PART I

INTRODUCTION

Part I lays the foundation for an individualized approach to assessment and treatment. In Chapter 1 we discuss the nature of separation anxiety and its related problems. More importantly, we introduce our conceptual framework, which emphasizes specific symptom dimensions rather than heterogeneous disorders. In Chapter 2 we discuss the normative experience of early separation-related fears and anxieties as well as developmental processes (i.e., attachment and temperament) that have relevance for clinical separation anxiety and panic responses.

CHAPTER 1

The Nature of Separation Anxiety

> I remember playing outside alone as a child. Now, I can't get myself to leave my son with a babysitter. My husband wants to get a surveillance system. My friends are thinking about it too.
>
> —CONCERNED PARENT

THE PHENOMENON OF SEPARATION ANXIETY

Nothing seems safe these days. It's not surprising, given the ubiquitous threats to our personal safety from terrorism, war, school killings, and natural disasters. Imagine contracting *E. coli* from swimming in a public pool or Lyme disease from playing outside decades ago in "your" day. Such environmental dangers are of great concern today (Rosen, 1998; Sloan, 1996), and for good reason. Understandably so, youngsters are experiencing more anxiety than ever before (Twenge, 2000).

Youngsters worry, and not just about environmental dangers. School performance, social problems, or health-related issues can easily become daily preoccupations. In large-scale community surveys, as many as 41% of children and adolescents reported separation concerns (Costello & Angold, 1995). The most frequent and highest rated concerns reported involved personal safety and injury (56%; Silverman, La Greca, & Wassertein, 1995), being alone (26%; Farach, 2002), and sleeping alone (51%; Farach, 2002).

Separation-related worries (i.e., calamitous events to self or others; getting sick) have also been shown to be prevalent in children who engage in both internalizing (29%) and externalizing (20%) samples (Barrios & Hartmann, 1997; Perrin & Last, 1997; Weems, Silverman, & La Greca, 2000). In our own work (Hajinlian et al., 2003), we have

found that separation fears are common not only in children who have DSM-IV (American Psychiatric Association, 1994) anxiety disorders but attention-deficit/hyperactivity disorder (ADHD) as well. In fact, youngsters with ADHD reported greater percentages of fear around being alone and sleeping alone than youngsters experiencing a wide range of anxiety disorders (see Table 1.1).

Throughout the book we suggest that case formulations should emphasize these key fear dimensions. First, however, let's take a look at the nature of separation anxiety disorder (SAD), given that the bulk of the extant literature is based on this condition.

DESCRIPTION AND PREVALENCE OF SEPARATION ANXIETY DISORDER

Description

The central feature of SAD is unrealistic and excessive anxiety upon separation or anticipation of separation from major attachment figures (American Psychiatric Association, 1994, 2000). Primary symptoms include excessive worry about potential harm to oneself (e.g., getting kidnapped) and/or major attachment figures (e.g., car accident), nightmares involving themes of separation, and somatic complaints (e.g., stomachaches, headaches, vomiting).

Youngsters may avoid situations that lead to separation from primary caregivers and/or safe places. Common situations include refusing to attend school, be alone, sleep alone, or be dropped off at a friend's house or social event (e.g., party). Youngsters may resort to oppositional behaviors (e.g., temper tantrums, screaming, pleading,

TABLE 1.1. Prevalence of Separation Fears across DSM-IV Disorders

Separation fear	SAD (n = 18)	Other Anxiety (n = 17)	ADHD (n = 21)
Being alone	75%	31%	50%
Sleeping alone	83%	50%	56%
Being abandoned	83%	63%	50%

Note. SAD = separation anxiety disorder; Other Anxiety = generalized anxiety disorder, social anxiety disorder, obsessive–compulsive disorder, panic disorder, adjustment disorder with anxiety; ADHD = attention-deficit/hyperactivity disorder.

threats) when avoidance of the dreaded scenario becomes unlikely. As a result, parental accommodations (i.e., allowing youngsters to avoid) are common and ultimately can strengthen the separation anxiety response.

Epidemiology

Prevalence estimates for SAD in community samples range from 3 to 13% for children (Anderson, Williams, McGee, & Silva, 1987; Bird et al., 1988; Cohen, Cohen, & Brook, 1993) and from 1.8 to 2.4% for adolescents (Bowen, Offord, & Boyle, 1990; Cohen et al., 1993; Fergussen, Horwood, & Lynsky, 1993; McGee, Feehan, Williams, & Anderson, 1992). SAD onset is most common during childhood (ages 7–12 years; Compton, Nelson & March, 2000; Last, Perrin, Hersen, & Kazdin, 1992), with marked declines of onset during mid-adolescence and young adulthood. Nevertheless, SAD continues to affect individuals throughout the lifespan. For example, in a sample of college students SAD was associated with adjustment problems, eating disorders, and the onset and maintenance of depressive disorders (Ollendick, Lease, & Cooper, 1993). In child and adolescent anxiety disorder clinics SAD has been found to be as high as 47% (Last, Hersen, Kazdin, Finkelstein, & Strauss, 1987).

In general, SAD tends to be observed more frequently in girls than boys (Compton et al., 2000; Last, Hersen, et al., 1987; Last et al., 1992). However, boys may be more likely to be brought to mental heath professionals. The nature of separation anxiety symptoms (e.g., fear of being alone) may be viewed as more socially undesirable in boys, thus prompting families to seek help more readily (Compton et al., 2000).

RATES AND PATTERNS OF COMORBIDITY

Anxious youth frequently present for treatment with comorbid disorders (Verduin & Kendall, 2003). In fact, 79% were found to have at least one other disorder (Kendall, Brady, & Verduin, 2001). In this section we review the co-occurrence of SAD with other anxiety disorders, depression, school refusal behavior, and behavioral and learning disorders.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) co-occurs in youngsters who have SAD approximately one-third of the time (Kendall et al., 2001; Masi, Mucci, Favilla, Romano, & Poli, 1999). This finding is not surprising,

given that both disorders are associated with frequent worry and somatic complaints. By definition, however, the focus of worry in GAD is not limited to calamitous events to self or others, and its course is more chronic in nature (Cantwell & Baker, 1989; Masi et al., 1999). Separation anxiety may develop subsequent to GAD, if a youngster's experiences (e.g., a car accident involving a parent) or perceptions (e.g., neighborhood robbery) threaten his or her personal safety. When the disorders co-occur, SAD should be the initial focus of treatment if the threat of being alone or abandoned accounts for the greatest interference in functioning.

Obsessive–Compulsive Disorder

Recent research also reports the co-occurrence of obsessive–compulsive disorder (OCD) and SAD in children and adolescents. Although prevalence estimates for these two disorders typically range between 4 and 7% (Brynska & Wolanczyk, 1998; Spence, 1997), rates for SAD have been found to be as high as 24–34% in patients with OCD (Geller, Biederman, Griffin, Jones, & Lefkowitz, 1996; Valleni-Basile et al., 1994). The combination of OCD and SAD is also associated with an earlier onset of panic disorder (Goodwin, Lipsitz, Chapman, Manuzza, & Fyer, 2001).

Clinically, youngsters with both SAD and OCD may avoid being alone due to preoccupation with images of harm to themselves or others. OCD is associated with compulsions to neutralize the anxiety, whereas SAD is associated with excessive need of safety signals (e.g., safe persons, objects). When the disorders co-occur, features of both can be targeted concurrently. If the OCD is too severe, however, negotiating SAD as a first step may help build the momentum for managing the OCD symptoms.

Panic Attacks

Although panic disorder (PD) typically emerges during young adulthood (Burke, Burke, Regier, & Rae, 1990), panic attacks may be observed in children and adolescents with SAD. For example, in one study antecedent or associated separation anxiety was reported in 73% of youngsters (ages 7–18 years) who had panic attacks (Masi, Favilla, Mucci, & Millepiedi, 2000). In addition, a number of case reports has suggested that children, in general, may experience cued panic symptoms (e.g., Garland & Smith, 1991; Vitiello, Behar, Wolfson, & McLeer, 1990). However, these occasional, discrete experiences should be differentiated from PD, which involves recurrent panic attacks, uncued by

the environment, as well as worries about having additional attacks (American Psychiatric Association, 1994). Concern regarding the implications of panic attacks (e.g., fear of dying, losing control) is generally not characteristic of children younger than 12 years of age (Kearney & Silverman, 1992; Nelles & Barlow, 1988). Hence, panic attacks in youngsters tend to be associated with physical (e.g., stomachaches, hyperventilation) rather than cognitive manifestations of anxiety. Separation-induced panic attacks tend to be associated with fears of abandonment and/or getting sick (Hahn, Hajinlian, Eisen, Winder, & Pincus, 2003).

Using structured interviews and questionnaires, prevalence estimates for PD in adolescence range from less than 1% (e.g., Wittchen, Reed, & Kessler, 1998) to greater than 10% (Hayward, Killen, Kraemer, & Taylor, 2000; Hayward, Killen, & Taylor, 1989), respectively. The most common symptoms reported include heart palpitations, trembling, dizziness, difficulty breathing, sweating, chest pain, and fear of dying.

Other Anxiety Disorders and Depression

Other anxiety disorders likely to coexist with SAD include social (8.3%) and specific phobias (12.5%; Kendall et al., 2001; Last, Hersen, et al., 1987; Verduin & Kendall, 2003). Youngsters who meet diagnostic criteria for posttraumatic stress disorder (PTSD) may also experience separation anxiety symptoms (e.g., refusing to be alone, school refusal behavior). However, such symptoms would be considered part of a PTSD diagnosis (Fischer, Himle, & Thyer, 1999). Given the association between anxiety and depression in children (e.g., Brady & Kendall, 1992), it's not surprising to find that SAD is frequently comorbid with depression. Approximately one-third of youngsters experience both SAD and a depressive disorder (Last, 1991; Last, Hersen, et al., 1987).

School Refusal Behavior

School refusal behavior is highly comorbid with SAD (Egger, Costello, & Angold, 2003). In fact, as many as 75% of children with SAD may also experience some form of school refusal behavior (Kearney, 2001; Last & Strauss, 1990; Masi, Mucci, & Millepiedi, 2001). In most cases, however, the school refusal behavior is acute, limited to mild forms (e.g., pleas to stay home, visits to nurse), and may not necessitate treatment.

Alternatively, chronic school refusal behavior is less likely to be associated with SAD. Rather, depression, panic, and agoraphobia, as

well as other incapacitating conditions are often evident (Berg & Jackson, 1985; Kearney, 1993, 2001). Careful assessment can help distinguish the function(s) of school refusal behavior (see Kearney, 2001; Kearney & Albano, 2004).

Behavioral and Learning Disorders

Behavioral disorders are also likely to coexist with SAD. For example, ADHD (16.7%), oppositional defiant disorder (16.7%), and enuresis (8.3%) were found to be the most frequent comorbid disorders with SAD (Kendall et al., 2001; Last, Hersen, et al., 1987). Youngsters with a learning disorder (LD) are at risk for experiencing anxiety, depression, poor academic performance, and low self-esteem (e.g., Ialongo, Edelsohn, Werthhamer-Larrson, Crockett, & Kellam, 1994; Lyon, 1996). The presence of an LD may further diminish a youngster's perception of control. When an LD co-occurs with SAD, strong safety needs often emerge (see Chapter 11).

DIAGNOSTIC CONSIDERATIONS

As with any classification system, the categorical approach of DSM-IV is not without shortcomings. Both developmental and diagnostic limitations should be considered when using DSM-IV criteria to diagnose children and adolescents with SAD.

Regarding the developmental domain, no distinction is made between childhood and adolescent symptoms of separation anxiety. Rather, an early onset is noted if the diagnosis is assigned before age 6. This criterion is problematic because the nature, frequency, and intensity of separation anxiety symptoms often differ across the lifespan. For example, whereas the fear of being alone may appear at any point across the lifespan (e.g., Wijeratne & Manicavasagar, 2003), the fear of abandonment is strongest in younger children. Similarly, younger children are more likely to experience primarily somatic complaints, whereas older children and adolescents are more likely to experience both cognitive and somatic symptoms as well as a proneness to panic. Therefore, specific separation-related symptoms may offer differential prognostic value based on the frequency and intensity of the symptoms as well as their developmental origins.

Using DSM-IV criteria for SAD, a youngster must manifest any three (of eight) symptoms to qualify for a diagnosis. But it is not clear that all the symptoms are equivalent prognostic indicators. As a result of this artificial threshold (Frances, Widiger, & Fyer, 1990), some

youngsters who are experiencing significant separation anxiety may fail to meet diagnostic criteria. It is important to keep in mind that family disruption can occur even when a youngster's separation anxiety is limited to one symptom (e.g., refusing to sleep alone at night).

In addition, the threshold problem (i.e., presence or absence of diagnosis) may obscure the heterogeneity that occurs within SAD. For example, some youngsters who experience separation anxiety are primarily concerned with being alone; others, with possible abandonment or getting sick (Eisen, Raleigh, & Neuhoff, 2003). A diagnosis of SAD, by itself, provides minimal information about the nature and intensity of the disorder. The one-month impairment criterion of DSM-IV is a step in the right diagnostic direction, because young children often experience developmentally appropriate separation anxiety that is transitory in nature (Rutter, 1981).

The overlap of disorders at both the symptom and diagnostic levels may also limit the usefulness of a SAD diagnosis. For example, at the level of the symptom, worry (Perrin & Last, 1997; Weems et al., 2000) and somatic complaints (Beidel, Christ, & Long, 1991; Last, 1991) are characteristic of emotional disorders in youth and are present to varying degrees in normative samples of youngsters (Egger, Angold, & Costello, 1998; Silverman et al., 1995). At the level of the disorder, SAD is frequently comorbid with both internalizing and externalizing disorders. Given these points of intersection, at times, it remains unclear as to which disorder is primary and should be addressed first (Eisen & Kearney, 1995).

KEY SYMPTOM DIMENSIONS

In general, given the limitations of DSM-IV and the frequent diagnostic comorbidity of disorders, there has been movement toward examining key symptom dimensions for specific adult (Barlow, 2002; Brown, Chorpita, & Barlow, 1998) and childhood internalizing problems (Chorpita, Albano, & Barlow, 1998; Eisen & Silverman, 1993, 1998; Kearney, 2001). In our work we have found that separation anxiety may be best understood by examining several key symptom dimensions that may account for separation-related symptoms individually or in combination and include fear of being alone (FBA), fear of abandonment (FAb), fear of physical illness (FPI), and worry about calamitous events (WCE; Hahn et al., 2003).

The first two dimensions directly capture the avoidance component of separation anxiety. The common fears associated with being alone and being abandoned are presented in Table 1.2.

TABLE 1.2. Fears of Being Alone and Abandoned

Being alone	Being abandoned
Living room	School
Family room	Carpool/bus
Bathroom	Play date
Bedroom	Extracurricular activity
Upstairs	Babysitter
Basement	Party
Attic	Parental errand
Kitchen	Sleep-over

Fear of Being Alone

Youngsters may be afraid to be left alone in certain areas of the house and therefore become the parent's shadow. Keep in mind that, in most cases, the FBA is strong even when a family member remains somewhere in the house. Daytime fears may include being alone in any room in the house or being on a different floor from other family members. At times, youngsters may be able to tolerate being alone if distracted by schoolwork, reading, television, or video games. Sometimes, however, distraction is not enough, especially if the entertainment system is in a more remote region of the house (e.g., finished attic or basement).

It is often easier for youngsters to be alone during the day than at night. Refusal to sleep alone is our most common referral. Youngsters who are afraid to sleep alone tend to have difficulty being alone during their nighttime routine as well. This may include going to the bathroom to brush their teeth or take a bath/shower, or simply settling down in their bedroom. As a result, bedtime may become a nightmare for the entire family.

If a youngster's separation anxiety is limited to FBA, his or her social and academic functioning outside of the home is typically unaffected. As long as the youngster is in the company of others, his or her perception of control generally remains intact. Compared to FBA, FAb tends to wield a broader influence and is more likely to threaten the nature of a youngster's academic and peer relationships.

Fear of Abandonment

Youngsters who fear abandonment may avoid certain places unless promised close proximity to a parent or major caregiver; for example,

they may refuse to take the school bus or to be dropped off at a play date, extracurricular activity, birthday party, or sleep-over. During the preschool years, a parent may routinely stay with his or her youngster during these events. However, as elementary school progresses and greater independence from family members is expected, it becomes the norm for youngsters to separate from parents. Youngsters with FAb may fiercely protest any parental attempts to force separation, and/or they may make excuses to avoid attending the events on their own. Social isolation is often the result if avoidance becomes routine.

FAb may also have untoward effects at home. For example, youngsters may vehemently protest being left with a babysitter or resist a parent's efforts to run an errand. Unlike FBA, having family members present (e.g., older sibling) is not enough to quell a youngster's anxiety. Rather, the fear is specifically directed at the primary caregiver and the possibility of not being reunited with him or her.

Somatic Complaints/Fear of Physical Illness

The second set of dimensions—FPI and WCE—help to maintain a youngster's separation anxiety. The common somatic complaints/fears and worries associated with separation anxiety are presented in Table 1.3.

Epidemiological surveys have suggested that between 10 and 30% of children and adolescents report frequent headaches, stomachaches, and muscle/joint pain (e.g., Alfven, 1993; Egger et al., 1998). The ubiquity of somatic complaints has also been demonstrated in samples of

TABLE 1.3. Common Somatic Complaints/Fears and Worries

Somatic complaints/fears	Worries
Headaches	Harm to self or others
Stomachaches	Health of others
Dizziness	Being unable to cope
Fatigue	Getting lost/being abandoned
Feeling uncomfortable	Getting sick
Feeling sick	Being alone/sleeping alone
Choking	Disasters
Having an accident	Future events

Note. Somatic complaints based on Egger, Costello, Erkanli, and Angold (1999) and Last (1991); worries based on Farach (2002), Silverman, La Greca, and Wassertein (1995), and Weems, Silverman, and La Greca (2000).

children with childhood anxiety disorders, in general, and SAD, in particular (e.g., Beidel et al., 1991; Bernstein et al., 1997; Egger et al., 1999; Last, 1991).

For youngsters with separation anxiety, somatic complaints are usually in response to anticipated separations and will decrease when the threat of separation is removed. Sometimes the physical symptoms are exaggerated to gain attention or postpone separation (Eisen & Kearney, 1995). In general, however, it is not the experience of the somatic complaints, per se, but what they represent that maintains the youngster's separation anxiety. For example, a stomachache or nauseous feeling upon separation may trigger the fear of getting sick.

Although the youngster's fear may be limited to one or two somatic sensations (e.g., vomiting, choking) and there may not be evidence of cognitive symptoms (e.g., fear of dying, losing control; Nelles & Barlow, 1988), the youngsters may avoid situations or places that trigger these somatic cues. This dynamic, termed "interoceptive avoidance" (Barlow, 2002), is characteristic of panic disorder in adults.

As children get older and cognitive belief systems begin to develop, FPI may become associated with heightened anxiety sensitivity (AS; Reiss, Silverman, & Weems, 2001). Youngsters with elevated AS worry about the consequences (e.g., getting sick, losing control) of their bodily sensations. AS is associated with separation anxiety, school refusal behavior, and panic attacks (Kearney, 2001; Rabian, Peterson, Richters, & Jensen, 1993). FAb, however, tends to be maintained by a youngster's worry about calamitous events to others.

Worry about Calamitous Events

Common worries in youngsters include harm to self (e.g., being kidnapped, killed, or abandoned) or others (e.g., heart attack, serious accident, death; Perrin & Last, 1997; Silverman et al., 1995; Weems et al., 2000). WCE may maintain FBA, especially if youngsters are worried about bad things happening to them at home (e.g., getting sick, burglar intrusion). As youngsters venture out to the world, however, WCE (to others) typically maintains FAb.

For example, a fear of not getting picked up at school is often fueled by a fearful preoccupation with possible catastrophic injury to the primary caregiver. Any sign of lateness on the caregiver's part may easily spiral a youngster's anxious apprehension. As a result, youngsters will often avoid a variety of separation-related situations unless promised close proximity to the caregiver. When separation does occur, as is inevitable, these youngsters are convinced that disaster has been averted only after reunion.

SAFETY SIGNALS

Given the nature of separation anxiety symptoms, it's not surprising that youngsters cling to safe persons, places, transitional objects, or actions during anticipated separations. Safety signals help individuals feel more secure and may lead to the perception of restored personal control in anxiety-provoking situations (Barlow, 2002; Craske, 1999). Common safety signals associated with separation anxiety are presented in Table 1.4.

Safety signals are frequently present across the dimensions of separation anxiety and related disorders (Hajinlian et al., 2003) and can easily allay a youngster's anxious apprehension. For example, regarding FBA, being with others augments the youngster's perception of personal safety (e.g., help is available if physical sickness develops) and minimizes preoccupation with the potential occurrence of calamitous events to self or others. Transitional objects (e.g., "blankie") and favorite activities (e.g., watching television, playing video games) also enhance a youngster's feelings of security when caregivers are unavailable.

Overall, it is important to keep in mind that safety signals can serve useful functions (e.g., as a lucky charm, so to speak) and at times may be considered developmentally appropriate. At the same time, however, excessive reliance on safety signals may serve to strengthen a youngster's separation anxiety (i.e., through avoidance behavior) and thereby result in a limited range of functioning in social and academic

TABLE 1.4. Common Safety Signals for Youngsters with Separation Anxiety

Persons	Places	Objects	Actions
Primary caregiver	Home	Night light	Calling a parent
Parent/ guardian	Relative's house	"Blankie"	Eliciting specific promises
Relative	Best friend's house	Special toy	"Shadowing" the caregiver
Sibling/pet	Parent's room	Stuffed animal	Sleeping with others
Best friend	Sibling's room	Book	Staying with the nurse
Teacher/ nurse/coach	Familiar place	Food/drink	Engaging in favorite activity

areas. The gradual elimination of unhealthy safety signals coupled with the learning of new coping strategies are considered integral to facilitating successful treatment outcome in separation-anxious youth.

SUMMARY

Separation anxiety disorder is characterized by unrealistic and excessive anxiety upon separation or anticipation of separation from major attachment figures. Given the diagnostic limitations of DSM-IV and the frequent comorbidity of SAD with other disorders, it may be best to examine the key symptom dimensions of FBA, FAb, FPI, and WCE. Careful attention must also be paid to the number, frequency, and intensity of safety signals developed by an anxious youngster. Our dimensional framework sets the stage for identifying and implementing prescriptive treatment strategies.

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