Under the guidance of Professor Moosang Kim, Leonard (Do-Sung) Kim's Presentations on Separation Anxiety as a Distinct Mental Disorder (Separation Anxiety Disorder or SAD) and as a Salubriously Developmental Term in Non-Clinical setting of Psychology

The presenter's preamble: I believe a good presentation strives to serve as a 'catalyst' for spirited class discussions. I also believe that a good presentation should **not** be boring or pedantic, and it should be readily available to the entire class of our LAW 032 course. **It should be moderate fun (but not excessively entertaining) without losing its seriousness of purpose and authenticity & accuracy of the contents.** I endeavored to serve all these ends in my presentations so **originally did make no hand-outs** to be given away in class **with some apprehension that such hand-outs could potently distract my audience, who are my LAW 032 classmates, from the presenter**, *important me*!! ----My past experiences at the University of Chicago actually tell that whenever I distributed hand-out(s) in class prior to my presentation, I **would frequently find with a bit frustration that no one was actually paying attention to** *important me, the presenter* **whereas everybody was just looking at my hand-outs with their head deep down and eyes set to them!**

Anyway, Professor Kim has recently made a piece of enlightening advice for me about the rationale for preparing hand-outs for the audience (the classmates) at each and every presentation I will deliver in the future. I was impressed and soon enamored of his strategies to make an ordinary presentation to an outstanding one with a bunch of handouts; the following is my hand-outs for the Part I, II, and III of my presentation on the subject. I would like to ask you to please give attention to *important me* and *my presentation* even though there are hand-out(s) in your hands all the time

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SYNOPSIS

The Part I

The term, *separation anxiety disorder* (SAD) is a medical term technically used in those fields such as clinical psychiatry and clinical psychology in order to diagnose and treat this disorder found among children and adolescence. Simultaneously, the terminology is also employed in non-clinical sector including developmental psychology. Recognizing such twofold (clinical vs. non-clinical) meanings of SA (D), my presentation first concentrated on the clinical side and then explored the definition, clinical signs and symptoms of SAD.

The Part II

In this part II, I explained about the associated features of SAD, the vivid characterization of SAD in DSM-III-R, and traced down the epidemiology and etiology

of SAD. We furthered our knowledge by discovering familial patterns, biological vulnerabilities, and genetic predisposition to SAD, and the course and prognosis of SAD. Finally, I briefly touched upon a multimodal and comprehensive treatment regimen.

The Part III

Throughout the part I and II, we have briefly gone over the cases in which separation anxiety become severe enough to be a disorder and now need to know about non-clinical side of separation anxiety. While the definitions of developmental psychology and child psychology are sought, differences and similarities between them were illustrated. Both of the disciplines reflect the view that human development and behavior throughout the life span is a function of interaction between biologically determined factors such as height or temperament, and environmental influences including family, schooling, and culture. In addition, Freud's developmental theory, personality formation and SAD, social relations and socialization of a child and separation anxiety are also investigated.

Hello, how are you everyone? Today, I would like to talk about separation anxiety with brevity, and I am quite glad, in fact, that today's topic and related psychological issues have some bearings on me in two ways; First, because I have once studied Freudian psychology and psychobiology a little bit in the University of Chicago and second,

because my uncle is a psychiatrist practicing in Cleveland, Ohio. Nevertheless, I have to tell you that I am certainly not knowledgeable enough to counsel you through psychoanalytic /dynamic methods or hypnotize... but anyways...

While preparing for this presentation, I have increasingly realized how gigantic the scope of this topic really is-- and the word, the term "separation anxiety" is a medical term technically used in clinical psychiatry and clinical psychology to define/diagnose, and characterize/treat a specific psychiatric disorder found among children and adolescence. At the same time, the terminology is also employed in the non-medical sector such as psychoanalysis, developmental psychology, child psychology and even educational and social psychologies. Recognizing this twofold, dual meanings, I will speak to you about separation anxiety as a medical term, first and then move onto address the non-medical, developmental usage of the term, which is perhaps in a far broader utilization.

The Definition, Clinical Signs and Symptoms

Characteristically associated with childhood and adolescence,

Separation Anxiety Disorder (SAD) is a clearly excessive and (pathologically) intense reaction to the specter of being separated from one's major attachment figures such as his/her parents or primary caregivers. Those attachments, so integral to the child's personal identity, emerge in the early months of life, at a time of rapid learning and unfolding of core gender identity, self-regard, and body image. ('Attachments' here mean relationships in time and space such that disruptions of the relationship are also ruptures of familiar surroundings and things---and familiar persons who rank below the mother, for instance, in a child's hierarchy of interrelatedness with significant others.) Since separation anxiety is a matter for easy and plausible conjecture and especially in early childhood, psychologists consider some degree of separation anxiety a normal phenomenon, a normal part of the development of a child. It usually begins when the child is 8 or 9 months old, peaks at about 14 months, and then gradually subsides. The onset of separation anxiety coincides with the child development of *object permanence,* the ability to understand that people and objects still exist even when they disappear from view.

When separation anxiety continues well into childhood or appears later in childhood or adolescence, psychiatrists may diagnose SAD. Such diagnosis as always requires a therapist's keen clinical judgment which must be employed in distinguishing the healthy from the pathological

The essential and predominant clinical feature of this disorder is excessive anxiety, worsening at times to the point of panic and the reaction-such panicky one is beyond that (simple crying) expected for the child's developmental level. Anxiety associated with this disorder is focused on specific situations (such as going to school away from home) other than generalized to a variety of situations. When separated from significant others to whom they are attached, the children with SAD are often preoccupied with morbid fears that accidents or illness will befall those to whom they are closely attached or even themselves. The exact nature of the fantasized mishaps varies but in general, younger children have less specific, more amorphous concerns. As the children become older, the fears may become systemized around identifiable potential dangers. Many children, even some older ones, are very reluctant to and ashamed of reporting fears of definite threats, but only pervasive anxiety

about ill-defined dangers or death. Children also typically exhibit anticipatory anxiety when separation is threatened or impending as research indicates.

It seems to be no doubt that the SAD children are uncomfortable when they travel independently away from the house, or from other familiar areas. No surprise, they may refuse to visit or sleep at friends' homes, to go on errands, or to attend camp or even school. This disorder can be especially incapacitating and sickening in not so uncommon cases of the children who cannot help but refusing to attend school because of their severe SAD symptoms. It also profoundly impairs the abilities of the child and his/her family in that the child patient is unable to function independently in a usual variety of basic areas (sleep in his own room other than his parents'), not to speak of becoming a "school refuser." And when school refusal/truancy occurs, common complications are social avoidance and academic difficulties. Nonetheless, it should be noted here that not all cases of school refusals are due to separation anxiety; in such cases, usually in adolescence, he/she actually fears the school situation because of anxiety about social or academic

performance, regardless of a parental accompaniment. Children with SAD may be unable to stay in a room by themselves, and may display “clinging” behavior, staying close to the parent, “shadowing” the parent around the house.

Hello, hi, how are you again? I am delightful to give the part II of my presentation on Separation Anxiety and its Disorder; let me recapitulate that last time in part I, there exist clinical and non-clinical usages for the term, SAD; my realization of such dual usages made me map out and organize my presentation in a binary manner. I spoke to you about separation anxiety as a distinct psychiatric disorder (SAD) and its clinical signs, symptoms, and features peculiar to SAD; such peculiar and unique features of SAD quite clearly distinguish it from other mental illnesses characteristically associated with childhood and adolescence. Today, we are going to discover what needed to be discovered two weeks ago. They are the associated features of SAD, and epidemiology, etiology, and biological variables of this disorder. We then move onto course and prognosis, and treatment of SAD

As for **associated features**, depression co-exists in over half of some series of clinical trials studied closely, and overanxious or generalized anxiety disorder is often present concurrently. In particular, panic disorder, often glibly said to arise only in adult life, may appear in cases of SAD during childhood, attended by either limited or extensive phobic avoidance. More specifically, children with this disorder often have fears of animals, monsters, and situations that are perceived as presenting danger to the integrity of the family or themselves. Furthermore, their version of fear is almost always likely to be exaggerated- exaggerated fears of muggers, traffic accidents, dying and death. Also common is the fearing of the dark, and some children have fixed fears that may appear bizarre-for example, they may report that bloody creatures are reaching for them.

When not with a major attachment figure, children with this disorder may exhibit recurrent instances of social withdrawal, apathy, sadness, or difficulty concentrating on studying, etc.

Children with this disorder are often described as demanding, intrusive, and in need of constant attention. Others are described as

unusually conscientious, compliant, and eager to please. When no demands for separation are made, children with SAD typically have no interpersonal difficulties and generally feel comfortable. Paradoxically, fear or anxiety in early childhood enhances attachment formations, but secure attachments, once formed, ward off feelings of fear and insecurity regarding subsequent losses and partings.

DSM-III-R (Diagnostic and Statistical Manual for Mental Disorders, published by American Psychiatric Association), the most authentic and up-to-date reference manual of its kind in the world, vividly characterizes the child with SAD. Most empirical studies of SAD have been done with school refusers/ truants though not all of them show the prototypical form of SAD.

Epidemiology: the study of the incidence and distribution of illness

Although feeling separation anxiety (not the disorder here) is nearly universal among children aged 9 to 36 months, it is a normal development sequence that tends to cement a child's attachments to reliable caregiving adults. By the age of 4, the child usually possesses language, helping the child to bind fluid time and space and to become

less independent on physical proximity to the now-proven-reliable attachment figures. Emotional attachments become, by age 4, both more intense and more axiomatic (self-evident) ---normally not an issue of great preoccupation. Hence, SAD is a condition enduring two weeks or more, usually in a child more than 3 years old, in which the anxiety, the contents of anxiety are unrealistic and excessive, which are very unlike normal children's "developmental" separation anxiety before the child has naturally attained an age of 3. So, developmental SA (non-clinical) and SAD (clinical) differ from each other not only in degree of anxiety but also in characteristics.

SAD may account for as many as 5 % of the all cases seen at general-purpose child and adolescent psychiatry clinic and probably has a lower than 2% prevalence in the general population. Treated cases are fairly evenly distributed among boys and girls.

Etiology: the causation of diseases and disorders as a subject of investigation

Its etiology is not clearly known although the rapidly growing knowledge of neuroscience continues to search for an answer; Freudian

ego psychologists have postulated a specific developmental stage, between 12 and 36 months, in which normal separation anxiety may become constellated, through fixation and regression, into a SAD. Clinically studied cases exhibit a mixture of emotions, cognitions, and behaviors that are redolent of ambivalent fits, starts, and regressions. The clung-to parent often testifies that the clinging child carries an oppressive, hostile-dependent aura, along with fear and trembling. The parents also attest that the child with SAD actually is short on trusting dependency but long on mistrust, suspicion, doubt, rage, vindictiveness and desire to enslave them.

Pointing to the high frequency of (severe) SAD during childhood as recorded on the histories of adult depressives, some researchers ask whether or not SAD is only an early manifestation of depression or a remote prodrome of later depression. They also inquire whether it is a freestanding disorder or a precursor form of panic disorder.

Familial pattern: biological vulnerabilities of and genetic predisposition to SAD

The disorder is apparently more common in first-degree biological

relatives than in the general population, and may be more frequent in children of mothers with panic disorder. Regarding predisposing factors, no specific premorbid personality disturbance is associated with SAD. In most cases, the disorder develops after some life stress, typically a loss, the death of a relative or pet, an illness of the child or a relative, or a change in the child's environment, such as a school change or a move to a new neighborhood.

Course and Prognosis

Typically, there are intervals of exacerbation and remission over a period of several years. In some cases both the anxiety about possible separation and the avoidance of situations involving separation (e.g., going away to boarding school) persist for many years. Prophylactically, perhaps the most cases in children of 6 years or younger are not treated in psychiatric facilities and undergo a spontaneous remission, though with unknown results. Hence, the prognosis, without treatment other than that directed by helpful parents and teachers, is favorable for young child's acute symptoms; young and acute cases also carry a highly favorable prognosis when psychiatric treatment is given alongside. Cases

that are left untreated without remitting become chronic, fears spread, and physical symptoms may be embraced and elaborated into other disorders. Delayed treatment is to be avoided because of its darkening of the eventual outcome. Still, taken all together, all prepubertal cases of SAD show fair to good outcomes in later adult life.

A comprehensive treatment plan is typically multimodal because it encompasses the child, the parents, and the child's world of peers and school. The most effective has been antidepressants such as *Imipramine* in the treatment of SAD and aside from its antidepressant effect, *Imipramine* has been postulated to yield results that allay panic and separation fear.

While the child is deriving a decline of symptoms from *Imipramine*, the parents are usually engaged in consideration of ways that the family can assist the child to achieve more wholesome adjustment, including a plan of exposure in vivo to graded separation experiences (gradually exposing the child patient to separating experiences: graded desensitization). The child patient is also taught how to cope with his/her anxiety and deal wisely with irrational thinking. Therapist often works with the parents to

ensure that they do not inadvertently aggravate their child's anxiety through over or under-protective parenting.

So far, we have briefly gone over SA as a disorder and now need to know about SA as a non-clinical and developmental term; two branches of psychology quite concerns SA —they are *developmental psychology*, study of behavioral changes and continuity from infancy to old age in which much emphasis is placed to the childhood and child psychology, study of child's behavior, emotion, growth and maturation, language, etc where a main attention is given specifically to the period from one's birth through adolescence. Viewed from any directions, these two disciplines share a lot of common denominator: both reflect the view that human development and behavior throughout the life span is a function of interaction between biologically determined factors, such as height or temperament, and environmental influences, such as family, schooling, and culture. Studies of these interactions focus on their consequences for people at different age levels. For example, developmental psychologists are interested in how children who were physically abused by their parents behave when they themselves become parents. Studies, although

inconclusive, suggest that abused children often become abusive parents. The research interest of child psychologists is, for instance, in developing methods of treating social, emotional (SAD), and learning problems and providing therapy privately and in schools, hospitals and other institutions.

Developmental and child psychology are particularly significant for the study of separation anxiety (not a disorder here) generally felt by children and early stage of adolescence since they provide for formal study of children and adolescence at every stage of their development. Among their dozens of research areas including physical, cognitive (memory and attention span), motor, linguistic, perceptual, social, emotional characteristics, personality formation, intelligence and learning, the role of cognition in children's sex-role learning and stereotypical thinking, and even recently genetics, we will see SA from a variety of perspectives

Historically, both Plato and Aristotle wrote in depth about children and their emotional characteristics such as "kids usually do not want to be separated from their parents (especially mothers)". In particular,

Aristotle, such a long time ago, proposed methods for observing children behaviors that were forerunners of modern methods. In the 18th cent. J.J, Rousseau's view suggests that normal and healthy development occurs best in a non-restrictive and supportive environment. S. Freud, who emphasized the effects of environmental variables on development particularly, stressed the influence of parental behavior during infancy. In addition, Freud's theories are based on the concept that healthy personality requires the satisfaction of instinctual needs and it is the same with children. As you already know well, according to Freud, the personality is composed of id, ego, and super-ego and libido at the bottom. The id (es) is the source of instinctual drives, largely sexual one. The role of the ego is to cope with the demands of the id while remaining within the rules of society, which in turn are represented by the superego. Libido is physiological and emotional energy associated with the sex drive, which Freud saw as linked not only with sexual desire but also with all constructive human activities... He believed that psychiatric illness including SAD were the result of misdirecting or suppressing the libido.

The physical focus of instinctual needs changes with age, and the periods of different focus are called stages, infants; for example, achieve maximum id satisfaction from sucking, which is called oral stage. Children progress through four stages—oral - anal- phallic- and then Oedipus complex--- which is an unconscious desire for sexual involvement with the parent of opposite sex and an unconscious sense of rivalry with the parent of the same sex. The term, Oedipus complex is introduced by Freud in his *interpretation of dream* and is derived from the mythological Oedipus, who killed his father and married his mother; its female analog is the Electra complex and it is considered a normal for such complex to begin during the development of children ages 5-7, the time right after the phallic stage and ends when the child identifies with parent of the same sex and represses its sexual instincts, which means the child's libido is suppressed into its latency. After the Oedipus ends, the libido which has been suppressed for fairly long time during the complex period, libido emerges during puberty and developed into adult sexuality we have. Freud thought that the process of overcoming the Oedipus complex gave rise to the superego.

Personality formation and SAD

Theories of personalities are attempts to describe how people behave in satisfying their physical and psychological needs and an inability to do so creates a personal conflict such as SAD. Personality formation is viewed as the process by which children learn how to avoid conflict when possible and how to cope with conflict when it inevitably occurs. Because an extensive body of studies have established that parental behaviors toward their child vary widely, ranging from warmth to hostility, and anxious involvement to calm detachment, and they are of huge influence to their child, it is now well known that overly restrictive or permissive parents limit their children's option in avoiding and coping with conflict such as SAD. It is also known that in family relationships, the attitudes and values of parents toward their children clearly influence patterns of development and vice verse. A normal response to separation anxiety is to revert to a defense mechanism such as rationalization. A child with healthy, balanced, and integrated personality feels accepted and loved and has been allowed to learn a number of appropriate coping mechanisms.

Social relations and socialization of a child and separation anxiety

Social relations among infants involve mutual interest without interaction and the process by which children learn acceptable and unacceptable behavior is called socialization. Children are expected to learn, for instance, that their extreme clinging to and shadowing around their parents are unacceptable, and that independence, cooperation and maturity during their developmental stages. Current theories suggest that the role of cognition, or perceiving, thinking, and knowing, thus mature socialization with no more separation anxiety requires that a child explicitly or implicitly understand the rules of social behavior that function in all situations

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