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Cognitive behavioral therapy for the treatment of separation anxiety disorder in children – a research review and case study

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Summary

The aim of this paper is to review studies available in scientific databases on the effectiveness of cognitive behavioral therapy programmes for separation anxiety disorder in children. The paper also includes a presentation of a clinical description of therapy for a 12-year-old girl with a diagnosis of separation anxiety according to ICD-10. The most widely researched and sole protocol for working with children with anxiety disorders in Poland, the Coping Cat programme, was used as the basic protocol. Its universality is both an advantage and a challenge, as it becomes necessary to adapt the protocol to work with a specific anxiety disorder. This required the authors of this article to review the scientific databases in search of examples of cognitive-behavioral protocol adaptations for treatment of separation anxiety in children. The case study describes the standard use of the Coping Cat protocol which, at some point, stopped delivering the desired results and needed to be modified based on analysis of the revisited conceptualisation together with the supervisor, which made it possible to achieve most of the assumed goals.

Key words: cognitive behavioral therapy, anxiety, separation, psychology, children

Introduction

Separation anxiety is considered to be natural between 12 and 18 months of age [1]. Anxiety becomes maladaptive when it impedes an individual's social functioning (e.g. is associated with exacerbation of avoidance behaviors) or is associated with persistent subjective distress. Childhood and adolescence are times of increased vulnerability to anxiety disorders [2]. Cognitive behavioral therapy (CBT) is a well-established treatment for anxiety disorders in children [3]. One of the most popular and universal protocols for treating anxiety disorders in children is the Coping Cat

[4, 5]. SAFT (Separation Anxiety Family Therapy) [6] or Cool Kids Program [7] are popular as well.

Review of studies on the effectiveness of different cognitive behavioral therapy programs for separation anxiety disorder in children

The most popular and widely researched protocol for cognitive behavioral therapy of anxiety disorders in children is the Coping Cat [4, 5] program. Lenz's 2015 meta-analysis [8] included 19 randomized controlled clinical trials conducted since the publication of this program in 1994 by Philip Kendall, involving a total of 1,358 participants (mean age – 10 years) and examining the effectiveness of CBT in reducing anxiety symptoms in children and adolescents compared to a group receiving no therapy, a group awaiting therapy or a group receiving another type of therapy. Hedges' *g* coefficient was used to measure effect size, with a 95% confidence interval, interpreting a score of ≥0.3 as small, ≥0.5 as medium, and ≥0.67 as large effect size. Compared to the no therapy group or the waiting group, the effect size in the group participating in therapy according to the Coping Cat protocol was – 0.67 (between – 0.88 and – 0.45 when considering the 95% confidence interval; $p < 0.1$; $\tau = 0.25$). In contrast, compared to alternative forms of therapy, the effect size was – 0.15 (between – 0.29 and – 0.01; $p = 0.03$; $\tau < 0.01$. Thus, the results indicate that the Coping Cat program is significantly more effective in reducing anxiety symptoms compared to no therapy and slightly more effective compared to the alternative forms of therapy included in this meta-analysis.

In 2020, James et al. [9] conducted a meta-analysis on the effectiveness of cognitive behavioral therapy involving direct contact with the child, parent or both. Results from an analysis of 39 studies involving 2,697 participants and rated as moderate quality indicated that the use of CBT increased remission of a major anxiety disorder compared to a waiting or no treatment group (49.4% and 17.8%, respectively; OR = 5.45; with a 95% confidence interval of 3.90 to 7.60). The analysis also indicated that there may be little or no difference between the use of CBT and other forms of therapy, but the 4 included studies were rated as low-quality evidence (OR = 0.89; between 0.35 and 2.23 with 95% confidence interval). No significant differences were noted between the different formats of CBT. Waters et al. [10] analyzed whether the effectiveness of group cognitive behavioral therapy (ACTION program) varied by the type of diagnosed anxiety disorder. They studied 205 children aged 4 to 12 years. Results indicated that this therapy was more effective for children with a principal diagnosis of specific phobia or separation anxiety disorder compared to children with a diagnosis of social anxiety disorder or generalized anxiety syndrome. The following sections present some of the interesting studies on the effectiveness of cognitive behavioral therapy programs for separation anxiety disorder in children other than the Coping Cat.

Schneider et al. [11] describe the results of a study on the effectiveness of cognitive-behavioral therapy for separation anxiety disorder in a group of 43 younger children (5–7 years old) randomly assigned to a treatment or waitlist group. 44.18% of children

assigned to the treatment group and 36.36% of children in the control group had co-occurring disorders, most often including different anxiety disorders. The study included an initial assessment followed by 16 treatment sessions over 12 weeks, an assessment immediately following the end of treatment, and a reassessment after one month. For therapy, the researchers used a treatment protocol constructed for the study. It included four 50-minute psychoeducational sessions with the child over a 4-week period, as well as the same number of sessions with the parent over the same period. The next 8 sessions were divided into 2 parts: meeting with the child and parent together and with the parents only. During these sessions, *in vivo* exposures were planned and conducted, the first by the therapist with the parents' observation, the second by the parents with the therapist present, and the next by the parents outside the session. Results showed that in the group receiving immediate treatment, 76.19% of children no longer met DSM-IV diagnostic criteria for SAD, compared to 13.64% of children in the waitlist group. The improvement achieved during treatment was maintained at reassessment after 4 weeks. After both groups completed treatment, 76.74% of children no longer met criteria for SAD, 9.30% still did, and data was unavailable for 13.95%. The results of the present study showed larger effects compared to previous analyses on the effectiveness of cognitive behavioral therapy for the treatment of anxiety disorders in children. However, it was not possible to determine the treatment components that increased effectiveness because of the comparison with the control group which consisted of children who were awaiting treatment and not receiving another type of treatment. Nevertheless, the results were promising regarding the effectiveness of a protocol that included parenting training and classical cognitive behavioral techniques aimed at treating SAD.

Furthermore, Schneider et al. [12] describe the results of a study on the effectiveness of using a family-based cognitive behavioral therapy for separation anxiety disorder (*Trennungsangstprogramm Fur Familien* – TAFF) with older children (ages 8 to 13) compared to the effectiveness of using a general protocol for treating anxiety disorders (Coping Cat). The study enrolled 64 children diagnosed with separation anxiety disorder. Four weeks after the initial measurement, 52 children still met inclusion criteria and received 16 weeks of treatment. Results showed a slight, non-statistically significant advantage of using TAFF compared to the Coping Cat. One month after the end of treatment, 87.5% of the children on TAFF and 82.1% of the children on the Coping Cat no longer met the criteria for a diagnosis of SAD. After one year, these results remained at 83% and 75% (TAFF vs. Coping Cat). This indicates that there was no significant effect of including parent training in the treatment on the effect size of the intervention. Both programs included many common elements, such as intensive *in vivo* training and psychoeducation. Additional elements in the TAFF program were separation anxiety-specific material, parent inclusion, work on dysfunctional parental beliefs, and parent training on separation exposure. Future research would therefore be valuable in examining the effectiveness of the various components of the used treatment programs.

In a clinical study by Afshari et al. [13], 15 girls and 15 boys aged 9 to 13 years and diagnosed with separation anxiety disorder were randomly assigned to one of

three groups: (1) receiving cognitive behavioral therapy (the Coping Cat program), (2) receiving emotion-focused behavioral therapy (ECBT) and (3) not receiving therapy (control group). The Coping Cat program consisted of 10 weekly meetings during which children learned skills to recognize and manage anxiety, while ECBT consisted of 12 weekly sessions (2 of which were attended by parents) during which they also developed skills to better recognize and manage various emotions (not just anxiety). Statistical analysis showed the effectiveness of both therapies in reducing symptoms of separation anxiety disorder and other anxiety symptoms, and no significant differences between them.

In 2013, Santucci and Ehrenreich [14] conducted a preliminary evaluation of cognitive behavioral therapy for separation anxiety disorder in the form of an intensive, one-week program delivered in a group format. They recruited 29 girls with SAD (mean age – 9.18; *SD* = 1.58) into the program, of whom 15 received therapy immediately and 14 were placed on a waiting list. Six editions of the weekly Child Anxiety Multi-Day Program (CAMP) were conducted over 3 consecutive years, with 4 to 6 participants at a time. The therapeutic program included typical cognitive behavioral interventions. Parent inclusion components were also added and based on the Cognitive Behavioral Family Therapy for Anxious Children Manual and the Family Anxiety Management program. During the week-long program, three 1-hour group sessions for parents were held. During the first four days, sessions for the children were held from 10:00 am to 3:00 pm and began with group therapy. The children had lunch at noon, after which they spent time together doing activities, they had previously avoided without their parents' present – during which they were able to put into practice the skills they had newly acquired during therapy. An increasing reduction in parental presence was also introduced. On the fifth day there was an evening meeting without the presence of parents and without formal activities. On the sixth day, participants stayed overnight at the meeting place and spent time together in social activities. Results of the analyses showed that compared to the waitlist group, children in the treatment group had clinically and statistically significant reductions in SAD severity, functional impairment and parent-assessed anxiety. After 6 weeks, mean SAD severity had fallen below clinical levels, and half of the treatment participants did not meet criteria for a clinical diagnosis. At the same time, SAD severity also decreased in the waiting group, however all girls continued to meet diagnostic criteria for the disorder. Symptoms of co-occurring anxiety disorders were also reduced over time, indicating that the newly acquired skills during therapy can be applied to similar psychopathology.

Pincus et al. [15] describe a modification of Parent-Child Interaction Therapy (PCIT) that they made to adapt this therapy for the treatment of separation anxiety disorder in children younger than 7 years. PCIT is a therapy with empirically proven efficacy, originally aimed at reducing destructive behavior in children. It consists of 2 phases: child-directed interaction (CDI) and parent-directed interaction (PDI). The first session in each phase involves teaching the parent appropriate skills, which in subsequent sessions the parent tries to implement while playing with the child, observed by the therapist from behind a one-way mirror. The observations made during

the study led the researchers to add a new phase to the program – bravery-directed interaction (BDI). BDI involves psychoeducating parents about anxiety, as well as teaching parents how to conduct 'separation practices.' The therapist observes parents' reactions that may reinforce separation anxiety in the child and teaches them to carry out the exposures outside of the office. Children are rewarded with stickers and praise for participating in previously avoided situations. Pincus et al. [16] conducted a controlled study on the effectiveness of a modified PCIT program, expanded to include the BDI, involving 38 children, ages 4-8, with a DSM-IV diagnosis of SAD. The results showed that 73% of the children participating in the therapy no longer met the criteria for the clinical diagnosis, and this effect persisted in the majority over the following 3 months. In the control group, which included children awaiting therapy, none of the children stopped meeting the criteria for a SAD diagnosis. Thus, the results of the present study indicate promising effects of enriching the original PCIT program with a new BDI phase in the treatment of SAD in children.

Case study

Below is a case study of therapy with the use of the Coping Cat protocol. At some point the therapy based on the standard protocol ceded to deliver the desired results. After re-examining the conceptualization of the problem together with the supervisor it was decided that the protocol needs to be modified and interventions regarding cooperation with the parents should be introduced.

The parents of 12-year-old J. visited a psychotherapist because their daughter felt anxious about going to sports camps. During the last sports camp, J. had trouble falling asleep, cried and felt strong anxiety about being separated from her parents. At the girl's request, the parents came to pick up their daughter on the second day of the camp. The data collected from the extended interview with the parents and the girl, as well as the observation during their separation, corresponded to the diagnostic criteria for separation anxiety in childhood (according to ICD-10: F93.0). No co-occurring disorders were identified.

The course of therapy

The first important stage was to define the goals of therapy together with the patient and the parents. The goals of the parents and the patient, cohesive with emergent problems occurring during sensitive periods of separation (especially with the mother), became the basis for the therapist to develop strategic goals of therapy possible to achieve based on the chosen therapeutic program (Table 1.).

Table 1. **Goals of psychotherapy**

Goals	Regarding J.	Regarding parents
Strategic	building a therapeutic relationship reducing anxiety symptoms, especially at times of separation from the mother reducing worry about the anticipated situation of separation from parents.	psychoeducation about the nature of anxiety, the importance of parental behavior in the process of shaping anxiety in their daughter working on parenting skills for reinforcing courageous behavior in their daughter
Tactical	providing a positive experience of a safe relationship with someone outside the family psychoeducation on the nature of emotions, especially anxiety working on distinguishing thoughts and feelings learning to control 'worry' and reduce the amount of time spent worrying (working on the belief that "I am helpless") working on behavioral options to reduce anxiety by introducing relaxation and mindfulness training learning to manage anxiety using exposure techniques and behavioral experiments	working with parents to analyze behaviors that reinforce separation anxiety parental support in reducing behaviors that reinforce separation anxiety and in introduction of behaviors that reinforce courageous behaviors in their daughter

At the beginning of therapy, J. showed signs of stress and anxiety. In order to support J. in a difficult situation and to maintain her motivation for therapy, a list of 'lifelines' she can use during therapy sessions was created e.g. break time with dad, phone call to mom and play break with the therapist. In the course of therapy, she used the 5-minute option several times, not once the longer option.

One of the key components of the Coping Cat program is putting into practice a technique based on the acronym STOP. It includes learning to recognize the somatic signals of anxiety and anxiety-provoking thoughts in oneself, creating alternative thoughts, and using techniques to help reduce tension, as well as appreciating oneself and rewarding oneself for making the effort.

Next, the exposure to anxiety-provoking situations arranged according to the "anxiety ladder" created earlier with J. has begun. The level of emotions declared by J. in the given situation was taken into account, measured from 0 to 10, where 0 is anxiety free and 10 is extreme anxiety. The girl arranged the following situations on the "ladder" (anxiety level in the brackets): going to a sports camp (9), parents go out in the evening (8), mom leaves the room when I fall asleep (7), coach talks about going to sports camp (6), parents say they want to go to the cinema/friends in the evening (5), a friend asks me if I can spend the night at her place (4), a friend asks me if she can spend the night at my place (3). The exposure work was divided into imaginal exposure and *in vivo* exposure – at the girl's home (without the participation of the therapist). One of the most difficult visualizations for J. was an exposure in her imagination regarding

sleeping alone. Through exposure in imagination, the girl gained *in vivo* readiness. The needs of J. were analyzed with the parents and the ways for them to support the daughter were agreed upon. A detailed plan of exposure to anxiety trigger was made in writing, and the therapist made sure, that both the parents, as well as the child, were equipped with the answers to questions they had on their independent work at home.

Her ability to cope with demanding situations (e.g. using relaxation and mindfulness methods) meant that she did not need mom and dad to calm her down, but did so more independently. The following plan was constructed: mom will only move the mattress away from the bed when J.'s anxiety scores are at a level 4. Each night J. will measure anxiety and task difficulty. Further steps in the exposure included the mattress being next to the bed → in the middle of the room → next to the door → outside of the room. During the next few weeks J. managed to successfully reach the third level of exposure and was able to sleep with mum sleeping on the mattress next to the door. Regular anxiety measurements during sessions pointed to efficiency of the method, because the girl reported lowering of the intensity of the feeling. However, during following sessions, the girl reported elevated levels of anxiety. Lowered motivation to do the therapeutic work as well as reluctance to perform behavioral exercises was observed. This prompted the scheduling of an additional meeting with J.'s parents to discuss the emerging problem. During the meeting it was found that the parents behaved in a way, which was not mentioned to the therapist before, e.g. they lied about staying at home, and then left the house to visit their friends. There has also been an instance of 'shock therapy' when influenced by their own impatience the parents left the daughter alone, in disregard of the previous therapeutic agreements. Taking into consideration the new information, in the conceptualization of the patient's problem, the therapist together with the supervisor, introduced modifications to the standard protocol and significantly increased the cooperation with the parents. The therapist noticed the necessity of including additional therapeutic aims regarding parent-child relations and building trust. They have also planned extra psychoeducation sessions focused on the analysis of parental behavior influencing the functioning of the patient.

The Coping Cat protocol includes cooperation with parents, but only to a limited extent (only 2 out of 16 sessions are for them). Therefore, in order to meet the strategic and tactical goals regarding parents, the therapy protocol was extended to include materials and exercises from the book *Lęk u dzieci. Poradnik z ćwiczeniami* (*Anxiety in Children. A Guide with Exercises*) [17]. It was determined that behaviors that reinforced anxiety were giving J. extra attention and her mother's presence when she had symptoms. The level of experienced anxiety was also reinforced by the parents' attempts to use 'shock' separation, that is, leaving their daughter alone without warning. Together with the parents, the need to reduce the above behaviors and to meet J.'s need for parental attention through their presence and availability, which is not increased by separation anxiety symptoms, was identified. The negative influence of lying to the child on the trust to the parents and willingness to collaborate with them and the therapist was analyzed. Reinforcement of courageous behaviors in the daughter through praise during the use of an *in vivo* exposure established according to a gradation was also supported and practiced with the parents. In addition, work was done to

strengthen parents' competence including supportive communication with the child, naming the child's emotions, reducing criticism of undesirable behaviors in favor of praising desirable behaviors, and not labeling the child as 'fearful' or 'tiny.'

It was found that the behavior of the parents influenced the level of worrying in J. regarding separation from the parents. Because of this, thought analysis in accordance with the protocol was reestablished. The attention in cognitive work was focused on identification of cognitive distortions as well as creation of alternative thoughts. As it turned out, the exercises lowered the worrying, but not on the satisfactory level. After supervision, it was decided that the basic therapy protocol needed to be expanded by additional materials and exercises on worrying, previously used by the therapist in other patients. The book *What To Do When You Worry Too Much* [18] aimed at children, was used, from which J. found a particularly helpful technique for controlling time spent on worrying about what dangers her parents might face when they leave home in the evening or J. when she stays home alone in the evening. The exercise from the book was modified as follows – the patient, together with her therapist, created a realistic box in which she then placed the worries written on cards. The patient could then pull out the worry cards at home and talk about them with her parents at a designated time, or she could take the box to psychotherapy and talk about the worries with the therapist. The effect of this exercise was to reduce the time for worrying during the day, as well as during the exercises related to exposure to anxiety situations, and when such a thought occurred, she could still engage in some other activity.

The final modification involved enriching the therapy protocol with the use of mindfulness techniques, the aim of which is not so much to reduce the level of anxiety – as in the case of the use of relaxation – but to accept it and to be able to act in spite of it. As it was described above, a dip in motivation to do therapy work occurred after the increase in the level of anxiety, which made the girl afraid. Together with the supervisor the expansion of the standard protocol by including mindfulness exercises was agreed upon. The book Sitting still like a frog [19] was used when working with mindfulness. A narrative that included normalizing anxiety, appreciating its function, and being able to pursue goals despite its presence brought relief to J., which also resulted in lower levels of tension. Breathing exercises were particularly enjoyed by the girl and proved to be the most understandable and enjoyable for the girl. The modification was substantial in sustaining J.'s motivation to participate in therapy and follow through with subsequent exposure levels. The outcome being J. falling asleep without mom in the same room and without experiencing elevated levels of anxiety (decrease from level 7 to 2). The reviewed "anxiety ladder" revealed all levels being decreased by half).

Therapy overview

Most of the projected goals were achieved during psychotherapy. The goals that were not met during therapy were related to following a plan related to gradual exposure to overnight situations without parents. The reason therapy was not completed as planned was because the family did not return for meetings after the summer break.

However, from the therapist's recent phone conversation with the parents, it appeared that the girl has been staying overnight with a friend away from home without any major problems and the family no longer sees the need for therapist support. It is probable that the effects of the therapy regarding independent sleeping at home were generalized to independent sleeping away from home. The therapy using the Coping Cat protocol with modifications focused on the needs of the patient and her parents brought positive changes in the girl's functioning.

Conclusions

Since separation anxiety disorder is one of the most common anxiety disorders found in the developmental population, there is a need to seek the most effective methods for its treatment. Research indicates that cognitive behavioral therapy, implemented in a variety of formats, is effective in this regard. Although randomized controlled clinical trials indicate the effectiveness of the basic Coping Cat protocol for anxiety disorder, especially when compared to no therapy, it is valuable to search for methods that have the potential to increase the level of symptom remission and the sustainability of effects over time, as well as take care of additional problems, frequently specific to SAD. Inspiring studies in this area can be found in the literature, in many cases extending the protocols to work with the parents. For reliable assessment of their effectiveness, further replications and detailed analysis of the scale of the effects are necessary.

Scientific research forms the basis for therapeutic practice, which should be based on empirically validated methods. According to their assumptions, they are conducted under controlled conditions, with the participation of a selected group of patients, based on a uniform protocol. As the above-mentioned research demonstrates, such conditions prove SAD cognitive behavioral therapy efficient. The rates are satisfactory, but never reach 100%. The question of factors influencing therapy failure arises. Unfortunately, none of the surveys measured these factors in any detail. Perhaps taking them into account when deciding on possible modifications to the therapy could ensure that the therapy would also bring the desired results in some of these patients. For this hypothesis to be verified it would require large, controlled surveys. In this article, we present a case study, in which the individually designed adjustments in protocol, taking the needs and patient's problem conceptualization into account, resulted in desired therapy advancements and the reduction of symptoms.

Clinical experience shows that patients who would probably not meet the criteria for inclusion in a controlled research study often come to the therapy office (e.g. due to the occurrence of problems additional to the main disorder). Nevertheless they are still in need of professional and individualized help. There are cases in which working with the base protocol makes therapy 'complicated' – the results are not satisfactory, patient's motivation and cooperation levels drop. There are particularly sensitive situations, during which the risk of patient's drop out increases. There are various reasons for this to occur. The estimated tempo of work may exceed patient's capabilities, the techniques may be insufficient in dealing with specific, strong symptoms manifesta-

tions. In J.'s case, the extension of baseline protocol over to work with parents, as well as including work with intense worry, was helpful.

The authors of this article hope that the presented ideas can be found helpful for other specialists dealing with children presenting intense separation anxiety. This paper is therefore a voice in discussion on whether the therapist should restrictively abide by the protocol or treat it as the 'spine' of the therapeutic work. In the authors' opinion, during supervision, it is valid to introduce modifications in response to specific needs of the patient resulting in increase in therapeutic success.

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Statement: *Joanna Preś – author of the article: Cognitive behavioral therapy in the treatment of separation anxiety disorders in children – a research review and case study/Terapia poznawczo-behawioralna w leczeniu zaburzeń lęku separacyjnego u dzieci – przegląd badań i opis przypadku, where she presented the course of cognitive behavioral therapy, declare that she obtained the consent of the patient's caregivers (described in the article as "J.") for the publication of the therapy description and anonymization of family data.*

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