Child Case Study

Summer Sievert

Regis College

Child Case Study

This paper presents the case study for Katy, a six-year-old girl of a middle-class family living in a suburban northwest city. The introductory paragraph provides patient information that is imperative in comprehending the girl’s condition.

**Patient history**

Katy’s delivery was normal even though she suffered colic the first three months that made her cry extensively. After three months, she became passive and cried very little with comfort from her mother. She developed normally and achieved all developmental milestones during her first three years. Her interaction with the parents and sister was normal but she would get anxious and tearful whenever her parents would get a babysitter. At the age of four, she was in nursery school and appeared to function normally except during the first month when her father dropped her off at school. Although she was shy, she made friends, adjusted and enjoyed going to the nursery school. When her mother became sick and and was unable to work, private school tuition became a problem and Katy was enrolled in her first grade at the public elementary institution in their neighborhood. For the past two weeks, she has refused to go to school and has missed six school days.

**Presenting Conditions**

 She is awake all night worrying about going to school. As the school day approaches, she cries and screams that she cannot go, chews holes in her shirt, pulls her hair, digs at her face, punches the wall, throws herself on the floor, as well as experiences headaches, stomachaches, and vomiting. Over the past two weeks, she is gloomy, has stopped reading for fun, and regularly worries about her mother's lupus and that she may die. Additionally, Katy is phobic to dogs, avoids speaking and writing in public, and wets the bed every night.

With regard to family history**,** her father has a history of treatment with medications for ADHD as a child, the mother has a history of panic disorder, and she has a cousin diagnosed with Asperger's syndrome. The objective findingsgathered byher primary care provider thorough physical exam found no signs of physical abnormalities and referred her to a psychiatric-mental health nurse practitioner (PMHNP).

**Provisional Diagnosis As well As the Possible Differentials for Katy’s Condition**

 **Provisional Diagnosis**

Based on my assessment as the PMHNP, Katy looks anxious, and anxiety is a usual part of children's conduct and emotional growth. A child can worry about starting school and wetting her bed, which are signs that a child's development is on track. The types of anxieties that can be experienced include school phobia, shyness, phobias, and separation anxiety. The increased anxiety and worry are the provisional diagnosis for separation anxiety disorder and school refusal, which demands confirmation with additional evaluation.

**Differential Diagnosis**

Various possible conditions mimic Katy’s presenting condition, including phobias, generalized anxiety disorder, social phobia and selective mutism, panic disorder, and separation anxiety disorder and school refusal, oppositional defiant disorder, and posttraumatic stress disorder. Undertaking a differential diagnosis is imperative in order to eliminate the least possible causes for Katy’s condition. A panic disorder would present with high anticipatory anxiety across different social situations and a recurrent, unanticipated pain attack in the absence of phobia. Persons suffering from panic attacks can interpret their increased physical symptoms as dangerous or threatening. Phobias present with an unrealistic or excessive fear of specific situations or objects, rather than fears of being negatively analyzed or embarrassed. Anxiety is cued by actual or anticipated exposure to the phobic stimuli. Generalized anxiety disorder is more diffuse in nature, marked by pervasive worry across domains such as school, relationships, and health (Scheeringa & Burns, 2018). In GAD, social events or fears of negative evaluation anxiety would not particularly be cue anxiety.

Separation anxiety disorder refers to the sensations of anxiety cued by discerned and actual separation from family members, rather than fears of criticism or negative evaluation by others. Oppositional defiant disorder would present with repetitive pattern vindictiveness, argumentative conduct or of irritable/angry mood lasting at least six months. Social phobia and selective mutism refers to a disorder in which a child is unable to speak aloud in particular conditions when there is an expectation of conversational speech. Posttraumatic stress disorder would present with obtrusive thoughts linked to a traumatic outcome, tenacious automatic memories, distressing dreams, and negative psychological response to traumatic triggers. Katy would also present with recklessness, increased vigilance for possible harms, increased reactivity, or self-harming actions.

Based on the history and presenting conditions, the differential diagnosis presents separation anxiety disorder (SAD) as the most likely cause of illness for Katy. According to Cooper-Vince, Emmert-Aronson, Pincus, and Comer (2014), anxiety disorder has a higher rate of occurrence in childhood and SAD is among the commonly diagnosed anxiety disorders in preadolescent children. SAD is a usual developmental event from about the age of 10 months to early preschool years. The condition often involves persistent issues with attending a school or other activities away from home because of fear of segregation. SAD elicits excessive and persistent anxiety exceeding that anticipated for the child’s developmental level related to segregation or imminent segregation from the attachment figure. The fear linked to separation may escalate into panic attacks or tantrums and lead to notable academic interference, emotional, and social development.

**Rationale of the Answer with DSM-5 Criteria**

DSM defines SAD as developmentally ill-suited and excessive anxiety regarding segregation from the attachment figure. The DSM-5 criteria refers to excessive anxiety linked to segregation as shown in the table below:

|  |
| --- |
| 1. “Repetitive immoderate distress when encountering or anticipating separation from home or from major attachment”
2. “Tenacious and immoderate worry about losing major attachment figures or about potential harm to them, such as illness”
3. “Tenacious and immoderate worry about encountering an event that causes separation from a major attachment figure”
4. “Tenacious refusal or reluctance to go out, away from home, to school or elsewhere because of fear of separation”
5. “Tenacious and immoderate worry fear of or reluctance about being alone or without major attachment figures at home or in other settings”
6. “Tenacious refusal or reluctance to sleep away from home or to go to sleep without being near a major attachment figure”
7. “Repeated nightmares involving the theme of separation”
8. “Repeated complaints or physical symptoms of vomiting, nausea, stomachaches, and headaches when separated from major attachment figures occurs or is anticipated”

(American Psychiatric Association, 2013) |

A child is considered to have SAD if he or she presents with any 3 of the 8 designated symptoms of SAD (Cooper-Vince et al., 2014). The rationale for diagnosing SAD is because Katy presents with four symptoms that meet the SAD diagnostic criteria listed below.

* Recurrent excessive distress when separated from major attachment figures occurs or is anticipated
* Persistent and excessive worry about losing her major attachments
* Persistent reluctance or refusal to go to school because of fear of separation
* Repeated complaints of physical symptoms (vomiting, stomach aches, and headaches) following separation from major attachment figures

(American Psychiatric Association, 2013)

**Is Katy Too Young To Diagnose or Is There a Basis for Early Identification and Intervention**

Anxiety disorders are usual, wearing, and start early in life, which makes prompt intercession imperative in at-risk children (Morgan, Rapee, & Bayer, 2016). Given the early onset and link with notable impediments, there is a precise rationale for early intercession with at-risk children. Katy is at risk of mental conditions because of genetic influences. Katy is not too young to diagnose because the mean age for SAD mainly manifests in preschool children around her age. A precise risk element in early childhood is temperamental inhibition, which has a firm genetic basis and refers to withdrawal and fearfulness in reaction to novel stimuli (Morgan et al., 2016). Preventive intercession for preschoolers is worthwhile given their possibility of modifying trajectories towards anxiety prior to the onset of impairment, distress, and secondary impediments. With parent involvement, preventive intercession drives parents away from maladaptive parenting outlooks and conducts that can increase a child's anxiety.

**Psychiatric Scales or Assessment Tools I Might Use With This Patient**

There are many diagnostic tools that assess anxiety among children but not all are applicable for Katy who is 6-years-old, for example, Children separation assessment scale (CSAS), which only applies for children above the age eight. In addition, structured parent interviews such as the preschool age psychiatric assessment (PAPA) would not meet the criteria because the design diagnoses psychiatric issues I children aged two to five years. As the managing PMHNP, the psychometric assessment tools that I would utilize for this age include Anxiety disorders interview schedule for children (ADIS-C) and diagnostic interview schedule for children (DISC). The diagnostic scale may include and screen for child anxiety-related emotional disorder (SACRED). ADIS-IV-C is a diagnostic interview that assesses anxiety disorder among children and adolescents. This parent and child interview schedule comprise composite sections for evaluating the patterns and functions of school refusal conduct, a grievous conduct impediment that mainly accompanies anxiety disorder. The model is appropriate because it evaluates DSM-IV pervasive developmental disorders, externalizing, mood, and anxiety and applies to children between the age of 6 and seventeen years.

SACRED is a parent and child self-account instrument that I would utilize to screen for childhood anxiety disorders including social phobia, panic disorder, SAD, and general anxiety disorder. This instrument assesses symptoms related to school phobia and consists of forty-one items and five elements that parallel the DSM-5 grouping of anxiety disorders. The parent and child SACRED versions would provide moderate parent-child accord and good internal consistency, discriminant validity, and test-retest reliability. The DISC-IV is a parent-child tool that covers 36 mental health events for children and youths, utilizing DSM-IV criteria and the tool would help assess Katy’s anxiety comprehensively. Another diagnostic interview that I would schedule is the kiddie schedule of affective disorders and schizophrenia for school-age children, present and lifetime version (K-SADS-PL), which is designed to evaluate all Axis I diagnosis, except pervasive developmental issues in children six to eighteen years of age. Psychopathology scales ASEBA and state-trait anxiety inventory for children (STAIC) have reasonable reliability and validity and would help evaluate SAD. The psychiatric evaluation would focus on evaluating the three critical classes of anxiety symptoms, including physical symptoms, thoughts, and behaviors.

**How the Typical Symptom Patterns and Phases Manifest in Children and in Adolescents**

As infants develop, their responses and reactions to the surrounding happen in an anticipated order. Before the age of eight months, infants are too new to the environment around them that they lack comprehension of what is safe and normal and what may become harmful. As a result, new people or change in the setting do not frighten them nor affect their emotional being. However, as they grow older, children frequently become frightened when they change settings or meet new persons. They examine their parents as safe and familiar, and feel unsafe and threatened whenever separated. It was normal for Katy to encounter this problem up to around the age of two years, but her conditions persisted and developed into SAD and resulted in her issues going to school. However, the occurrence of this fear from the age of six years in excessive and lasting longer indicated possible SAD. SAD is not a usual development stage by a grievous emotional problem marked by extreme distress when a child is separated from a primary caregiver or trusted persons. The key differences between ordinary separation anxiety and SAD are the intensity of the fear as well as whether the worries restrict the child from undertaking normal activities. The usual causes of SAD include insecure attachment, over-protective parent, stress, and change in the environment.

The patterns for SAD symptoms involve thoughts, physical feelings, emotions, and behaviors and broadly group into clinginess, separation, and sleep. The typical symptom for SAD includes repeated temper tantrums or pleading, complaints of physical symptoms of stomachaches and headaches o school days, bed wetting, nightmares about being separated, fear of being alone, refusal of going to sleep alone or away from home, and refusal of attending school in order to stay with a caregiver. Additionally, SAD symptoms present with unrealistic and lasting worry that something bad might occur if she leaves the caregiver as well as the unrealistic and lasting worry that something bad will occur to the parent if she leaves. Although SAD is more usual in elementary-school-aged children, adolescents may encounter anxiety when adjusting to a stressful event, such as loss of a parent.

These teenagers may present with behavioral symptoms such as not being able to utilize public transport alone, go to school trips unless a parent accompanies them, stay at school if a trusted person is not around, or go for sleepovers with friends they know well. Among adolescents, symptoms may vary from one person to the other and generally include a tendency to be excessively vigilant and wary, feelings of inner restlessness, and excessive fears and worries. In a social setting, an anxious adolescent may appear uneasy, withdrawn, or dependent and may seem either overly emotional or overly restrained. Adolescents who suffer excessive anxiety encounter a range of physical symptoms including stomachaches, or muscle cramps and tension. They may also startle, tremble, hyperventilate, sweat, flush, and blotch easily. These teenagers may avoid common actions, refuse to take part in new encounters, or protest whenever they separate from trusted persons.

**Treatment Plan for Medications**

The strategy for managing SAD involves cognitive-behavioral therapies, family therapy, and play therapy. However, drug therapy is also imperative in managing severe SAD, employed along with other therapies in a complementary way when the level of functional impairment is moderate to severe. Worth a note, pharmacotherapy intercession would take place in addition to psychotherapeutic intervention. This would help avert further loss of function and enable or hasten productive outcomes of behavioral intercessions. The category of drugs I would prescribe for Katy is a selective serotonin reuptake inhibitors (SSRIs), which has shown efficiency in managing anxiety issues among adolescents and children (Patel, Feucht, Brown, & Ramsay, 2018). Not all forms of SSRIs can apply for Katy because of age considerations. However, SSRIs such as venlafaxine and sertraline (Patel et al., 2018) can help manage her anxiety and boost normal health.

Sertraline is an antidepressant formulation that affects brain chemicals that may be unbalanced in persons with anxiety issues. The prescription would begin with a low dose and be titrated weekly while monitoring the clinical reactions and potential side effects. Essential information I would note is that some children have suicidal thoughts when first taking an antidepressant, which would demand staying alert to changes in Katy’s mood or symptoms. This would require immediate medical attention if symptoms of serotonin syndrome present, such as diarrhea, loss of coordination, twitching, muscle stiffness, dry mouth, increased heart rate, shivering, sweating, fever, hallucination, or agitation appeared (Hussain, Dobson, & Strawn, 2016). To guarantee safe prescription of this medication, I would assess for bipolar, low levels of sodium, or a seizure because some drugs can interact with sertraline to cause a grievous condition referred to as serotonin syndrome. Education on the side effects of this medication is imperative because sertraline use would require Katy's caregiver to report any worsening or new symptom, including convulsions, racing thoughts, unusual risky conduct, hyperactivity, being irritated, extreme happiness, headaches, feeling unsteady, severe weakness, memory issues, and blurred or tunnel vision. The usual side effects of this medication include insomnia, tremors, stomach upset, sweating, anorexia, and drowsiness (Patel et al., 2018).

SSRI like sertraline are efficacious and present with a minimal side effect, which make the formulation the first line therapeutics for SAD and other anxiety disorder. The SSRI would act by restoring the chemical stability of neurotransmitters in Katy’s imbalance.

**School-Based Treatment Plan for SAD**

Schools are a key setting for giving psychiatrist services to children and they provide relatively inexpensive and convenient services, thus addressing challenges to accessing special care such as transportation and expense. One school-based treatment plan I would examine is the cool kids’ program which is an 8 sitting cognitive-behavioral intercession for symptoms of anxiety in children, adapted for the setting from previous group therapies (Hudson et al., 2015). This is a group therapy initiative aimed at educating children on how to manage anxiety issues. Children and parents both attend therapists-bed sittings and are exposed to cognitive behavioral procedures for dealing with anxiety. The sessions center in cognitive behavioral treatment (CBT) elements, including graduated exposure and reaction prevention, modeling, ameliorating problem-solving mastery, cognitive restructuring, and psycho-education. Exposure and reaction prevention are key components of CBT and would help Katy pinpoint the top anxiety-provoking events. This would act as an elementary description of the symptoms and will later help to measure the treatment progress.

Addressing and working on social skills, coping with teasing, child management approaches, exposure to feared cues, recognition of anxiety and emotions, realistic thinking, and assertiveness is instrumental. The families would also get guides, summaries, and worksheets for practicing techniques at home between sessions. CBT is the primary kind of psychotherapy advocated for SAD treatment. CBT techniques would focus on the child’s thought habits that lead her to anxiousness. A cognitive therapist would aid the child to become aware of and to define her beliefs and thoughts to see if they make logical sense. Through this technique, Katy can learn how to examine her anxious feelings as well as the physical responses to anxious thoughts. She can learn to pinpoint triggers and the thought patterns that donate to her anxious feelings and through a variety of procedures, she can learn approaches to manage her anxious thoughts and feelings and subsist with her emotions.

At schools, teachers can give extra time for transitioning to dissimilar actions, reward children strives, stimulate small group interactions, give alternative actions to distract the child from physical symptoms, and stimulate practicing of relaxation strategies established at home. Teachers can also pinpoint safe places where the child can go to lower anxiety during spikes, enable a shorter school day and lengthen it gradually, enable an attachment figure to initially accompany the child, and supervise the child's arrival to school, preferably the same person every time. Teachers may also assess the cause of child's school refusal and address it, initiate a scheme to stimulate the child's return to school and preserve regular meeting with parents to enable partnership in approaches to aid the normalize schooling.

**Implications for the Families of Children and Adolescents with SAD**

Family plays an essential role in SAD and child anxiety has a notable, distinct impact on family functioning, specifically parental adjustment. Having a child with mental event negatively affect family functioning in many ways, including lowered parental adjustment, impaired restricted actions and social interactions, strained family relationship, added costs and loss of income, and increased concerns and worries about a child. Discerned family influence of a child’s condition is a crucial index of impairment because of the rooted characteristic of children’s conduct within the family surrounding. Family is an essential setting in which impairments are evident, and caregivers can change the surrounding to minimize the effects of SAD. For example, the family may limit exposure-provoking elements or alter routines to lower the child's distress.

Because parents can unintentionally brace anxiety when they are comforting an anxious child, management should involve parent training on how to react to anxiety. As a PMHNP, I would advocate contingency management, which a method of reinforcing brave conduct by rewarding children for attaining their management goals. Family therapy can provide useful skills to assist the child when anxiety spikes. Approaches that parents can utilize to help children learn to manage anxiety include empathizing with a child and comment on progress achieved, alert a child to changes in routine ahead of time, and writing daily lunchbox notes that include positive phrases. In addition, families can avoid overscheduling by focusing on healthy sleep habits, downtime, and playtime, make plans to aid a child transition to school in the morning, and assist their child to reframe anxious thoughts by developing a list of positive thoughts.

Behavioral management is imperative and helps families and loved ones how to manage maladaptive attitudes and mild symptoms such as cognitive biases or avoidant conducts. Behavioral management provides children with supportive and flexible surrounding to overcome their symptoms of separation anxiety. Therefore, one of the recommendations I as the PMHNP would include is supporting the child’s early return to school and help the child to organize a list of potential strategies in case anxiety occurs, such as preparing to bed at night or getting to school in the morning and listening to the child’s feelings. Families should keep calm when the child becomes anxious and reiterate coping skills. Training relaxation strategies such as visualizing a relaxing scene, counting to ten, deep breathing gives a sense of control over their body.

Parent-child interaction therapy is imperative for children aged four to eight years with SAD and the model has three stages including child-directed interaction, bravery-directed interaction, and parent-directed interaction. The parent-directed interaction would teach parents how to manage the child's conduct based on the operant concept of conduct, such as negative repercussions and consistent positive. In addition, parents learn not to brace the child’s anxious conduct, for instance, not giving the child more attention when she skips school. To enhance bravery-directed interaction, I would work with the child and the parent to establish a list of events the child is currently avoiding or fearful of, in order gravity. The family would establish a reward list to brace the child’s strives. The child-directed interaction would teach the parents to be praiseful and warm, to boost the girl’s feeling of certainty in order to enable segregation from the parent.

**How The Mother’s Health Play Into the Picture of Katy’s Diagnosis**

The mother’s condition plays a critical role in the image of Katy’s diagnosis. Lupus is a chronic autoimmune disorder in which the body network becomes hyperactive and attacks normal, healthy cells. Lupus results in increased hospitalizations, emergency visits, and ambulatory visits which can cause more worries for Katy (Chang, Mandell, & Knight, 2018). One of the fears expressed by Katy is that of losing her sick mother who no longer has the capacity to participate in financial obligations of the family. The presumption to this that the condition is in the advanced level and Katy can recognize the extent of the illness. Being one of the triggers for Katy’s SAD, putting the mother's health into the picture is imperative in easing the anxious feeling of losing the parent, exhibited by Katy. Talking to Katy about the possible outcomes of her mother's illness can help reduce anxiety and should be precise to avoid confusion.

**Resources for Patients/Families with SAD in the Form of Community Groups, Web Sites, Advocacy, As Well As Treatment Resources Available In Your Service Area**

There are various resources application for Katy's diagnosis, for example, support groups. Support groups would provide openings where the patient and families come together to share their encounters and live in a manner that aid reduced loneliness and isolation. Support groups are open for people and finding the right support group can be helpful. Websites such as the Anxiety and Depression Association of America (ADAA), which is a nonprofit membership organization with experts in coaching, training, and research for anxiety and depression related events. ADAA is an imperative online resource that can provide current management, research information, and access to free supplies and support. Resources in the community include programs and initiative developed to help and support parents of children SAD, for example, the camp-like CBT and the friend's program.

**Worries about This Case**

My worry to Katy's management is the uptake capacity for the recommended intervention. Her mother is sick and unable to contribute to the needed family demands and financial obligations. With this in mind, providing adequate services for Katy and her mother can cause a financial burden to the healthcare access for both of them. This can impede follow up as well as optimum care, which is imperative to patient recovery. Limited income can also cause health disparities impeding treatment compliance for Katy's SAD. Unfortunately, inadequate management of SAD in childhood can lead to further disorders including panic disorder, major depressive disorder, obsessive-compulsive disorder, and other anxiety disorders. The occurrence of the two conditions can also overwhelm the family's emotional status making it hard to intervene to Katy's condition appropriately. This may deny Katy a suitable family setting that boosts understanding and recovery from an anxiety disorder.

Reference List

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Chang, J. C., Mandell, D. S., & Knight, A. M. (2018). High health care utilization preceding diagnosis of systemic lupus erythematosus in youth. *Arthritis care & research*, *70*(9), 1303-1311.

Cooper-Vince, C. E., Emmert-Aronson, B. O., Pincus, D. B., & Comer, J. S. (2014). The diagnostic utility of separation anxiety disorder symptoms: An item response theory analysis. *Journal of abnormal child psychology*, *42*(3), 417-428.

Hudson, J. L., Rapee, R. M., Lyneham, H. J., McLellan, L. F., Wuthrich, V. M., & Schniering, C. A. (2015). Comparing outcomes for children with different anxiety disorders following cognitive behavioural therapy. *Behaviour Research and Therapy*, *72*, 30-37.

Hussain, F. S., Dobson, E. T., & Strawn, J. R. (2016). Pharmacologic treatment of pediatric anxiety disorders. *Current treatment options in psychiatry*, *3*(2), 151-160.

Morgan, A. J., Rapee, R. M., & Bayer, J. K. (2016). Prevention and early intervention of anxiety problems in young children: A pilot evaluation of Cool Little Kids Online. *Internet Interventions*, *4*, 105-112.

Patel, D. R., Feucht, C., Brown, K., & Ramsay, J. (2018). Pharmacological treatment of anxiety disorders in children and adolescents: a review for practitioners. *Translational pediatrics*, *7*(1), 23.

Scheeringa, M. S., & Burns, L. C. (2018). Generalized Anxiety Disorder in Very Young Children: First Case Reports on Stability and Developmental Considerations. *Case reports in psychiatry*, *2018*.