

“Invisible child” – Integrative psychotherapeutic treatment of a child with anxiety disorder

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Summary

In this case study I am going to present the work with an eight-year old girl, a second grader of a primary school, who has been coming to the therapy for five months.

In the initial part of the therapy it was being worked on the establishment of the relationships between the therapist and the client, in the central part it was about the overall improvement of an image of oneself, reduction of anxiety, strengthening and expressing of one's own emotions and their verbalisation, psychoeducation of parents and school. In the final part of the therapy, the accent is on the strengthening of parents' competences and gradual exposing of the girl to the fears and planning of the therapy ending.

The objective of this paper is to present the importance of recognising the early traumatic events at children, which may be triggers later for anxiety disorders and contributions to the involvement of parents and school as a co-therapist for having a better outcome of the entire treatment.

Key words: *anxiety disorders, expressing emotions at children, psychoeducation*

Sažetak

U ovoj studiji slučaja prikazat ću rad s osmogodišnjom djevojčicom učenicom drugog razreda osnovne škole, koja dolazi na terapiju pet mjeseci.

U početnom dijelu terapije radilo se na uspostavljanju odnosa između terapeuta i klijenta, u središnjem dijelu radilo se o sveukupnom poboljšanju slike o sebi, smanjenju anksioznosti, osnaživanju i iskazivanju vlastitih emocija te verbalizaciji istih, psihoedukaciji roditelja i škole. U završnom dijelu terapije akcenat je na jačanju roditeljskih kompetencija, te postepenom izlaganju strahovima djevojčice i planiranju kraja terapije.

Cilj ovog rada je prikazati važnost prepoznavanja ranih traumatskih događaja kod djece, koji kasnije mogu biti okidači anksioznih poremećaja i doprinosa uključenosti roditelja i škole kao koterapeuta, radi boljeg ishoda cjelokupnog tretmana.

Ključne riječi: *anksiozni poremećaji, izražavanje emocija kod djece, psihoedukacija*

Introduction

Anxiety (sinking feeling, dread, fear, panic, uneasiness, concern) is an experience in the development of the personality, experienced by every person during their development. It is important for preserving the organism integrity. A certain degree of anxiety is desirable because of the motivation of a person for more productive behaviour. It is important to learn how to control it (Begić 2014).

Fears and different forms of anxiety make the integral part of the development of every child. An estimation is that more than 90% of children in the age 2 - 14 has at least one specific fear, and most of them has several fears. Fears and anxiety, either they are normal part of the development, or they are a response to the specific threatening situation, represent an adaptive response because they warn the child to take precautionary measures and to get prepared for numerous challenges which they will have to deal with (Paulton, Trainor, Stanton, McGee, Davies and Silva, 1997). Anxiety is a condition, characterised by feeling of internal disorder and fear that something horrible will happen. A person often feels like they are going to lose control over themselves. That person is not aware of their tension and where it comes from, they are not aware of that unpleasant condition, and anxious reaction is the attempt of the body to get rid of tension. When the anxiety becomes long-lasting and intensive and when it starts to disturb normal social and psychic functioning - then it is about a disorder (Lebedina – Manzoni, 2007); resp. when the fear and anxiety substantially affect the functioning of the child, disturb the normal psychosocial development and lead to the difficulties in school, social and family environment – then it is talked about the anxiety disorder (Boričević-Maršanić, 2013). As the most of other psychological phenomena, the fear and anxiety are interwoven a lot in the childhood and it is difficult to differ them (Poulton et al., 1997, according to Vulić- Prtolić, 2002). Because of the afore-mentioned, the fears and anxieties are most often researched on a parallel level.

The most often changes in behaviour that are connected to the anxiety are the outbursts of rage, cry, confused behaviour, but shyness or insecurity are also possible to take place in social context (Vulić – Prtolić, 2006). When it is spoken about the risk factors for development of anxiety disorders, we find general and specific factors in literature that are related to certain anxiety disorder. Many variables are considered as risk factors at anxiety disorders (Beesdo et al. 2009). Experiences in childhood have a great role, most of epidemiologic studies find a connection between the damaging experiences in childhood (f.e. loss of parents, divorce, child abuse and negligence) with the phenomenon of mental disorders (Beesdo et al. 2009).

Family history and dynamics – researches prove that anxiety disorders appear more frequently between close relatives. Researchers point out that the children may learn fears and phobia by looking at and imitating their parents (Beesdo et al. 2009). Researches from developmental psychology show that the different forms of insecure de-

votion (avoiding, ambivalent and disorganised devotion) of children are the risk factor for the development of anxiety disorders (Sroufle LA, 2005).

Objective of this paper

The objective of this paper is to present the importance of recognising the early traumatic events at children, which may be triggers later for anxiety disorders and contributions to the involvement of parents and school as the co-therapist for having a better outcome of the entire treatment, but also to present an integrative approach in working with children and adolescents.

Presentation of the case

At the period of our first meeting, the girl was the second-grader of the primary school, who was eight years old at that time. She lives in a four-member family with her parents and older brother. Her parents had occasional difficulties in their partner relationship during the pregnancy period when the mother was expecting this girl, and also later on when the girl was at the age of four. Mum states that her pregnancy was taking a normal course, but that she occasionally felt a loss of vitality, weakness in the first months of her pregnancy, she had often morning sicknesses and she vomited a lot. Overdue pregnancy, baby delivery by C-section. Parents also state that the pregnancy with the girl has not been planned. In the infancy she was calm, she slept a lot, and based on the mother's statements her early development was in accordance with the expectations for that age. At the age of three and a half, she underwent the tonsillectomy surgery, she cried a lot during her stay in a hospital and she cried a lot also after the medical treatment, she slept badly. The reason for her coming to the therapy is having the difficulties in learning – poor concentration, fear from public expression, somatic symptoms (pain in abdomen...) – psychosomatization, physical tension and internal uneasiness – animation; recently, the fears also appeared which are shown by the girl especially when it comes to the visiting a dentist or driving in an elevator. The girl had been attending the day nursery for two years before she went to school, she did not communicate to children and nursery-school teachers, it was suspected of a selective mutism disorder.

After the birth of the girl and problems, which were experienced by the parents, the family dynamics was changing, partner relationship is full of lack of trust, as stated by her mother, they are more oriented onto parents' responsibility and obligations which they have about their children, especially in relation to the girl.

During the conversation with parents, I ask also for their permit to get in touch with the school and to talk to the teacher and nursery-school teacher, who works in the

extended day programme as to get the whole picture about the girl, her behaviour in school and academic achievements.

Course of the treatment and diagnostics

Already at the very beginning, an insight can be received into family dynamics, relationships of parents and insecure attachment. An initial diagnostic picture, which can be seen at the girl based on the symptoms, as described by the parents, which can be also seen both in the family and in the development anamnesis (refuse to talk in the nursery – refuse to talk in specific situations with a retained ability to speak in other circumstances, f.e. she talks at home, resp. in situations in which she feels pleasant and secure; specific phobia – dentist, public expressions, driving in an elevator as well as other symptoms that were appearing – fright, uneasiness, tension, pain in abdomen and other somatic symptoms, exaggerated concern about her parents, tension in muscles) started manifesting significantly in her pre-school period; and some of the symptoms are present even today in her everyday life, their recognising according to the classification of disorders may indicate some of the anxiety disorders. The anxiety disorders are diagnosed when they are the subjectively experienced feelings of anxiety that meet the criteria of classification of mental illnesses and disorders (DSM - *Diagnostic and Statistical Manual of Mental Disorders* - 5 and ICD - *International Classification of Diseases* - 10). The very course of the therapy was going in several phases according to the objectives of the therapeutic work, which were the following: establish the relation of trust and security, discover the cause/background of fears and anxiety and help the girl through the treatment to integrate causes in a healthy and functional way, psychoeducation of parents and school.

The hypotheses in relation to the set objectives are the following: authentic and correct experience of **a therapist – client** opens the space of resilience – secure organismic self-regulation; parents behaviour, experience in childhood and traumatic events, which may be triggers for development of anxiety disorder, psychoeducation of parents, school environment may reduce symptoms, prevent further deterioration, keep healthy development and have strong implications to the prognosis and treatment.

In the beginning of the psychotherapeutic treatment, we have also agreed the plan of having a meeting once a week, which includes the work with the girl and psychoeducation of parents. I have also offered and referred parents to my colleague for family/partner or marriage counselling and individual therapy. I believe that fears and anxiety, shown by the girl in everyday life, have their background in traumatic experience of being abandoned by her father and his leaving their family home, which has resulted in impossibility and inability to express emotions, which additionally strengthen the anxiety symptoms and they are manifested as anxiety disorders. It can be also seen through

the anamnesis that the first symptoms of anxiety disorders at the girl are manifested through the prism of selective mutism – anxiety disorder, and previously the traumatic event took place related to her father's leaving their family home. It is important for me to have a broad picture through this therapeutic experience and observe the parallel processes that appear, as well as the symptoms and their manifestation through everyday life of the girl.

Our first meetings were very quiet, she communicated but only with encouragement through my questions. I was making her acquainted with toys and what I like; sometimes it seemed to me that I talked to myself, she was quiet until I discovered the magic of her great love for board games. We used our first several meetings for getting to know each other and creating the feeling of safety, better contact with the girl. I had a feeling that she was checking my patience and ability to stay with her. Using the play therapy, we started to know each other increasingly better, and the girl started to talk more about herself, things that she liked and her family. Due to the girl's tension that I felt at our first meetings, she showed the anxiety also by her body, she had a bent body posture, her shoulders were bent forward and hands were squeezed and interwoven. I had a feeling that she felt very tight in her own body and that she felt great unpleasantness. In addition to the board games, which became our everyday ritual and her great joy because somebody spends some time playing with her, which she confirmed to me several times, I was thinking that it was necessary to work out something that would reduce tension also for her body. I had a feeling that the body requested larger energy, relaxedness and growth. I decide to continue with the board games because it was the only thing that she wanted to do with me at our first meetings, and in addition to the afore-mentioned I choose a relaxation technique and a safe place technique. I believed that the relaxation techniques would be useful for her to calm down her body, tension and anxiety, which was physically visible. I knew that the relaxation represented a condition of psychic and physical relaxedness, in which we bring body to the condition and feeling of being calmed down and pleasantness. Since then our meetings included also the breathing techniques, sometimes we did it in silence, and occasionally with a quiet and relaxing music.

After several sessions, get-acquainted meetings, eliminating tension, introducing and relaxing, and perhaps first of all and the most important one - creating trust and staying in contact, the girl starts to share her emotions. She believes me and feels safe. I come back to the question that has bothered me for a long time, and I could not answer it to myself. What is it that I cannot see, and the girl tries to tell me?

She brings me to my answer at the end of one of our meetings, when we were already before the very end, packing the board games, she looked at me and said: "You know, nobody has ever tried this hard with me like you do". Exactly at that moment, the exchange of trust took place between me and the girl, which represents at the same time also the key moment in our therapeutic work. For the first time the girl admits me that

she is finally seen now, that nobody saw her for the past seven years until now, i.e. she was a completely invisible child.

After showing her needs and emotions in front of her mother, the girl has been significantly opened in a therapeutic relation. We have continued to use projective techniques, when the girl continues to express her emotions with drawing and modelling clay. We talk about things which make her happy, what makes her sad, when she feels fear, how it looks like when she is sad, she increasingly talks, draws, writes, works out the games through which she is going to talk to me and open the topic of emotions and feelings. We have worked a lot also on completing the sentences, which were related to the attitude towards her mother, father, family as a whole, obligations, identification, male/female friends – other children, reactions to frustration, feeling of pleasantness and unpleasantness. She gives me a lot of information here about her attitudes and feelings, I can say also about her needs. The most important were the answers that she gave me about her father.

Through the play therapy – a game with masks, she supported herself and made herself stronger to express her needs, tension and defencelessness that she felt, and to show her emotions in the right way, and not through the confuse and closing towards herself that was manifested as anxiety. She spoke frankly about the emotions, and so did her mum, too; they supported each other. I realised how much the girl had the need to show and to express her emotions to her mother, which she had kept for a long time.

Through the work with the client I constantly relied on and supported myself with the theory, especially on a comprehensive theory of personality development, which includes also a potential crisis in every developmental task, resp. indicates the possibility for inadequate overcoming of the developmental task. If we have not overcome the previous tasks, we will have troubles to deal with the following life tasks. Based on the concept of this theory an integrated and functional person should overcome one's life cycles successfully enough, with the aim of having the feeling that one's own life is complete. Erik Erikson, a renowned psychoanalyst, gave his systematisation of a human development and he assumed that every degree of the development brought the potential crisis with itself, resp. a danger to have the developmental tasks completed inadequately. Erikson spoke about several principles that are necessarily brought by the development, as well as about the development phases through which every being would have to go.

Occasionally, I invite parents for conversation, in the beginning we agreed to have regular meetings as I work with the girl and that they would start with an individual therapy and a partner counselling. I talked to the parents about the development periods of every child, devotion, development of fears at children, anxiety, needs, self-respect, parents' relationships and how they affect the children.

In this final part, it is important for me to make together with the parents and the girl a plan for gradual exposing and to strengthen parents' competences through psychoedu-

cation. I plan also to take a look with the parents and the girl to the passed joint pathway which we stepped through, to look at all challenges, difficulties and successes that we have made on this no-return travel. It is very important for me that the girl does not experience the ending of the therapy as leaving because it was one of her fears in the first place. I want to have the positive ending, especially for the girl. A good ending may be celebrated as a concert, entertainment, recognition and joy for one good ending, well done homework, with the view to everything that we have done and with the view to the future. I want to have the ending of the therapy as the agreed ending between me as the therapist, the parents and the girl; resp. when we jointly agree that the therapy shall end – to leave and plan enough space for processing the feelings, arisen by the very notion of the therapy ending, but definitely to leave the possibility for coming back to the therapy in case of some changed circumstances, when and if additional help might be needed again.

Conclusion

The family of the girl has changed a lot after the very appearance at the therapy. The change is not only visible in relation to the girl, but it is also reflected in the first place through the relationship of the parents and the dynamics of the whole family. I have to point out that after their initial inaccessibility, they have opened the contents of their relationships and accepted the help that has been offered to them. It can be seen that they have the will and that they want things to be improved and to function in the best possible way.

The girl has achieved large breakthroughs in the therapeutic process, the anxiety has been reduced, pain in abdomen is increasingly rare, she has become more liberate in expressing and showing her emotions and feelings, her concern about her parents is still present but to the far less extent, she speaks more frankly about her fears. One thing that I do not know and that I cannot be sure about how the things will proceed is the partner relationships between her parents, insecurity and severity that the girl has carried. There is her need to keep them, but I know that the therapeutic process at children is clearer to me now and that through the correct experience, which the girl has received during this therapeutic process, the organism opens the pathway for itself towards health and growth. I believe in her capacities.

References:

1. Američka psihijatrijska udruga, DSM-IV: Dijagnostički i statistički priručnik za duševne poremećaje (1996). Jastrebarsko: Naklada Slap.
2. Begić D (2014) Psihoterapijski tretman djece i adolescenata. U: Dodig-Ćurković K,
3. Beesdo K, Knappe S, Pine DS (2009) Anxiety and Anxiety Disorder in Children and Adolescents: Developmental Issues and Implications for DSM-V. *Psychiatr Clin North Am* 32(3):483-524.
4. Boričević-Maršanić V, Benić D, Franić T, Grgić M i sur. Psihopatologija dječje i adolescentne dobi. Osijek: Svjetla grada, str.402-409.
5. Boričević-Maršanić V (2013), Anksiozni poremećaji dječje i adolescentne dobi.U: Dodig Ćurković
6. K, Boričević-Maršanić V, Benić D, Franić T, Grgić M i sur. Psihopatologija dječje i adolescentne dobi. Osijek: Svjetla grada, str. 96-108.
7. Diagnostic and Statistical Manual of Mental Disorders. 5th edition. Washington DC:American Psychiatric Association.
8. Erikson, Erik H. 2008. Identitet i životni ciklus. Beograd: Zavod za udžbenike.
9. Erskine, R.G., Moursund, P.J., (2011), Integrative Psychotherapy in Action, Karnac, London
10. Sroufe LA. Attachment and development: a prospective, longitudinal study from birth to adulthood. *Attach Hum Dev* 2005; 7(4) : 349 - 67.
11. Lebedina – Manzoni, M. (2007). Psihološke osnove poremećaja u ponašanju. Jastrebarsko: Naklada Slap
12. Poulton R., Trainor P., Stanton W., McGee R., Davies S., Silva P. (1997). The (in)stability of adolescent fears, *Behavior Research and Therapy*, 35, 159-163.
13. Vulić-Prtorić A (2006) Anksiozna osjetljivost: fenomenologija i teorije. *Suvremena psihologija* 9(2):171-194.
14. Vulić-Prtorić A (2002) Strahovi u djetinjstvu i adolescenciji. *Suvremena psihologija* 5(2): 271-293.