

The Implementation of Modified Parent-Child Interaction Therapy for Youth with Separation Anxiety Disorder

Donna B. Pincus, Lauren C. Santucci, Jill T. Ehrenreich, *Boston University*
Sheila M. Eyberg, *University of Florida*

Separation Anxiety Disorder (SAD) is the most prevalent anxiety disorder experienced by children, and yet empirical treatment studies of SAD in young children are virtually nonexistent. This paper will describe the development and implementation of an innovative treatment for SAD in young children. First, we will highlight the rationale for developing interventions specifically for SAD in young children. Second, we will describe an existing empirically supported treatment, Parent-Child Interaction Therapy (PCIT; Brinkmeyer, M. Y., & Eyberg, S.M., (2003)), that may have particular applicability to very young children with SAD and their parents. We present how results from 10 pilot participants were utilized to modify PCIT to better address the needs of children with SAD and their families. The benefits and challenges of implementing this modified version of PCIT are reviewed, along with potential directions for future research in this area.

SEPARATION ANXIETY DISORDER (SAD) is the most prevalent anxiety disorder experienced by children, accounting for one half of the referrals for mental health treatment of anxiety disorders (Bell-Dolan, 1995; Cartwright-Hatton, McNicol & Doubleday, 2006). A recent epidemiological study suggests that 4.1% of children demonstrate a clinical level of separation anxiety, and that approximately one third of these childhood cases (36.1%) persist into adulthood (Shear, Jin, Ruscio, Walters, & Kessler, 2006). SAD has also been identified as a specific risk factor for the development of panic disorder in adolescence and adulthood (Lease & Strauss, 1993). Furthermore, a prospective study of individuals diagnosed with SAD in childhood supports a modest association with major depression (Klein, 1995).

Phenomenology of SAD

At early stages in development, separation anxiety is a normal phenomenon that typically dissipates around 30 months of age. A diagnosis of SAD is only assigned when the child's anxiety and distress during separation is inappropriate given his or her age and developmental level (American Psychiatric Association, 2000). The defining feature of SAD is an excessive fear response to real or imaged separation from a caregiver, most typically a

parent. This fear is exhibited through disproportionate and persistent worry about separation, including apprehension about harm befalling a parent or the child when they are not together, as well as fear that the parent will leave and never return. Young children with SAD are likely to cry, protest, tantrum, or complain of physical symptoms (i.e., headaches, stomachaches) upon the parent's departure. Nightmares with separation themes are also common in younger children with separation difficulties.

Related to distress surrounding separation, children with SAD often exhibit disruptive, oppositional, and avoidant behaviors that interfere with child and family functioning and normative social development. Specifically, young children with this disorder often display disruptive behavior at bedtime, including refusal to sleep in their own room, and frequent sleeping with the parents. In addition, young children may make excessive attempts to contact parents after separation occurs, refuse to engage in developmentally appropriate peer activities (i.e., birthday parties, sleepovers, play dates, sports), and demonstrate reluctance or unwillingness to attend school. Research suggests that approximately 75% of children with SAD exhibit school-refusal behavior (Last, Francis, Hersen, Kazdin, & Strauss, 1987). Thus, symptoms of SAD can result in significant disruption of the child's family, social, and academic functioning.

Etiology of SAD

There are likely many factors contributing to the etiology of separation anxiety in young children. For example,

biologically, children may inherit a general vulnerability to be anxious, and given particular environmental circumstances, this vulnerability may be displayed specifically through separation concerns (see Barlow, 2002, for full review of the etiology of anxiety). Given that a major developmental task of the preschool years is separation from caregivers, it is not surprising that during this time period, without the appropriate environmental supports, many children can struggle with navigating the task of separating easily. Furthermore, given literature on parenting styles of parents of anxious children (e.g., more controlling, less warm, overprotective, and more critical; Eisen, Engler, & Geyer, 1998), it is also not surprising that children who begin to display some early anxiety concerns may have factors in their environment (such as parents' style of interacting with them) that foster anxious behaviors.

Overview of Paper

Given the prevalence of SAD in young children, the distress endured by children with this disorder, and its impact on functioning, it is imperative that treatments are designed to target SAD at its earliest stages. This paper will describe the development and implementation of a treatment for SAD in young children. First, we will highlight the need to develop interventions specifically for younger children. Second, an existing empirically supported treatment is described that may have particular applicability to very young children with SAD and their parents: Parent-Child Interaction Therapy (PCIT; Brinkmeyer & Eyberg, 2003). We describe results from 10 pilot participants that were utilized to modify PCIT to meet the needs of children with SAD and their families. The challenges of implementing this modified version of PCIT are presented in the discussion, along with potential directions for future research in this area.

Rationale for Developing a Treatment for SAD in Young Children

While evidence exists supporting the efficacy of CBT for anxiety disorders in children and adolescents (i.e., Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Kendall et al., 1997), very few treatments for anxiety have been tested using a sample of children under the age of 7 (see Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004, for a review; Ollendick & King, 1998). A cognitive-behavioral treatment recently developed for anxious children ages 4 to 7 by Hirshfeld-Becker and colleagues (2006) shows some initial promise for treating a spectrum of anxiety symptoms in early childhood. However, this intervention is not tailored specifically to children with SAD, and instead aims to treat anxious children more generally. In fact, most of the treatment studies that have been conducted in the area of child anxiety have included

mixed samples of anxious children, and thus, the efficacy for any individual disorder remains unclear. It is possible that if we tailor our treatments to specific disorders, response rates may be improved. Given that developmentally inappropriate and clinically interfering symptoms of separation anxiety may be evident as early as age 3 (Kearney, Sims, Pursell, & Tillotson, 2003), the lack of empirically based treatments for these young, distressed children may result in the use of age-inappropriate or untested treatment techniques with this population.

When compared with older children, meta-analytic studies suggest that younger children may benefit less from traditional CBT approaches (Bennett & Gibbons, 2000). For instance, traditional CBT approaches require the utilization of cognitive skills that may be developmentally inappropriate for younger children (Grave & Blissett, 2004). Thus, new or adapted interventions appropriate for younger children with anxiety disorders are needed, and preliminary evidence suggests that interventions targeting the parents of children with internalizing disorders may facilitate symptom improvement (Cartwright-Hatton, McNally & White, 2005). Furthermore, as 63% of children with a diagnosis of SAD also have a parent with clinical levels of anxiety (Manicavasagar, Silove, Rapee, Waters, & Momartin, 2001), teaching effective parenting strategies for dealing with anxious children may be particularly important. Although parents of children with anxiety may have good general parenting skills, they are likely to benefit from specific skills regarding how to change maladaptive interactions with their child, and how to understand, manage, and address their child's anxiety symptoms.

PCIT

PCIT (Brinkmeyer & Eyberg, 2003) is an empirically supported treatment originally designed to reduce disruptive behaviors in children. The treatment aims to help parents foster a warm and responsive relationship with their child while also learning to manage their child's disruptive behavior more effectively. PCIT treatment consists of two phases: the Child-Directed Interaction (CDI) and the Parent-Directed Interaction (PDI). The CDI phase aims to improve the quality of the parent-child relationship, social skills, and children's self-esteem. Parents are taught to apply specific skills while interacting with their children that promote warmth and responsiveness (i.e., decreased criticism, questions and commands; increased labeled praise, reflection, imitation, behavioral description, and enthusiasm). Throughout the CDI phase, parents are also coached to differentially reinforce their child's behavior, praising appropriate responses while ignoring those deemed undesirable. This positive behavior-management strategy is introduced during CDI, yet its application is encouraged throughout the duration

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