



Separation Anxiety Disorder (SAD) in a 5-year-old Child: A Case Report

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Abstract

Background: One of the most frequent emotional disorders in children is Separation Anxiety Disorder (SAD), which can lead to poorer mental and physical health and is estimated at 50% of anxiety disorders. But based on the facts, many adults think that many symptoms of SAD are normal. When suffering from this illness at a young onset, it increases the suicide possibility, morbidity and mortality. Furthermore, early-onset anxiety disorders are also potent indicators of later psychiatric diseases, such as depression, substance use disorders and other anxiety disorders, impairing physical health and academic and social functioning.

Case Report: A 5-year-old girl is taken to a primary care clinic by her mother with complaints of not wanting to go to school for the last two months and has started to be too lazy to go to school four months ago. She always cries at home whenever her mother is not around. According to the patient, she is afraid of being left alone, being kidnapped by others or having an accident or death happen to her or her mother. Her social relationships with her friends and academics at school were not optimal because she could not concentrate. Initially, she often complained of abdominal pain, nausea, headache and tantrums every morning when it was approaching the time for school. She also often complained of frequent nightmares during sleep. Her mother also complained that she could not control her bowels and bladder at night recently, even though she could do it on her own back then. Previously, the patient lived with her parents in Pekanbaru but then moved to Batusangkar because her mother moved for work, so the patient had to move house, change school and be far away from her father.

Conclusion: The criteria for SAD are exaggerated anxiety and development inappropriate upon separation from an attachment figure, as manifested by the following three items at a minimum: Repeated severe distress with actual or threatened separation from home or an attachment figure, lasting for four weeks in children and adolescents, resulting in clinically significant disturbance in a substantial life function (academic or work performance). Treatments for SAD are psychoeducation (parenting), psychotherapy and pharmacotherapy.

Keywords: Separation anxiety disorder, SAD, psychoeducation, cognitive behavioural therapy (CBT).

Introduction

The global population comprises approximately 2.2 billion children, about 28% of the total population.[1] One of the most frequent emotional disorders in children is Separation Anxiety Disorder (SAD)[2,3], which can lead to poorer mental and physical health[4] and is estimated to account for up to 50% of anxiety disorders. Based on studies, SAD prevalence is estimated at 4% in the population and 7.6% in paediatric clinical samples, with approximately one-third continuing into adulthood if untreated [5], thus requiring early treatment and preventative efforts.[6] However, the fact is that there are still many adults who think that the symptoms of SAD are normal. This can be seen from the low rate of health services for anxiety in general (<20%) compared to other behavioural disorders, which is 45%-60%, making it a significant risk factor for mental health throughout life. Anxiety becomes abnormal when it is so exaggerated that it causes ongoing distress, decreased quality of life, and impairment in their activities.[7] Suffering from it at a young onset increases the suicide possibility, morbidity and mortality. Furthermore, early-onset anxiety disorders are also potent indicators of later psychiatric illnesses, such as depression, substance use disorders and other anxiety disorders.[8]

SAD is characterized by unrealistic anxiety and an exaggerated fear that separation from an attachment figure who is closely involved with the child will result in adverse effects that are highly disruptive to the child's daily activities and development.[9] Patients are so fearful that their parents or themselves will be hurt during their separation from each other that they will probably never be met again with inappropriate intentions at an inappropriate time or in an inappropriate situation. It is common for separation anxiety to start between 6 to 12 months of age and climax at 9 to 18 months old (experiencing stranger anxiety) and dissipates after approximately 2.5 years of age, when the child develops a feeling of autonomy, advanced cognitive abilities and an understanding that the separated attachment figure will be back.[5] As many as 15% of children and adolescents with SAD will withdraw when faced with strangers and the environment.[10] Two possible etiological mechanisms are greater stimulus conditioning to a danger signal and disrupted inhibitory conditioning to a safety signal.[5]

The recurrence of separation anxiety is the most typical in the first starting of school for children and can be assumed to be a natural reaction. However, this response can lead to the advancement of SAD, particularly when it has occurred for several weeks. It is estimated that 75% of children with SAD have school rejection behaviours due to feeling anxious and depressed. These behaviours vary, but this can also include refusing to enter school premises, clinging to parents, yelling when trying to separate and exhibiting physical symptoms such as headaches, abdominal pain, or other types of illness[5] so children can fall behind in schoolwork or have frequent absences from school which interfere with their ability to progress well in school[11] and even decreases the child's creativity.[12] In addition, they may be isolated from classmates, and family conflict may arise when parents are unhappy with their child's condition[11], which can affect physical health, academics, and social skills.[13] Separation Anxiety Disorder in Children and Adolescents may be linked to increased suicide risk, especially with comorbidities[11]. It will have a more severe course of illness in children who are maltreated at an early age.[14]

Case Report

A 5-year-old girl is taken to a primary care clinic by her mother with complaints of not wanting to go to school for the last two months and has started to be too lazy to go to school for the previous four months. She always cries at home whenever her mother is not around, so she always follows wherever her mother goes, including going to work and often gets angry if her requests are not fulfilled. She came twice to the primary care clinic. On the first visit, she was uncooperative, and on the second visit, she cooperated. According to the patient, she was afraid of being left alone, being kidnapped by others or having an accident or death happen to her or her mother. Initially, she often complained of abdominal pain, nausea, headache and tantrums every morning when approaching the time for school. She would go home to be delivered by her teacher before school hours were over. She also often complained of frequent nightmares during sleep, namely dreams of being kidnapped or having an accident. Afterwards, she

asked her mother to accompany her to school and wait in the classroom. She cried loudly if her mother left her or waited outside the classroom. Even during resting time, she did not dare to play with her friends without her mother and tried to withdraw. Her condition affected her social relationships with her friends, and her academics at school became not optimal because she could not concentrate if she did not see her mother around her. During the two months of not wanting to go to school, her mother also complained that the patient liked to wet the bed at night even though previously she could urinate on her own, and now she also likes to hold her bowel movements. The mother admitted that she was confused because once, the patient was a friendly, sociable child and showed age-appropriate independence.

Previously, the patient lived with her parents in Pekanbaru but then moved to Batusangkar because her mother moved for work, so the patient had to move house, change school and be far away from her father. She often asked her mother to move back to the old house so that she could reunite with her father and friends. Her mother has said that she often asked for video calls with her father and friends in Pekanbaru. The patient is close to her father, constantly playing and sharing stories, especially during the COVID-19 pandemic. Her father worked from home and made their relationship even closer. Previously, the patient had entered school starting from KB (playgroup) at the age of 3. Her relationship with her friends at that time was close. Her parents, grandparents and other family members had been overprotecting the patient, such as spoiling her and making a big deal out of minor problems. Her mother was also the anxious type who always feared everything. The patient was rarely invited to hang out with neighbourhood children for fear of bad influences.

In personal history during infancy and toddlerhood (0-3 years), the patient was an expected child as the first child of her parents, born full term, with 3400 grams birth weight. When the mother was pregnant, the mother continued to work, and the father also worked, so her parents were financially well off. In language/speech development, the patient started spontaneous babbling and responsive cooing at the age of 3 months, started calling "mama papa" and imitating sounds by six months, understood simple commands with gestures by one year and used words by about one year with a small vocabulary and started to recognize colours at the age of 2 years and started telling short stories from the age of 3 years old. In gross motor development, she raised her head slightly when lying face down at one month; at six months old, she could be seated when placed in position and had good head control. The patient started walking up and down stairs unaided at 18 months and pointed to her body part. She began to speak Indonesian fluently, up to 250 words, and used three words sentences at two years old. The patient can control his bowels and bladder at 2.5 years old. In the intellectual development/symbolic capacity area, the patient started to explore objects with her mouth at five months old. She liked certain toys at ten months old and played pretend at 2.5 years old. While her parents were working, she lived at home with her grandmother, grandfather and attachment figure. Grandma and Grandpa loved and pampered her. In early childhood (3-5 years), the patient attended a playgroup at the age of 3 years and was very happy with her teachers and friends. She was friendly and sociable and often played with her friends. At the age of 4 years, she entered PAUD and became closer to her friends. She could memorize (counting, prayers, telling a short story and *shalawat*) and recognize the alphabet. At the end of 4 years of age, she moved to PAUD and moved house because her mother moved for work. In middle childhood (5 years old until now), she entered kindergarten and started to be too lazy to go to school from 4 months ago. Currently, she can run, walk, jump and ride a bicycle. She can also bathe, dress and eat by herself. In the development of fine motor movements, she has been able to draw with pencils/crayons since the age of 4.5 years in the form of fine lines, draw asymmetrical circles, stack blocks > 10, draw people with heads, bodies, hands and feet, can make a triangle from an example, can write letters, numbers and understand counting. Her affect/mood has been able to smile (reflex) at one-month-old. These Gross motor movements at this time: she can skip on alternate feet and catch a ball with two hands. Language development: she can define simple nouns, ask the meaning of words and tell many stories. She can also follow the rules of simple games. Before moving to this school, she often smiled at others and laughed when happy. Intellectual development/symbolic capacity at this time, she has started to understand values (right or wrong, what is fair) and can evaluate her ability and count to 100.

On mental status examination, there was a general description of the appearance of a girl according to age, neatness, impression of not being able to take care of herself, regular body posture, behaviour and psychomotor activity: normoactive, motor and sensory according to age, attitude towards the examiner: eye contact is sometimes found. Speech: Normal flow, normal tone, age-appropriate word productivity, age-appropriate vocabulary, relevant content. Affect: Appropriate, Mood: Euthymic, Other emotions: Anxiety when not seeing her mother around her (difficulty establishing relationships with others). The coherent thought process, thought content: the fear of separation from her mother. Perceptual disturbances (hallucinations, illusions, depersonalization and derealization) were absent. Dreams and fantasies were not present. Sensorium alertness *compos mentis*, the orientation of time, place and person, is good. Concentration and calculation are impaired because the patient cannot focus without seeing the presence of her mother around her. Distant and slightly long memories are good. Recent memory and immediate memory are impaired because the patient cannot concentrate. General knowledge and cognition: age-appropriate intelligence. Abstract thought is difficult to assess. Insight: 5. Social judgement is impaired because the patient does not want to play even though many friends and toys are in front of the house without her mother beside her—the ability to control internal stimuli is poor.

On vital signs examination, there was a pulse frequency of 88 beats per minute, Breathing Frequency of 17 beats per minute, Body Temperature of Afebris, Body Weight of 32 kg, and height of 110 cm. Physical examination and neurological examination revealed no abnormalities. The multiaxial diagnosis in this patient was Axis I: Separation Anxiety Disorder - Childhood Anxiety Disorder (F.90.3). Axis II: No diagnosis, age-appropriate intelligence, the patient can already draw and count. Axis III: no diagnosis. Axis IV: Moved house, changed schools and separated from her father. Axis V: GAF scale 51-40. This patient was only given psychoeducational therapy focused on the parents because her parents refused to be referred to a psychiatrist.

Discussion

The case occurred in a girl aged five years. This follows APA, 2021, which states that childhood SAD is more common in girls at almost twice the rate of boys. This suggests that females experience anxiety at a higher rate - approximately 2/3. Attachment analysis explains the relationship needs of a child with an attachment figure for healthy social and emotional well-being. There are four main types of attachment: secure, anxious-avoidant, disorganized and anxious-ambivalent. Anxious-ambivalent attachment is the most frequent attachment pattern in SAD patients. Common signs of ambivalent attachment are anxiety when the attachment figure is absent and restricted comfort when the attachment figure is present again.[5] This also happened to the patient who did not want to go to school two months ago and always followed wherever her mother went because she was anxious about being separated from her mother and did not like to play with her friends at school. The patient feels fear or anxiety about separation from her mother at a level that is not developmentally appropriate. The patient will feel calm and relieved if the patient sees her mother around the patient, so her attachment type is anxious-ambivalent attachment.

SAD often occurs after a stressful life event, particularly bereavement (e.g., death of a family member or pet, the sickness of a loved one or relative), difficulty in coping with a change in circumstances such as moving house or getting married, changing schools, divorce of parents, moving to a new neighbourhood, immigration, a disaster involving a period of separation from an intimate figure).[11] One way out of their fears is to make frequent phone calls, follow rigid routines or talk excessively. Although most young people suffering from Separation Anxiety Disorder are expected to recover well through puberty and adult life, some may persist into adulthood.[15] Another general sign of SAD is a persistent fear that danger will occur if the attachment figure is parted, causing distress and haunting recurring nightmares. Furthermore, the child may be anxious about being lost, kidnapped, or having an unfortunate incident if they are parted from the attached figure.[9] When children become confused and experience an enforced separation, they may act aggressively towards the one

separating them.[11] This also happened when the patient moved home and changed schools from Pekanbaru to Batusangkar because her mother moved to work. The patient also often asks for video calls with her father and friends who are still in Pekanbaru and often gets angry if her requests are not fulfilled.

Risk factors for SAD are influenced by the parenting provided by parents and their families overprotecting and exaggerating small problems [16], thus contributing to the development of children's anxiety. In most cases, children of parents who have experienced depression and anxiety disorders have the most significant risk of suffering from depressive disorders or anxiety disorders. They can be a source of behavioural modelling for children to learn anxious behaviours [5] up to 73% and higher found in girls [11]. Her mother is the type of worrier who is always afraid of everything and forbids the patient to hang out with neighbouring children because she is worried about bad influences. Such parenting makes the patient a model from her parents, which causes the patient not to dare to deal with the world outside the house without her mother.

According to the DSM-5-TR, the criteria for SAD is developmentally inappropriate and exaggerated anxiety upon separation from an attachment person, as manifested by at a minimum of 3 of the items listed below: (1) Persistent and recurrent overwhelming distress with an actual or threatened separation from home or an attachment figure; Persistent and pervasive anxiety about missing an attachment figure or the possibility of harm happening to them, such as disease, accident, injury, disaster, or death; Persistent and recurrent fear that an unwanted incident will be endured by the patient and cause prolonged or long-lasting separation; Unwillingness or resistance to going out, such as to school or work, due to fear of separation; Refusal to be alone at home or elsewhere; Refusal to sleep without having an attachment figure around; Repeated nightmares regarding separation; Recurrent physical phenomena when separation is present or threatened, Constant complains about physical manifestations such as headache, heartburn, nausea, vomiting which are actually anticipation of separation from the attached person. (2) The symptoms must be present in children and adolescents for at least four weeks, usually six months or more, among adults. (3) The disorder causes clinically meaningful distress in a substantial life function (academic or work performance). (4) Another psychiatric disorder cannot better describe the symptoms [7].

Meanwhile, according to PPDGJ III, Childhood Separation Anxiety Disorder (F93.0) is included in emotional disorders with a typical onset in childhood (F93), which is not only part of generalized anxiety related to various situations but also part of the generalized anxiety associated with separation from a familiar figure. Anxieties may take the following forms: (a) unrealistic and severe anxiety that some misfortune will strike the attached figure or that the person will disappear and not be back, (b) unrealistic and severe anxiety that some bad event will happen, such as the child being lost, kidnapped, hospitalized, or killed, (c) persistent refusal or unwillingness to attend school, for fear of separation (not for any other motive such as fear of what might happen at school), (d) persistent refusal or unwillingness to go to sleep unless accompanied by his/her most beloved character, (e) persistent unreasonable fear of being left alone, or unaccompanied by a familiar person by the time of day, (f) recurring bad dreams about being apart, (g) frequent onset of somatic symptoms (nausea, abdominal pain, headache, vomiting, etc.) upon separation from a familiar person, (h) having extreme distress (as manifested by anxiety, crying, agitation, moodiness, apathy, or social withdrawal), before, during or after the separation from a known person. The diagnosis implies no generalized disorder in the development of personality functioning [9].

Based on the DSM-5-TR and PPDGJ III criteria, the patient fulfils the criteria for SAD in children, namely excessive suffering when facing separation from the leading attachment figure (her mother), extreme, persistent worry that an unexpected event will cause separation from the leading attachment figure (lost or abducted). This disorder has occurred for two months and causes clinically meaningful suffering or impairment in social function (the patient does not want to play anymore with her friends) and academics (not focusing at school if she does not see her mother around her) so that she does not want to go to school anymore. When upset by the separation,

she showed anger by crying and regression by re-wetting the bed and delaying defecation.

Treatments for SAD include psychoeducation (parenting), psychotherapy and pharmacotherapy. Psychoeducation or parenting therapy is done in mild cases as early as possible and only requires support and encouragement from the patient and parents to help patients continue regular activities. Keeping a well-organized schedule of meals, bedtime, and workouts with the elimination of inconsistent actions should be advised. Other psychoeducational strategies include emotional, verbal, cognitive, and child-centred techniques. In dynamic tactics, parents focus on showing their love, care, trust and rapport with their children. In verbal tactics, parents focus on their communication with their kids. In cognitive strategies, parents support their children to understand their emotions and situations. Fading is one of the methods of behaviour modification that is so simple that parents can quickly train the child's ability to sit alone in class by gradually removing the prompt until the child can sit alone in class without her mother by her side [16],[17]. In this patient, only focused psychoeducation was given because her parents refused to be referred to a psychiatrist.

If psychoeducation is unsuccessful, cognitive behavioural therapy may be prescribed. Cognitive behavioural therapy (CBT) is about changing maladaptive thought patterns or parenting styles to avoid and gradually manage anxiety-inducing situations.[11] An effective CBT usually needs 10 to 15 sessions in an outpatient setting (60-90 minutes duration each) with frequent exercises done at home. As many as 44% of the pediatric population who had CBT for anxiety disorders were not recovered. CBT may include both family and play therapies to treat separation anxiety disorder. Play connects the child's inside mind with the outside world. It makes it possible for the child to express feelings, build relationships, describe experiences, express desires, self-actualization, problem-solving, decision-making, creative and critical thinking, effectively communicate, develop good interpersonal skills, empathy, self-awareness, and handle uncomfortable feelings and distress so that it reduces anxiety in children and overcomes children's behavioural and emotional problems and can enable them to understand and tolerate separation. Hence, it reduces separation anxiety in them.[18] Parents can also give rewards as motivation if the child can reduce their separation anxiety.[19] Other Cognitive Behavioural Therapies are Disorder Specific Treatments involving the parents, Family Cognitive Behaviour Therapy (FBCBT), Brief Cognitive Behaviour Therapy (BCBT) to see the effectiveness of brief CBT, One-Week Summer Treatment, Controlled Trial of the Child Anxiety Multi-Day Program (CAMP), Eye Movement Desensitization and processing (EMDR) as one of the characteristics of SAD symptoms (avoidance of eyes and attention), Triple P, Parent Training, and Integrative Family Approach.[7]

The pharmacotherapy is a selective serotonin reuptake inhibitor. The amygdala and fear neurocircuitry have a similar neuroanatomy to anxiety neurocircuits. The amygdala and its pathways involve the frontal cortex (perirhinal cortex, ventrolateral prefrontal cortex, anterior insula). Functional magnetic resonance imaging (fMRI) studies have discovered that hypofunction of the prefrontal cortex and anterior cingulate cortex is connected to emotional dysregulation and cognitive dysfunction in those with anxiety. This activation of the neurocircuitry of fear and the neurocircuitry of anxiety involves the release of numerous neurochemicals, such as norepinephrine, epinephrine, cortisol, neurosteroids, and vasopressin, leading to sympathetic stimulation. Dopamine has a modulatory role in producing anxiety-like symptoms. A low level of postsynaptic serotonin 5-HT_{1A} receptor activity facilitates pathological anxiety, creating pharmacotherapies that try to modulate this receptor to treat anxiety.[5] In this patient, no pharmacological therapy was given.

The prognosis of SAD was 56% improved within one year and 32% in three years. Among 21.7% of cases, patients have stable remission, 48% relapse, and 30% are chronically ill at four years old. A diagnosis of SAD in childhood may increase the incidence of panic disorder and other anxiety disorders in adulthood. Complications of SAD include impairment of visuospatial working memory, semantic memory, verbal language, and writing words in children with anxiety disorders, resulting in memory and language deficits in some of them and even a risk factor for suicide of 7 to 10% in adolescent patients with anxiety disorders.[5]

Conclusion

The criteria for SAD are exaggerated anxiety and development inappropriate upon separation from an attachment figure, as manifested by the following three items at a minimum: Repeated severe distress with actual or threatened separation from home or an attachment figure, lasting for four weeks in children and adolescents, resulting in clinically significant disturbance in a substantial life function (academic or work performance). Treatments for SAD are psychoeducation (parenting), psychotherapy and pharmacotherapy.

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