

MANUALIZED PSYCHOLOGICAL TREATMENT OF SEPERATION ANXIETY DISORDER: A CASE STUDY

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ABSTRACT

Separation anxiety disorder (SAD) is one of the most common anxiety disorders in children. Recently, a manualized psychological treatment for children's mental disorders has been developed, with clinical experiment demonstrating superior treatment outcomes with this new method of intervention relative to alternatives (e.g., CBT). The current case study of Sara, a 7-year-old girl with SAD, implemented this manualized psychological treatment for SAD. Treatment consisted of 15 individual sessions; with follow-ups happening 6 months post intervention. Sara showed marked decreases in SAD symptoms throughout the period of therapy, leading to thorough remission of SAD at the end of treatment. Her SAD maintained to be in remission at the 6-month follow-up sessions. This case study illustrates the usefulness of a manualized psychological treatment for SAD.

Keywords: *Case Study, Manualized Psychological Treatment, Separation Anxiety Disorder*

INTRODUCTION

Theoretical and Research Basis for Treatment

Separation anxiety disorder (SAD) is one of the most common mental health disorders in children. SAD is a psychological condition in which a one experiences extreme anxiety regarding separation and distance from home or from people to whom the individual has a powerful emotional attachment. Pursuant to the American Psychology Association, SAD is the excessive and inappropriate show of worry and distress once confronted with situations of separation from a specific attachment individual or from the house. The anxiety that is expressed is categorized as being uncommon of the age and expected developmental level (Ehrenreich *et al.*, 2008). The severity of the symptoms ranges from anticipatory uneasiness to full-blown anxiety about separation (Masi *et al.*, 2001).

SAD may occasion significant negative results within a child's everyday life, likewise. These effects can be seen in areas of physical health, family life, emotional and social functioning, and within the academic context (Ehrenreich *et al.*, 2008). The duration of this problem must persist for at least four weeks and must present itself before a child is 18 years of age to be diagnosed as SAD, as specified by the DSM-IV (Beesdo *et al.*, 2009). Anxiety disorders are the most common type of psychopathology to occur in today's youth, affecting from 5–25% of children world-wide (Ehrenreich *et al.*, 2008). Of these anxiety disorders, SAD accounts for a large proportion of diagnoses. SAD may account for up to 50% of the anxiety disorders as recorded in referrals for mental health treatment (Ehrenreich *et al.*, 2008). SAD is noted as one of the earliest-happening of all anxiety disorders (Beesdo *et al.*, 2009). SAD symptoms may differ in how individuals show them, in what theme, and the severity. Some common symptoms that persons with SAD represent involve: Significant worry, distress, and fear at the thought of or occurrence of separation; throwing tantrums, crying, clinging to the parent, and denying to participate in activities that need separation from the attachment figure (Ehrenreich *et al.*, 2008). Fear of harm coming to the attachment figure or the self when separated if they are separated Difficulties sleeping without the attachment figure present; persistent nightmares (Altman *et al.*, 2009) Somatic symptoms including complaints of headaches, nausea, stomachaches, or which, may or may not really be occurring (Altman *et al.*, 2009), reluctance, avoidance, refusal, and oppositional behaviors in attempt to arrest separation from occurring (Bogels & Zigterman, 2000).

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toward anxiety disorders such as ASD, cognitive behavioral therapy is the well-studied treatment and generally the treatment of selection owing to the positive research proof (Kendall *et al.*, 2008). Recently a manualized psychological treatment for children has been expanded for the individual treatment of children's mental disorders such as SAD. Treatment following this manual has been shown to be efficacious in individual clinical experiments (Khalili-Kermani *et al.*, 2014a, 2014b, 2012). The following case study is an example of this manualized psychological treatment for a child with SAD.

Case Introduction

“Sara” was a 7-year-old girl whose mother brought her to a university pediatric clinic for assistance with her disruptive behavioral issues associated with anxiety. These behavior problems (i.e., she wants her mother to confront her for all the times such as going to the bathroom and even during sleeping; she often has to seek the aid of her mother; she asked her mother help her with her homework; she was apprehensive about thief; she fears of their house and everything there) occurred across home settings and were becoming increasingly difficult to manage. Sara went to first grade, and these behaviors were likely to affect her ability to achieve at her full potential and succeed socially and academically. Sara had accessed several interventions before to this visitation, none of which remarkably improved her level of operation or were well sustained by Sara. At that time Sara presented to this clinic, she had been diagnosed by numerous community providers with ASD, and ADHD.

Presenting Complaints

Sara's mother described her as dependent, aggressive and anxious, especially when facing situations which she should become alone. She engaged in tantrums that could last up to an hour. Once she became upset or even glad, she had difficulty managing herself and her emotions. Her mother reported that she was jealous off her 1-year-old brother. She wants her mother to hug her like an infant and give her milk in a bottle. Her aggressive behavior was growing up by birthday of her brother. Her mother noted that the more positive approaches, such as praise or positive behavior charts, were most effective at helping her to manage her behaviors, but she remained concerned that she was “giving in” and rewarding her for inappropriate behavior. In her school classroom, Sara tried to follow teacher directions and class's rules. Sometimes, she volunteered for class activities and spent most of the times with the teacher, according to her teacher. She experienced difficulty getting along with the other children. She couldn't find stable friend for herself. She spoke other children in not acceptable ways such as giving them strict instruction, violent behavior and on the other hand, sometimes shame on sharing her ideas.

History

Sara was born following a healthy pregnancy and delivery. In her history, she had two surgeries; one was heart surgery in age of 4 months, and other one was eye surgery in age of 17 months. In addition to these problems, Sara has gastro reflux which had her to carry a plastic bag in every situation which was not so pleasant for her. She didn't like these conditions and asked her family to pray for her. Additionally, she wore glasses which cause other people show affection to her. Subsequently Sara became even more demanding of her mother and her attention; her social relation became limited which needed mother support to make a relationship with another children and play with them.

Three weeks ago, a rubbery token place in front of their apartment and the thieves stole a bag with a lot of gold from Sara's uncle car. Sara and her family observed these situations from the windows of their house and shouted and seek people's help. But unfortunately, they didn't success and the thieves escaped. These caused Sara to scare from thief, their house and aloneness.

Recently, Sara's mother discussed her concerns about Sara's behavior to her pediatrician. The pediatrician suspected that Sara might have ADHD and ASD and referred her to counselor for intervention. It is also notable that Sara's father works in other city, requiring her to be deployed for long periods of time. Sara missed her father greatly during these separations, and subsequently became even more demanding of her mother and her attention. Sara has a 1 year old brother which she also is still jealous of her baby brother. Finally, for many years, Sara was an only child, therefore restricting her chances to play with and learn from other siblings in her extended family. This condition led Sara to interact with older people which support her enormously.

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Assessment

Psychological assessments were conducted by a specialty team of pediatric providers, and included behavior observations, IQ assessment, and behavior rating scales completed by her mother.

IQ assessment was completed utilizing the Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV) (Wechsler, 2003) and resulted in a complete Scale IQ score in the range of 90 to 110 is considered average (complete Scale IQ = 132). The Achenbach Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2000) was completed by her mother to assess adaptive functioning and to assist in diagnosis. The CBCL resulted in scores above the clinical cutoff for pervasive developmental problems, anxiety problems, oppositional defiant problems, and attention deficit/ hyperactivity. Thus, these data showed that Sara has significant behavior problems, less competence in adaptive functioning relative to same-age peers. She met the DSM-IV-TR diagnoses for ASD and ADHD.

Behavior rating scales completed at pre–post-PCIT (parent child interaction therapy) intervention and follow-up included the CBCL. The CBCL is a standardized assessment system that is used to measure various aspects of behavior and personality, including competencies and behavioral or emotional problems. T-scores with a mean of 50 and standard deviation of 10 are used to identify behavior problems relative to a standardization sample, and scores above 70 are considered to reflect a risk for behavioral health problems. Scores are summed up into total problems and DSM-oriented scales. At pre-assessment, parent ratings indicated significant risk for behavioral health problems, related to attention deficit and hyperactivity problems, affective problems, anxiety problems, pervasive developmental problems, and oppositional defiant problems. Sara’s T-scores declined over the course of intervention and follow-up for parent ratings, with the exception of attention deficit/hyperactivity problems, which continued to be significant at follow- up assessment.

Sara’s scores were significant as per parent initial ratings and declined over the course of the intervention and into the follow-up period. Data from the CBCL are summarized in Table 1.

Table 1: Pre–Post Assessment and 6-Month Follow-Up Results

Assessment tool	Pre	Post	6-Month Follow-Up
CBCL (T-scores, M = 50, SD = 10)			
Affective problems	81	50	56
Anxiety problems	85	64	65
Aggressive behavior	74	42	42
Attention deficit/hyperactivity	76	50	51
Oppositional defiant problems	71	52	53
Conduct problems	69	46	48
Isolation and depression	72	55	56
Social problems	80	54	55
Thinking Problems	81	52	52
Attention problems	81	55	57
Rule-Breaking Behavior	76	52	52

Note: CBCL = Child Behavior Checklist

Scores above 70 are considered to reach the clinical cutoff, whereas those above 65 are described as borderline clinical for all age ranges.

Case Conceptualization

Sara’s behavior problems and anxiety were defined through interviews and standardized behavior rating scales completed by her mother. Sara’s problem behaviors included annoying her brother, disobedience of her mother, and aggressive behavior mostly in front of her mother. Anxious behaviors included more demanding of her mother and her attention, clinging to her mother, fear of thief, fears of their house and everything there. Most of these problems occurred at home especially in front of her mother and she was more disobedient with her mother than with other, per her mother’s report. The perceived function of her

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behavior was fear of thief and theft which led her to seek her mother attention, to gain security. These behaviors were limited to home where the theft was happen. On the other hand, at school she tried to be so polite in front of her teacher to receive her attention. Since she was not so proficient in getting along with her peers, she behaved in aggressive manner with her peer, and disobedient from game's rules. Our purpose with Sara was to release her fear and make better her relationship with mother, and to teach her to obtain attention with appropriate behavior, follow directions, and use appropriate communication when she was at home. Our target with her mother was to assist her learn to reinforce Sara's appropriate behavior to help her confidence development, provide secure, and apply a consistent discipline scheme when needed. Indirect speech was selected as the intervention plan because of the evidence for this approach in treating young children with separation anxiety disorder and other behavioral issues (Khalili-Kermani *et al.*, 2014a, 2014b, 2012).

Course of Treatment and Assessment of Progress

Sara and her mother were seen in weekly, 50-min sessions over the course of 2 months for a total of 12 sessions. Consistent with the treatment manual, treatment progressed through the two distinct phases of indirect and direct speech. During the first phase of psychological treatment, after making relationship with child through play, the therapist asked child to make a story for the pictures of the Children's Apperception Test (CAT). After telling story for each picture, the therapist asked some questions to achieve more information about the defined situation. In fact, the therapist tried to lead child to talk about her thought and emotions about the situation which make her anxious, aggressive, and shy. This step of therapy contained indirect speech which led child to talk about pictures, answers the questions which the therapist asked her and unconsciously elicit hidden aspect of herself and her behaviors' reasons. During each therapy session, the clinician allocated a time to play with child in present of her mother to teach her the rules of PCIT, which goal is to shape verbalizations and behavior during the play with their child via the use of positive reinforcement and teach them how to use effective discipline strategies. Parent's use of these core skills are thought to foster greater attachment and parent-child warmth (Eyberg *et al.*, 1995). In addition, during playing with child in the both phase of therapy, the therapist focused on developing Sara's self-confidence, teaching her how to get along with other children, and teaching her how to express her ideas in a correct way. Child behavior, her reaction to therapy sessions, and Parents' communication skills and plays were documented during the first 5 min of each session, and the therapist provided essential information for parents as needed. During the first therapy phase, after telling story about CAT picture, the therapist indirectly talked with child about pervious conversation which the child said about each picture and encourage child to say why she think in this way and describe her reasons. In fact, after recognizing child's thoughts and beliefs, the therapist helped child to change her irrational thinking to rational one. In result, child understood that she thinks incorrectly in some situation and after changing her beliefs she changed her behavior. In second therapy phase, the therapist and child enter the direct speech together which emphasis on the child and her behavior. This step of therapy help child to generalize her new beliefs to her thoughts and behaviors.

Complicating Factors

Sara was bilingual which spook Persian and Arabic. As her parents spoke Arabic at home, she had a little problem in understanding Persian conversation's main idea. In addition, Sara's mother minor depression made the process of therapy a little difficult, which the therapist had to expend more than usual time in motivating mother to apply parent child interaction's techniques at home and follow the direction of therapy.

Access and Barriers to Care

There were no apparent access issues or barriers to care considerations as the family had adequate transportation and the university pediatric clinic where they sought treatment accepted their insurance policy.

Follow-up

Follow-up data were acquired 6-months post-treatment. In addition to a parent interview, behavior ratings administered at baseline and discharge were completed. Baseline refers to the assessment session, in

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which the parent completed standardized behavior rating scales. Discharge is reached upon changing SAD features in child and CBCL behavior ratings falling below the clinical range. Sara's mother reported sustained improvement with Sara's behavior and compliance at home, and her behavior at school improved over the course of the school year. Most encouragingly, Sara was able to successfully interact with other children specially her little brother.

Treatment Implications of the Case

This case study described how manualized psychological intervention, could be used to treat SAD in a young child. This intervention helps to improve the parent-child relationship by providing parents with the skills and knowledge to implement behavior management principles that improve their child's behavior through modeling incorrect behavior by therapist. An effective parent-child relationship is essential to development of children. Given that pharmacological treatments may be detrimental to children and show only modest efficacy for the treatment of symptoms of SAD, manualized psychological intervention should be considered as one of the first step in treating symptoms of SAD and behavior problems which can be combined with PCIT (Poncin & Scahill, 2007; Schapiro *et al.*, 2007).

Recommendations to Clinicians and Students

This case study supported the effectiveness of manualized psychological intervention combined with PCIT in treating a young child with SAD. In this case, manualized psychological intervention was effective in reducing symptoms associated with SAD and behavior problems in this child, increasing her compliance, and served to improve the parent-child relationship. Modeling correct relationship with child by therapist helps parents pay attention to their child in a way that strengthens their relationship and builds child self-confidence and self-esteem. In Sara's case, her anxiety and emotional outbursts were greatly reduced in response to her mother's focused attention on more positive and adaptive behaviors. In addition, her narrow range of interests diminished, while her play skills improved, another important goal for children with SAD.

Further research on manualized psychological intervention for children with SAD and disruptive behavior is critical toward identifying evidence-based interventions that may help to ameliorate the negative outcomes related to disruptive behaviors and ASDs in early childhood.

Key Points

- In indirect phase of manualized psychological treatment, the therapist tried to lead child to talk about her thought and emotions.
- In indirect phase of therapy, the child talks about CAT pictures and answers the questions which the therapist asked her and unconsciously elicits hidden aspect of herself and the reasons of her behaviors.
- During each therapy session, the clinician allocated a time to play with child in present of parents to teach them the rules of PCIT.

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