Treatment of Separation Anxiety Disorder-A Clinical Case Study.

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Abstract

Children having anxiety when separated from the parents are common. But when this anxiety hampers the day to day life then this could be a sign of Separation Anxiety Disorder. This case provides knowledge about the diagnosis and treatment of 5 years old Indian school boy "Rajat Sharma". After 2 months of regular sessions, Rajat was able to attend school without any problem. The sessions also included family therapy as the parents' relation also seemed to be major cause of child's anxious behavior. The treatment strategy for present case includes behavioral interventions, psychotherapy including cognitive behavioral interventions and family interventions.

Keywords: *Separation Anxiety Disorder (SAD), behavioral interventions, psychotherapy, cognitive behavioral interventions, family interventions.*

Theoretical and Research Basis for Treatment

Diagnostic Criteria

The basic features of SAD are panic level anxiety when the child is separated from the primary caregiver which leads to impaired independent functioning. The appearance and features of SAD differ by age (Francis, Last & Strauss, 1987). The child may cry, freeze, complaint somatically, withdraw socially, throw tantrums. He/she may even show fear of harm, getting lost, death, kidnapping, assault and permanent separation from caretaker. And majorly the child shows school refusal. Some occasional features of SAD include somatic symptoms of distress, nightmares with separation theme, refusal to sleep alone, demanding behavior for caretakers' attention.

Terms 'school phobia' or 'school refusal' are used as one of the features of SAD. School refusal is of two types, first, young children refuse to attend school and second, older children become reluctant of attending school. The former appears in well-adjusted families and later happens in family with psychological issues (Kennedy, 1965).

The prevalence of SAD is as high as 4% (American Psychiatric Association, 1994). Cantwell and Baker (1987) reported a high prevalence of SAD and social phobia (10%) in children who are going through the treatment for communication disorders. The typical onset age is 5-9 years and it is more prevalent in females. Common comorbid conditions can be generalized anxiety disorder, social phobia, specific phobia and depressive disorders.

Various researches support the biological and genetic contribution to SAD. Researchers found that 85% of mothers of children suffering from separation anxiety disorder had a lifetime history of anxiety disorder (Last, Phillips & Statfeld, 1987). Even the families of children suffering from SAD reported higher prevalence of anxiety and mood disorders (Black, 1995).

Table 1: ***Treatment Options/ Recommendations***

1. Behavioral Interventions
   a. In vivo desensitization
   b. Flooding/ implosive therapy
   c. Contingency management
   d. Modeling techniques
2. Psychotherapy
   a. Cognitive-behavioral interventions
      (i) Self-monitoring
      (ii) Self-talk
      (iii) Distraction
      (iv) Self-reinforcement
      (v) Relaxation techniques
3. Family Interventions
   a. Parent education and support
   b. Family therapy

Behavioral Interventions: The various effective methods used to treat separation anxiety disorder include vivo desensitization, flooding, contingency management and modeling (Ollendick & King, 1998; Werry & Wollersheim, 1991).

Vivo desensitization is a treating technique where the child goes through the actual separation from

the parent. It could be through relaxation, distraction or engagement in another activity.

In *Flooding and implosive therapy* the child is directly exposed to the real or imagined stimuli which elicit anxiety. The former involves actual stimulus whereas the later involves the imagined stimulus. But both the techniques should be handled with caution.

Contingency management or *operant conditioning* includes various positive and negative reinforcers which helps the child in reducing the anxiety. Similarly, *modeling* technique, that is, using of live models or filmed models (Husain & Kashani, 1992) can also be an effective treatment technique for SAD. Behavioral interventions have been proven to be very effective treatment strategy for SAD (Ollendick & King, 1998; Thyer, 1991).

Psychotherapy: *Cognitive behavioral treatment* includes teaching a child to find out the causes of anxiety and applying the coping strategies for lowering down the anxiety level on that particular time. Though this technique is used with the older children (Kendall, 1994) but in this case this technique has been used by the parents.

Family Interventions: *Parent Intervention* includes educating the parents about the symptoms, etiology and treatment of separation anxiety disorder. The main purpose of educating the parents is to calm them down and this would ultimately help them to change their behavior and motivate their child.

In *Family therapy* the family roles get restored, the whole family hierarchy becomes the target of this therapy (Mayer & Deitsch, 1996). This basically starts when the parents have difficulty in going on with behavioral interventions.

Case Introduction

Rajat (pseudonym), a 5 years old Indian school boy was presented as a violent, always crying and throwing tantrums on the gate of the school for not going inside and not leaving his mother. The child joined the PQR school approximately 4 months back. Just after joining he was fine though very excited to go to the school, had made friends and was enjoying his school life. Just after the 2 months he had summer vacations everything was fine uptill then. He enjoyed his vacations at his maternal grandfather's place with his cousins and was very happy. But after returning from the vacations he became very stubborn and refused to go to school. He wanted his mother to be physically close to him always. Even at home he didn't leave his mother alone. When forced to leave his mother, he would become violent (mostly self-harming behavior) and cry so harshly that even sometimes his breathing stops. The most common sentence he used to say while crying was that his mother is going to leave him and he is going to die. Then just the other minute he will apologize to his teacher who was asking him to get in the class and he will ask her to beat him for being so cranky. Ultimately seeing the child's condition, the teacher used to send back Rajat with his parents. This happened for almost a week before the case was brought to the psychologist.

Presenting Complaints

The child psychologist visited Rajat when he was on the gate of the school with his parents and crying not to go inside. Rajat's parents (Mrs. & Mr. Sharma) seemed to be very concerned about his behavior, Mrs. Sharma though was quite submissive and also had tears in her eyes whereas Mr. Sharma was very strict with the child and was getting irritated on the child as well as on the mother as he was getting late for his work. The child also seemed to be bit scared from his father as he would forcibly stop crying and stop breathing as soon as Mr. Sharma would ask him to stop crying. When asked from the child separately, he replied that he doesn't like the school and loves his mother a lot, he will not leave his mother at any cost and he even mentioned. Then immediately he stopped crying and apologized for whatever he said and begged for going back home and asked not to tell anything to his father as then he would send him to the hostel which is away from his mother.

While speaking to the parents and teachers separately it came into notice that the child is showing this kind of behavior since approximately 10 days, though the child is very intelligent and had been attentive and active in the class but now because of not attending the classes regularly he doesn't feel like studying at all. Rajat was the only child and was highly pampered by his grandparents who used to stay with them. Mrs. Sharma complaint that his grandparents complete all of the Rajat's wishes and it becomes difficult for her to stop them. There was no problem in the birth and education history from the parents' side.

History

'Child clinician's intake summary form' was used for first interview and evaluation purpose. Rajat was the only child born in a joint family. Both parents and grandparents were educated but father was the only earning source of the family. School principal referred him to the child psychologist. This was the first time anybody in his whole family was visiting a psychologist. The major reason was because of the excessive attachment he was showing with his mother and even his disappearance from the school due to this reason. Because of regular crying, his health was one of the major issues. The problem started when the school reopened and even a few days before that when Rajat forced his mother to sleep with him. During the interview session, the parents did confess that the father due to frustration told Rajat that if he won't stop

showing this particular behavior then he would be sent to hostel. Due to which after crying he suddenly stops and calls himself a 'bad boy' and starts apologizing for showing misbehavior.

As per the *developmental history*, the pregnancy was planned, though the mother was into stress for few months due to some family issue and then she delivered the baby at her parents' place. But there were no complication during the delivery and the baby was born healthy. Sitting, crawling, walking, language, toilet training, reading etc. was all on time. Since infancy only the child was friendly, active, curious to learn new things, apt appetite and on time sleep. But the parents mention that during his early infancy months, Rajat was scared of strangers. He did not use to go to other people and used feel comfortable when mother used to be around.

There was no *medical history*, the child had not been under any treatment or medication. None of the family members (either paternal or maternal) had any of the psychological disturbances ever. According to Mr. Sharma, there had not been any kind of problem in the family, but when spoken to Mrs. Sharma, she reported of some marital issues. As she was disturbed because of constant interference of her in-laws in her personal space and even with Mr. Sharma and Rajat. According to her, she was not allowed to take any decision for her child, it's only the grandparents who are going to decide. Due to this sometimes there used to be loud verbal arguments in front of Rajat and this has made him scared many times, she confessed. The father was not involved in any kinds of drugs, alcohol or smoking.

As per the *social history* report, Rajat was a friendly boy, others liked him and vice versa. Though he didn't have any one best friend but he did gel around with most of the boys and girls in the class (till the time he didn't refuse to go to school). He has been an obedient child and has shown respectful behavior to others. Being a single child, he has been a pampered child though.

Academically also the child has been a healthy student. He has started his education on time with good scores in examinations. He has been in the list of favorite students of his teachers. His reading, writing skills have been above average. His grasping capacity is good, he learns quite faster.

The above stressors were making the child weak physical, emotionally and mentally. And he coped up by going to his mother for help, refusing to talk to anybody, becoming anxious, tearful, angry, throwing tantrums, getting physically ill, withdrawing from others and showing self-harming behavior.

Assessment

After the observation, child clinician's intake form and interview part, Rajat and his family had were assessed with semi-structured mental status examination, self-report, parent-report, teacher-report forms for further diagnosis.

Syndrome specific tests

Clinician administered

Semi-structured mental status examination (SMSE) (Silverman & Albano, 1996) is a form-based tool used for conducting / recording information obtained from mental status examination. It diagnoses the patient on the basis of demographics, appearance, attitude, motor behavior, though processes, sensorium and intellect, thought content, sensation and perception, somatic functioning, mood affect, speech and language, social interaction and relationships, self-concept, stress and coping.

Draw-A-Person Test (Goodenough, 1926) is an intelligence test basically measures the child's cognitive level functioning. Here the child is instructed to draw a human figure, as clear as possible. There is no time limit but mostly by 10-15 minutes the child is done with it. It is for young children, upto middle school. Each body part the child makes has a score and in total there are 64 items which can be scored.

Child report

Revised Children's Manifest Anxiety Scale (RCMAS) (Reynolds & Richmond, 1978) has 37 items including 8 forming lie scale. The subject has to choose between 2 options either yes or no for each item. There are 3 subscales: worry/oversensitivity, physiological and concentration. It assesses the strong co-occurrence of anxiety and depression.

State Trait Anxiety Inventory for Children (STAIC) (Spielberger et. al., 1973) has 20 items which differentiate between transitory and stable anxiety.

Parent report

Multidimensional Anxiety Scale for Children (MASC) (March, 1997) is a 39 item scale divided into 4 subscales- physical symptom (with 2 subscales: tense and somatic symptoms), harm avoidance (perfectionism and anxious coping subscales), social anxiety (humiliation fears and performance anxiety subscales) and separation/panic.

Behavioral Assessment

Child Symptom Inventory-4 is a parent-report and teacher-report form. It is a checklist which helps in the screening of the case and evaluates the state of anxiety. Here children with SAD are expected to be high on anxious-depressed, somatic complaints, withdrawal, social problems and internalizing scales of *Child Behavior Checklist (CBCL)* (Achenbach, 1991a, 1992) and *Teacher Report Form* (Achenbach, 1991b).

Behavioral Assessment System for Children (BASC) (Reynolds & Kamphaus, 1992) is again a parent and teacher report form. On BASC, children having separation anxiety disorder are expected to be high on anxiety, somatization, withdrawal subscales, reflecting general anxiety, physical complaints and social withdrawal respectively; and, a low score on adaptive and leadership subscales.

Case Conceptualization

The case of Rajat came up with a major problem of rejecting to go to school and having an extreme attachment with his mother. He showed the symptoms like throwing tantrums, crying when trying to keep him away from the mother, violent and self-harming behavior, refusal of sleeping alone, sometimes even feeling physically ill due to severe crying. On the basis of diagnosis, the child was confirmed of having separation anxiety disorder.

Father reported of being a healthy family but mother showed the symptoms of anxiety too. She reported having conflicts with the in-laws and sometimes it has become a concern for the child because the loud arguments have even happened in front of him. Rajat has always seen his mother to be the sufferer and as he has been threatened to go to the hostel. This has made him think that he and his mother are the victims. He wants to save himself for keeping his mother safe. Moreover, the grandparents have pampered him a lot so whenever he used to cry for not going to school, they used to support him.

During the clinical interview, parents have shown anxiety and distress for their child's problem. They have felt guilt for being helpless and unsupportive, this may be due to the lack of knowledge about the problem or even because of the societal pressure, as in India still many people think meeting a psychologist as a negative thing.

On the basis of clinical interviews, observation and various assessment techniques it was diagnosed that the child is having a mild separation anxiety disorder and on the basis of this diagnosis various behavioral and family interventions were adopted for the treatment purpose.

Course of Treatment and Assessment Progress

Behavioral Interventions

Various methods of behavior therapy have been used to treat SAD (Werry & Wollersheim, 1991) including in vivo desensitization, flooding, contingency management and modeling (table 1). According to Ollendick & King (1998), all these techniques are effective in treating anxiety related problems. Behavioral techniques are imposed during the onset of SAD rewarding techniques are used during the elimination (Black, 1995).

Vivo desensitization treatment consists of exposure of the child to actual separation from the parent. Progression through a hierarchy of anxiety producing situations is used to gradually expose the child to increasingly threatening separation experiences.

For example, in this case where school avoidance was the major concern, firstly, the mothers was allowed to sit with the child in the class for alternate lectures and the child was kept in the school just for half day, after that she was made to sit outside the class where the child could see her and meet her whenever required. Few days later the mother was asked to sit in another room and the child was allowed to meet her every alternate lecture. Gradually, it was asked from the parents to start sending Rajat in school van with other students in the morning and few hours later the mother could come. This process started showing improvement after almost 2 months. Regular counseling, relaxation therapy and play therapy were simultaneously given.

To make this therapy successful, certain set of rule were formed which had to be followed by the child, parents and teachers. Like, if the meeting time is after 1 hour then the child should be made clear that within this time he has to focus on his studies and no matter what he won't be allowed to go out and meet his mother.

Flooding and implosive therapy involve continuous actual or imagined exposure to object or situation that elicit anxiety until the child's anxiety level decreases. This treatment could be effective but it was used in this case with caution as the child used to become violent and showed self-harming behavior when kept in avoiding situation. Hence initially just the imagined exposure was given during the counseling sessions, slowly and gradually the actual exposure was given. This made the treatment though delayed but effective.

Operant conditioning or contingency management begins with proper evaluation of positive reinforcement and negative reinforcement which the child gets for showing separation anxiety. In the present case, the common positive reinforcement given to Rajat were praise for being regular to school, incentives and stars from the teachers, staying at home and playing games with the mother, access to his favorite dish or any place he wants to visit. Common negative reinforcement were avoidance of the fear that something will happen to his mother, avoidance of failure and work at school, avoidance of general anxiety at being separated from the mother. For example when Rajat was at home, avoiding school, then parents were instructed that he should not be allowed to see television and no play activity with the peers.

Social learning treatments, like *modeling*, may also be effective for treating SAD. It includes the used of

real and filmed models. For this purpose, Rajat was given real life examples of his batchmates, he was made to interact with them. And, short stories and movies were also shown to him demonstrating the child's successful separation from the caregiver. An interesting role play (related to SAD) was also done where Rajat himself participated and enjoyed. In all the activities he was able to associate himself with the model and tried to be like them whenever was reminded off.

All the above behavioral interventions have had shown positive results in this case.

Psychotherapy

Cognitive behavioral treatment methods teach the child to identify anxiety and to apply specific coping responses. The treatment includes self-monitoring tasks. For example in the present case the parents were asked to maintain a diary for anxiety provoking situations and cues. On the basis of this, the child was then taught the coping strategies like positive self-talk, distraction, self-reinforcement etc. this ultimately helps the child in separation event.

Family Interventions

Parent intervention involves the education of parents about the etiology, symptoms and treatment of SAD. This education motivated Mrs. & Mr. Sharma to change their behavior and support the child. The grandparents were also involved in some of the sessions. The family was taught about the role of their behaviors and environmental stresses in evoking SAD symptoms in their child.

Behavioral interventions are also more effective when they include a component of support for the parents. During clinical interview it was seen that the parents were feeling guilty and doubtful about the limits that they were imposing on Rajat. Education and reassurance allayed parental concern and provide information to encourage the parent to adhere to the ongoing behavioral intervention.

Family Therapy: It helped the whole Sharma family to focus on their boundaries and roles which may address systematic characteristics that are maintaining SAD (Bernstein, 1990). Restoration of appropriate family roles, reinforcement of child-parent boundaries and reinstatement of the proper family hierarchy may then become targets of therapy (Meyer & Deitsch, 1996).

Post-treatment Assessment

At the initial stage, Rajat was showing from various symptoms of separation anxiety disorder. Even the family showed some chords of conflict. On the basis of initial observation, the child and family were assessed using various psychological tools such as:

Semi-structured mental status examination (SMSE) (Silverman & Albano, 1996) was done before and after the treatment. Earlier the parents reported child showing excessive attached attitude towards mother and a detached attitude from others especially from school, they even reported an aggressive attitude of the child when taken away from the mother. Earlier the child was also having difficulties in sleeping alone and there was more stress and no coping strategy but later when the child gave the same examination, it was seen that he is again going to school happily, without any tantrums. It was not necessary that mother should always be with him. He was spending equal quality time with father as well. The aggressive attitude was also not there, though on very rare occasions he did use to become little aggressive. On both the tests of anxiety, which are, *Revised Children's Manifest Anxiety Scale (RCMAS)* (Reynolds & Richmond, 1978) and *State Trait Anxiety Inventory for Children (STAIC)* (Spielberger et. al., 1978), the child scored very high on anxiety level though it did not come out to be comorbid with depression. But later, that is, after the treatment, it was surprising to see that the anxiety level dropped down. Now the child was calmer and emotionally stable. Earlier the family members were also having conflicts but after the family therapy, the parents reported to me happy, more supportive and understanding; though from grandparents side the situation was not a lot better but still some improvement could be seen.

Complicating Factors

The initial sessions were difficult to deal with. Rajat was very stubborn initially, he didn't want to sit in the class even when his mother was sitting with him. When forced to sit alone for some time, he banged his head on the table and became very violent. That day he was sent back home. Dealing with the parents was also difficult. Mother was constantly blaming the father and in-laws and vice versa. To resolve the family conflict for child's benefit was also a challenging as well as difficult part. The grandfather was very arrogant and argumentative on bringing the child to a psychologist. He himself didn't want to come for counseling. Making the family believe and forming a rapport was actually a complicated task. Sometimes even the teachers used to get irritated because of Rajat's behavior and it used to be difficult for them to maintain discipline in the class. As Rajat was only in upper KG so when he used to be violent and used to cry, some of the other children also used to cry because they used to get scared. This used to frustrate the teachers. They complaint of not being able to teach properly and the syllabus was also suffering. All these things were difficult to deal with but with time things started to fall on right place and positive results were shown.

Assess and Barriers to Care

Many hurdles came from child's side, parents' side and teachers' side during the whole treatment session. Rajat used to get violent many time when he was forcefully kept away from his mother. He used to show self-harming behavior which used to make the psychologist stop the therapy/ session. Initially, there were time when he was not living upto the commitment, for example, it was committed that if the child will sit in the class for 45 minutes then he will be allowed to meet his mother for 5 minutes; but for initial few sessions, it was very difficult for Rajat to sit in the class, he used to cry out loud. Due to his excessive crying even the other students used to get scared and they also used to star crying. This used to make situation worse.

Dealing with parents and grandparents was also a barrier in the treatment. The parents did not have any knowledge about separation anxiety disorder so their behavior towards the child was negative initially. Educating the parents about the problem, its etiology, symptoms and treatment was a difficult task. Initially the parents used to become defensive and had difficulty in accepting that their child was suffering from SAD. During the family therapy, resolving the conflict between the parents was also not an easy thing to do. Sometimes the father used to be neglecting and sometimes the mother used to be very judgmental. As the whole treatment was time consuming, it was difficult for to the parents to take out that much time. Mr. Sharma had difficulty in taking off from his work regularly and it was even worse for Mrs. Sharma as she had to sit in the school for the whole day leaving all her work aside. There were times when they were irregular and used to skip the sessions. The biggest barrier was dealing with the grandparents. They were strictly against Rajat meeting the psychologist. They were very dominating and were blaming Mrs. Sharma for everything happening to Rajat.

From teachers' side the cooperation used to be poor initially. They found it difficult to just look after one child and ignoring others. According to them their syllabus was also suffering because of this regular disturbance. They wanted Rajat to first get well and then come to the class. So convincing teachers was also a difficult task.

Follow-up

A month after the termination of the treatment, whole Sharma family was called for the follow-up session. Individual and group counseling was done and positive results were found then. Rajat had scored well in his weekly tests and Mrs. & Mr. Sharma were also leading a healthy life. In-between telephonic follow-up was also given by Mrs. Sharma. The family has made it a rule to spend time with each other. Rajat and Mr. Sharma's father-son bond has become stronger, they play together, they talk to each other, and father helps his child in doing his homework whenever possible. The anxiety level was again diagnosed and it came out to be low in Rajat's case.

Treatment Implications of the Case

Behavioral interventions have produced generally positive results for SAD (Ollendick & King, 1998; Thyer, 1991). However, to choose which one would be more effective, depending upon the condition of the child is upto the clinician to decide. a miltimodel approach involving modeling, contingency management, in vivo desensitization is likely to be effective for most children.

Researchers have even reported psychotherapy to be an effective treatment approach. For example, in a study Kendall (1994) did 16 week treatment to a child suffering from SAD using cognitive behavioral treatment. His intervention included recognizing somatic reactions and anxious feelings, knowing one's anxiety related cognitions, developing a coping plan, evaluating coping responses and applying self-reinforcement. After 1 year, the follow-up reported to be beneficial.

Although it is unlikely that children with SAD will need a referral to legal authorities, excessive school refusal will sometimes result in legal action taken by the school. In these cases, coordination of the efforts of clinician and school are even more important than usual. Direct communication between the clinician and school is important in cases of parent or family pathology, because the parent may distort information in such cases (Bernstein, 1990).

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