2. ASSESSMENT AND DIAGNOSIS

Separation Anxiety

Diagnosis

Children suffering from SAD often come to the clinician's attention when problems with school attendance develop. Presentation may range from great reluctance to refusal and temper tantrums if parents insist on taking the child to school. Once separation takes place, these children may worry incessantly about the misfortunes that might befall their loved ones. Nightmares with prominent themes of separation are sometimes reported. Fears of being lost and never reunited with their families often beset these children. Typically the "storm" is resolved once the child is returned to home. Somatic complaints such as morning stomach aches, headaches, nausea and vomiting, are more often seen in younger children, while older ones may also complain of palpitations and feeling faint.

A detailed history is the most helpful diagnostic resource. As is true for most of the internalizing disorders (i.e., anxiety, depression), accounts from the child are usually more telling than parents and teachers report. Descriptions of the events preceding the separation, response to parents' departure, ensuing behavior (usually in school) and the consequences of separation are helpful in understanding the pattern of distress and precipitants. Gathering a comprehensive family history of psychiatric disorders is important, given the notable family patterns involving SAD. Anxiety rating scales such

as the Screen for Child Anxiety Related Emotional Disorders (SCARED) or the Multidimensional Anxiety Scale for Children (MASC) may be used diagnostically and as measures of treatment outcome. General psychiatric symptom rating scales, such as the Connors Parent and Teacher Questionnaires may assist in the diagnosis of comorbid disorders, which are common for these children. Routinely available laboratory studies do not increase the accuracy of the diagnosis.

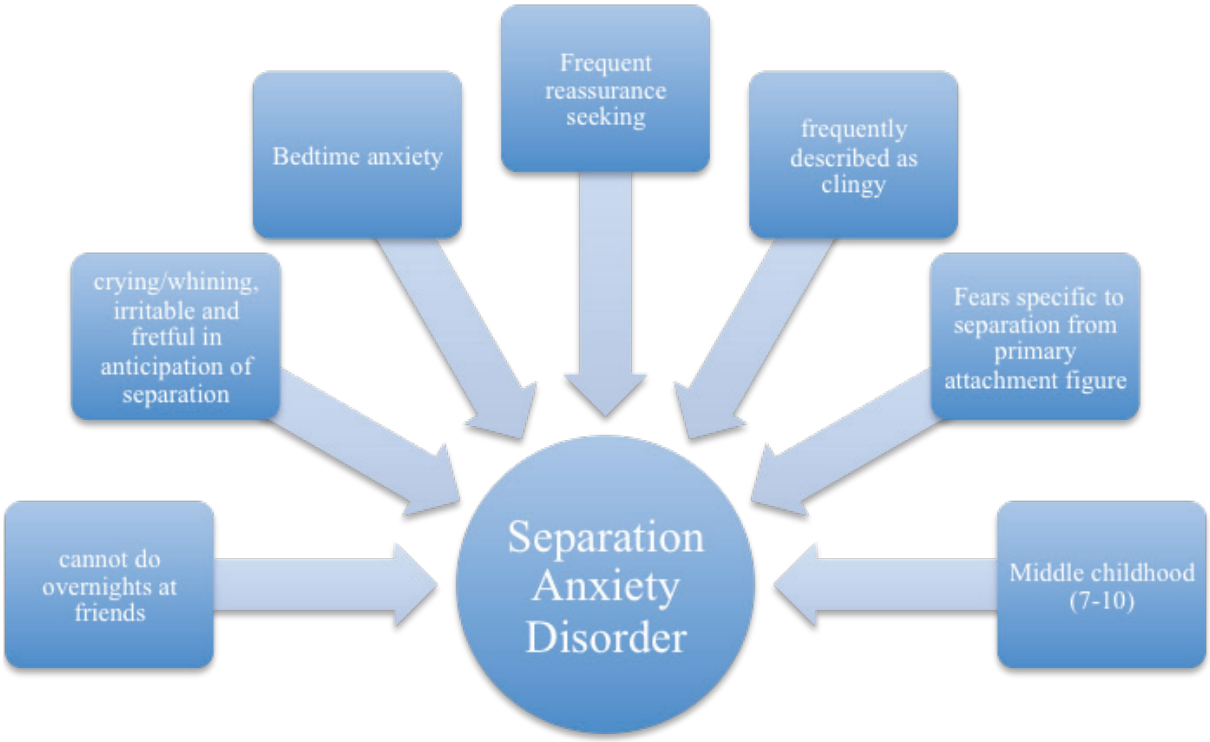
Differential Diagnosis

The clinician must differentiate separation anxiety from developmentally appropriate fears accompanying separation from loved ones. These developmentally normal separation fears occur earlier in childhood, have milder presentations, and tend to be transient and self-limiting. Functional impairment is not a typical feature of fears accompanying normal development.

Delineation of SAD from other disorders sharing "school refusal" as a symptom is sometimes a challenging task. After conduct disorder and oppositional defiant disorder (i.e., truancy) have been ruled out, one should carefully evaluate evidence for other anxiety disorders. School refusal may be based in a specific phobia (e.g., test taking and, or fear of humiliation), in situationally bound panic disorder or in social phobia, as well as SAD.

Relative comfort in social settings will differentiate separation anxiety from social phobia. Well-defined and usually singular phobic objects characterize specific phobias. Distress can occur even in the presence of an attachment figure.

Several additional points bear emphasizing. First, children with SAD commonly have parents with an anxiety or depressive disorder. Careful assessment and, if necessary, treatment of the parent may be called for. This may entail simple psychoeducation of the parents regarding their inadvertent support of the child's anxiety versus frank treatment for an anxiety disorder in the parent. Second, a complete evaluation is important as over half of children with SAD have a second comorbid anxiety diagnosis which can unnecessarily complicate treatment if it is missed.



School Refusal

Diagnosis

Because of the variability in the clinical presentations of school refusal, evaluations prior to treatment should engage multiple informants. The child and the family should undergo clinical interviews. Members of the school, daycare and the family doctor are all potentially important sources of collateral information, though this may not be practical in a busy Primary Care Clinician's office. Patterns of family dynamics need to be explored for potential weaknesses, e.g., inadequate parental oversight, conflicting parental tactics. A thorough medical exam should be undertaken to rule out any organic cause for the child's somatic complaints, if these are part of the presentation. Once the primary diagnosis is made, search should continue for associated comorbid disorders, as comorbidities are common.

Differential Diagnosis

Because school refusal is not a diagnostic entity, the goal of a clinical evaluation will be to identify the primary disorder, of which the school refusal is a symptom (See Table 1).

Table 1	**Differential DIAGNOSIS OF SCHOOL REFUSAL**
Conduct/Oppositional Defiant	(Truancy) in addition to school refusal. "Hangs out" with friends when not in school, often complicated by substance abuse or antisocial behavior.
Separation Anxiety Disorder	Fears separation from parent or attachment figure. Spends "Out of school time" in presence of parent.
Generalized Anxiety Disorder	Anxiety in multiple domains, not limited to school setting, fretful, overly conscientious/ fearful.
Specific Phobia	Exhibits anxiety toward teacher, other student, activity, test taking or other specific object or circumstance.
Social Phobia	Social setting, per se, is the primary fear. May fear scrutiny in test taking, being observed in bathroom etc.
Panic Disorder	May have situationally bound or predisposed panic attacks. Some panic attacks have occurred out of school or unexpectedly, anticipatory anxiety, agoraphobia.
Posttraumatic Stress Disorder	Multiple symptoms in addition to school refusal: irritability, depression, re-experiencing, all related to a specified trauma.
Obsessive-Compulsive Disorder	Presence of obsessive thoughts/compulsive rituals that may be a source of embarrassment or result in phobic avoidance.

Generalized Anxiety Disorder

Diagnosis

The differential diagnosis of GAD can be complicated, as it frequently involves symptom overlap with other anxiety disorders. Children and adolescents with GAD tend to worry excessively about their performance and competence, even in the absence of external scrutiny. Ruminating about past mistakes and worrying about future adversities (i.e., "what if concerns) may cause a decline in academic function and precipitate a referral. Parents will often report children's apprehension about "adult issues:" illness, old age, death, financial matters, wars and natural disasters. Children with GAD are often seen as perfectionistic and self-cautious, frequently seeking reassurance. Because they "cannot stop worrying" these youths often appear de-concentrated, restless, fragile, tense and irritable. Somatic complaints such as stomachaches and headaches are often reported by youngsters suffering from GAD and can precipitate frequent visits to pediatricians.

Several anxiety scales are available for use. These include: the Revised Children's Manifest Anxiety Scale (RCMAS), the Multidimensional Anxiety Scale for Children (MASC)) and the Child Behavior Checklist (CBCL). These scales have potential value both in identifying anxiety disorders as well as monitoring treatment progress.

Differential Diagnosis

GAD can be differentiated from separation anxiety by its pervasive nature and presence across different contexts (e.g. school, home and peer relations). Panic disorder is more "phasic" in comparison to the more "tonic" GAD. The content of anxiety in panic disorder is usually focused on future panic attacks. In specific phobia, fears center on the phobic object. Obsessive thoughts can be distinguished from GAD by their intrusive nature and concomitant compulsive rituals used to alleviate anxiety. In Post-Traumatic Stress Disorder (PTSD), anxiety is usually related to a past traumatic event or reexperiencing of the event. Prevalence of depressed mood, anhedonia and vegetative signs set depressive episodes apart from GAD, in spite of significant symptom overlap.

Finally, medical conditions often present with symptoms that may mimic GAD. Caution is warranted not to overlook hyperthyroidism, diabetes mellitus, and the more rare syndromes such as pheochromocytoma or systemic lupus erythematosis. Excessive stimulant use, alcohol withdrawal or drug dependence can also mimic GAD. The recreational use of steroids, primarily by adolescent boys, bears monitoring as this practice has been associated with anxiety.