„Ne idi, molim te“ – kognitivno-bihevioralni tretman djeteta sa separacijskim anksioznim poremećajem

/ “Don’t leave, please” – cognitive behavioural treatment of a child with separation anxiety disorder

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Separacijski anksiozni poremećaj (SAP) ili anksiozni poremećaj zbog separacije u djetinjstvu dijagnosticira se kada strah od odvajanja od osoba za koje je dijete vezano (roditelj ili druge osobe – figure privrženosti) čini žarište anksioznosti. Ubraja se u najučestalije anksiozne poremećaje u djece mlađe od 12 godina s tipičnim početkom u dobi 8-12 godina. Povezan je s izbjegavajućim ponašanjem što može dovesti do poteškoća na emocionalnom i socijalnom planu, a u težim slučajevima rezultirati narušenim školskim funkcioniranjem te reduciranim sveopćim funkcioniranjem djeteta. Prikazujemo slučaj dječaka u dobi od 10,5 godina, koji je nakon multidisciplinske timske obrade kojom je utvrđeno postojanje značajnih teškoća iz anksioznog kruga s dominantnim separacijskim poteškoćama, uključen u kognitivno-bihevioralni tretman. Cilj ovog rada je prikazati važnost multidisciplinskog pristupa dijagnostici i liječenju, suvremene spoznaje kognitivno-bihevioralnog pristupa i tretmana te doprinos uključenosti roditelja kao koterapeuta u implementaciji tehnika radi boljeg ishoda cjelokupnog tretmana.

/ Separation anxiety disorder (SAD), or anxiety disorder due to separation in childhood, is diagnosed when the fear of separation from an attachment figure is the focus of anxiety. The level of separation anxiety has to be inappropriate for the age of the child and accompanied by impaired functioning. SAD is the most common anxiety disorder among children under the age of 12, with a typical onset at the age of 8-12 years. A common feature of separation anxiety disorder is avoidance behaviour, and if left untreated can lead to strong emotional distress or affect social life of a child, family and educational functioning. In this paper, we describe a boy aged 10 years and 5 months (4th grade of elementary school), who was referred for multidisciplinary team assessment, was diagnosed with anxiety disorder (with dominant separation anxiety problems) and was later included in cognitive-behavioural therapy. This article presents recent findings on cognitive-behavioural approach and treatment and discusses the importance of a multidisciplinary approach in assessment and treatment of SAD as well as the parents’ participation in CBT implementation to improve treatment outcome.

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KLJUČNE RIJEČI / *KEY WORDS*:

Anksiozni poremećaji / *Anxiety Disorders*

Separacijski anksiozni poremećaj, / *Separation Anxiety Disorder*

Djeca, / *Children*

Kognitivno–bihevioralna terapija / *Cognitive Behavioural Therapy*

TO LINK TO THIS ARTICLE:

UVOD

Separacijski anksiozni poremećaj (SAP) (ili anksiozni poremećaj zbog separacije u djetinjstvu) najučestaliji je anksiozni poremećaj u djece mlađe od 12 godina te obično počinje u dobi između osme i dvanaeste godine (1). Osnovno obilježje ovog poremećaja je razvojno neprimjerena razina anksioznosti koja se odnosi na odvajanje od osoba za koje je dijete vezano (roditelj ili druge osobe – figure privrženosti), a manifestacije su (2): nerealne, preokupirajuće brige o povredi osobe za koju je dijete vezano te strah da se neće vratiti; nerealne, preokupirajuće brige da će neki neugodan događaj dovesti do odvajanja od osobe za koju je najviše vezano; trajno odbijanje ili protivljenje odlasku na spavanje bez blizine osobe za koju je dijete najviše vezano; trajni, za tu dob neodgovarajući strah da bude samo ili bez osobe za koju je najviše vezano kod kuće tijekom dana, prekomjerna, ponavljajuća uznemirenost u situacijama očekivanja, za vrijeme ili odmah nakon separacije od bliske osobe (2) i drugi. U situacijama izloženosti separaciji od doma ili figure privrženosti djeca doživljavaju značajan distres te pokušavaju izbjeći separaciju, a izbjegavajuće ponašanje uključuje plač, tantrume ili odbijanje sudjelovanja u aktivnostima koje zahtijevaju separaciju (na primjer odlazak na spavanje, izlete i sl.). Prema Dijagnostičkom i statističkom priručniku (DSM-V) za duševne poremećaje Američkog psihijatrijskog udruženja (3) za dijagnozu SAP-a moraju biti zadovoljena barem tri kriterija, smetnje moraju trajati barem četiri tjedna i značajno ometati svakodnevno socijalno, akademsko ili obiteljsko funkcioniranje. Početak poremećaja je najčešće prije osamnaeste godine, a vrlo rijetko se dijagnosticira prije šeste godine života budući da je ovaj tip anksioznosti česta pojava u djece u dobi od sedmog mjeseca do šeste godine života (3).

Prema istraživanju Bacow i sur. (4) prosječna dob početka smetnji je 8,59 godina. Procjena životne prevalencije SAP-a u općoj populaciji

INTRODUCTION

Separation anxiety disorder (SAP) (or childhood separation anxiety disorder) is the most common anxiety disorder in children under the age of 12 and usually develops at the age of 8 to 12 (1). The main feature of this disorder is a developmentally inappropriate level of anxiety concerning separation from attachment figures (parents or other persons), and its manifestations are the following (2): an unrealistic, preoccupying concern about hurting an attachment figure and the fear of never seeing that figure again; unrealistic, preoccupying concern about an unpleasant event leading to the separation from a major attachment figure; permanent refusal or reluctance to go to sleep without being near a major attachment figure; permanent, age-inappropriate fear of being home alone or without a major attachment figure during the day; excessive, recurrent agitation while waiting for an attachment figure or immediately after the separation from an attachment figure (2) and others. When exposed to separation from home or attachment figures, children experience significant distress and try to prevent the separation from happening by means of crying, throwing a tantrum or refusing activities that require separation (for instance, going to bed, field trips, etc.). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) of the American Psychiatric Association (3), in order to diagnose SAP, at least three of the criteria must be fulfilled, the disturbances must be present for at least four weeks and must cause significant impairment of everyday social, academic or family functioning. The disorder usually occurs before the age of 18 and is very seldom diagnosed before the age of 6, since this type of anxiety is common in children between 7 months and 6 years of age (3).

According to a study conducted by Bacow and associates (4), the average age of onset of disturbances is 8.59. The prevalence of SAP in the

je 4,1 % (5), učestaliji je kod djevojčica (6,8 %), nego kod dječaka (3,2 %), a prema istraživanju Foley i sur. (6) 50 – 70 % djece s dijagnozom SAP-a dolazi iz obitelji nižeg socioekonomskog statusa. U kliničkom uzorku djece i mladih SAP je najučestaliji od svih anksioznih poremećaja (49 %).

Nastanak i održavanje SAP-a uključuju interakciju bioloških, kognitivnih, okolinskih i bihevioralnih faktora, kao i karakteristike temperamenta djeteta. Nasljednost SAP-a je procijenjena na 73 % u općem uzorku šestogodišnjih blizanaca, uz veću stopu zastupljenosti kod djevojčica (7). Također, disregulacija neurotransmiterskih sustava noradrenalina, serotonina i dopamina te promjene u strukturama kao što su amigdala i hipokampus imaju značajnu ulogu u razvoju SAP-a (8). „Bihevioralno inhibirani temperament" u kojem dijete pokazuje znakove pretjerane anksioznosti kad je izloženo novim, nepoznatim situacijama povezan je s nastankom SAP-a.

Istraživanja ukazuju kako je SAP najviše od svih anksioznih poremećaja oblikovan okolinskim faktorima (7). Roditeljska ponašanja kao što su niska razina topline (9) te pretjerano zaštićivanje i intruzivnost u obliku pretjerane uključenosti u djetetove svakodnevne aktivnosti (kupanje, hranjenje, navike spavanja, oblačenje, donošenje odluka) kojima se obeshrabruje razvoj autonomije djeteta (10) povezana su s nastankom i održavanjem SAP-a. Roditelji često podržavaju sigurnosna (ponašanja koja služe za trenutno smanjenje anksioznosti i straha kad osoba osjeća intenzivnu prijetnju ili tjeskobu ili procjenjuje da je ugrožena i u opasnosti) i izbjegavajuća ponašanja djeteta (neučinkovite strategije suočavanja koje uključuju izbjegavanje situacija/ljudi i sl. – sve ono što provocira tjeskobu i/ili strah, a što sveukupno može ojačati već postojeće simptome u djece) (11).

Istraživanja iz razvojne psihologije ukazuju da su različiti oblici nesigurne privrženosti (izbjegavajuća, ambivalentna i dezorganizirana pri-

general population is estimated to be 4.1% (5), and is more common in girls (6.8%) than in boys (3.2%). According to a study by Foley and associates (6), 50-70% of children diagnosed with SAP come from families of lower socio-economic status. SAP is the most recurrent anxiety disorder in the clinical sample of children and youth (49%).

Onset and persistence of SAP entail the interaction of biological, cognitive, environmental and behavioural factors, as well as the child's temperament features. SAP heritability was estimated at 73% in a general sample of six-year-old twins, with a higher incidence rate with girls (7). Furthermore, the dysfunction of the norepinephrine, serotonin and dopamine neurotransmitter system, as well as the changes in structures such as amygdala and hippocampus, significantly contribute to the development of SAP (8). A child with a "behaviourally inhibited temperament", which is associated with the onset of SAP, demonstrates signs of excessive anxiety when exposed to new, unfamiliar situations.

Studies suggest that SAP is an anxiety disorder modelled by environmental factors, more so than any other anxiety disorder (7). Parental behaviour such as low levels of emotional warmth (9), overprotection and intrusiveness, demonstrated as over-engagement in the child's everyday activities (bathing, feeding, sleeping habits, dressing, decision making) which discourages the development of the child's autonomy, (10) are associated with the onset and persistence of SAP. Parents often support the child's safety behaviour (behaviour used to reduce anxiety and fear when the person feels intensely threatened or anxious or believes to be threatened and in danger) and the child's avoidant behaviour (non-efficient coping strategies that entail situation/people avoidance, etc. – everything that provokes anxiety and/or fear, which may result in an increase of the child's already existent symptoms) (11).

vrženost) djece čimbenik rizika za razvoj anksioznih poremećaja (12). Djeca su u riziku razvoja SAP-a ako je jednom od roditelja dijagnosticiran psihički poremećaj (13). Djeca roditelja s anksioznim poremećajem imaju čak pet puta veći rizik za razvoj anksioznog poremećaja, a potvrđena je i povezanost paničnog poremećaja kod roditelja s razvojem SAP-a kod djece (14). Rana trauma ili separacije od primarnog skrbnika djeteta (izloženost zlostavljanju, dugotrajna hospitalizacija, traumatizirajući događaji, rođenje brata/sestre) imaju snažan utjecaj na razvoj SAP-a, školske fobije te smetnje iz depresivnog kruga.

SAP se često razvije nakon vanjskog stresogenog događaja. Uobičajeni precipitirajući čimbenici su: gubitak bliske osobe (iz obitelji ili kućnog ljubimca), oboljenje djeteta ili bliske osobe, promjene škole, razvod roditelja, promjene mjesta prebivališta, hospitalizacije ili određene katastrofe koje su uključivale odvojenost od osoba kojima je dijete privrženo. Kod adolescenata nastanak SAP-a može biti povezan s odlaskom na fakultet, napuštanjem roditeljskog doma, kao i s prihvaćanjem uloge roditelja.

U kliničkoj slici SAP-a u mlađe djece pri separaciji ili anticipaciji separacije pri odlasku u vrtić ili školu česte su somatske pritužbe (trbuhobolje, glavobolje, mučnine, povraćanje). U djece i adolescenata s recidivirajućim bolovima u trbuhu, kod 79 % bio je dijagnosticiran anksiozni poremećaj od čega je 43 % djece imalo separacijski anksiozni poremećaj, 31 % generalizirani anksiozni poremećaj te 21 % socijalnu fobiju (15). Somatizacije se javljaju dominantno tijekom tjedna te su odsutne u dane vikenda i školskih praznika (16). Anksioznost pri pokušaju separacije može progredirati do paničnih ataka (lupanje srca, mučnina, skraćenje daha, vrtoglavica).

Simptomi separacijske anksioznosti manifestiraju se različito, ovisno o dobi djece: manja djeca (5-8 godina) uglavnom izražavaju zabrinutost vezanu za nerealno ozljeđivanje osoba

Developmental psychology studies suggest that different forms of insecure attachment in children (avoidant, ambivalent and disorganized) represent a risk factor for developing anxiety disorders (12). Children risk developing SAP if one of their parents has been diagnosed with a psychotic disorder (13). Children of parents with anxiety disorders have a fivefold increased risk of developing an anxiety disorder. Furthermore, the link between parents with panic disorders and children developing SAP has been confirmed (14). An early trauma or separation from the child's primary guardian (exposure to abuse, long period of hospitalisation, traumatic events and birth of a sibling) can significantly contribute to developing SAP, school phobias and depressive disorders.

SAP often develops after an external stressogenic event. Common precipitating factors are: loss of a loved one (relative or a pet), disease of a child or a loved one, change of school, parents' divorce, change of residence, hospitalisation or a disastrous event that involved the child's separation from his/her attachment figures. SAP onset in adolescents may be associated with starting university, leaving their parental home, as well as accepting their parental role.

The clinical manifestation of SAP in younger children during separation or the anticipation of separation on their way to kindergarten or school are often of the somatic type (stomach aches, headaches, nausea, vomiting). 79% of children and adolescents with recurring stomach aches were diagnosed with an anxiety disorder, 43% of whom were diagnosed with separation anxiety disorder, 31% with a generalised anxiety disorder and 21% with a social phobia (15). Somatic manifestations occur predominantly on workdays and not on weekends and school holidays (16). Anxiety while trying to separate may progress to panic attacks (palpitations, nausea, shortness of breath, vertigo).

Separation anxiety symptoms have different manifestations depending on the child's age:

kojima je dijete privrženo te odbijanje odlaska u školu; djeca u dobi 9-12 godina često pokazuju snažnu uznemirenost u situacijama separacije, dok se kod adolescenata (13-16 godina) najčešće uočava odbijanje odlaska u školu i tjelesne komplikacije. Noćne more sa separacijskim sadržajima uglavnom su prisutne kod djece mlađe dobi dok su rijetke kod djece u dobi 9 - 16 godina (17). U većini istraživanja se pokazalo kako separacijska anksioznost u djetinjstvu prerasta tijekom adolescencije u socijalnu fobiju te agorafobiju ili panični poremećaj.

Kad su odvojena od osobe za koju su privržena, djeca sa SAP-om mogu manifestirati razne patološke reakcije: socijalno povlačenje, tugu, teškoće koncentracije, difuzne fobije (životinje, mrak, provalnici, strah od aviona i letenja). Neka djeca izvijestila su o neobičnim perceptivnim iskustvima kad su sama, posebice u mraku (obrisi sjena ili osoba u mraku, oči u mraku koje ih gledaju, zastrašujuća stvorenja koja ih pokušavaju dograbiti) (3). Kad su jako uznemirena, pri anticipaciji ili pokušaju separacije, djeca mogu pokazivati izrazitu agitiranost, ali i opozicionalno ponašanje (tantrume bijesa, agresivnost, vrištanje, prijetnje) (18).

Djeca sa SAP-om često su preokupirana brigom kako će, na primjer, biti oteta, izgubiti se ili biti napuštena te da će oni sami ili osobe uz koje su vezani oboljeti od neke bolesti. Prateća izbjegavajuća ponašanja protežu se na kontinuumu ovisno o težini poremećaja: kod blažih oblika SAP-a uključuju nastojanja da su roditelji lako dostupni kada je dijete separirano od njih (npr. da ih može telefonski kontaktirati), umjereni stupanj uključuje odbijanja spavanja kod prijatelja (jer to uključuje višesatno odvajanje od roditelja). Djeca s težim oblicima SAP-a odbijaju odlaske u školu ili spavanje u vlastitoj sobi (dolaze roditeljima ili braći/sestrama noću u krevet, žele stalno biti uz svoje roditelje). Mnoga djeca, posebice manja, često slijede roditelje te odbijaju separaciju i u okviru svoga doma dok starija djeca odbijaju odlazak od kuće i sudjelo-

young children (ages 5-8) usually express their concern about unrealistic injuries of their attachment figures and refuse to go to school; children ages 9-12 often demonstrate agitation in separation situations, while adolescents (ages 13-16) usually refuse going to school and suffer from physical complications. Nightmares of separation usually occur in children of a young age and are very rare with children ages 9-16 (17). Most studies show that childhood separation anxiety evolves into social phobia, agoraphobia or panic disorder during adolescence.

When separated from their attachment figure, children with SAP may demonstrate different pathological reactions: social withdrawal, sadness, difficulty concentrating, diffuse phobias (animals, dark, burglars, fear of air planes and flying). Some children reported having unusual perceptual experiences when alone, especially in the dark (outlines of shadows or people in the dark, eyes looking at them from the dark, frightening creatures that are trying to grab them) (3). When very upset, while anticipating the separation or when trying to separate, the children may demonstrate exceptional aggressiveness but also oppositional behaviour (temper tantrums, aggressiveness, screaming and threats) (18).

Children with SAP are often worried that they will, for example, get kidnapped, lost or abandoned and that they themselves or their attachment figures will be diagnosed with a disease. There is a wide range of accompanying avoidant behaviour which depends on the disorder severity: milder forms of SAP involve the child's desire to be able to easily access parents during separation (for example, by phone), while the moderate form of SAP involves refusing sleepovers (because that would imply being separated from parent for hours). Children with more severe forms of SAP refuse going to school or sleeping in their rooms (they come to their parents' or siblings' beds at

vanje u vršnjačkim aktivnostima bez prisutnosti roditelja (17).

Djeca s ovim poremećajem pokazuju poteškoće funkcioniranja u različitim područjima: izbjegavaju i/ili prestaju pohađati sportske ili grupne aktivnosti s vršnjacima (rođendane, zabave, druženja). Akademski uspjeh može biti narušen zbog odbijanja odlazaka u školu (veliki broj izostanaka, pad školske godine, školovanje kod kuće, čak i napuštanje školovanja u ekstremnim slučajevima). Prema Kearneyju (16) 75 % djece sa SAP-om pokazuje neki oblik odbijanja odlazaka u školu. Odbijanje pohađanja škole utvrđeno je kod 75 % djece sa SAP-om, a SAP je dijagnosticiran kod 80 % djece koja su odbijala odlazak u školu (5).

Anksiozni poremećaji se često javljaju udruženi s ostalim psihijatrijskim poremećajima (19), naročito kod djevojčica. Tako je u 79 % djece sa SAP-om utvrđen barem još jedan, a u 54 % dva ili više komorbidnih psihijatrijskih poremećaja (20). Uz SAP se često javlja specifična fobija i generalizirani anksiozni poremećaj. Povezanost anksioznosti i depresije je utvrđena mnogobrojnim istraživanjima te tako jedna trećina djece sa SAP-om razvije depresivni poremećaj (18).

U dijagnostici SAP-a važan je multidisciplinski pristup što uključuje pregled dječjeg i adolescentnog psihijatra, psihologijsku obradu, pregled logopeda i neuropedijatra te EEG radi diferencijalne dijagnostike i procjene komorbidnih stanja. Uz klinički intervju u okviru kojeg je potrebno prikupiti podatke o razvoju djeteta, funkcioniranju i psihosocijalnoj situaciji obitelji od različitih izvora (roditelji, članovi obitelji, odgajatelji, stručni suradnici škole/vrtića, učitelje, liječnik primarne zdravstvene zaštite ili školske medicine), potrebna je i opservacija djeteta. Također je važno napraviti funkcionalnu analizu djetetova ponašanja (FAP) kojom se utvrđuje disfunkcionalno ponašanje, odnosno što prethodi određenom ponašanju, koje oblike ponašanja dijete pokazuje, prati se učestalost,

night and want to be near their parents all the time). Many children, especially young ones, often follow their parents around the house and refuse separation even within the house, while older children refuse to leave the house and participate in peer activities without their parents present (17).

Children with this disorder demonstrate difficulties functioning in different areas: they avoid and/or stop attending sports or group activities with their peers (birthday parties, celebrations, gatherings). School attendance refusal may impair the child's academic performance (increased absence, failing a grade, home-schooling, in extreme cases, even leaving school). According to Kearney (16), 75% of children with SAP demonstrate a certain form of school attendance refusal. School attendance refusal was found in 75% of children with SAP, and SAP was diagnosed in 80% of children refusing school attendance (5).

Anxiety disorders frequently co-occur with other anxiety disorders (19), especially in girls. At least one comorbid psychiatric disorder was diagnosed in 79% of children with SAP, and two or more comorbid psychiatric disorders in 54% of them (20). Specific phobia and generalised anxiety disorder frequently co-occur with SAP. Many studies have confirmed the link between anxiety and depression: one third of children with SAP develop a depressive disorder (18).

When diagnosing SAP, it is relevant to have a multidisciplinary approach, which involves an examination by a child and adolescent psychiatrist, psychological evaluation, examination by a speech-language pathologist and neuropaediatrician and an EEG as a part of differential diagnostics and assessment of comorbidities. Alongside a clinical interview which requires gathering data concerning the child's development as well as the functioning and psycho-social situation of the family from different sources (parents, family members, educators, school and kindergarten expert associates, teachers,

trajanje, intenzitet ponašanja i posljedice koje slijede nakon ponašanja.

FAP ima za cilj identificirati što dijete određenim ponašanjem dobije ili izbjegava te kako se određeno ponašanje održava i što ga potiče te koje socijalno značenje ima. U FAP-u, uz pomoć roditelja, nastoji se ispitati precipitante (događaje koji neposredno prethode ili mogu služiti kao okidač), predisponirajuće čimbenike (čimbenici koji čine osobu podložnom ili ranjivom za razvoj određenog poremećaja), kontekst i modulirajuće varijable (varijable koje utječu na intenzitet i frekvenciju smetnji), podržavajuće okolnosti te izbjegavajuća ponašanja djeteta. Mogu se koristiti i različiti upitnici i ljestvice za procjenu anksioznosti, ostale psihopatologije i funkcioniranja djeteta koje ispunjavaju starije dijete, roditelji ili odgajatelj/učitelj.

U diferencijalnoj dijagnostici iznimno je važno razlikovati razvojno primjerenu i prekomjernu razinu separacijske anksioznosti. Normalna razvojno primjerena separacijska anksioznost doseže vrhunac između devetog i trinaestog mjeseca života djeteta te se smanjuje nakon druge godine uz tendenciju povećanja autonomije djeteta do treće godine života. Simptomi separacijske anksioznosti opet se povećavaju od četvrte do pete godine te posebice u razdoblju polaska u školu (21).

Granice kliničke značajnosti separacijske anksioznosti mogu biti kulturološki uvjetovane jer različite kulture imaju različita očekivanja glede autonomije djeteta, potrebne razine nadzora odrasle osobe te navika spavanja (22).

Liječenje separacijskog anksioznog poremećaja zahtijeva primjenu različitih terapijskih postupaka te multimodalan pristup u planiranju i provođenju tretmana. Većina dostupnih podataka o učinkovitosti tretmana SAP-a referira se na nefarmakološke terapijske tehnike liječenja, i to psihoedukaciju, bihevioralni tretman te kognitivno-bihevioralnu terapiju (KBT) (20). Međutim, kod težih kliničkih slika SAP-a lijekovi

primary care physician or school physician), child observation is also necessary. Furthermore, it is important to conduct a functional analysis of the child's behaviour (FAP), which will detect dysfunctional behaviour, i.e. what precedes certain behaviour and what forms of behaviour the child demonstrates, examine the frequency, duration, and intensity of the behaviour, as well as the consequences that derive from it.

The aim of FAP is to identify the child's gains from certain behaviour or what the child wishes to avoid by behaving in a certain manner, as well as how that particular behaviour persists, what it is that incites it, and what its social connotations are. FAP, with the help of the child's parents, tries to examine the precipitating factors (events that immediately precede or may trigger the behaviour) and predisposing factors (factors that make the person susceptible or inclined to develop a certain disorder), context and modulating variables (variables that influence the intensity and frequency of disturbances), supporting environment, and child's avoidant behaviour. Different questionnaires and rating scales for anxiety, other psychopathologies and child functioning filled out by an older child, parent or educator/teacher may be used.

In differential diagnostics, it is of utmost importance to distinguish between developmentally appropriate and excessive levels of separation anxiety. Normal, developmentally appropriate separation anxiety peaks when the child is aged between 9 and 13 months and decreases after the age of 2, and the child's autonomy tends to increase by the age of 3. Separation anxiety symptoms increase again in the age of 4 to 5, especially in the period before starting school (21).

The clinical relevance of the separation anxiety level may be culturally determined because different cultures have different expectations concerning the child's autonomy, level of necessary adult supervision and sleeping habits (22).

prvog izbora su antidepresivi iz skupine selektivnih inhibitora ponovne pohrane serotonina (SIPPS). Multimodalna studija (CAMS) ukazala je na kratkotrajnu učinkovitost monoterapije KBT-om i monoterapije sertalinom u liječenju SAP-a, dok je kombinacija sertalina i KBT-a davala dugoročnije učinke (23). Međutim, za sada regulatorne agencije za lijekove nisu odobrile ni jedan SIPPS za liječenje SAP-a.

Cilj ovog rada je prikazati važnost multidisciplinarnog pristupa dijagnostici i liječenju SAP-a, suvremene spoznaje kognitivno–bihevioralnog pristupa i tretmana te uključenosti roditelja kao koterapeuta u implementaciji tehnika radi boljeg ishoda cjelokupnog tretmana.

KOGNITIVNO–BIHEVIORALNI TRETMAN SEPARACIJSKOG ANKSIOZNOG POREMEĆAJA

Temeljem snažne empirijske podloge već preko 20 godina se u liječenju anksioznih poremećaja djece u dobi od 7 godina i više primjenjuje kognitivno-bihevioralni tretman (24). U terapiju mogu biti uključeni i roditelji, a osnovne komponente uključuju: psihoedukaciju o anksioznosti, vještine upravljanja somatskom anksioznošću, kognitivno restrukturiranje, metode izlaganja i plan prevencije povrata simptoma. Psihoedukacija pruža razvojno primjerene informacije o anksioznosti, o stimulatorima straha te uključuje pojašnjavanje koncepta povezanosti misli, osjećaja i ponašanja. Također, roditeljima kao koterapeutima u procesu liječenja važno je razjasniti pozitivno i negativno potkrepljenje koje održava poremećaj, ulogu sigurnosnih ponašanja u održavanju poremećaja te osnovne postavke KBT-a.

Tehnika upravljanja somatskim simptomima usmjerena je na autonomno uzbuđenje, a uključuje podučavanje djeteta kako prepoznati simptome anksioznosti i tjelesne reakcije na anksioznost, a somatski simptomi anksioznosti mogu

Treatment of separation anxiety disorder requires the application of different therapy procedures and a multimodal approach to planning and conducting treatments. Most of the available SAP treatment efficacy data refers to non-pharmacological therapy treatment techniques, in particular psychoeducation, behavioural treatment and cognitive-behavioural treatment (CBT) (20). However, in case of a more severe clinical manifestation of SAP, selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed antidepressants. The Child/Adolescent Anxiety Multimodal Study (CAMS) revealed a short-term efficacy of CBT monotherapy and sertaline monotherapy in treating SAP, whereas the combination of CBT monotherapy and sertaline monotherapy ensured a long-term effect (23). However, medicines regulatory agencies have not yet approved a single SSRI for treating SAP.

The aim of this article is to explain the relevance of a multidisciplinary approach to SAP diagnostics and treatment, contemporary advancements of the cognitive-behavioural approach and treatment and including parents as co-therapists during technique implementation in order to obtain better outcomes of the whole treatment.

COGNITIVE-BEHAVIOURAL TREATMENT FOR SEPARATION ANXIETY DISORDER

Due to strong empirical grounds, cognitive-behavioural treatment has been used for treating anxiety disorders in children of the age of 7 and above for over 20 years (24). This therapy may involve parents and its main components entail: psychoeducation in the area of anxiety, somatic anxiety management skills, cognitive restructuring, exposure therapy methods and relapse prevention plan. Psychoeducation provides developmentally appropriate information on anxiety, fear stimulation and involves ex-

se umanjiti tehnikama relaksacije (progresivna mišićna relaksacija, abdominalno disanje).

Kognitivno restrukturiranje treba biti razvojno primjereno i usmjereno na prepoznavanje maladaptivnih misli i poučavanje novim, realističnijim mislima, usmjerenih k rješavanju problema, a kognitivne intervencije su usmjerene na modifikaciju maladaptivnih misli i kognitivnih distorzija te usvajanje novih adaptivnijih misli.

Bihevioralnim intervencijama oblikuju se nova, željena ponašanja i uče se nove vještine upravljanja starim, anksioznim obrascima ponašanja. Tehnike izlaganja uključuju postupno, sistematično izlaganje situacijama straha. Prevencija povrata simptoma se usredotočuje na konsolidiranje i generaliziranje naučenog u tretman i tijekom vremena (25).

Meta-analiza primjene KBT-a kod anksioznih poremećaja djece i mladih pokazala je uspješnost u individualnom i grupnom terapijskom okviru (26). U istraživanju Walters i sur. (27) ispitivana je učinkovitost grupnog KBT tretmana u 80 djece u dobi 4 - 8 godina s dijagnozama SAP-a, socijalne fobije te generaliziranog anksioznog poremećaja. Uspoređivana je učinkovitost terapije orijentirane samo na roditelje te kombinacije tretmana „dijete + roditelj". Moduli s djecom uključivali su psihoedukaciju o anksioznosti, relaksacijski trening, *problem-solving* tehnike, razvijanje socijalnih vještina, kognitivno restrukturiranje te samoupute. Modul za roditelje uključivao je psihoedukaciju, strategije nošenja s anksioznošću, savjetovanje o odnosu s djetetom, vještine komunikacije te rješavanja problema uz smjernice za potkrepljivanje ponašanja koje je dijete naučilo na modulima. Kriterijima za anksiozni poremećaj u odnosu na 60 % djece u skupini koja je imala samo tretman za roditelje više nije udovoljavalo 75 % djece koja su prošla kombinirani KBT tretman za djecu i roditelje. Moduli za roditelje mogu biti korisni, posebice za manju djecu koja su nedostupna kognitivnim intervencijama u okviru KBT-a. Tako se za djecu predškolske dobi učinkovitim

plaining the concept of thoughts, feelings and behaviour interconnectedness. Furthermore, it is important to explain to parents, who act as co-therapists, the positive and negative reinforcement which preserves the disorder, the role of safety behaviour in disorder persistence and basic principles of CBT.

The somatic anxiety management technique focuses on autonomic arousal and involves teaching the child to recognise anxiety symptoms and physical reactions to anxiety. The somatic anxiety symptoms may be alleviated by relaxation techniques (progressive muscle relaxation, abdominal breathing).

Cognitive restructuring should be developmentally appropriate and directed towards recognising maladaptive thoughts and learning how to engage in new, more realistic and solution-oriented thoughts. Cognitive interventions are directed towards modifying maladaptive thoughts and cognitive distortions and adopting new, more adaptive thoughts.

Behavioural interventions shape new, desired behaviours and teach new skills for managing old anxiety behaviour patterns. Exposure therapy techniques involve gradual, systematic exposure to fear-inducing situations. The relapse prevention plan focuses on consolidating and generalising the knowledge gained through treatment and over time (25).

Meta-analysis of CBT application in cases of anxiety disorders in children and youth has proven the success of CBT in both individual and group therapy (26). The study conducted by Walters and associates (27) examined the efficacy of group CBT treatment with 80 children aged 4-8 who were diagnosed with SAP, social phobia and generalised anxiety disorder. The study compared the efficacy of parent-focused therapy and combined "child + parent" treatment. The children modules involved psychoeducation in the area of anxiety, relaxation training, problem-solving techniques, social skills development, cognitive restructuring

pokazao program CALM (*Coaching Approach Behavior and Leading by Modeling* – Oblikovanje ponašanja kroz vođenje i modeliranje) (28), a to je oblik tretmana „dijete + roditelj". Program se primjenjuje za djecu u dobi 3-7 godina, usmjeren je prema roditeljima, odnosno uči roditelje vještine učinkovitog potkrepljivanja ciljanih pomaka u ponašanju djeteta, odnosno vježbanje i primjenu tih vještina u samoj seansi interakciji roditelj - dijete, a kasnije i primjenom u svakodnevnom životu djeteta (24).

Eisen i sur. (11) su razvili desetotjedni program za djecu sa SAP-om koji uključuje roditeljsku implementaciju KBT strategija kod kuće (psihoedukacija, relaksacija, kognitivne intervencije, postupno izlaganje, prevencija povrata simptoma). Ove intervencije pokazale su se vrlo učinkovitima te nakon primjene čak petero od šestero djece nije više zadovoljavalo kriterije za SAP.

Ako postoji izbjegavanje pohađanja nastave, potrebna je suradnja terapeuta sa školom. Neke od korisnih strategija kod nepohađanja nastave su: održavanje suradnje i redovitih sastanaka s roditeljima, rješavanje eventualnih poteškoća u školi koje mogu biti povezane s izbjegavanjem škole (strah od određenog učitelja, sukobi s vršnjacima), izrada postupnog plana povratka djeteta u školu, dopuštenje roditelju da inicijalno prati dijete u školu te po potrebi bude uz dijete (postupno izlaganje), dopuštenje inicijalno kraćeg boravka djeteta u školi te postupno produljivanje vremena boravka, utvrđivanje „sigurnog mjesta" kamo će dijete moći otići, ako ga preplavi anksioznost (npr. soba psihologa, pedagoga...), ohrabrivanje interakcije u malim grupama, potkrepljivanje pozitivnih rezultata djeteta te nagrađivanje nastojanja i zalaganja djeteta, a ne samo krajnjeg rezultata (29).

Uključenost roditelja u tretman anksioznog poremećaja djeteta je od velike važnosti zbog implementacije terapijskih tehnika kod kuće i generalizacije rezultata. Također, roditelji često nisu svjesni činjenice da potkrepljuju anksio-

and self-instruction techniques. The parents module involved psychoeducation, anxiety coping strategies, counselling on the relationship with the children, communication and problem-solving skills with guidance for reinforcing behaviour the children acquired through their module. 75% of children who underwent combined CBT treatment for children and parents no longer met the anxiety disorder criteria, in comparison with 60% of children in the group whose parents underwent the parent-focused therapy. Parent modules may be useful, especially for younger children who cannot participate in cognitive interventions of CBT. For example, along those lines, the program Coaching Approach behaviour and Leading by Modelling (CALM) (28), a form of "child + parent" treatment, proved to be efficient for pre-school children. The program is used for children of ages 3-7 and is parent-focused, i.e. it teaches parents the skill of efficiently reinforcing improvements in their child's behaviour, and in particular coaches the use of these skills during in-session parent-child interactions and later in the child's everyday life (24).

Eisen and associates (11) devised a ten-week program for children with SAP that requires parents to implement CBT strategies at home (psychoeducation, relaxation, cognitive interventions, gradual exposure, relapse prevention plan). These interventions have proven to be very efficient, and after their application as many as 5 out of 6 children no longer met the SAP criteria.

If school attendance avoidance exists, the therapist needs to cooperate with the school. Some useful strategies for tackling school attendance refusal are the following: cooperating with the parents and meeting them on a regular basis; eliminating potential issues in school that might be connected to school avoidance (fear of a certain teacher, peer conflicts); devising a gradual school re-entry plan; allowing the parent to initially accompany the child to

zna ponašanja svoje djece i time održavaju trajanje poremećaja (30).

PRIKAZ SLUČAJA

Dječak u dobi 10,5 godina, učenik četvrtog razreda osnovne škole, živi s roditeljima, jedinac, upućen je na psihijatrijski pregled zbog intenzivnog straha ostati sam kod kuće, biti odvojen od roditelja uz zabrinutost za njihovo zdravlje te promjene u navikama spavanja (dolazi roditeljima u krevet gotovo svaku noć) u trajanju od šest mjeseci. Pojavi smetnji prethodio je događaj kada je majka otišla do obližnje trgovine dok je dječak spavao. Kad se probudio, zvao je majku na mobitel, no ona se nije javljala jer je mobitel ostavila kod kuće. U iščekivanju i nakon dolaska majke dječak je postao izrazito uznemiren, uz grčevit plač. Od tada je sklon prekomjernoj brizi za zdravlje roditelja te učestalo propituje: „Je li sve u redu?“, „Hoće li mama i tata biti dobro?“ Ne može ostati sam kod kuće bez bliske osobe (roditelj, baka ili djed). Ako kraće vrijeme ostaje sam kod kuće, kada majka ode na posao, a otac još nije došao s posla, mora biti u stalnoj telefonskoj vezi s majkom. Boji se spavati sam u svojoj sobi, noću dolazi roditeljima u krevet. Smetnje su izraženije tijekom tjedna, a manje intenzivne vikendom. Dječak ne odbija odlaske u školu te je svladavanje gradiva uredno. Ranije je dječak bio dobro socijaliziran i vršnjaci su ga dobro prihvaćali. Unatrag šest mjeseci ne ide na vanškolske aktivnosti, što uključuje sportske aktivnosti i strani jezik, a slobodno vrijeme provodi kod kuće te uz kompjuter, izbjegava kontakte s vršnjacima, fiksiran je na roditelje.

Rani psihomotorni razvoj dječaka bio je uredan. Nije teže bolovao, somatski je zdrav te nije ranije psihologijski ni psihijatrijski liječen. Pri polasku u vrtić ispoljavao je poteškoće adaptacije uz plačljivost i teže odvajanje od majke. Spavao je s roditeljima u sobi do šeste godine života. Nakon polaska u školu, na izletima na more sa sportskom grupom svakodnevno je više puta

school and, if necessary, staying with the child (gradual exposure); initially allowing a shorter school stay for the child and gradually increasing the school stay period; finding a “safe place” the child may visit if overwhelmed with anxiety (for example, the school counsellor or psychologist’s office); encouraging small group interaction; reinforcing the child’s positive results and rewarding the child’s effort and engagement, not just the final results (29).

The parents’ inclusion in the child’s anxiety disorder treatment is very important in order to enable the implementation of therapy techniques at home and generalise the results. Furthermore, parents are often not aware of the fact that they reinforce their children’s anxious behaviour and help the disorder persist (30).

CASE STUDY

A boy, 10.5 years old, in the fourth grade of elementary school, living with his parents and an only child, was referred for a psychiatric examination due to intense fear of staying home alone and being separated from his parents, concerns for his parents’ health and changes in sleeping habits (coming to his parents’ bed almost every night) in a period of 6 months. The disturbances started after one particular event: the child’s mother went to a nearby store while the child was asleep. When he woke up, he tried reaching his mother on her cell phone, but she did not answer as she had left her cell phone at home. While waiting for his mother to return, he became extremely agitated and started crying frantically, which continued even after his mother returned home. Ever since, the boy was prone to excessive concern for his parents’ health and often asked: “Is everything all right?”, “Will mum and dad be all right?” He could not stay home alone without a person close to him (parents, grandparents). If he had to stay home alone for a shorter period of time, when his mother went to work and his father

nazivao roditelje. Tijekom ljetovanja s bakom na moru zahtijevao je da spava s njom u sobi.

Majka dječaka je tijekom studija liječena zbog anksioznosti i paničnih ataka te je ponovno nakon poroda bila uključena u psihijatrijski tretman do šeste godine dječaka. U odgoju je hiperprotektivna, visoke razine kontrole, pomaže dječaku u učenju. Roditelji opisuju dječaka kao senzibilnog, a u odgoju su permisivni. Različito percipiraju dječakove teškoće: otac smatra da dječak „privlači pažnju" dok majka zauzima zaštitnički stav. Oboje navode teškoće u vlastitom funkcioniranju zbog smetnji djeteta.

Multidisciplinska obrada dječaka (EEG i pregled neurologa, psihijatra i obrada psihologa i logopeda) pokazala je da se radi o dječaku iznadprosječnih intelektualnih sposobnosti sa simptomima separacijske anksioznosti te izrazitije narušenim obiteljskim i socijalnim funkcioniranjem.

Slika 1. prikazuje dijagram kognitivne konceptualizacije za dječaka s ključnim bazičnim i posredujućim vjerovanjima i glavnim strategijama suočavanja.

Tijek tretmana

Na početku psihoterapijskog liječenja s dječakom i roditeljima definirani su sljedeći terapijski ciljevi: naučiti opustiti se i umiriti (usvojiti tehnike relaksacije), povećati samostalnost dječaka (da ostaje sam kod kuće i spava u svojoj sobi), uključivati u aktivnosti s vršnjacima.

Tretman je započet psihoedukacijom roditelja i djeteta, a u nastavku su primijenjene bihevioralne i kognitivne tehnike. Roditeljima i dječaku su prikazani KBT model anksioznosti, povezanost misli, osjećaja, ponašanja, pozitivno i negativno potkrepljenje koje održava poremećaj, uloga sigurnosnog ponašanja te osnovne postavke KBT-a.

Dječak je podučen *tehnikama relaksacije* (abdominalno disanje i progresivna mišićna re-

had not yet returned, he had to be on the phone with his mother the whole time. He was afraid of sleeping alone in his room and would come to his parents' bed at night. The disturbances were more present on workdays, and less present on weekends. The child did not refuse going to school and his academic performance did not change. The boy used to be well-socialised and accepted among peers. Six months ago, he stopped attending his extra-curricular activities, including sports activities and foreign language classes, and was spending his time at home in front of the computer, avoiding contact with peers, fixated on his parents.

The boy's early psychomotor development was normal. He suffered no severe illness, had no somatic symptoms, nor had he undergone psychological or psychiatric treatment. When starting kindergarten, he had troubles adapting and wold cry and have difficulties separating from his mother. He slept in the room with his parents until the age of 6. After starting elementary school, during field trips to the sea side with his sports team, he would call his parents several times a day. He spent summer holidays at the seaside with his grandmother and would ask to sleep in the room with her.

The child's mother was treated for anxiety and panic attacks during her university studies and underwent psychiatric treatment again after giving birth, until the boy was 6. She is an overprotective parent, exercises a high level of control and helps the child study. The parents describe the child as sensitive and their parenting as permissive. They perceive the child's difficulties differently: the father believes that the child "wants to attract attention", whereas the mother has a protective attitude. Both of them confirm having difficulties functioning due to their child's disturbances.

Multidisciplinary examination of the child (EEG and neurologist and psychiatrist examination, psychological and speech-language pathologist evaluation) showed that the child is of above

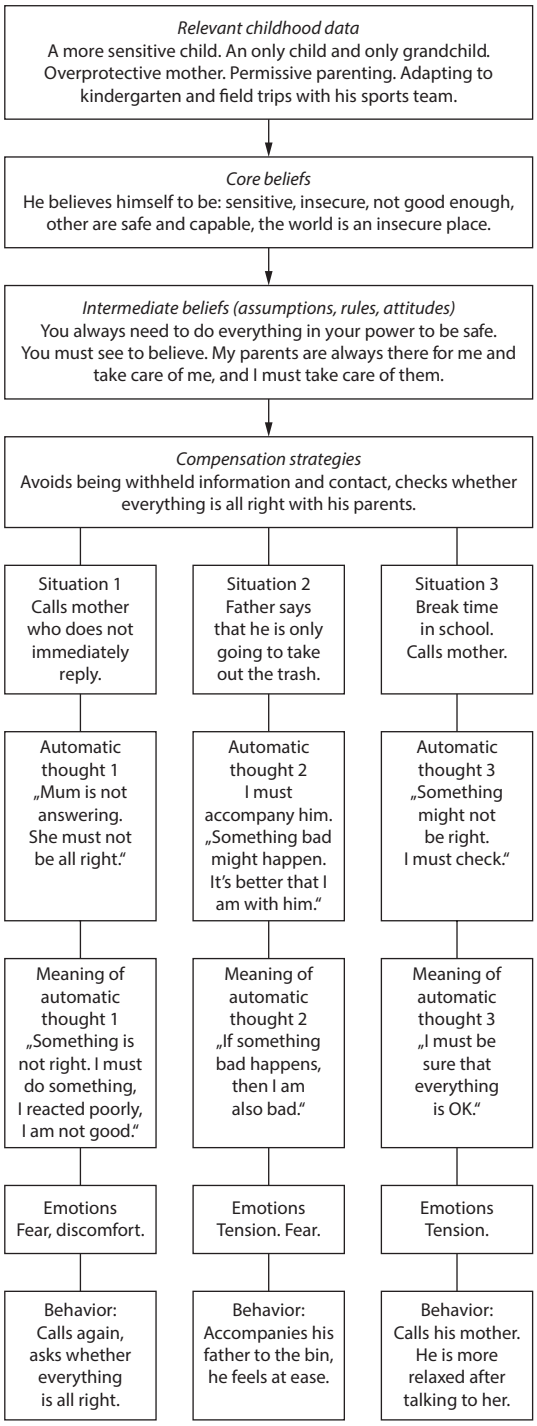

FIGURE 1. Overview of the child's cognitive conceptualisation.

laksacija prilagođena djeci). Navedene tehnike dječak je prihvatio, marljivo vježbao te naučio prepoznati razliku između napetog i opuštenog fizičkog stanja. Usporedno je provedena *edukacija o osjećajima* kako bi lakše prepoznao prve znakove pobuđenosti i primijenio tehnike relaksacije prije eskalacije anksioznosti.

average intelligence and that he demonstrates symptoms of separation anxiety and substantially impaired family and social functioning.

Figure 1 shows a diagram of the child's cognitive conceptualisation with key core and intermediate beliefs and main coping strategies.

The treatment process

The following therapy goals were set with the child and parents at the beginning of the psychotherapy treatment: learn how to relax and calm down (adopt relaxation techniques), increase the child's independence (staying at home alone and sleeping in his room) and inclusion of peer activities.

The treatment began with the psychoeducation of the parents and the child, and behavioural and cognitive techniques were applied later on. The parents and child were presented the CBT anxiety model; thoughts, feelings and behaviour interconnectedness; positive and negative reinforcement which reflect the disorder; role of safety behaviour; and basic principles of CBT.

The boy was shown relaxation techniques (abdominal breathing and progressive muscle relaxation adapted for use with children). The child accepted the aforementioned techniques, practised them diligently, and learned how to recognise the difference between a tense and relaxed physical state. At the same time, the child participated in an *education on feelings* in order to become able to easily recognise the first signs of anxiety and apply relaxation techniques before the anxiety escalated.

The *gradual exposure* technique was used in order to develop the child's independence in terms of staying home alone and sleeping in his own bed. At the beginning, relaxation techniques, distraction and self-calming sentences were used during exposure; but in later stages, the child would expose himself to uncomfortable situations without distractions (for example, it was agreed that the child, when his mother was

Tehnika *postupnog izlaganja* korištena je kako bi se razvila samostalnost dječaka u ostajanju kod kuće i u spavanju u vlastitom krevetu. U početku su pri izlaganju korištene tehnike relaksacije, distrakcija i samoumirujuće rečenice, a u kasnijim fazama izlagao se neugodnim situacijama bez distrakcije (npr. kad je majka odlazila na posao, dogovoreno je da dječak gleda crtane filmove na TV-u i koristi umirujući samogovor: „Još ću malo izdržati, sve je u redu." Kad je otac odlazio baciti smeće, dječak je najprije gledao oca kroz prozor, zatim ostajao u sobi uz jedan telefonski poziv i konačno ostajao sam u sobi uz umirujući samogovor). Postupno je smanjivao sigurnosna ponašanja (pozivi majci i povremeno ocu) i sve dulja razdoblja ostajao sam kod kuće. Za svaki pozitivan pomak dječak je nagrađivan pohvalama roditelja i terapeuta te je koristio i pozitivne samoizjave (samopohvale) s ciljem potkrepljenja željenih obrazaca ponašanja.

Kod buđenja noću dogovoreno je da roditelji u početku dođu u sobu dječaka i pomognu mu da se umiri pomoću tehnika relaksacije i potom vrate u svoju sobu. Potom su, sukladno dogovoru s terapeutom i uz pristanak dječaka, na pozive dječaka i nakon buđenja dječaka tijekom noći, roditelji ostajali u svojoj sobi i odgovarali umirujućom rečenicom: „Tu smo, sve je u redu." Dječak je pritom koristio umirujuće rečenice, distrakciju, relaksaciju, imaginaciju ugodnih prizora kako bi se umirio i ostao u svom krevetu bez odlaženja u krevet roditeljima. Dječak je konačno spavao sam u sobi, uz otvorena vrata i lagano noćno svjetlo. Tijekom postupnog izlaganja dječak je vodio dnevnik spavanja te je za samostalno spavanje u svom krevetu korištena tehnika žetoniranja uz podupiruće potkrepljivače prema dječakovom izboru. Tehnika žetoniranja ili „ekonomija žetona" je sustav potkrepljivanja temeljen na upotrebi žetona koji mogu biti zvjezdice, kvačice, sličice, a sami žetoni se zarađuju izvođenjem poželjnih ponašanja i zatim se mogu

at work, would watch cartoons on the TV and use a self-calming speech: "I will hold on for a little bit longer, everything is all right". When his father would go to take out the trash, the child would, at first, watch his father through the window, then stay in the room while talking with him on the phone and, finally, stay in the room using a self-calming speech). The child gradually reduced his safety behaviour (phone calls to mother and occasionally father) and extended the periods of staying home alone. Each positive improvement of the child was praised by his parents and therapist, and he used positive self-statements (self-praise) in order to reinforce the desired behaviour patterns.

When it comes to waking up at night, it was agreed that the parents would initially come to the child's room and help him calm down using relaxation techniques and then return to their room. Later on, as agreed with the therapist and with the child's consent, when the child would wake up and call his parents to come to his room, the parents would stay in their room and answer with the following calming sentence: "We are here, everything is all right". The child would then use calming sentences, distraction and relaxation and imagine pleasant scenes in order to calm down and stay in his bed without going to his parents' bed. Finally, the child began sleeping alone in his room, with the door open and a discrete night light. During his gradual exposure, the child kept a sleep diary and used the token economy technique with supporting reinforcers of his choice for sleeping alone in his bed. The token technique or the "token economy" is a reinforcement system based on the use of tokens (stars, clips, cards), and one can earn a token by engaging in desired behaviour, which can then be exchanged for a range of other reinforcers such as activities, etc. The rules for applying the token technique is to specify the desired behaviour for which tokens may be obtained and define the number of tokens given for exhibiting one of the defined desired behaviours.

zamijeniti nizom drugih potkrepljivača kao što su aktivnosti, itd. Pravila za primjenu žetoniranja su specificirati ciljna ponašanja za koja se mogu dobiti žetoni te definirati broj žetona koje je moguće dobiti za izvođenje pojedinog ciljnog ponašanja.

Uz navedeno su korištene i pohvale roditelja i terapeuta, kao i samopohvale, za svaki napredak.

Od kognitivnih intervencija provodila se *kognitivna restrukturacija* koja je započeta identifikacijom negativnih automatskih misli (NAM) i prepoznavanjem kognitivnih distorzija (katastrofiziranje, emocionalno zaključivanje). Dječak je za domaću zadaću vodio dnevnik misli, osjećaja, ponašanja. Raspravljene su prednosti briga (dobije blizinu roditelja) te nedostatci (gubitak vremena, napetost, ljutnja roditelja), kao i sklonost precjenjivanju opasnosti, podcjenjivanje svojih snaga te je stavljen naglasak na normalizaciju stanja. Potom se radilo na modifikaciji NAM-a i nalaženju alternativnih, funkcionalnijih misli (npr. negativna misao „Mama se ne javlja, sigurno joj se nešto dogodilo" zamijenjena je adaptivnijom „Znam da je na poslu i da je dobro. Vjerojatno sada ne može pričati. Zvat ću ju kasnije kako smo se dogovorili."). Dječak je usvojio novo „pravilo" kojeg bi se prisjetio u situacijama kad bi prepoznao svoje NAM, a glasilo je: „Misli nisu činjenice. To što ja mislim da bi moglo biti nešto loše, ne znači da će se dogoditi."

Poticano je i druženje izvan obitelji, u početku s najboljim prijateljem, potom druženje s većom skupinom djece (3-4 dječaka). Broj i vrijeme druženja postupno je povećavano uz redukciju sigurnosnih ponašanja (pozivi roditeljima).

Evaluacija, problemi i zapreke te rezultati tretmana

Tretman koji je provodio certificirani KBT terapeut trajao je pet mjeseci, ukupno je provedeno 13 seansi s čestoćom susreta u prosjeku

In addition to the above, praise from the parents and therapists as well as self-praise were used for any type of progress.

Concerning the cognitive interventions, *cognitive restructuring* was implemented, which started by identifying negative automatic thoughts and recognising cognitive distortions (catastrophisation, emotional conclusion). The child was given the task of keeping a diary of his thoughts, feelings and behaviour. The advantages of worrying (being close to his parents) and disadvantages of worrying (loss of time, tension, parents' anger) were discussed, as well as the proneness to overstate danger and understate his own strength; emphasis was placed on the normalisation of the condition. This was followed by work on negative automatic thoughts modification and finding alternative, more functional thoughts (for example, the negative thought: "Mum is not answering, something must have happened to her" was replaced by a more adaptive one: "I know she is at work and that she is all right. She probably cannot talk now. I will call her later, as agreed."). The child adopted a new "rule" that he would recall in situations when he would recognise his negative automatic thoughts: "Thoughts are not facts. If I believe that something bad might happen, it does not mean that it will necessarily happen".

Socialising outside the family was encouraged: at first with his best friend, then with a larger group of children (3-4 boys). The frequency and duration of these encounters increased with the reduction of safety behaviour (calls to parents).

Evaluation, problems, obstacles and the results of the treatment

The treatment conducted by a certified CBT therapist lasted for 5 months and comprised a total of 13 sessions, on average 1 session in every 10 days. The obstacles in working with the client consisted in the initial difficulties in establishing cooperation with the child's par-

jednom u deset dana. Poteškoće u radu s klijentom odnosile su se na početnu nešto teže uspostavljenu suradnju s roditeljima, vezanu uz stavove oca kako dječak svojim ponašanjem samo privlači pozornost zbog čega je povremeno gubio strpljenje i pokazivao iritabilnost dok je majka u tim situacijama bila pojačano zaštitničkog stava i time pozitivno (pažnja) i negativno (izbjegavanje neugodnih situacija) potkrepljivala probleme djeteta. Stoga je opetovano provođena psihoedukacija roditelja o KBT modelu anksioznosti i važnosti usklađenosti u odgoju i dosljednosti.

Dječak je dobro napredovao uz pomoć roditelja te uz potkrepljivanja i naglasak na njegovoj snazi i prednosti. Naučio je samoopažanje i prepoznavanje vlastite anksioznosti i brige. Usvojio je tehnike relaksacije te je naučio osvijestiti i preuzeti kontrolu nad svojim fiziološkim reakcijama i mišićnom tenzijom u stresnim situacijama. Također, naučio je identificirati i modificirati NAM, odnosno naći adaptivniji odgovor na negativne projekcije budućnosti. Sigurnosna ponašanja (telefonski pozivi majci i ocu) u potpunosti su prekinuta. Spavanje dječaka u vlastitom krevetu regulirano je već nakon mjesec dana tretmana, a roditelji iskazuju zadovoljstvo jer mogu otići van iz stana te ponovno spavaju zajedno. S obzirom na značajan postignuti napredak, seanse su prorijeđene na jednom u mjesecu. S ciljem smanjenja mogućnosti povrata simptoma stavljen je naglasak na *problem solving* tehniku.

RASPRAVA

Povezanost i privrženost djeteta i odrasle osobe ima vrlo važnu ulogu u psihičkom razvoju svakog pojedinca, no određene poteškoće i poremećaj samog odnosa mogu biti izrazito onesposobljavajući za samu osobu (u ovom slučaju dijete koje će pokazivati teškoće funkcioniranja na raznim životnim poljima), ali i utjecati na sveopće funkcioniranje cjelokupne obitelji.

ents, due to the father's attitude that the child was merely attracting attention, which led to occasional lack of patience and signs of irritability, whereas the mother would show an increasingly protective attitude in those situations and thus positively (attention) and negatively (avoiding unpleasant situations) reinforced the child's issues. Therefore, the psychoeducation of the parents concerning the CBT anxiety level and the importance of harmonised parenting approaches and consistency was repeated.

The child made good progress with the help of his parents and reinforcement, as well as through stressing his strengths and advantages. He learned how to be self-reflective and how to recognise his own anxiety and concerns. He adopted relaxation techniques and learned how to become aware of his physiological reactions and muscle tension in stressful situations and control them. Furthermore, he learned how to identify and modify negative automatic thoughts, i.e. to find a more adaptive response to negative predictions. His safety behaviour (phone calls to the mother and father) has been completely eliminated. Sleeping in his own bed was regulated already after a month of treatment, and the parents were very satisfied that they could leave the apartment and sleep together again. Considering the significant progress made, the sessions now take place once a month. In order to decrease the possibility of relapse, the problem solving technique is being employed.

DISCUSSION

The connection and attachment between a child and adult play a significant role in the psychological development of every individual. However, certain difficulties and relationship disorders can prove exceptionally disabling for the person (in this case, the child that will demonstrate difficulties functioning in different areas) but can also affect the overall functioning of the whole family. Due to the developmental specifics of

Zbog razvojnih specifičnosti djeteta tijekom terapije bilo je važno prilagoditi primijenjene kognitivno-bihevioralne tehnike (npr. progresivna mišićna relaksacija s elementima igre, afektivna edukacija uz biblioterapiju i terapijske lopte, kao i kognitivna restrukturacija za koju su korištene priče, crtani misaoni oblačići ili strip uz pomoć terapeuta), te ih unijeti u svakodnevni život djeteta uz pomoć roditelja. Stavljen je naglasak na nužnost istodobnog terapijskog rada i s djetetom i s roditeljima, korištenja roditelja kao koterapeuta budući da neka roditeljska ponašanja mogu podržavati sigurnosna i izbjegavajuća ponašanja djeteta te da anksioznost roditelja može egzacerbirati djetetovu anksioznost te time dovesti do začaranog kruga. Također, otežavajući faktor u terapijskom radu s dječakom bio je i pozitivan psihijatrijski hereditet kod majke dječaka. Psihopatologija majke s hiperprotektivnim odgojem doprinosila je razvoju i održavanju poremećaja kod dječaka, stoga je bilo važno, a u cilju što boljeg ishoda tretmana, uzeti u obzir što više faktora te pomno isplanirati seanse i način terapijskog rada.

ZAKLJUČAK

Separacijski anksiozni poremećaj čest je u kliničkoj praksi u dječjoj psihijatriji. Stresni životni događaji u predisponiranih pojedinaca u okviru specifične obiteljske dinamike dovode do razvoja poremećaja. Prikazani slučaj potvrđuje nužnost uključivanja roditelja u tretman mlađeg djeteta sa SAP-om te učinkovitost KBT-a kao terapije prvog izbora i kod djece sa značajnije oštećenim obiteljskim i socijalnim funkcioniranjem, što je i u skladu s rezultatima istraživanja (26).

the child, it was important to adapt the behavioural and cognitive techniques applied (for example, combine progressive muscle relaxation with ludic elements, affective education with bibliotherapy and therapy balls, and cognitive restructuring which used stories, thought bubbles or comics with the therapist's assistance) during the treatment and implement them in the child's everyday life with the help of his parents. Emphasis was placed on the necessity of simultaneous therapy work with both the child and parents, using parents as co-therapists, since some parental behaviour may support the child's safety and avoidant behaviour, and the parents' anxiety may exacerbate the child's anxiety, thus creating a vicious circle. Furthermore, an aggravating factor in the child's therapy was his mother's positive history of psychiatric disorders. The mother's psychopathology combined with overprotective parenting contributed to the onset and persistence of the child's disorder. Therefore, in order to achieve the optimal result of the treatment, it was important to take into account as many factors as possible and to carefully plan the sessions and the mode of therapy.

CONCLUSION

Separation anxiety disorder is common both in clinical practice and child psychiatry. Stressful life events in the lives of predisposed individuals within a specific family dynamic lead to the development of the disorder. The present case confirms the necessity of the parents' inclusion in the treatment of a younger child with SAP as well as the efficacy of CBT as the first choice of treatment, even with children with substantially impaired family and social functioning, which also agrees with the study results (26).

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