

Parent-Child Interaction Therapy for Treatment of Separation Anxiety Disorder in Young Children: A Pilot Study

Molly L. Choate, Donna B. Pincus, Sheila M. Eyberg, and David H. Barlow,
Center for Anxiety and Related Disorders, Boston

Research suggests that Parent-Child Interaction therapy (PCIT) works to improve the child's behavior by changing the child-parent interaction. PCIT has been effective in treating disruptive behavior in young children. This article describes a pilot study to apply PCIT to the treatment of separation anxiety disorder (SAD). A multiple-baseline design was used with 3 families with a child between the ages of 4 and 8 who had a principal diagnosis of SAD. Following treatment with PCIT, clinically significant change in separation anxiety was observed on all measures. Disruptive behaviors also decreased following treatment. Treatment gains were maintained at a 3-month follow-up interval. These findings suggest that PCIT may be particularly useful for treatment of young children with SAD, the most prevalent yet underresearched anxiety disorder of childhood. The results of this study support research delineating the important contribution of family factors to anxiety in childhood. Several mechanisms are proposed that may account for the dramatic decrease in separation-anxious behaviors seen in children during PCIT, including increased levels of child control, increased social reinforcement of brave behaviors, improved parent-child attachment, and decreased levels of parent anxiety. Results of this study provide promising initial evidence that PCIT may be efficacious for treating young children with SAD. A randomized clinical trial is warranted to further elucidate the efficacy of PCIT for treatment of SAD in young children.

SEPARATION ANXIETY DISORDER (SAD) is characterized by “developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached” (American Psychiatric Association, 1994, p. 75). Children who experience SAD are significantly distressed by separation from an attachment figure, usually a parent, and seek to avoid separation at all costs. Research suggests that 3.5% to 4.1% of children may develop SAD (Benjamin, Costello, & Warren, 1990; Schniering, Hudson, & Rapee, 2000). Although SAD is relatively common, it can have serious repercussions throughout the child's life. For example, the child, out of fear that negative consequences will occur upon separation from the parent, may refuse to participate in play activities or even to attend school. SAD also affects family life and parental stress because the child's anxiety may limit the activities of siblings and parents (Fischer, Himle, & Thyer, 1999).

Current treatments of SAD primarily focus on cognitive-behavioral methods to treat separation anxiety (Fischer et al., 1999). The treatments generally include elements of exposure in which children gradually face situations in a hierarchical fashion (Albano, Chorpita, & Barlow, 1996; Dadds, Heard, & Rapee, 1991). A list of feared situations is established, and the child practices facing the situations to counteract the avoidance that

often co-occurs with separation fears (Albano et al., 1996). In addition, relaxation training, modeling, coping self-statements, and contingent reinforcement strategies have been used in SAD treatment (Fischer et al., 1999). Available studies suggest that cognitive-behavioral strategies have been effective in reducing separation anxiety, with changes that have been maintained during follow-up periods of up to 2 years (Fischer et al., 1999). Additional studies examining treatment effects of CBT on child anxiety disorders including SAD have found sustained treatment gains at 6 years following treatment (e.g., Barrett, Duffy, Dadds, & Rapee, 2001). Study children have typically been between the ages of 8 and 12, although successful behavioral treatment of a 6-year-old child with SAD has also been reported (Fischer et al., 1999).

The factors that lead to the development of SAD have not been fully identified. Current theories suggest that separation anxiety develops from an interaction of factors that include genetic vulnerabilities to experience anxiety, temperamental and biological vulnerabilities, stressful transition events (like beginning school), insecure attachment relationships, and negative family experiences (Chorpita, 2001; Tonge, 1994). In particular, research has begun to examine the effects of family interactions on childhood anxiety (Barrett, Rapee, Dadds, & Ryan, 1996). Similarly, research on anxiety suggests that early experiences that foster a sense of diminished control over the environment may contribute to a vulnerability to develop anxiety (Chorpita & Barlow, 1998).

Family factors identified as significant contributors to the development of anxiety in children are important

to consider when treating anxiety in children. For example, parental-anxious rearing strategies have been positively related to anxiety symptomatology in nonclinical children (Muris & Merckelbach, 1998). In addition, anxious mothers have been found to be more critical and less granting of autonomy with their children than nonanxious mothers (Whaley, Pinto, & Sigman, 1999). Thus, Whaley et al. suggest that treatment interventions should incorporate a component that targets the interaction between mothers and their children. Treatment studies with anxious children between the ages of 7 and 14 have demonstrated enhanced effectiveness when a parent training component is included in which parents are taught specific skills for helping their anxious children (Cobham, Dadds, & Spence, 1998; Mendlowitz et al., 1999). A parent training component is likely to be even more essential for children under the age of 7, as young children typically spend more time with their parents than older children, who are usually in school and are beginning to spend more time with peers.

Research from developmental psychology also supports an understanding that parent factors may be important to consider in treatment of separation anxiety (Bowlby, 1973; Hoffman, 2000; Rutter, 1980). For example, Reiss et al. (1995) suggest that healthy child adjustment is associated with parental warmth, acceptance, and parental encouragement of psychological autonomy. Difficulties in child adjustment, such as the development of anxiety, are likely associated with low parental warmth and little encouragement of autonomy. This finding is consistent with research on attachment, which has consistently shown that children with early insecure attachment relations are significantly more likely to develop psychopathology, including both emotional and behavior problems (Foote, Eyberg, & Schuhmann, 1998; Warren, Huston, Egeland, & Sroufe, 1997). Similarly, research on anxiety suggests that early experiences that foster a sense of diminished control over the environment may contribute to a vulnerability to develop anxiety (Chorpita & Barlow, 1998). As described, current anxiety treatments for SAD do not specifically address the interaction between parents and their children. A treatment that addresses the parent-child attachment and fosters a sense of control in the child may be beneficial in targeting early forms of separation anxiety.

Young children with SAD may display disruptive, oppositional behaviors in addition to the avoidance behaviors that can cause significant interference in child and family functioning and in normal social development (Tonge, 1994). For example, children may refuse to sleep in their own rooms, refuse to attend school, may tantrum when presented with situations that might involve separation, and may outright refuse to comply with parents' commands. While some parents report that their chil-

dren display comorbid oppositional behaviors, other parents state that their children are in fact very compliant except for when situations involving separation arise. Comorbid SAD and oppositional behavior may arise due to parents inadvertently reinforcing children's misbehavior (in the case of oppositional behavior) or to parents inadvertently reinforcing children's avoidance (in the case of SAD). In addition, a high frequency of aversive parent-child interactions may be at the root of both disorders. A treatment for SAD in early childhood that specifically targets parents by instructing them in ways to reduce negative parent-child interactions would likely be helpful in also reducing children's oppositional behaviors.

Parent-child interaction therapy (PCIT; Eyberg, 1988) is a treatment approach that integrates traditional and behavioral techniques in the treatment of behavior problems in young children. PCIT has two equally important components: child-directed and parent-directed interactions (Hembree-Kigin & McNeil, 1995; Herschell, Calzada, Eyberg, & McNeil, 2002). PCIT is based on the assumption that improving parent-child interactions results in improvement in child and family functioning (Foote et al., 1998). Research has demonstrated the effectiveness of PCIT for treating disruptive behavior in young children (Nixon, Sweeney, Erickson, & Touyz, 2003; Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). In addition, PCIT directly targets the parents' overcontrolling behavior, which has been identified as an important factor in anxiety development (Chorpita, Brown, & Barlow, 1998).

As PCIT addresses the parent-child interaction, it may also be effective in treating separation anxiety behaviors in young children. Some evidence suggests that the parent's reaction to the child's anxiety serves to maintain SAD (Thyer, Himle, & Fischer, 1993). Positive and negative reinforcement patterns surrounding the child's distress at separation may reinforce or escalate fears. PCIT teaches the parent how to change those reinforcement contingencies. Similarly, the improved attachment following PCIT (Neary, Harwood, Bell, Adams, & Eyberg, 2002) may help the child to be more secure when away from the parent and thus able to separate without distress. The child-directed interaction component of PCIT focuses on allowing the child to lead the interaction, which may foster a sense of control within the child, thus reducing separation anxiety. The parent-directed interaction component of PCIT also allows the child to have some control in the interaction, as a child can prevent a time-out by choosing to obey the parent's command or rule. Application of PCIT with young children may prevent further development of more severe anxiety as children become older.

This article describes a pilot study designed to examine the effects of PCIT with children presenting for treat-

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