburg, 2013).

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We believed that these pictorial techniques were not appropriate for all children with visual impairments, since some of them would be unable to see the pictures. Therefore, we conducted the qualitative study (focus groups) to ascertain the existing extent of knowledge held by children with visual impairments relating to the concepts, feelings, and thoughts, and to determine the best ways in which to explain these concepts during the cognitive behavior therapy anxiety intervention program.

- The existing coping behaviors—It was also important for us to gain an idea of the coping behaviors that children with visual impairments already possess. This knowledge would help guide the development of the cognitive behavior therapy anxiety intervention. By asking children about their existing coping strategies, we were able to gain an idea of the problem-solving and coping strategies these children already possessed and specific skills that would be helpful to teach them.
- The inclusion of exposures—Last, most existing cognitive behavior therapy-based interventions put heavy emphasis on graded exposure approaches, since these approaches are seen as a key ingredient in cognitive behavior therapy interventions for anxiety (Kendall & Headtke, cited in Reaven et al., 2012; Silverman & Kurtines, 1996). As a result of the children’s physical limitations (and various safety concerns), however, we were concerned about how these approaches would be incorporated. We wanted to determine whether strategies such as imaginal exposure would be effective and suit-

able for use with visually impaired children in the tailored cognitive behavior therapy anxiety intervention.

The sequence of questions was varied and altered to take advantage of the topics and assertions that arose naturally during the course of the focus group interview. The researcher also tested some of the activities that were envisaged for the tailored cognitive behavior therapy program during the focus group. The following section lists examples of questions that were included in the focus group interview.

### *Opening question*

All of us feel worried or nervous from time to time, even grownups. Have any of you ever felt this way? Can you tell me about what happened to make you feel like this? What things are difficult for you?

### *Key questions: Coping (current way of coping)*

How did you handle it when you were feeling worried or nervous? What were some things that you did to make yourself feel better? What made you feel worse or did not work for you? There are other kids who have these types of feelings. What are some things that you think may be difficult for other kids like you, other kids who cannot see so well? What is difficult for children with visual impairments? What are some things that kids like you can do to help them feel better, to handle their worries? What kinds of things do you do to feel good if you have had a bad day? What kinds of things do you like to do? What things make you feel good?

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### **Key questions: Feelings and thoughts**

Part of what I am thinking about doing in my program is teaching children about different feelings and different thoughts. Do you think this is a good idea?

*Feelings.* Do you know what feelings are and what the word “feelings” means? If you had to explain what feelings are to your friend, what would you tell him or her? What are some feelings that people can have? What are some times when, and places where, people will have these feelings? What can happen to make a person feel [a feeling that a child mentioned]? How do we know how other people are feeling? What do you do when you are feeling happy, sad, scared, excited?

*Thoughts.* Do you know what thoughts are and what the word “thoughts” means? If you had to explain what thoughts are to your friend, what would you tell him or her?

### **Closing question**

If you were going to have a program like this at your school, what would you like to learn from the program? What do you think could help you?

### **DATA ANALYSIS**

Each participant was assigned a code, and the focus group discussions were transcribed verbatim from the digital audio recordings by the first author. These transcripts were thematically analyzed by the first author, following Braun and Clarke’s (2006) guidelines for content analyses. These guidelines comprised (1) becoming familiar with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, and (5) defining and naming themes (Braun & Clarke, 2006;

Taylor et al., 2014). These themes constituted the findings of the study, which are presented and discussed below. In order to ensure trustworthiness, the readings and interpretation of the findings were discussed with the second author, and emerging themes were cross-checked with two independent researchers who were familiar with the field of childhood anxiety research.

### **Results**

The total sample ( $N = 16$ ) consisted of 8 girls and 8 boys of whom 8 children were from the Black community, 2 were from the White community, and 6 were from a mixed-race community. Their ages ranged between 9 and 13 years ( $M = 11.56$ ,  $SD = 1.15$ ). The degree of vision loss experienced by participants differed, with totally blind ( $n = 2$ , 12.5%), severely visually impaired ( $n = 3$ , 18.75%), and low vision ( $n = 11$ , 68.75%) children taking part. Eleven children received their formal schooling in English, while the remaining 5 received their schooling in Afrikaans.

Three overall themes evolved from the focus group data: (1) difficulties encountered by children with visual impairments; (2) existing coping behaviors; and (3) insight into concepts central to cognitive behavior therapy, namely feelings and thoughts. Within each of these overarching themes, various subthemes were also noted.

#### **THEME 1: DIFFICULTIES ENCOUNTERED BY CHILDREN WITH VISUAL IMPAIRMENTS**

Because it was important for us to gain insight into the things that are difficult or worrying for children with visual impairments, participants were asked directly

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what they specifically worried about and what things might be difficult for them.

Three sub-themes emerged: physical limitations, socioevaluative concerns, and injury-related concerns.

### ***Physical limitations***

Not being able to play certain games or partake in certain activities as a direct consequence of their visual impairment was a difficulty reported by participants. Watching television is also an activity that most children enjoy, and not being able to follow what is happening on the television, as well as not being able to ask others for explanations (or asking others for an explanation but being ignored) was a factor that was identified in both focus groups as being difficult or frustrating. A participant responded in this regard: "Playing with other children, . . . other children who can see better than me, . . . they are playing with a ball . . . that small, round ball . . . I want to play [with] it, but I can't see it. . . ."

### ***Socioevaluative concerns***

Children with visual impairments also reported difficulties that related to socioevaluative situations, including teasing or questioning by others about their disability, and worries about how their disability affects their physical appearance. A participant responded in this regard: "They [other children] ask you constantly why are you blind? What did you do to make you blind? What makes your eyes look so white? I don't like it when people say my eyes are white."

### ***Injury-related concerns***

Children with visual impairments also noted that it was difficult for them when

they bump into objects or other people because they did not know that they were there, or when their vision is limited due to changes in their surrounding conditions (it was dark or things were moved). A participant responded in this regard: "For me it is difficult to see at night . . . because I am night blind, I have genetic RP [retinopathy of prematurity]."

## **THEME 2: EXISTING COPING BEHAVIORS**

We also wanted to gain insights about the children's existing coping behaviors to guide the development of the tailored cognitive behavior therapy anxiety intervention. As a result, participants were asked what they do when they feel worried or nervous and what they could do to feel better. They were also asked what other children with visual impairments can or should do when they are feeling worried or nervous. Therefore, responses were divided into two subthemes: things that I can do and things that others can do.

### ***Things that I or others can do***

Verbatim examples of "things that I can do" included, "I sometimes count, or I listen to music, or I just walk away. I sing a song or something." For "things that others can do," verbatim examples included, "Talk to a friend; they can talk to friends or family."

## **THEME 3: INSIGHT INTO CONCEPTS CENTRAL TO COGNITIVE BEHAVIOR THERAPY**

A further important step was to gain insight into children with visual impairments' understanding of the concepts of feelings and thoughts, and how they perceive these concepts and deal with them in their everyday lives. Participants were

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asked if they knew what feelings (or thoughts) were and what the words “feelings” and “thoughts” meant. Responses are presented in two subthemes: the concept of feelings and the concept of thoughts.

### *Feelings as a concept*

Although *feelings* is an abstract term, most of the children had good insight into this concept. When asked if they could name a few feelings, they did so with ease, with each participant naming at least one kind of feeling, and with the majority stating that feelings are important. Children mentioned several feelings, and they included the four basic feelings (scared, angry, sad, and happy). One of the participants (a boy, aged 13 years), when discussing feelings mentioned that he sometimes feels like kicking someone when they make him angry. With some prompting, he realized that kicking is not a feeling, but that anger is the underlying feeling. The thing that he wants to do is kick (the behavior) someone when he is feeling angry. He asked, “OK, but you can feel like you want to kick someone?” The interviewer responded, “OK, so let’s think—when you feel like you want to kick someone, what is the feeling? Anger, angry. So that is the feeling, and the kicking is the thing you want to. . . .?” Group answers, “Do!”

Another response example was from a 12-year-old girl, who said, “[Feelings are] how you feel when something happens. Like when you do something or take something that is wrong, then you are going to feel angry or guilty, and feel all of those things. . . . [O]r if you maybe hear a joke, then you will feel happy and joyful.”

### *Thoughts as a concept*

As anticipated, thoughts seemed a bit more challenging for children to define, and the interviewer had to prompt and make suggestions as to what thoughts could possibly be. At first, participants were asked, “Do you know what thoughts are and what the word *thoughts* means?” Answers were very vague. A 13-year-old boy said, “[A thought] is something that you thought.” A 12-year-old girl responded, “Thoughts are when someone tells you something and you tell them you will go and think about it.” “. . . [W]hen someone tells you something and you thought it is the truth. Then it comes again, and it is not the truth. . . .” said a boy, age 11 years. “[Thoughts are] everything that happens in your head . . . [when you] brainstorm or whatever,” said a girl, age 12 years.

With a bit of further help and prompting from the interviewer, however, the children came to different conclusions. Two 11-year-old boys said, “Thoughts are in your brain” and “[Thoughts are] all your brain stories.” “[Thoughts] are something that you hear, like a voice,” (said a boy, age 13 years). “Only I can hear [my thoughts],” said another 13-year-old boy.

When asked to explain the concept of thoughts to their friends, answers were clearer, and the children were able to articulate the concept more easily. One participant (a boy, age 11 years) was able to take things one step further and start with the process of linking his thoughts and feelings, which was very promising, and can be seen in the following exchange. The boy said, “Maybe sometimes you think . . . your friend says he is going

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to come and fetch you because you don't have a TV. . . . You think he is going to come, and then he doesn't come. It was a lie." The interviewer commented, "That's bad. . . . [H]ow do you feel then if he doesn't come?" "Then I cry like a baby," said the boy. "[W]hen you cry like a baby, how do you feel?" the interviewer asked the group. The group answered, "Sad."

## **Discussion and implications**

This study advances understanding about the nature of worries, methods of coping, and the perception of feelings, thoughts, and behaviors in children with visual impairments.

### **THEME 1: DIFFICULTIES ENCOUNTERED BY CHILDREN WITH VISUAL IMPAIRMENTS**

All participants agreed that anxiety and worry was something that they had all experienced. One participant even remarked that this happens to her a lot (a girl, age 12 years). Children were also able to contextualize some difficulties that they perceived as being especially relevant to children who have visual impairments. Their responses were classified into three subthemes.

#### ***Physical limitations***

The general anxiety literature states that at about age 9 or 10 years (during middle childhood), worries turn to performance and social concerns. Fears of taking tests, of giving oral reports, and of school performance in general arise. Children might also express concern relating to nonacademic activities, such as their performance on the sports field, competence in music class, or any out-of-school activity (Last, 2006; Silverman, La Greca, & Wasserstein, 1995; Weems, Silverman, &

La Greca, 2000). The latter statement was especially true for children with visual impairments: When participants were asked what they specifically worried about, they reported difficulties first related to physical limitations that included not being able to play certain games or partake in certain activities as a direct consequence of their disability. Socially, middle childhood is also a time when children start to value abilities that other people admire, such as being good at sports or reading well (this is in line with Erikson's view of industry versus inferiority) (Erikson, 1993). Children in the present study noted that their visual impairment made it difficult for them to partake in some activities (such as ball games or watching television) that they would have liked to do. Interestingly, in contrast to the general anxiety literature, children with visual impairments did not report worries that related to academic or school performance.

#### ***Socioevaluative concerns***

During middle childhood, children also become aware of their physical appearance and of how others, especially their peers, perceive them (Last, Perrin, Hersen, & Kazdin, 1996). They want to be accepted by their peers and to fit in. The downside is that anyone who does not conform, such as a child who has a disability, may get noticed. The latter statement was true for children with visual impairments, since they reported difficulties related to socioevaluative situations, including teasing or questioning by others about their disability; and worries about how their disability affected their physical appearance. Children with visual impairments stated that they did not like it when other

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children asked them about their disability (why their eyes looked a certain way or when others called them names). This observation is especially noteworthy, since negative comments from other children could possibly lead to children experiencing social anxiety. In the general fear and anxiety literature, socioevaluative concerns (fear of social rejection and social anxiety) are usually more prominent in adolescence (Elbedour, Shulman, & Kedem, 1997; Gullone & King, 1997; Ollendick et al., 1985; Westenberg, Drewes, Goedhart, Siebelink, & Treffers, 2004), since sociocognitive maturation entails a rise in self-consciousness and self-awareness.

### *Injury-related concerns*

To a lesser extent, participant responses also related to worries of being injured or hurting themselves. Children noted that it was difficult for them when they bump into other objects or people because they did not know that they were there or their vision is limited due to changes in their surrounding conditions caused by, for example, darkness or windiness.

The above-mentioned three subthemes each highlight a different aspect relating to the difficulties that children with visual impairments experience. From this information, we concluded that the following points should be kept in mind when developing or implementing the tailored cognitive behavior therapy anxiety intervention.

- Children with visual impairments reported concerns relating to physical limitations: It is important to address issues such as being different and being

okay with having different strengths and difficulties.

- Middle-childhood children with visual impairments reported more socioevaluative concerns than expected. It is important to also address these issues.
- Children with visual impairments also reported injury-related concerns. Because these concerns are genuine for these children, it is important that the tailored cognitive behavior therapy anxiety intervention encourages children who have visual impairments to ask for help when things become difficult, relating to both physical and emotional difficulties.

### **THEME 2: EXISTING COPING BEHAVIORS**

In the present study, *coping strategies* can be understood as the specific ways in which children who have visual impairments cope with stressors or difficult situations; that is, how they usually cope or what they do when faced with a problem (Ayers, Sandier, West, & Roosa, 1996; Jemtå, Dahl, Nordahl, & Fugl-Meyer, 2007). It was important for us to have an idea of the children's existing coping behaviors to guide the development of the tailored cognitive behavior therapy intervention.

A primary control, secondary control, and relinquished control model of coping in response to stressful situations was postulated by Band and Weisz (1988) to be appropriate for describing coping behaviors in young children. According to these authors, primary coping strategies involve attempts to change stressful situations and include direct problem solving (changing the environment). Secondary coping strategies involve attempts such as

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seeking social and spiritual support to adjust to current stressful circumstances (changing the self to adapt to the environment). And relinquished coping strategies involve no attempt to change the stressful situation or to adapt to it. The majority of coping behaviors that children with visual impairments in the present study reported can be classified as secondary coping strategies (Band & Weisz, 1988), and are related to seeking social support (for example, talking to friends or parents, praying, or going to church) or doing something to distract themselves from the problem at hand (such as sleeping, drawing, singing, or listening to the radio). Children with visual impairments also reported relinquished coping strategies (for instance, doing nothing, walking away, or ignoring the person who caused the problem). These strategies highlight the fact that children with visual impairments employ various ways of coping; however, these coping strategies may not be the most helpful when it comes to coping with anxiety. The following point should be kept in mind when developing the tailored cognitive behavior therapy intervention: It is important that the intervention encourage children to use more active coping strategies (in other words, to focus on teaching children relaxation skills and steps that they can take when faced with a problem).

### **THEME 3: INSIGHT INTO CONCEPTS CENTRAL TO COGNITIVE BEHAVIOR THERAPY**

The focus groups were integral in providing us with an overview of what children with visual impairments already know about the concepts, thoughts, and feelings, and could thus help determine to

what extent these concepts need to be covered during the tailored cognitive behavior therapy intervention.

#### ***Feelings as a concept***

Being able to accurately report one's internal emotional states during cognitive behavior therapy is dependent on the ability to recognize different feelings and accurately label and discriminate between them (Ellis, 1979; Lickel, MacLean, Blakeley-Smith, & Hepburn, 2012; Willner, 2005). Overall, participants did not seem to have a problem with the concept of feelings. This heightened awareness of feelings might be linked to the fact that this is a topic that is covered in the children's school work (the subject of life skills, grade 6). One participant (a boy, age 12 years) stated that he and his classmates know what feelings are because they learn about them in life-orientation classes.

#### ***Thoughts as a concept***

The concept of thoughts was more challenging than the concept of feelings for participants to understand. During the focus group, the interviewer had to assist by making suggestions and prompts as to what thoughts could be.

After questioning participants about feelings and thoughts and considering their responses, it was concluded that the following aspects should be kept in mind when developing the tailored cognitive behavior therapy intervention.

- Overall, children with visual impairments had good ideas relating to the concept of feelings. The majority were able to accurately label and discriminate between different feelings.

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However, when asked how they knew how others were feeling (what things tell us how others are feeling?), only children with low vision and severely visually impaired children gave responses. Their responses related to body language and facial expressions and hinted at factors such as tone of voice and intonation. The totally blind children did not give any answers relating to this question because they cannot see others' body language, which may be a challenging aspect relating to teaching children with visual impairments about the expression of feelings. The fact that children who are blind cannot observe body language is important for presenters to keep in mind during the implementation of the tailored cognitive behavior therapy intervention program—namely, presenters should put extra emphasis on the various verbal aspects relating to the expression of feelings (tone of voice, intonation, and the words people use).

- Presenters should put extra emphasis on the concept of thoughts and make sure that participants understand the difference between feelings and thoughts before moving on to the next steps of the intervention.
- Older children (aged 11 to 13 years) were able to answer the questions relating to feelings and thoughts more easily, while the younger children (aged 9 to 10 years) seemed unsure or did not give answers. It is important for presenters to double-check that the younger children in their group are indeed able to grasp these concepts, and spend more time on explaining them if necessary.

## **Limitations, recommendations, and conclusion**

Like all studies, this one also had limitations. One limitation of all focus group studies relates to the sample size, and in the present study only 16 children were available to take part on the scheduled day. As mentioned, almost 50% ( $n = 20$ ) of the participants at the second school whose parents gave their consent did not reside in the school dormitory and, therefore, were unavailable to participate in the focus group interviews that were scheduled in the afternoon after school. It is possible that the opinions of the day scholars may have differed from those of the children who did participate in the study. A further limitation is that all children from grades four to seven had a chance to be included in the focus group, and the researchers noted that the older children were more confident in talking and that they sometimes talked over the younger children. Even though the researcher afforded the younger children the opportunity to talk, they did not say as much as the older children. One suggestion may be to stratify the groups according to age: include younger children (ages 9 to 10 years) in one group and older children (ages 11 to 13 years) in another group.

Although the children's coping behaviors were explored, the perceived efficacy of these behaviors was not assessed. The researcher asked the children what they do to cope with stressful or anxiety-provoking circumstances, but she did not ask the children whether the things they do work for them or not. Future studies should preferably also include a question on perceived efficacy.

Despite its limitations, the study had strengths. It became evident that children with visual impairments face various difficulties, and in the majority of cases these difficulties can be directly linked to their visual impairments. Furthermore, overall, children with visual impairments were able to conceptualize the elements of cognitive behavior therapy; this finding is very promising for the development of the “new” tailored cognitive behavior therapy anxiety intervention. It was also noted that the children were able to engage with the researcher in a group format, and they seemed very excited about the possibility of an anxiety-management program being delivered at their schools. For this reason, it can be concluded that existing cognitive behavior therapy-based anxiety interventions are suitable foundations for the creation of tailored cognitive behavior therapy anxiety interventions. These existing programs need to be adapted to take the above-mentioned factors into account while simultaneously keeping the abilities and unique visual world of children with visual impairments in mind. Due to the exploratory nature of the research, it is important to note that the results and implications noted above are preliminary and will be confirmed or revised after the tailored cognitive behavior therapy program has been implemented. Future research needs to develop, modify, and evaluate anxiety intervention programs for vulnerable children with specific disabilities.

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