



# Separation Anxiety Disorder in Children and Adolescents

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## Symptom Presentation

The core feature of separation anxiety disorder (SAD) is developmentally inappropriate and excessive anxiety about separation from attachment figures. Youth with SAD experience distress when separating or anticipating separation from attachment figures, worry about harm coming to or losing major attachment figures, and/or worry about experiencing an untoward event (e.g., kidnapping) that results in separation from an attachment figure (American Psychiatric Association, 2013). Youth may also resist leaving home due to fear of separation, show fear of or reluctance about being alone at home alone, and insist on sleeping near an attachment figure. Less commonly, they experience nightmares involving the theme of separation (e.g., Allen et al., 2010c; Cooper-Vince et al., 2014). Youth with SAD may be described as “clingy,” follow caregivers around at home, and cry or tantrum in an effort to avoid separation. Also, youth may frequently “check in” with caregivers (e.g., by texting, calling to them from another room). Because youth with SAD often experience intense discomfort when apart from attachment figures, they may refrain from engaging in age-appropriate social

activities (e.g., sleepovers, play dates). To meet criteria for diagnosis according to the DSM-5 (APA, 2013), symptoms must persist for at least 4 weeks and cause clinically significant distress or impairments in functioning.

## Prevalence and Course

The mean lifetime prevalence estimates of SAD have ranged from 4% to 5% in preadolescent and adult samples (e.g., Copeland et al., 2014; Kessler et al., 2005; Silove et al., 2015). Relative to other anxiety disorders, SAD typically onsets early (mean = 6–7 years old; Kessler et al., 2005; Shear et al., 2006) and the prevalence rate decreases with age (e.g., Copeland et al., 2014). Some studies have shown higher prevalence rates among girls than boys (Silove et al., 2015; Shear et al., 2006) and others have found no difference (e.g., Copeland et al., 2014). Among clinic-referred youth with anxiety disorders, non-White youth have been significantly more likely than White youth to meet criteria for comorbid SAD and social phobia (Kendall & Peterman, 2015). There is some evidence that separation anxiety disproportionately affects youth from low-income families (e.g., Vine et al., 2012) and countries (e.g., Silove et al., 2015).

Separation anxiety in infants and toddlers is developmentally typical and likely adaptive; it peaks at 15–18 months and wanes slowly through

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4 years of age (e.g., Battaglia et al., 2016; Sroufe, 1997). Parental unemployment, maternal depression, and tobacco exposure in pregnancy have been uniquely associated with high separation anxiety at 1.5 years that increases through 6 years of age (Battaglia et al., 2016). Although the majority of cases remit before adulthood (e.g., Foley et al., 2004), SAD warrants intervention to reduce impairments in functioning that could interfere with development (e.g., Foley et al., 2008) and to prevent the onset of secondary disorders (e.g., Cummings et al., 2014). Elevated separation anxiety in preschool that increases over time has predicted greater internalizing symptoms, worse academic achievement, and poorer physical health throughout middle childhood and preadolescence (Battaglia et al., 2017).

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## Clinical Features

SAD is among the most common disorders diagnosed in youth who present with school refusal (e.g., Egger et al., 2003) and as many as 75% of children with SAD exhibit some form of school avoidance (Last et al., 1987). SAD is highly comorbid with other anxiety disorders (e.g., Shear et al., 2006). It has generally been associated with later anxiety disorders, including panic disorder (e.g., Kossowsky et al., 2013) – with which it appears to share a genetic diathesis (Roberson-Nay et al., 2012). Studies have also identified SAD as a risk factor for the development of disruptive behavior disorders, mood disorders, and substance use problems (e.g., Silove et al., 2015; Brückl et al., 2007), but findings are mixed (Kossowsky et al., 2013).

More than 90% of youth with SAD experience at least one sleep-related problem (e.g., Alfano et al., 2007). SAD is associated with greater number and severity of somatic complaints (Crawley et al., 2014), and approximately 30–50% of youth with SAD complain of physical symptoms upon separating (Allen et al., 2010c). Indeed, experimental research has documented that youth with SAD exhibit exaggerated physiological responses to separation relative to youth with other anxiety disorders and/or youth

with no anxiety disorder (e.g., Kossowsky et al., 2012).

In line with cognitive theories of fear and anxiety (e.g., Kendall, 1985), there is evidence of general and content-specific interpretation bias in youth with SAD; when presented with ambiguous scenarios related to the threat of separation, self-reported separation anxiety has predicted youths' negative interpretations (e.g., Klein et al., 2019). Also, there is some evidence that children with fear (versus distress) disorders, including SAD, exhibit an attention bias toward threat (i.e., angry faces relative to neutral faces) (e.g., Waters et al., 2014). Youth with separation anxiety commonly present with broader emotion regulation difficulties (e.g., with goal-directed behavior), which may predict increases in separation anxiety over time (e.g., Schneider et al., 2018). Although insecure attachment has also been considered a vulnerability for the development of anxiety disorders, few studies have investigated attachment security in relation to separation anxiety specifically (e.g., Colonnese et al., 2011).

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## Family Factors

Twin studies have documented a shared environmental effect on SAD (e.g., Scaini et al., 2012). Along with other anxiety disorders, SAD has been associated with parental overcontrol, particularly over-involvement and low levels of autonomy granting (e.g., Hughes et al., 2008); decreased latency to rescue children from situations that cause distress (e.g., Aschenbrand & Kendall, 2012); and elevated psychological control or coercive, passive-aggressive, and intrusive strategies for manipulating youths' thoughts, feelings, and activities (e.g., Settiani et al., 2013). Consistent with the possibility that parental overcontrol has a causal influence, Kiel et al. (2016) found that extreme observer ratings of maternal encouragement to approach novelty (reflecting either very protective or intrusive behavior) were related to increases in toddlers' separation anxiety from 2 to 3 years old.

Parents of youth with SAD may also model anxious thoughts (e.g., threatening interpretations of ambiguous situations) and avoidance

behavior for children (e.g., Barrett et al., 1996). Relative to parents of children without anxiety disorders, they report more negative expectations of their child's skill and coping ability (e.g., Micco & Ehrenreich, 2008). Parents' negative beliefs about their child's disposition, coping ability, and potential for success have been linked to children's low expectations for coping and relatively high levels of anxiety (Herren et al., 2013; Wheatcroft & Creswell, 2007).

Parents often accommodate youths' separation anxiety; for example, by sleeping in the child's bed, modifying their schedules to avoid leaving the child with other caregivers, providing repeated reassurance when separated, and even seeking part-time employment at the child's school to avoid separation (e.g., Benito et al., 2015). Family accommodation, which is directly associated with symptom severity (Inieta-Sepulveda et al., 2021), is thought to maintain or exacerbate anxiety by interfering with the habituation or violation of expectancies that would occur with exposure to anxiety triggers and by decreasing motivation for change (e.g., Caporino, 2020). Of the anxiety disorders, separation anxiety has shown the strongest relationship to family accommodation (e.g., Lebowitz et al., 2013). Both have been linked to relatively low levels of salivary oxytocin, which is implicated in the regulation of anxiety and close interpersonal behavior (Lebowitz et al., 2016, 2017).

Families may experience significant burden associated with caring for youth with SAD, particularly when engaging in high levels of accommodation (e.g., Thompson-Hollands et al., 2014). Also, mothers of children with SAD have exhibited lower levels of parenting self-efficacy than mothers of children with social anxiety disorder, and lower levels of parenting self-efficacy and satisfaction than mothers of children without a disorder (Herren et al., 2013).

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## Assessment and Diagnosis

**Differential diagnosis** An important consideration for differential diagnosis is whether the core fear leading to youths' attempts to avoid

separation is the fear that they will not be reunited with attachment figures. Youth may resist separation for reasons other than fear of permanent separation; for example, children with social anxiety disorder may resist separating from caregivers who speak on their behalf in public, children with OCD may resist separating from caregivers who accommodate compulsions, and children with generalized anxiety disorder (GAD) may resist separating from caregivers who reassure them of safety. Also, worry about harm befalling caregivers (without a clear focus on the permanent separation that could ensue) may reflect GAD or OCD and has not discriminated well between youth with high and low levels of separation anxiety (Cooper-Vince et al., 2014).

Behaviors exhibited by youth with SAD (e.g., repeated reassurance-seeking) may raise concern about possible OCD. Youth with separation anxiety sometimes engage in elaborate "goodbye" routines, which serve to delay separation, and are distinct from compulsions. Youth with OCD are more likely to engage in rituals with intent to prevent some feared outcome (e.g., harm befalling parents) and typically present with multiple OCD symptoms that change over time (e.g., Rettew et al., 1992).

A common challenge is determining when multiple diagnoses are appropriate. Although youth with SAD may defy commands to separate or tantrum to avoid separation, an ODD diagnosis should only be considered when there is persistent oppositional behavior unrelated to anticipation or occurrence of separation. In youth who present with GAD, important considerations for diagnosing comorbid SAD are whether concerns about separation occur consistently and cause distress and impairment independent of worry across other domains. The DSM-5 offers additional guidance in differentiating SAD from other disorders (APA, 2013).

**Cultural context** Culture may influence symptom presentation; relative to non-Hispanic White youth, Hispanic and Asian youth with SAD may be more likely to present with somatic complaints (e.g., headaches, stomachaches; Gee, 2004; Pina

& Silverman, 2004). Because the extent to which youth are expected to tolerate separation varies by culture, it is important to view a child's behavior in the context of demands and opportunities to separate from parents (APA, 2013). For example, many families do not expect children to sleep apart from caregivers; so, bedsharing would not be considered a symptom of SAD. Additionally, SAD should be distinguished from the value that collectivistic cultures place on interdependence among family members (e.g., Triandis, 2018). Parenting practices reflecting high levels of control may be normative and adaptive in some cultural contexts (e.g., Mexican American; Varela & Hensley-Maloney, 2009).

**Assessment in school-aged children and adolescents** There are many reliable and valid parent- and self-report measures that could be used to assess separation anxiety in school-aged youth (see Table 17.1 for descriptions and psychometric properties). The Revised Children's Anxiety and Depression Scale (Chorpita et al., 2005), the Screen for Child Anxiety Related Emotional Disorders-Revised (Birmaher et al., 1997, 1999), the Spence Children's Anxiety Scale (SCAS; Spence, 1998; Nauta et al., 2004), and the Multidimensional Anxiety Scale (March et al., 1997; March, 2012) have parallel parent- and child-report forms and yield separate scores for separation anxiety among other types of anxiety. A 30% reduction on the Separation Anxiety/Panic scale of the parent-report MASC from pre- to post-treatment can be used as a benchmark for evaluating remission (Palitz et al., 2018).

Disorder-specific measures (summarized in Table 17.1) include parent- and child-report forms of the 12-item Separation Anxiety Avoidance Inventory (Schneider & In-Albon, 2005), which has demonstrated reliability and validity (In-Albon et al., 2013). The 20-item self-report Children's Separation Anxiety Scale (Méndez et al., 2014) has been validated using a large, community sample and yields scores for worry about separation, distress from separation, opposition to separation, and calm at separation (i.e., self-confidence that is distinct from the

absence of fear). The 34-item Separation Anxiety Assessment Scale (Eisen & Schaefer, 2007) can inform treatment planning, though published reports of psychometric properties are needed. The Separation Anxiety Daily Diary assesses the frequency of anxiety-provoking and nonanxiety-provoking separations, along with associated thoughts, feelings, behaviors, and corresponding parental reactions by parent (Allen et al., 2010a) and child report (Allen et al., 2010b).

Elevated scores on the 18-item Childhood Anxiety Sensitivity Index (Silverman et al., 1991), which measures fears of anxiety sensations and beliefs that they have harmful consequences, have been useful in identifying youth with separation anxiety who are also prone to panic disorder (e.g., Kearney et al., 1997). The Child Anxiety Impact Scale (Langley et al., 2014) and the Child Anxiety Life Interference Scale (Lyneham et al., 2013) can be used to measure impairment across anxiety disorders, with the latter including an assessment of the impact on caregivers.

Commonly used (semi-)structured diagnostic interviews, such as the Anxiety Disorders Interview Schedule for DSM (Silverman & Albano, 1996), the Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS; Kaufman et al., 1997), and the Diagnostic Interview Schedule for Children (Shaffer et al., 2000), include SAD modules. Modifications may be required to bring these interviews into line with the DSM-5, though changes to SAD criteria from DSM-IV to DSM-5 were minimal apart from allowing for adult onset (APA, 1994, 2013). The Pediatric Anxiety Rating Scale (RUPP, 2002) is a briefer, clinician-rated measure of anxiety symptoms across diagnoses with cutoff scores that can be used to assess the progress of individual patients against the standard of outcomes reported in clinical trials (Caporino et al., 2013).

**Assessment in early childhood** Although SAD may onset as early as preschool age, it must be differentiated from age-appropriate fear of separating from a caregiver. The use of normed assessments that yield separation anxiety scores,

**Table 17.1** Parent- and child-report measures of separation anxiety: description and psychometric properties

Assessment	Age range	Informants	Items and response scale	Scales and psychometric properties
<p>Anxiety measures with separation anxiety subscale</p> <p><i>Multidimensional Anxiety Scale for Children</i> (MASC, March et al., 1997; MASC 2, March, 2012)</p>	8–19 years	Parent, child	9 items for Separation/Panic on MASC (39 items total) and Separation Anxiety/Phobias on MASC 2 (50 items total); 0–3 scale	<p>Original MASC yields scores for Separation/Panic, Physical Symptoms, Harm Avoidance, and Social Anxiety as well as Total Anxiety</p> <p>MASC 2 yields additional scores: GAD Index, Obsessions and Compulsions, Inconsistency Index (response style), Anxiety Probability Score (chance of having at least one anxiety disorder)</p> <p>MASC Separation/Panic scale renamed Separation Anxiety/Phobias on MASC 2 (“SAD scale” below)</p> <p>Support for MASC four-factor model (e.g., Baldwin &amp; Dadds, 2007) and MASC 2 five-factor model, which excluded GAD Index due to item overlap (March, 2012)</p> <p>Norms from clinical and nonclinical samples available (Etkin et al., 2021a, b; March, 2012)</p> <p>SAD scale shows Cronbach’s alphas &gt;.65 for child report and &gt;.70 for parent report (e.g., Baldwin &amp; Dadds, 2007; March, 2012; Villabø et al., 2012)</p> <p>SAD scale test-retest reliability <math>r = .70</math> for parent report and <math>.55</math> for child report (Baldwin &amp; Dadds); ICC’s (across raters) above <math>.80</math> for 3-week and 3-month intervals (March et al., 1997)</p> <p>Parent- and child-report MASC each predict presence and severity of SAD in youth, with fair prediction power in youth and fair to good prediction power in adolescents (e.g., Wei et al., 2014)</p> <p>SAD scale has convergent and divergent validity for parent and child versions (Baldwin &amp; Dadds, 2007; March, 2012; Muris et al., 2002)</p> <p>SAD scale is sensitive to treatment effects (e.g., Evans et al., 2017; Pallitz et al., 2018)</p> <p>Parent-child agreement for SAD scale: <math>r = .30-.40</math> (e.g., Baldwin &amp; Dadds, 2007; Villabø et al., 2012), corrected <math>r = .54</math> (March, 2012)</p>

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**Table 17.1** (continued)

<p><i>Preschool Anxiety Scale</i> (Spence et al.), <i>Preschool Anxiety Scale-Revised</i> (Edwards et al., 2010)</p>	<p>2–6 years</p>	<p>Parent</p>	<p>5 items for SAD on PAS-R (28 total); 0–4 response scale</p>	<p>Yields scores for Separation Anxiety, Social Anxiety, Generalized Anxiety, OCD, and Physical Injury fears (based on results from exploratory and confirmatory factor analyses; Spence et al., 2001) Developed with feedback from parents and experts (Spence et al., 2001) Some independently replicated evidence of construct validity (Etkin et al., 2021b) Norms from nonclinical sample available Cronbach’s alpha generally &gt;.70 for SAD scale (e.g., Edwards et al., 2010) 12-month test-retest reliability: <math>r \geq .60</math> for SAD scale (Edwards et al., 2010) SAD subscale predicted DSM diagnosis of separation anxiety disorder (Edwards et al., 2010)</p>
<p><i>Revised Children’s Anxiety and Depression Scale</i> (RCADS; Chorpita et al., 2000, 2005)</p>	<p>8–18 years</p>	<p>Parent, child</p>	<p>7 items for SAD (47 total)</p>	<p>Yields scores for Separation Anxiety, Social Phobia, Panic Disorder, GAD, OCD, and Major Depression (supported by results of confirmatory factor analysis) Cronbach’s alpha of .78 for child-report SAD scale and .87 for parent-report SAD scale Child-report SAD scale cutoff of 5 showed sensitivity of .73 and a specificity of .69 for the prediction of separation anxiety disorder Parent-report SAD scale cutoff of 4 showed sensitivity of .92 and a specificity of .73, Convergent and divergent validity established for child-report SAD scale and for parent-report total score Parent and child scores showed small, significant associations (Chorpita et al., 2005; Ebesutani et al., 2010)</p>

<p><i>Screen for Child Anxiety Related Emotion Disorders-Revised</i> (SCARED-R; Birmaher et al., 1997, 1999)</p>	<p>6–18 years</p>	<p>Parent, child</p>	<p>8 items for SAD (66 total); 0–2 scale</p>	<p>Yields scores for Separation Anxiety, Panic/Somatic Symptoms, General Anxiety, Social Phobia, School Phobia (supported by results of confirmatory analyses)                  Norms from clinical and nonclinical samples available for self-report (Etkin et al., 2021a, b)                  SAD scale has Cronbach's alphas &gt; .70 for child report and around .80 for parent report (Runyon et al., 2018)                  40-day test-retest reliability was moderate to high: ICC of .59 for child-report SAD scale and .85 for parent-report SAD scale (Behrens et al., 2019)                  Cutoff score of 5 on child-report SAD scale had .76 sensitivity and .80 specificity for identifying SAD in treatment-seeking sample (Birmaher et al., 1997)                  Cutoff score of 8 on parent-report SAD scale had .84 sensitivity and .85 specificity in treatment-seeking sample (Van Meter et al., 2018)                  Convergent and divergent validity established for child- and parent-report SAD scale (e.g., Monga et al., 2000; Muris et al., 2002)                  Child- and parent-report SAD scale is sensitive to treatment effects (e.g., Monga et al., 2015; Muris et al., 2002)                  Parent-child agreement: <math>r = .45</math> for SAD subscale (Birmaher et al., 1997)</p>
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**Table 17.1** (continued)

<p><i>Spence Children's Anxiety Scale (SCAS;</i> Spence, 1998; Nauta et al., 2004)</p>	<p>8–15 years</p>	<p>Parent, child</p>	<p>6 items for SAD (38 total, +6 filler items for child version); 0–3 scale</p>	<p>Yields scores for Separation Anxiety, Panic and Agoraphobia, Social Phobia, GAD, OCD, and Physical Injury Fears (supported by results of confirmatory factor analysis; Orgiles et al., 2016) Norms from clinical and nonclinical samples available for self-report Child-report SAD subscale had Cronbach's alpha of .70 in a meta-analysis (Orgiles et al., 2016) Parent report SAD subscale had Cronbach's alpha of .74 in nonclinical and .76 in clinical samples (Nauta et al., 2004) Test-retest reliability: <math>r &gt; .75</math> for child report and <math>&gt;.80</math> for parent-report SAD scale at 2-week and 3-month intervals in community samples (e.g., Arendt et al., 2014) Six-month test-retest reliability: <math>r = .57</math> child-reported SAD in community sample 8–12 years old (Spence, 1998) Optimal SAD scale cutoff scores for each reporter (child = 6.5, mother = 8.5, father = 6.5) identified youth with SAD, with sensitivity values of at .70–78 and corresponding specificity values of .62–.75 (Reardon et al., 2019) SAD subscale shows convergent and divergent validity (e.g., Essau et al., 2002) Parent- and child-report SAD subscale has shown sensitivity to treatment effects (e.g., Evans et al., 2017) Relatively high parent-child agreement on SAD subscale (e.g., <math>r = .74</math>; Brown-Jacobsen et al., 2011)</p>
<p><i>Youth Anxiety Measure for DSM-5</i> (Muris et al., 2017a, b)</p>	<p>8–18 years</p>	<p>Child and parent</p>	<p>6 items for SAD (50 total); 0–3 response scale</p>	<p>Part 1 (28 items) assesses major anxiety disorders and Part 2 (22 items) assesses specific phobias and agoraphobia Developed with expert feedback Cronbach's alpha <math>\geq .80</math> for child-report SAD subscale across clinical and nonclinical samples Cronbach's alpha of .84 for parent-report SAD subscale in clinical sample Convergent and divergent validity for total score and groups of subscales Parent-child agreement for SAD subscale: <math>r = .73</math> (Muris et al., 2017a, b)</p>

Disorder-specific measures



<p><i>Children's Separation Anxiety Scale</i> (CSAS; Méndez et al., 2014)</p>	<p>8–11 years</p>	<p>Child</p>	<p>20</p>	<p>Yields scores for worry about separation, distress from separation, opposition to separation, and calm at separation (based on results of exploratory and confirmatory factor analyses) Validated with large samples of schoolchildren (N = 1908; N = 6016) in Spain Cronbach's alpha of .88 for total scale, &gt;.70 for every subscale Four-week test-retest reliability: <math>r = .83</math> for total score and &gt;.65 for every subscale Showed convergent and divergent validity Cutoff score of 68 showed good sensitivity and specificity for identifying youth with SAD (Méndez et al., 2014)</p>
<p><i>Separation Anxiety Avoidance Inventory</i> (SAAI; Schneider &amp; In-Albon, 2005)</p>	<p>4–18 years</p>	<p>Child and parent</p>	<p>12</p>	<p>Yields total score and 2 subscale scores, for "going to school, to bed alone" and "being or going home alone when no-one is there" (based on results of exploratory and confirmatory factor analyses) Cronbach's alphas <math>\geq .80</math> for child report and <math>\geq .75</math> for parent report Four-week test-retest reliability: <math>r &gt; .80</math> for parent report across school and clinical samples; .80 for child report in school sample and .60 for child report in clinical sample Child-report form showed convergent and divergent validity Children with SAD scored significantly higher on child-report form than children with other anxiety disorders and schoolchildren Parent- and child-report forms both showed sensitivity to treatment change Parent-child agreement: <math>r</math> ranged from .33 to .63 across samples (In-Albon et al., 2013)</p>
<p><i>Separation Anxiety Assessment Scale</i> (Eisen &amp; Schaefer, 2007)</p>	<p>N/A</p>	<p>Child</p>	<p>34; 1–4 response scale</p>	<p>Items assess fear of being alone, fear of abandonment, fear of physical illness, worry about calamitous events, and dependence on safety signals May inform treatment planning Preliminary support for the factor structure, reliability, validity, and clinical utility of the SAAS has been described (e.g., Eisen et al., 2011) but findings not peer-reviewed</p>

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**Table 17.1** (continued)

<p><i>Separation Anxiety Daily Diary (SADD);</i> Allen et al., 2010a)</p>	<p>7–14 years</p>	<p>Child and parent</p>	<p>Daily Diary Entry</p>	<p>Assesses the frequency of anxiety-provoking and nonanxiety-provoking separations, along with associated thoughts, feelings, behaviors, and corresponding parental reactions</p> <p>Content informed by a literature review and parent interviews</p> <p>Compliance was acceptable for parent version</p> <p>Mothers of youth with SAD reported more anxious and fewer nonanxious separations on the daily diary than mothers of children with other anxiety disorders and healthy children</p> <p>Substantial improvement in the prediction of diagnostic group membership was shown when SADD items assessing child symptoms were added to information gathered from a separation anxiety symptom questionnaire</p> <p>Child version discriminated youth with SAD from healthy youth but not youth with other anxiety disorders (Allen et al., 2010a, b)</p>
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Note. Except for the MASC, these measures are all available to use at no cost

such as the Preschool Anxiety Scale (ages 2–6 years; Spence et al., 2001), as well as structured diagnostic interviews, such as the Preschool Age Psychiatric Assessment (PAPA, ages 2–5 years; Egger et al., 2006), may assist with accurate diagnosis. Using machine learning tools, Carpenter et al. (2016) developed a method for using the PAPA to quantify risk for SAD with accuracy >96% while limiting burden associated with assessment. The Child Anxiety Life Interference Scale-Preschool Version (Gilbertson et al., 2017) can be used to assess the impact of symptoms on the child and caregiver(s). Finally, the Dyadic Parent-Child Interaction Coding System II (DPICS-II; Eyberg et al., 1994), a validated system for coding observations during child- and parent-directed interactions, has been modified for use with young children with separation anxiety and can be used at intake and to monitor progress in treatment (Pincus et al., 2006). For youth of all ages, less formal observations (e.g., of child responses to prompts to separate for intake interviews) can corroborate other assessment data but may not be representative of behavior outside of the clinic setting.

**Informant discrepancies** Informant discrepancies in reports of psychopathology in youth are typical and may reflect contextual variations in displays of mental health concerns, reporting bias, and/or measurement error (de los Reyes et al., 2015). There is evidence of incremental validity of cross-informants reports of separation anxiety; for example, adding parent reports to child self-reports (on the MASC) has increased prediction of youths' anxiety disorder diagnoses (Villabø et al., 2012). Parents of youth with SAD may be better at judging impairment whereas youth are more likely to report distress (Allen et al., 2010c).

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## Psychological Treatment

**Cognitive-behavioral therapy** Given high rates of comorbidity, CBT studies have targeted SAD along with GAD and social anxiety disorder. Protocols for school-aged youth have typi-

cally included some combination of psychoeducation about anxiety; training in relaxation, cognitive restructuring/coping skills, and problem-solving; exposure to anxiety-provoking situations; and relapse prevention (e.g., Kendall & Hedtke, 2006). In efficacy trials, approximately 60–80% of youth show meaningful symptom reduction (response) and 50–70% achieve remission (the absence of the principal diagnosis following treatment) (Kendall & Peterman, 2015). CBT protocols modified to target anxiety disorders in early childhood, such as the Being Brave Program (Hirshfeld-Becker et al., 2010), have shown similar response rates. Research has suggested that most CBT-related symptom improvement happens after exposure is introduced, with cognitive restructuring also contributing substantially to gains made by school-aged youth (e.g., Peris et al., 2015). CBT protocols that emphasize exposure over anxiety management appear to produce larger effects (Whiteside et al., 2020).

Several studies have reported findings specific to SAD. For example, Hudson et al. (2015) evaluated the family-based CBT program Cool Kids (Lyneham et al., 2003; Rapee et al., 2006) delivered in group format to youth 6–18 years old ( $N = 842$ ) with a principal DSM-IV diagnosis of an anxiety disorder. The remission rate for SAD was 42.2% at post-treatment and 56% at 3- to 12-month follow-up, though the protocol was deemed most efficacious for youth with principal GAD or OCD. The Child-Adolescent Anxiety Multimodal Study (CAMS; Walkup et al., 2008) was a six-site, randomized controlled trial that examined the relative efficacy of CBT (Coping Cat; Kendall & Hedtke, 2006), sertraline, their combination, and pill placebo for the treatment of SAD, social phobia, and GAD in youth 7–17 years old ( $N = 488$ ). CBT and sertraline each reduced anxiety severity and their combination had a superior response rate. Although combined treatment was most efficacious across all anxiety disorders, the effect sizes relative to monotherapies were the largest for youth with principal SAD (Cohen's  $d = -0.91$  to  $-0.98$ ) compared to other principal anxiety disorders

(Cohen's  $d = -0.16$  to  $-0.69$ ; Compton et al., 2014). Also, active treatments (CBT, sertraline, their combination) yielded significantly greater reductions in parent-reported separation-related sleep difficulties than pill placebo, with the greatest reductions reported by parents of youth whose active treatment included sertraline (Caporino et al., 2017). Acute treatment responders in CAMS were less likely to exhibit chronic anxiety across a 4-year period beginning 4–12 years after randomization (Ginsburg et al., 2018).

Disorder-specific protocols for SAD in youth have been developed (e.g., Eisen et al., 2008). In a waitlist-controlled trial that sampled youth 5–7 years old ( $N = 43$ ), 76.19% of children who were randomized to a 16-session family-based CBT protocol that included parental cognition as a treatment target no longer met criteria for SAD at post-treatment (Schneider et al., 2011). The same protocol was compared to individual CBT in youth 8–13 years old ( $N = 64$ ), and both programs showed medium to large effects across measures at post-treatment, with no significant group differences in remission rates at 4-week or 1-year follow-up (Schneider et al., 2013).

**Family involvement in CBT** The majority of youth CBT manuals incorporate caregiver sessions (e.g., to promote the generalization of skills learned in session to outside settings; Howard et al., 2000). In addition to facilitating within-session exposure tasks involving separation, parents may be taught contingency management strategies for encouraging between-session exposure. Family-based treatment may also target parental overcontrol, rejection/criticism, anxious cognitive style and modeling, and accommodation (Caporino, 2020). Although meta-analyses have reported limited evidence that CBT with family involvement has added benefit over individual or group CBT for youth without family involvement (e.g., Peris et al., 2021), treatment-related decreases in parental overcontrol and family accommodation have been significantly associated with treatment outcomes (e.g., Kagan et al., 2016; Settapani et al., 2013). Also, family-based CBT appears to be more efficacious than

individual and family-based CBT when parents have clinical levels of anxiety (e.g., Kendall et al., 2010). Recently, a standalone parent-based treatment targeting family accommodation (Lebowitz & Omer, 2013) was found noninferior to standard CBT based on ratings provided by independent evaluators, parents, and children (Lebowitz et al., 2020).

**Parent-child interaction therapy** Parent-child interaction therapy (PCIT; Eyberg, 1988) is an intervention based on both social learning theory and attachment theory. PCIT incorporates child-directed interaction to strengthen the parent-child attachment as a foundation for parent-directed interaction within a behavioral framework. Although PCIT was initially used to treat externalizing problems in early childhood, it has been adapted to treat SAD and other common anxiety disorders (e.g., Puliafico et al., 2013). Pilot research and an unpublished RCT have suggested that PCIT is efficacious in the treatment of SAD only when it incorporates a focus on exposure (i.e., “bravery-directed interactions”; e.g., Pincus et al., 2008; Carpenter et al., 2014). The extent to which exposure (versus the synergy of exposure and PCIT) explains symptom improvement is unclear.

**Cognitive-behavioral and attachment-based family therapy** Attachment-based family therapy was developed to target adolescent depression (e.g., Diamond et al., 2002) and has been integrated with CBT to target SAD, social anxiety disorder, and GAD in adolescents (Siqueland et al., 2005). In addition to including all elements of standard CBT, the treatment targets parental beliefs about anxiety, overprotection, and psychological control to help the adolescent negotiate autonomy and make parent-child attachment bonds more flexible. Pilot research has established feasibility but adequately powered tests of efficacy are needed (Siqueland et al., 2005).

**Formats of delivery** Research on nonstandard formats of treatment delivery may inform efforts to improve access to CBT for SAD. Group CBT may be more cost-effective than individual CBT

and reduce the average time to intervention. Studies that have directly compared group to individual CBT for anxiety in youth have generally not found significant differences in outcomes (e.g., Liber et al., 2008; Wergeland et al., 2014), though individual CBT appears to be associated with larger effects than group CBT (e.g., in waitlist-controlled trials; Reynolds et al., 2012). A waitlist-controlled trial of intensive 1-week group CBT in a summer camp setting for school-aged females with SAD ( $N = 29$ ) found remission rates of 43% at post-treatment and 61% at 6-week follow-up (Santucci & Ehrenreich-May, 2013). Intensive treatment in this setting may be more time-efficient and accessible to families for whom travel to weekly sessions would not be feasible, and provides opportunities for exposure to situations (e.g., sleepovers) that could not be replicated during a standard clinic visit.

Like group CBT, computer-assisted CBT may reduce the cost of treatment by reducing the time burden on clinicians. Camp Cope-A-Lot (Khanna & Kendall, 2008), a computer-assisted adaptation of the Coping Cat (Kendall & Hedtke, 2006) that requires clinician time for exposure sessions only, has demonstrated efficacy in youth with SAD, social phobia, and/or GAD; in an RCT powered to detect moderate to large effects, there were no significant differences in outcomes between Camp Cope-A-Lot and individual CBT (Khanna & Kendall, 2010). Camp Cope-A-Lot used by CBT-naïve clinicians was also found superior to treatment as usual delivered in community mental health centers (Storch et al., 2015). The internet-based BRAVE program has been found superior to a waitlist control in the treatment of DSM-IV anxiety disorders (including OCD and PTSD) in children and adolescents (March et al., 2009) and equivalent to clinic-based CBT in adolescents (with power to detect medium effects; e.g., Spence et al., 2011) – though the program may not be effective with adolescents in routine clinical care settings (e.g., Waite et al., 2019). There is some evidence that the presence of SAD predicts relatively favorable outcomes of BRAVE-Online, as reported by parents and children (Spence et al., 2020). Other

computer-based CBT programs targeting anxiety in school-aged children and adolescents have been found superior to waitlist controls (e.g., Vigerland et al., 2016; Wuthrich et al., 2012). There is preliminary support for the efficacy of online parent-focused CBT in reducing anxiety symptoms in youth 3–6 years old (Donovan & March, 2014; Morgan et al., 2016).

Webcam-delivered CBT, which retains the real-time clinician interaction of clinic-based treatment, has potential to increase access to evidence-based care when logistical constraints (e.g., time, distance from clinic, a pandemic) interfere with pursuing or continuing clinic-based sessions. A pilot study of real-time videoconferencing CBT for SAD, social anxiety disorder, and/or GAD in youth ( $N = 11$ ) established its feasibility, acceptability, and preliminary efficacy (Carpenter et al., 2018). A large-scale, federally funded study comparing the effectiveness of web-based to in-person CBT for anxiety disorders in youth ages 3–18 is currently underway.

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## Psychopharmacological Treatment

**Selective serotonin reuptake inhibitors** The American Academy of Child and Adolescent Psychiatry recommends selective serotonin reuptake inhibitors (SSRIs) or selective norepinephrine reuptake inhibitors (SNRIs) for treating anxiety disorders in children and adolescents, as these medications are generally well tolerated and safe (Connolly & Bernstein, 2007). However, studies sampling youth with separation anxiety have yielded mixed findings depending on the medication administered. In the CAMS (Walkup et al., 2008), combined CBT and sertraline yielded a higher response rate (80.7%) among youth with SAD, GAD, and/or social phobia compared to CBT alone (59.7%) and sertraline alone (54.9%). There were no significant differences between the monotherapies, which were each more efficacious than pill placebo. An RCT that sampled 125 youth with these same disorders showed that 8 weeks of a flexible dose of fluvoxamine was significantly more efficacious than placebo (Walkup et al., 2001). Birmaher et al. (2003) found fluoxetine to

be superior to placebo in the treatment of social phobia and GAD, but there were no significant group differences in clinical response among youth with SAD.

**Selective norepinephrine reuptake inhibitors** Compared to SSRIs, SNRIs have smaller effects and yield less rapid improvement in youth anxiety but are less likely to produce adverse events (e.g., activation) than SSRIs (Mills & Strawn, 2020; Strawn et al., 2015; Strawn et al., 2018). Only one RCT of SNRI medication evaluated efficacy for reducing anxiety in youth with SAD, along with other anxiety disorders (Geller et al., 2007). Youth with attention deficit hyperactivity disorder (ADHD) and comorbid anxiety disorders receiving atomoxetine showed improvement in ADHD and anxiety symptoms after 12 weeks of treatment compared to those in the placebo group (Geller et al., 2007).

**Other medication classes** A pilot, randomized, placebo-controlled trial of guanfacine, an adrenergic receptor agonist, in the treatment of SAD, GAD, and social anxiety disorder demonstrated safety and tolerability (Strawn et al., 2017) but adequately powered tests of efficacy are needed. Tricyclic antidepressants are generally not recommended for treating SAD. In an RCT that sampled youth with SAD who did not respond to brief behavioral intervention, there were no significant differences in symptom improvement between imipramine and pill placebo treatment conditions (Klein et al., 1992). Further, tricyclic antidepressants are generally not tolerated as well as SSRIs and SNRIs and require higher levels of monitoring (Strawn et al., 2021). Although benzodiazepines (e.g., alprazolam, clonazepam) are tolerable and effective for treating short-term anxiety in procedural settings (Kuang et al., 2017), they have not demonstrated benefit in the treatment of chronic SAD (e.g., Graae et al., 1994).

## Summary

SAD is characterized by excessive anxiety upon separation or anticipation of separation from major attachment figures (APA, 2013) and is

associated with impairments in functioning as well as heightened risk for developing subsequent anxiety disorders. SAD is most common in early childhood and may be accompanied by somatic complaints, sleep problems, and/or school avoidance. Parents of youth with SAD may have negative expectations for their child's ability to cope with anxiety and may be quick to rescue their children from distress or accommodate symptoms, experiencing substantial burden as a result. A multi-informant approach to the assessment of SAD is recommended and there are well-validated measures of SAD symptoms in youth of all ages. Research has established the efficacy of CBT and SSRI medication (e.g., sertraline and fluvoxamine) in the treatment of SAD, with their combination yielding the highest response rate. Group CBT and computer-assisted CBT also have empirical support and may be particularly cost-effective, improving access to evidence-based care for SAD. Preliminary research has suggested that webcam-delivered and intensive CBT are also promising formats of treatment delivery.

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