

REVIEW / PRACA POGLĄDOWA

Małgorzata Maria Dąbkowska

**SEPARATION ANXIETY IN CHILDREN
AS THE MOST COMMON DISORDER CO-OCCURRING WITH SCHOOL REFUSAL**

**ŁĘK SEPARACYJNY U DZIECI
JAKO NAJCZĘSTSZE ZABURZENIE SKUTKUJĄCE UNIKANIEM SZKOŁY**

Department of Psychiatry Collegium Medicum, Bydgoszcz, Nicolaus Copernicus University, Torun, Poland
Headmaster: Prof. dr hab. Aleksander Araszkiewicz

S u m m a r y

Anxiety disorders form a part of the most common health disorders existing at the evolutionary age. School refusal could be defined as a difficulty in attending school associated with emotional distress, especially anxiety and depression. Separation anxiety can be a meaningful factor of school attendance reluctance.

Children suffering from separation anxiety usually experience unrealistic fear of being separated from their meaningful persons. The squeals of childhood anxiety disorders include social, family, and academic impairments. Anxiety separation disorders disrupt the normal psychosocial development of a child.

S t r e s z c z e n i e

Zaburzenia lękowe należą do najczęściej spotykanych zaburzeń wieku rozwojowego. Unikanie szkoły można zdefiniować jako trudności w uczęszczaniu do szkoły związane z emocjonalnymi zaburzeniami, szczególnie lękowymi i depre-syjnymi. Lęk separacyjny jest głównym podło-żem odmowy chodzenia do szkoły.

Dzieciom cierpiącym z powodu lęku separacyjnego towarzyszy nierealistyczny strach przed oddzieleniem od bliskiej osoby. Następstwem zaburzeń lękowych u dzieci jest obniżone funkcjonowanie społeczne, rodzinne i gorsze wykształcenie. Lęk separacyjny upośledza prawidłowy rozwój psychospołeczny dziecka.

Key words: anxiety disorders, separation anxiety, school phobia, children

Słowa kluczowe: zaburzenia lękowe, lęk separacyjny, fobia szkolna, dzieci

Reviews of epidemiologic studies conclude that anxiety disorders are common and possibly the most prevalent category of disorder in youth [1]. Prevalence rates of anxiety disorders in children and adolescents range from 2% to 27%, depending on age and assessment used [2, 3, 4]. The effects of anxiety are not confined to childhood and adolescence, but can lead to problems in later functioning. Negative squeal of childhood anxiety include adult anxiety disorders, mood disorders, and substance use problems [5, 6]. School attendance reluctance on the ground of anxiety disorders is called a school phobia. School refusal

could be defined as a difficulty in attending school associated with emotional distress, especially anxiety and depression. School refusal is considered a symptom rather than a clinical diagnosis and can manifest itself as a sign of many psychiatric disorders, with anxiety disorders predominantly. Identified main predictors of school refusal behavior were in connection with distinctive feature of community, school and family [7, 8]. Separation anxiety disorder, generalized anxiety disorder, social phobia, specific phobia and adjustment disorder with anxiety symptoms are the most common disorders co-occurring with

school refusal [9]. Most cases of severe separation anxiety result in school refusal. According to the majority of authors, separation anxiety forms a ground for school phobia performance, whereas school anxiety is normally connected with difficulties in learning and with different events happening at school. Children suffering from school phobia equaled to separation anxiety mostly do not experience difficulties in learning and are, paradoxically, very good students with high intellectual potentials.

For separation anxiety disorder, the essential feature is excessive anxiety consuming separation from the home or from those to whom the person is attached, an issue that may first surface when a child begins formal schooling. While separation anxiety disorder is associated with school refusal in younger children, other anxiety disorders, especially phobias, are associated with school refusal in adolescents. School phobia has traditionally referred to the youngsters who refuse school with parental knowledge and because of separation anxiety or specific fears. Terms such as separation anxiety and school phobia are often used interchangeably with school refusal. Johnson et al. (1941) coining the term 'school phobia', defined it as an anxious fear of school caused by the child and mother's separation anxieties [10, 11]. Such definitions include the youths who are completely absent from school, initially attend school but then leave during the school day and those who go to school after having behavioral problems such as morning tantrums or psychosomatic complaints, and who display marked distress on school days and ask their caregivers to allow them not to go to school. The rates of school absenteeism are much higher in some urban areas. The most common age of onset is 10 to 13 years. Anxious school refuses can be divided into three types: those with separation anxiety, social phobia, and those who are anxious and depressed [8]. The prevalence of school refusal has been reported to be approximately 1% in school-age children and 5% in child psychiatry samples. The prevalence of school refusal is similar among boys and girls. School refusal can occur at any time throughout the child's academic life and at all socio-economic levels. The vulnerabilities associated with pure anxious school refusal include living in a single-parent home, attending a dangerous school, and having a biological or non biological parent who had been treated for a mental health problem [12]. Among different kinds of risk factors of school phobia there are genetic, biological (obstetric, neonatal),

temperament, comorbidity and environmental risk factors such as developmental experience, life events, history of childhood, parent-child relationship [7, 13, 14, 15]. The psychiatric disorders are more frequently seen in adult relatives of children with school refusal. This fact supports a significant role of genetic and environmental factors in the etiology of school refusal. Approximately 52% of adolescents with school refusal behavior meet criteria for an anxiety, depressive, conduct-personality, or other psychiatric disorder later in life [16]. Berg et al. (1993) found that a half of young people with attendance problems had no psychiatric disorder, one third had a disruptive behavior disorder, and one fifth had an anxiety or mood disorder [17]. School refusal is reported in about 75% of children with SAD, and SAD is reported to occur in up to 80% of children with school refusal [9, 18].

Children suffering from separation anxiety will usually experience unrealistic fear of being separated from their meaningful persons by: getting lost, being kidnapped, being taken to hospital, death of the meaningful person. At home such children are reluctant to go to sleep if they are not accompanied by the person they are strongly related to. The nightmares on background of separation are observed. In situations connected with temporal separation from meaningful person like leaving home for school, the physical symptoms occur, including nausea, stomachache, headache, vomit. At a moment of being disconnected from the most meaningful person or soon after that, a distress is observed in child, with symptoms like anxiety, tears, irritation, anger, experiencing disastrous feeling, apathy, or social withdrawal in expectation of meaningful person's return. Anxiety related to home leave leads to psychosomatic symptoms which prevent a child from attending to school. It is easier for a child to accept symptoms of somatic disease than an appearance of anxiety. Both sense of guilt caused by school attendance reluctance, and awareness of a situation different from the peers' lead to reluctance in going out, meeting peers and eventually to a total isolation from social background. When child's school attendance reluctance is being performed successfully, the school situation gets worse and a child becomes irritable. Child's aggression in such case will be directed against its parents. If the situation extends, anxiety disorders are accompanied by mood swings and behavioral instability. Separation anxiety is therefore followed up by school anxiety on the

background of rising arrears of school assignment. Results of studies support the association between anxious school refusal and somatic symptoms (headache, gastrointestinal complaints) occurring mostly in the morning, disturbed sleep, nightmares [12, 19, 20]. A young person with anxiety disorder diagnoses (also separation anxiety disorder) demonstrates significantly lower levels of school functioning than those without anxiety disorders [4]. School refusal behavior can lead to serious short-term problems, such as distress, academic decline, alienation from peers, family conflict, interfamilial violence, financial and legal consequences. Long-term consequences may include fewer opportunities to attend facilities of higher education, employment problems, social difficulties, and increased risk for later psychiatric illness [21]. Paternal absence was found to have an important influence on vulnerability for SAD, whereas the effect of socioeconomic disadvantage was less robust [22]. Long term follow-up studies of children treated for school refusal due to SAD show that despite their return to school, many continue to present significant social and affective limitations [21, 23]. In relation to educational outcomes, about half of school refuses underachieve academically [21, 24, 25, 26]. Children and adolescents with school refusal are a heterogeneous population and require individualized treatment planning. Variables such as diagnosis and severity at the start of treatment should be taken into consideration when planning treatment. Often children and parents assess basic reasons for school refusal in a different way [27]. Dabkowska's study (2007) noticed substantial disagreement between children and parent in identifying the function of school refusal behaviors [28].

The separation anxiety disorder (SAD) is qualitatively different from early worries and the normative anxieties. Fear and worry are common in healthy children. Developmentally, normal fear does not impair a child's functioning. Infants typically experience fear of loud noises, fear of being startled, and later a fear of strangers. Toddlers experience fears of imaginary creatures, fears of darkness, and normative separation anxiety. School-age children commonly have worries about injury and storms. Older children have worries and fears related to school performance, social competence, and health issues. Fears during childhood become problematic if they do not subside with time or impair the child's functioning.

Depending on the age, developmental differences are observed in the expression of childhood anxiety symptoms and fears. Results also point toward specific symptoms predominant at certain ages (i.e. separation anxiety symptoms in youths aged 6-9 years, in partial support of predictions [29]). Normal separation distress usually intensifies during early childhood, then gradually subsides at 3 to 5 years of age, although a percentage of children continue to present closed relation to parents and separation distress into their first school attendance. Separation anxiety diathesis may manifest itself differently over the life span [30].

Separation anxiety disorder represents a more severe and disabling form of a maturational experience that all children normally have. As specified in DSM-IV-TR criteria, separation anxiety disorders are defined largely by the persistence of such symptoms for duration long enough to be considered pathological [31]. In DSM-IV, disorders that have been long recognized as manifested during childhood are placed in a separate category of 'Disorders usually first diagnosed in infancy, childhood or adolescence.'. As for the anxiety disorders, these include only separation anxiety disorder (SAD) in DSM-IV. A DSM-IV-TR-based diagnosis of separation anxiety disorder requires that a child shows at least three of the following symptoms for at least four weeks [31]. The characteristic symptoms include three types of distress or worry, three types of behaviors and two physiological symptoms.

DSM-IV-TR diagnostic criteria for separation anxiety disorder (309.21):

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

(1) recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated

(2) persistent and excessive worry about losing, or about possible harm befalling, major attachment figures

(3) persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)

(4) persistent reluctance or refusal to go to school or elsewhere because of fear of separation

(5) persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings

(6) persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home

(7) repeated nightmares involving the theme of separation

(8) repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before the age of 18.

D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is better not accounted for by Panic Disorder with Agoraphobia.

Specify if:

Early Onset: if onset occurs before the age 6 years [31].

Diagnostic guidelines of the ICD-10 Classification of Mental and Behavioural Disorders of World Health Organization lists similar criteria for separation anxiety disorder (F93.0) [32]. Developmental differences have been reported in the presentation of symptoms. Younger children have more symptoms than older children. Children aged 5 to 8 years most commonly report unrealistic worry about harm to attachment figures and school refusal. In children aged 9 to 12 years, the disorder is usually manifested by excessive distress at times of separation [33]. In adolescents, somatic complaints and school refusal are most common. The most frequently observed ages for occurrence of separation anxiety disorder are in children aged five to seven years old and again from the age of 11 to 14 years old. Many studies report a declining prevalence of SAD as children age into adolescence. Separation anxiety in children with severe school refusal often evokes concern about the future with regard to professional career and social integration. In the study of Von Widdern & Lehmkuhl (2011), in the group of inpatient treatment because of a separation anxiety disorder assessed at follow up ranged from 4.3 to 11.1 years (average 7.1 years) at least one clinical psychiatric diagnosis in one third of all patients at follow-up [34] was found. Even more of the former inpatients reported sub threshold psychiatric

symptoms (55%). Estimated remission rate for the separation anxiety disorder was high (89%). The results revealed an important shift of diagnosis to social phobia in one third of cases. The majority of young people considered academic outcome satisfactory but reported pronounced problems in the social integration [34]. Anxiety disorders in childhood are predictors of a range of psychiatric disorders in adolescence. The sequelae of childhood anxiety disorders include social, family, and academic impairments. Anxiety separation disorders disrupt the normal psychosocial development of a child. Children with SAD may not have the opportunity to develop independence from adults. Social problems include poor problem-solving skills and low self-esteem. Severe separation anxiety can result intra-familial violence.

Children are usually brought to the clinician when SAD results in school refusal or somatic symptoms such as recurrent pain of different parts of body occur. Anxiety disorders can be managed by using non-pharmacological and pharmacological options, or a combination of them. Treatment of the separation anxiety disorder includes behavioral, cognitive, and individual psychotherapies, as well as parent counseling and guiding teachers on how to help a child. The most recent evidence for empirically supported treatments shows that the cognitive-behavioral therapy (CBT) and selective serotonin-reuptake inhibitors (SSRI) are the most efficacious for the improvement of the children health with the separation anxiety disorder. Different classes of medications have been used in pediatric anxiety disorders, including benzodiazepines, tricyclics and buspirone. Recent antidepressants (SSRIs and beyond) have had fewer side effects, lower toxicity in overdose and a broader range of indications [35]. Cognitive behavioral therapies have the best evidence-based support for the treatment of the separation anxiety disorder in children and adolescents [36]. The outcomes of a randomized clinical trial evaluating an individual cognitive-behavioral, family-based cognitive-behavioral, and family-based education, support and attention treatment for anxious youth, also with diagnosis of separation anxiety disorder showed good efficacy of the psychotherapy [37]. The treated youth exhibited a reduction in anxiety and increased anxiety self-efficacy and emotional awareness at post treatment. The cognitive-behavioral therapy for the anxious youth, also with separation anxiety disorder

could change in emotion regulation. Children's coping skills have been considered to be protective factors in childhood anxiety disorders. Learning to use active coping strategies, distraction strategies, and problem-focused rather than avoidant-focused coping have been encouraged in the anxious youths [38]. Non pharmacological treatments are the first choice approach in separation anxiety disorder or school refusal. This kind of treatment contains psychoeducational intervention (education of child and parents, collaboration with school personnel, training to increase child's autonomy and competence) and psychotherapeutic approach (behavioral, cognitive-behavioral, psychodynamic or family therapy). Pharmacological management of separation anxiety disorder uses mainly selective serotonin reuptake inhibitors; previously used tricyclic antidepressants, possibly benzodiazepines or buspirone. The major aim of the treatment is to help the child return to school in the shortest time possible. The treatment should be carried out in cooperation with the child's parents and the school personnel. A widely accepted approach to the treatment of school refusal is one that is concerned with the application of a multi-faceted treatment. Psychosocial and psychopharmacological approaches constitute the crucial parts of the therapeutic process. Today, cognitive behavior therapy is the most frequently employed approach in the treatment of school refusal [39]. The anxious school refusal can be effectively treated with other behavioral interventions, also pharmacotherapy, where mainly selective serotonin reuptake inhibitors could be useful. Finally, it is important to intervene at school to improve child's comfort and safety.

REFERENCES

- Albano, A. M., Chorpita, B. F., & Barlow, D. H. Childhood anxiety disorders. In Mash, E. J., & Barkley, R. A. (Eds.), *Child psychopathology* (2nd ed., pp. 279-329). New York: Guilford Press 2003.
- Costello, J. E., Egger, H. L., & Angold, A. Developmental epidemiology of anxiety disorders. In Ollendick, T. H., & March, J. S. (Eds.), *Phobic and anxiety disorders in children and adolescents: A clinician's guide to effective psychosocial and pharmacological interventions* (pp. 61-91), New York: Oxford University Press 2004.
- Phillips, B. *School stress and anxiety: theory, research, and intervention*. New York: Human Sciences Press 1978.
- Matthew P. Mychailyszyn, Julia L. Méndez, Philip C. Kendall: *School Functioning in Youth With and Without Anxiety Disorders: Comparisons by Diagnosis and Comorbidity*. *School Psychology Review* 2010, 39, 1, pp. 106-121.
- Kendall, P. C, Safford, S., Flannery-Schroeder, E., & Webb, A. Child anxiety treatment: Outcomes in adolescence and impact on substance abuse and depression at 7.4 year follow-up. *J Consult Clin Psychol*, 2004, 72, 276-287.
- Woodward, L. J., & Fergusson, D. M. Life course outcomes of young people with anxiety disorders in adolescence. *J Am Acad Child Adolesc Psychiatry* 2001, 40, 1086-1093.
- Kearney, C.A. & Hugelshofer, D.S. Systemic and Clinical Strategies for Preventing School Refusal Behavior in Youth, *Journal of Cognitive Psychotherapy* 2000, 14,1, pp. 51-65.
- King, N. J. & Bernstein, G. A. School Refusal in Children and Adolescents: A Review of the past 10 Years. *J Am Acad Child Adolesc Psychiatry* 2001, 40:2 197-205.
- King, N., Ollendick, T.H. & Tonge, B.J. *School refusal: assessment and treatment*, Allyn & Bacon, Needham Heights, MA 1995.
- Johnson, A.M., Falstein, E.I. & Szureck, S.A. School phobia, *Am J Orthopsychiatry*, 1941, 11, pp. 702-711.
- Kearney, C.A. & Silverman, W.K. The evolution and reconciliation of taxonomic strategies for school refusal behavior, *Clinical Psychology: Science and Practice* 1996, 3, pp. 339-354.
- Egger, H.L., Costello, E.J. & Angold, A. School refusal and psychiatric disorders: a community study, *J Am Acad Child Adolesc Psychiatry* 2003, 42, 7, pp. 797-807.
- Bernstein, G.A., Warren, S.L., Massie, E.D. & Thuras, P.D. Family dimensions in anxious-depressed school refusers, *J Anxiety Dis* 1999, 13, pp. 513-528.
- Dabkowska, M. Risk factors for school phobia. *Lęk i Depresja* 1999, 4, 3, pp.186-196
- Dabkowska, M. School phobia in children with anxiety disorders, *Psychiatria w Praktyce Ogólnolekarskie*, 2002, 2, 3, pp. 167-170.
- Kearney, C.A. Solutions to school refusal for parents and kids: Pinpoint and address reinforcers of the child's behavior, *Cur Psychiatry* 2006, 5, 12, pp. 67-69, 73-76, 78, 83.
- Berg, I., Butler, A., Franklin, J., Hayes, H., Lucas, C., & Sims, R. DSM-III-R Disorders, social factors and management of school attendance problems in the normal population, *J Child Psychol Psychiatry* 1993, 34, pp. 1187-1203.
- Borchardt, C.M., Giesler, J., Bernstein, G.A., et al. A comparison of inpatient and outpatient school refusers. *Child Psychiatry Human Development*, 1994, 24, 4, pp. 255-64.
- Bernstein, G.A., Massie, E.D., Thuras, P.D., Perwien, A.R., Borchardt, C.M. & Crosby, R.D. Somatic symptoms in anxious-depressed school refusers. *J Am Acad Child Adolesc Psychiatry* 1997, 36, pp. 661-668.
- Dabkowska, M. The somatic mask of school phobia, *Ped Pol* 2006, 81, 11, pp. 839-843.

21. Flakierska-Praquin, N., Lindstrom, M. & Gillberg, C. School phobia with separation anxiety disorder: a comparative 20- to 29-year follow-up study of 35 school refusers, *Compr Psychiatry* 1997, 38, pp. 17-22.
22. Cronk NJ, Slutske WS, Madden PA, Bucholz KK, Heath AC. Risk for separation anxiety disorder among girls: paternal absence, socioeconomic disadvantage, and genetic vulnerability. *J Abnorm Psychol* 2004, 113(2):237-47.
23. Berg, I. & Jackson, A. Teenage school refusers grow-up: a followup study of 168 subjects, ten years on average after in-patient treatment. *Brit J Psychiatry* 1985, 147, pp. 366-70.
24. Kearney, C.A. & Albano, A.M. When children refuse school: A cognitive-behavioral therapy approach/Therapist's guide, The Psychological Corporation, San Antonio, TX 2000.
25. Coplan, R. J., Girardi, A., Findlay, L. C, & Frohlick, S, L. Understanding solitude: Young children's attitudes and responses towards hypothetically socially withdrawn peers. *Social Development*, 2007, 16, 390-409.
26. Nelson, L. J., Rubin, K. H., & Fox, N. A. Social withdrawal, observed peer acceptance, and the development of self-perceptions in children ages 4 to 7 years. *Early Childhood Research Quarterly*, 2005, 20, 185-200.
27. Kearney, C.A. Identifying the function of school refusal behavior: A revision of the School Refusal Assessment Scale, *Journal of Psychopathology and Behavioral Assessment* 2002, 24, pp. 235-245.
28. Dąbkowska, M. Basic reasons for school refusal behaviour by school children and their parents, *Psychiatr Psychol Klin* 2007, 17, 2, pp. 76-83.
29. Weems, C.F. & Costa, N. Developmental differences in the expression of childhood anxiety symptoms and fears, *J Am Acad Child Adolesc Psychiatry* 2005, 44, 7, pp. 656-663.
30. Deltito, J.A. & Hahn, R. A three-generational presentation of separation anxiety, *Psychopharmacol Bull* 1993, 29, 2, pp. 189-93.
31. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th ed., text rev.), Washington, DC 2000.
32. World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders, World Health Organization, Geneva 1992.
33. Francis, G., Last, C.G. & Strauss, C.C. Expression of separation anxiety disorder: the role of age and gender, *Child Psychiatry and Human Development* 1987, 18, 2, pp. 82-9.
34. von Widdern, S. & Lehmkuhl, G. How do children with separation anxiety disorder develop after inpatient treatment?, *Praxis Der Kinderpsychologie Und Kinderpsychiatrie*, 2011, 60, 2, pp.143-57.
35. Masi, G., Millepiedi, S. & Mucci, M. Efficacy of newer antidepressants for childhood anxiety disorders. *Expert Review of Neurotherapeutics* 2002, 2, 4, pp. 523-31.
36. Seligman, L.D. & Ollendick, T.H. Cognitive-behavioral therapy for anxiety disorders in youth, *Child Adolesc Psychiatric Clin North Am* 2011, 20, 2, pp. 217-38.
37. Suveg, C., Hudson, J.L., Brewer, G., Flannery-Schroeder, E., Gosch, E., Kendall, P.C. Cognitive-behavioral therapy for anxiety-disordered youth: Secondary outcomes from a randomized clinical trial evaluating child and family modalities. *J Anxiety Dis* 2009, 23, 3, pp. 341-349.
38. Ayers, T. S., Sandler, I. N., West, S. G., & Roosa, M. W. A dispositional and situational assessment of children's coping: Testing alternative models of coping, *Journal of Personality and Social Psychology* 1996, 64, pp. 923-958.
39. Bahali, K., & Tahiroğlu, A.Y. School Refusal: Clinical Features, Diagnosis and Treatment, *Current Approaches in Psychiatry / Psikiyatride Guncel Yaklasimlar*, 2010, 2, 3, pp. 362-383.

Address for correspondence:

dr med. Małgorzata Maria Dąbkowska
85-096 Bydgoszcz
Kurpiskiego 19
tel.: 0048 52 5854270
fax: 0048 52 5853766
e-mail: gosiadabkowska@yahoo.com

Received: 13.11.2011

Accepted for publication: 12.04.2012