A review of separation anxiety disorder with a focus on research based intervention strategies

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Abstract
The purpose of this paper is to discuss what Separation Anxiety Disorder is, what causes SAD symptoms in some children, successful assessment methods, and finally treatment and intervention options available and the efficacy of each one. The focus of this paper is on research based interventions with the intention of finding the most successful and empirically based intervention available. The most widely used and empirically based intervention available at this time is Cognitive Behavioral Therapy (CBT). Alternative methods of treatment include psycho-education for mild cases and CBT plus medication for severe cases.

Many areas need further research and future studies need more comparisons to active control groups, not just wait-list control groups. Some of the areas needing future research include: medications and their safety; CBT and variations of it; and the affects of the family on recovery. Lastly, the most effective and time efficient therapy should be found that includes both group and family components.
A Review of Separation Anxiety Disorder with a Focus on Research Based Intervention Strategies

A Research Paper Submitted in Partial Fulfillment of the Requirements of the Degree Masters of Arts in Education

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The purpose of this paper is to discuss what Separation Anxiety Disorder is, what causes SAD symptoms in some children, successful assessment methods, and finally treatment and intervention options available and the efficacy of each one. The focus of this paper is on research based interventions with the intention of finding the most successful and empirically based intervention available. The most widely used and empirically based intervention available at this time is Cognitive Behavioral Therapy (CBT). Alternative methods of treatment include psychoeducation for mild cases and CBT plus medication for severe cases. Many areas need further research and future studies need more comparisons to active control groups, not just wait-list control groups. Some of the areas needing future research include: medications and their safety, CBT and variations of it, and the affects of the family on recovery. Lastly, the most effective and time efficient therapy should be found that includes both group and family components.
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Chapter 1: Introduction

Introduction

Anxiety disorders are one of the most widespread disorders of childhood and yet are also one of the least likely to be diagnosed or observed in an inflicted child. Children with anxiety disorders are relatively easy to identify but are often considered to not really have problems (Walkup & Ginsburg, 2002). For many years anxiety disorders were considered to be exaggerations of normal fear or worry (Walkup & Ginsburg, 2002). Fears are very common in children and are, for the most part, a normal, common and transitory part of the developmental process (Deluty & DeVitis, 1996). Anxiety is actually slightly different than fear. While anxiety is a transient, disagreeable feeling associated with a sense of impending danger or doom, fear is a more intense feeling that is associated with a clear threat (Schlozman, 2002). On some occasions these generalized fears, or anxiety, may deter development and impinge on mastery, growth, and success (Deluty & DeVitis, 1996). Many children go without treatment or support for years before their problems with anxiety become apparent to their teachers and parents. Although worries and fears are a normal part of childhood, pathological anxiety is quite different (Walkup & Ginsburg, 2002). In youth, pathological anxiety can disrupt academic performance as well as social and cognitive development (Schlozman, 2002). Therefore, it is important that anxiety disorders are detected in youth as early as possible.

As a whole, anxiety disorders are the most prevalent psychiatric disorders in children and adolescents and have a higher prevalence than attention-deficit hyperactivity
disorder (Murphy, Bengtson, Tan, Carbonell & Levin, 2000). The prevalence of anxiety disorders in children is around 10-20% (Barrett, Dadds & Rapee, 1996; Moore, 2002). Some general anxiety disorders that impact children such as generalized anxiety disorder, separation anxiety and social phobias are found in about 5-10% of children (Barrett et al., 1996; Moore, 2002). One type of anxiety disorder that affects many children in school systems is Separation Anxiety Disorder or SAD. SAD is the only anxiety disorder identified in the Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition (DSM-IV; American Psychiatric Association, 1994) that primarily affects children and adolescents (Strauss & Todaro, 2001).

Separation Anxiety Disorder is defined as an unrealistic and excessive fear of separation from home or from major attachment figures (Strauss & Todaro, 2001). Symptoms include excessive worries about the primary caregiver, and extreme distress is shown upon separation from this individual. SAD affects children from about age 5 on and shows up frequently when children first leave their primary caregiver for a long period of time, usually when attending school. Before the age of 5 it is considered normal to have these anxieties regarding separation from the primary caregiver and anxiety as a result of separation varies widely from child to child. It can range from no distress at all when a primary caregiver is gone to extreme distress when the primary caregiver simply leaves the room. Strauss and Todaro (2001) state that separation anxiety is considered normal and common from approximately six months of age until approximately 2 or 3 years of age. Symptoms of separation anxiety tend to peak in children around 18 months of age and then start to dissipate (Strauss & Todaro, 2001). In
most children these behaviors start to dissipate at least by the age of 5 and therefore should not cause significant problems for the child once he or she has entered school.

Separation anxiety should not be confused with attachment disorder. Although they both deal with emotions and behaviors that are intertwined with the child’s relationship with the primary caregiver there are very important differences. Greenberg, Cicchetti & Cummings (1990) state that attachments are developed quite early, starting around the age of 6-8 months. Either a secure or insecure attachment develops during infancy and influences behavior in infancy and toddler years as well as beyond (Greenberg et al., 1990). A child with a secure attachment will have developed a set of expectations that the attachment figure will be sensitive and responsive to his or her needs, and also will develop a sense of self as a loveable and valuable person (Greenberg et al., 1990). Many problems may emerge if a child has not developed a secure attachment with a primary caregiver (Greenberg et al., 1990). However, separation anxiety disorder does not seem to have much of a connection with this disorder. SAD is based more on an underlying anxiety within the youth that does not appear to have any direct environmental cause where attachment disorder is a result of severe environmental factors such as neglect or abuse or institutionalization in an emotionally sterile environment (Moore, 2002). This severe abuse or neglect has many intense impacts on the child’s social and emotional well-being as well as his or her capacity for learning. However, it is based clearly on the lack of stimulation in a very sensitive period of development. SAD may occur at any point in the child’s life and usually does not develop following a period of severe neglect or abuse.
The purpose of this paper is to discuss what Separation Anxiety Disorder is, what causes SAD symptoms in some children, successful assessment methods, and finally treatment and intervention options available and the efficacy of each. The focus of this paper is on research based interventions with the intention of describing the most successful and empirically based intervention found in the literature.

Chapter 2: Review of the Literature

The literature review will include an overview of anxiety disorders that affect youth, as well as an explanation of what separation anxiety disorder is, including its prevalence, symptoms, comorbidity, and prognosis. An overview of the cognitive-behavioral model of anxiety is also presented. Then a review of etiologies is given followed by a review of successful assessment methods. Finally, research based interventions and treatments are presented.

Overview of Anxiety Disorders in Youth

It was only recently that anxiety disorders were looked at specifically in youth. Velting, Setzer, & Albano (2002) report that before a separate section was put in for childhood anxiety disorders in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III), very little attention was paid to children and adolescents with anxiety disorders. Three anxiety disorders were introduced in the DSM-III including separation anxiety disorder, avoidant disorder of childhood and adolescence,
and overanxious disorder (Velting et al., 2002). However, only separation anxiety
disorder was kept as a specific childhood anxiety disorder in the *DSM-IV*. The overall
prevalence of anxiety disorders among youth is reported by Velting et al. (2002) to be
between 12% and 20%. This is startlingly high and implies that we must become more
aware of and sensitive to the different anxiety disorders present in our youth. There are
also many risks that come along with having an anxiety disorder as a child or adolescent.
Anxiety disorders in youth are often associated with significant impairment in
functioning in areas such as school performance, family, social, and peer functioning
(Velting et al., 2002). Velting et al. (2002) also state that often childhood anxiety can be
a direct pathway to substance abuse in adolescence if untreated. It is also often
associated with impairment extending into adulthood, and can be predictive of adult
anxiety disorders, major depression, suicide attempts and psychiatric hospitalization
(Velting et al., 2002). However, more specific anxiety disorders such as SAD were not
associated with suicide attempts or ideations in the study conducted by Strauss, Birmaher,
Bridge, Axelson, Chiappetta, Brent, et al. (2000). Even so, the variety of problems that
go along with anxiety disorders that are mentioned above are significant enough to
warrant assessment and treatment. Anxiety disorders tend to have an early onset in
childhood and run a chronic and fluctuating course into adulthood if proper interventions
are not put into place (Strauss et al., 2002). For these reasons, more of an emphasis needs
to be put on the diagnosis and treatment of anxiety disorders in our youth. In our school
systems, school psychologists as well as counselors and classroom teachers need to
become aware and educated about anxiety disorders so that they are better able to detect them and are more efficient at treating them.

**What is SAD?**

*Definition*

The defining characteristic of SAD as given by Velting et al. (2002) is excessive anxiety regarding separation from the home or from primary caretakers to whom the child is attached. The anxiety that children experience when they are separated from their primary caregivers is a phenomena that is apparent in all children at some point in their developmental history. Gittelman (1986) states that when infants develop a focused attachment with their primary caregivers, they begin to avoid strangers and to seek protection and comfort with their primary attachment figure. The ages that this behavior is considered to be normal falls from 6 months through 5 years with some variations being found within the literature. After 5 years of age, most children’s anxiety in separating from those they know tapers off. However, if the anxiety and distress that separation causes is excessive and causes significant problems in the daily functioning of the child during this age, or if the distress continues on after this age, the child may be diagnosed with Separation Anxiety Disorder (SAD). However, Silverman and Kurtines (1996) stress that in infants and toddlers, distress and protest surrounding separation are age-appropriate and are not viewed as a diagnosable problem. Therefore the child’s age as well as his or her developmental level must be taken into consideration when diagnosing this disorder. An onset of SAD after the age of 10 is unusual and an onset
before the age of 18 is required to be considered for a diagnosis of SAD (Kronenberger & Meyer, 2001).

**Prevalence**

SAD is one of the most common childhood anxiety disorders (Kronenberger & Meyer, 2001). It has an average prevalence of about 4% for school age children. However, SAD is still quite common in adolescents and affects on average about 2% of adolescents (Kronenberger & Meyer, 2001; Moore, 2002). SAD is more common in females than males with a ratio of about 1:2-3 (Kronenberger & Meyer, 2001; Moore, 2002). The onset of this disorder usually occurs around ages 5-9 (Kronenberger & Meyer, 2001). The mean age of onset of the disorder is approximately 7.5 years (Masi, Mucci & Millepiedi, 2001). This is interesting since the mean age of onset occurs after most children enter school. Possible hypotheses for this are that onset could be due to longer periods of time away from adults, more stress at school because of harder work, negative events at school, or a developmental awareness of mortality at this age.

**Symptoms**

Symptoms associated with SAD often appear upon separation or the threat of separation from parents including such activities as going to school or the parents going out for the night or going on a trip. Symptoms may even occur when the child or the parent goes to sleep causing the child to insist on sleeping with the parent or outside the door of the parent’s room if this is refused. Many of the symptoms that go along with
SAD may also be present in normally functioning children at some point in their life. However, it is when these symptoms begin to interfere with the individual functioning of the child that treatment for this condition is sought.

While separated from primary caregivers, a child with SAD may experience excessive worries about injury, illness, harm, or other circumstances preventing a reunion with them. The child may resist participating in any activities including play, sleep, and school while the primary caregiver is away. Velting et al. (2002) report that most children with this disorder regularly have increased anxiety at bedtime. The child may insist that someone stay with them until they fall asleep or may develop a pattern of sleeping close to the primary attachment figure. The child may experience nightmares and be preoccupied with thoughts of loss, danger or disease. Husain and Kashani (1992) found that children with SAD may experience a variety of fears and especially tend to be fearful of the dark. A child with SAD may insist on leaving the bedroom light on at night and may attribute this fear to seeing or feeling eyes staring at them in the dark or to mythical animals or creatures ganging up on them (Husain & Kashani, 1992). This tends to be a common fear in young children, however if this continues to be a problem and disrupt sleep for the child as he or she gets older, it may be an important symptom to modify.

Children with SAD may also develop symptoms that affect their emotional or physical wellbeing. Children with SAD may look sad and report feeling depressed and may even express wishes to die (Husain & Kashani, 1992). They may cry easily and sometimes complain about not being loved or that siblings are favored over them (Husain
& Kashani, 1992). Somatic complaints including headaches and stomachaches are also common in children afflicted with SAD. In fact, Strauss and Todaro (2001) report that up to 78 percent of clinical cases of children and adolescents diagnosed with SAD have somatic complaints. The child may be preoccupied with reunion fantasies when separated and may even become physically or verbally violent towards the person who is demanding separation (Deluty, 1996). A child with SAD may be described as demanding, intrusive and requiring constant attention which may lead to parental frustration and family conflict (Velting et al., 2002).

Strauss and Todaro (2001) also report that there are two main patterns of symptoms apparent in young children with SAD. The first pattern includes worry about harm befalling an attachment figure and worry that a calamitous event will separate the child from the attachment figure (Strauss and Todaro, 2001). The second pattern includes worry about harm befalling an attachment figure and reluctance or refusal to go to school (Strauss and Todaro, 2001). The DSM-IV criteria for Separation Anxiety Disorder appear in Table 1 below. (Kronenberger & Meyer, 2001; Moore, 2002).

Table 1: Summary of DSM-IV Criteria for Separation Anxiety Disorder

A. Extreme and age-inappropriate anxiety in relation to various separation situations.

1. Extreme and consistent distress in situations in which separation from home or caretaker is imminent.

2. Excessive and consistent worry that harm will befall parent or loved one.
3. Extreme and consistent worry of situations that involve separation from caretaker (e.g., getting lost, kidnapped).

4. Consistent refusal to engage in situations that involve separation.

5. Steady fear of being alone at home and in other situations.

6. Frequent refusal to go to sleep without parent or loved one or to sleep over at friends’ homes.

7. Numerous disturbing dreams of separation.

8. Several reports of having somatic complaints (e.g., stomachaches, headaches) in separation situations.

At least 3 of 8 above symptoms must be present in the child.

B. The disturbance should be experienced for at least 4 weeks.

C. The onset is experienced before the age of 18.

D. The disturbance should cause clinically significant impairment or distress in social, academic, or other important areas of functioning.

E. The disturbance does not occur during the course of Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. In adolescents, the disturbance is not better accounted for by Panic Disorder with Agoraphobia.

_School Refusal_

A common occurrence that often is a symptom of SAD is school refusal. Strauss and Todaro (2001) report that approximately 75 percent of clinic-referred children who were diagnosed with SAD showed the diagnostic criterion of school reluctance or
avoidance. School refusal, in this case, is not a separate disorder, but rather is a culmination of all of the anxiety problems that the child is experiencing (Strauss & Todaro, 2001). School refusal is usually what prompts the teacher or parent to seek help for the child, however because there are so many anxiety problems underlying this behavioral problem it would be difficult to treat the school refusal successfully without first treating the anxiety (Kronenberger & Meyer, 2001). School refusal is prominent in about three fourths of SAD cases, but is not always a symptom. Also, in as many as two-thirds of the cases of school refusal, SAD is not the primary diagnosis (Kronenberger & Meyer, 2001). School refusal may be diagnosed separately in these cases as a specific phobia, social phobia or generalized anxiety disorder (Kronenberger & Meyer, 2001).

Comorbidity

SAD is commonly associated with other anxiety or mood disorders. Velting et al. (2002) report that a comorbid diagnosis of major depressive disorder and dysthymic disorder are common in children with SAD and that SAD may lead to the development of panic disorder with agoraphobia in adulthood. Over one-half of children diagnosed with SAD will also be diagnosed with Generalized Anxiety Disorder (GAD) or Specific Phobia. As many as one-third may be diagnosed with depression. Masi et al. (2001) says that although high rates of comorbidity are very common in children with anxiety disorders, children with a primary diagnosis of SAD are the least likely of all the anxiety disorders to meet criteria for a concurrent anxiety disorder.
Prognosis

SAD may affect the child or adolescent throughout his or her lifetime in a variety of ways. The symptoms of SAD may wax and wane throughout childhood and adulthood with symptoms becoming exacerbated in the presence of threats to intimate bonds (Masi et al., 2001). SAD has been found to be relatively more unstable than other DSM-III anxiety disorders and this has been attributed primarily to the relatively young age of the group usually affected (Husain & Kashani, 1992). SAD may remit spontaneously after one episode or may come and go over the course of several years (Husain & Kashani, 1992). It may be exacerbated during adolescence or young adulthood when an individual faces situations such as leaving home for college or geographic relocation for a new job (Husain & Kashani, 1992). An older adolescent or young adult may refuse to leave the home or may suffer from severe anxiety if forced to do so. They may still be preoccupied with the parent’s wellbeing and may be fearful of a variety of environmental factors in their new environment.

However, the prognosis for this disorder overall is typically good with spontaneous recovery for most before the end of adolescence (Kronenberger & Meyer, 2001). However, this does not mean that treatment should not be sought for these children. Before the age that spontaneous recovery may occur in adolescence, the frequent absenteeism that is often associated with this disorder as well as emotional problems for the child and his or her family may vastly affect the child’s academic and social success (Kronenberger & Meyer, 2001; Moore, 2002). The severity of symptoms in youth suffering from SAD ranges from anticipatory uneasiness to full-blown anxiety.
Long-term follow-up studies of children treated for school refusal due to SAD find that despite a return to school, many children and adolescents continue to have significant social and affective problems (Masi et al., 2001). Treatment only includes a focus on school refusal and therefore emphasizes the need for treatment of the underlying disorder of SAD that is contributing to the school refusal.

Masi et al. (2001) acknowledge that a history of SAD may identify a particular heritable early-onset form of panic disorder. However, more research is needed in order to decide whether this occurs within a particular subgroup of youth with SAD or whether the youth have an overall tendency to experience heightened anxiety that may or may not result in panic disorder (Masi et al., 2001). Husain and Kashani (1992) also reported that SAD predisposes individuals to the development of agoraphobia in adulthood and also suggested that children with SAD may be more likely to develop work phobia in adulthood.

**Origin of Anxiety**

The most popular and accepted model of anxiety today is the cognitive-behavioral model of anxiety (Velting et al., 2002). This model has its roots in the basic behavioral principles and models of learning such as operant conditioning, classical conditioning, and social learning theory. First the behavioral aspect will be looked at. The classical conditioning paradigm of fear acquisition was brought to our attention with the case of "Little Albert", a boy whose fear of a rat was acquired through paring the presence of the rat with a loud noise (Velting et al., 2002). Mowrer (2002) proposed a two factor
learning theory for the development and maintenance of phobic behavior that proposes that both classical and operant conditioning are involved in the development of anxiety disorders. Through classical conditioning an individual associates different stimuli that it does not control such as "Little Albert" associating a rat with a loud noise. Through operant conditioning, the individual associates its behaviors with consequences. Behaviors followed by reinforcers tend to increase while those followed by punishment decrease. Although it is criticized for not accounting for all instances of fear acquisition, it remains a popular factor in learning theory. In addition to the avoidance behavior introduced by Mowrer (2002), anxiety may be maintained through certain parental rearing styles such as overprotection and overcontrol and other environmental conditioning and shaping experiences. In conclusion, behavioral models of anxiety stress that the anxious response is a learned response and is reinforced through experience or observation. Also, the anxious response is maintained through avoidance and further conditioning experiences.

It has been found that an entirely behavioral explanation of anxiety is not sufficient because it does not involve any of the cognitions that are prevalent and ultimately play a role in a person's behavior. In response to this, cognitive models were developed that emphasize the role of maladaptive thoughts in individuals suffering from anxiety (Velting et al., 2002). Cognitive models propose that people perceive events in their environment through schemas, which are previously developed templates of the world around them. Unhealthy schemas may cause individuals to interpret ambiguous stimuli as threatening and automatically engage in maladaptive thinking when a certain
stimulus is present (Velting et al., 2002). Children as well as adults with psychological problems make systematic errors in thinking called cognitive distortions and have skill deficits that maintain this problem (Dia, 2001). The cognitive model hypothesizes that a person’s cognitive distortions influence the way he or she will react to certain stimuli cognitively and ultimately behaviorally (Dia, 2001). The principles of Cognitive Behavioral Therapy (CBT) that are used for adults can also be used for children with developmental modifications (Dia, 2001). SAD has many of the same clinical features that panic disorder with agoraphobia has in adults including phobic avoidance, catastrophic interpretations, and panic symptoms (Dia, 2001). Therefore many of the components of CBT that work with these adults will also help children with SAD (Dia, 2001).

Neither the behavioral or cognitive model is a sufficient explanation of anxiety by itself. An integrated cognitive-behavioral model of anxiety disorders that focuses on the role of anxious thoughts, physical sensations, and behaviors in the development and maintenance of anxiety disorders is the most encompassing view of anxiety disorders we have.

**Etiologies**

The anxiety that is experienced when a child is separated from an attachment figure is a normal occurrence and in fact happens even in non-human primates (Bowlby, 1973). This is because being alone carries an increased risk of danger, especially for young individuals. Therefore a fear response when threatened with separation may be an
adaptable response in many situations (Bowlby, 1973). The attachment theory contends that separation anxiety is a primary instinctual system that has evolved in order to establish close social bonds and to make maternal or other caregiver separation precipitate anxiety, thus ensuring survival (Husain & Kashani, 1992). However, it has already been discussed that these normal fears tend to dissipate by the time a child enters school. Normal separation anxiety manifests itself in children around 6 to 8 months of age when an infant starts to recognize his or her caregivers and to develop an emotional bond or attachment with this individual (Husain & Kashani, 1992). In some individuals, these fears continue and eventually cause many problems for the person. Some reasons for the continuation of these fears in certain individuals have been hypothesized and researched.

Onset of SAD may be acute or chronic. Strauss and Todaro (2001) report that SAD often occurs in children following a major life stressor. Such things as a death or illness of a relative or moving to a new school or a new neighborhood may bring on these symptoms in an otherwise normal child or may worsen them in a child who already shows signs of high anxiety (Strauss and Todaro, 2001). Traumatic experiences have an affect not just on the child or adolescent but also on the caregivers themselves (Copping, Warling, Benner & Woodside, 2002). Trauma can have a particularly harsh effect on the youth’s attachment to his or her primary caregiver (Copping et al., 2002). Onset of SAD has also been reported to have occurred after prolonged vacations or absences from school such as summer vacation or physical illness resulting in missed school (Strauss &
Todaro, 2001). Also, SAD may occur at certain developmental transitions such as entering into elementary school or middle/junior high school (Strauss & Todaro, 2001).

Many other factors have also been found to be linked to the development of SAD symptoms. SAD may also be associated with low socio-economic status. Masi et al. (2001) report that most youth with anxiety disorders come from middle to upper-middle class homes. However, 50 to 75 percent of youth with SAD come from low socioeconomic status homes (Masi et al., 2001). A possible explanation for this would be that more youth from low socioeconomic status homes have seen violence and death around them than children coming from middle to upper class communities. This may create more anxiety for the youth from low socioeconomic homes related to danger for themselves and the primary caregiver.

Southam-Gerow and Kendall (2000) looked at the emotional understanding of youth referred for treatment of anxiety disorders including separation anxiety disorder, generalized anxiety disorder or social phobia. They found that youth referred for anxiety disorders tend to have poorer understanding of hiding emotions and changing emotions compared with nonreferred youth (Southam-Gerow & Kendall, 2000). However, there was no difference found between the two groups concerning their understanding of emotion cues and multiple emotions or in general intelligence (Southam-Gerow & Kendall, 2000). According to the research, emotional awareness may play a small part in the development of anxiety disorders, however intelligence does not seem to be linked to anxiety.
Although environmental factors almost certainly do play a part in the development and maintenance of anxiety disorders, environment is most likely not the only factor involved. Bandelow, Tichauer, Spath, Broocks, Hajack, Bleich, et al. (2001) reported that although traumatic life events and unfavorable parental attitudes, such as overprotectiveness, during childhood may be associated with the development of anxiety disorders, many studies support the hypothesis that panic disorder cannot be attributed mainly to only one cause. One could apply this same conclusion to SAD and any other anxiety disorder. Family and twin studies support a genetic component to anxiety disorders (Bandelow et al., 2001). Bandelow et al. (2001) report that a twin study revealed a substantial genetic contribution to separation anxiety in women but not in men as to the risk of developing panic disorder later in adulthood. In conclusion, Bandelow et al. (2001) report that it seems probable that an individual inherits a sensitivity to anxiety which then may be triggered by early traumatic life events but that neither in itself is sufficient to cause a disorder. A child with SAD is likely born with a sensitivity to anxiety which is then brought out by stressful life circumstances.

Assessment Methods

Assessment is important for a variety of reasons including diagnosis and most importantly intervention planning. It is important to understand what difficulties a child with an anxiety disorder may have to deal with on a day to day basis. Knowing a child’s diagnosis may help professionals and family and friends make predictions about what the child may have trouble with. Assessment also helps in treatment planning. Assessment
will give individuals valuable information about the child’s strengths and weaknesses in dealing with stressors. It will also give individuals information about cognitions that the child has when dealing with these stressors. This information will be very important in the development of treatment methods and intervention strategies.

**Multimethod Assessment Approach**

Assessment of a child exhibiting symptoms of Separation Anxiety Disorder should include a multimethod assessment approach (Velting et al., 2002). A thorough assessment of the youth’s thoughts, feelings and behaviors is necessary before treatment begins. An idea of what cognitions fuel the child’s anxiety will be beneficial in the treatment of the child later on. A fuller diagnostic picture must include the youth’s individual strengths and weaknesses in managing anxiety in a variety of settings and contexts (Velting et al., 2002). A functional analysis of the child or adolescent’s anxiety problems must be conducted in order to find the best treatment method (Velting et al., 2002). The parents and educators should ask themselves what the student might gain from staying at home and what risks he or she takes by attending school (Schlozman, 2002). A history from the child, parents and other informed persons such as teachers and relatives should be considered (Masi et al., 2001). The presence of biopsychological stress factors and negative life events must be considered including the quality of attachments, fears and adaptability (Masi et al., 2001). Temperament should be looked at as well. It is important to see if symptoms are present only in specific contexts or across settings. If school refusal is present the school history should be thoroughly explored.
including attendance patterns, attitude toward school and learning, academic functioning, and teacher/peer relationships (Masi et al., 2001). A careful assessment of parental beliefs and behaviors concerning separation should be done as well as an assessment of relatives’ psychiatric history (Masi et al., 2001).

Interview

The first step in the assessment process should be the administration of a semistructured or structured interview of the child as well as the primary caregiver. Either format is beneficial, however the semistructured format allows the clinician the flexibility to pursue specific questions in greater detail when needed (Velting et al., 2002). The interviews should be used to find underlying cognitions behind aspects of the child’s personality and behaviors. Interviews with parents and teachers as well as with the student will give different perspectives on the functional basis of particular behaviors.

The Schedule for Affective Disorders and Schizophrenia-Epidemiologic version (K-SADS; Orvaschel, et al., 1982) is an example given by Strauss and Todaro (2001) of a structured interview that may be used in this circumstance. Masi et al. (2001) recommend using the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS; Orvasschel, 1995) or the Diagnostic Interview for Children and Adolescents-Revised (DICA-R; Reich, 1997). If using the K-SADS it is recommended that you explain that SAD has no correlation with Schizophrenia and the assessment is being used merely for the anxiety problems that the child is dealing with. An interview recommended by Velting et al. (2002) is the Anxiety Disorders Interview Schedule for
DSM-IV (ADIS-IV) which has an accompanying parent version. It helps to evaluate the presence and severity of anxiety, mood, and externalizing disorders (Velting et al., 2002). It also screens for learning and developmental disorders, substance abuse, eating disorders, psychotic symptoms, and somatoform disorders (Velting et al., 2002). A major benefit of the ADIS-IV is its clear and detailed sections for evaluating each of the anxiety disorders individually (Velting et al., 2002). An interview with classroom teachers as well as peers is also recommended.

**Self-Report**

The second step in assessment of a child with SAD symptoms should be the administration of self-report measures to both the child and the primary caregiver as well as any teachers if this is beneficial. The self-report measures help to understand the kinds of fears and anxieties that affect the child and will also show whether the parents are also suffering from anxiety related difficulties. This will show whether a family based intervention should be developed.

Strauss and Todaro (2001) recommend using the State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973) and the Fear Survey Schedule for Children Revised (Ollendick, 1983) to determine the levels of anxiety expressed by the child. Also, they recommend giving the primary caretaker a self-report measure to determine the level of anxiety and/or depression expressed by the parent/caretaker. Masi et al. (2001) recommend using the Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher, Brent, Chiappetta et al., 1999) or the Multidimensional Anxiety
Scale for Children (MASC; March, Parker, Sullivan et al., 1997). Velting et al. (2002) express reservations against using the standardized self-report measure, the State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973) and also the Revised Children’s Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). These instruments are described as nonspecific and thus are recommended to be merely a measure of general negative affectivity. The scales that are recommended by Velting et al. (2002) are the same as those recommended by Masi et al. (2001); the Multidimensional Anxiety Scale for Children (MASC) and the Screen for Child Anxiety Related Emotional Disorders (SCARED). Muris, Mayer, Bartelds, Tierney & Bogie (2001) tested the SCARED-R and found that it should be regarded as a useful self-report index of childhood anxiety in clinical and research settings. Masi et al. (2001) also recommend that you give a rating scale for depressive symptoms such as the Children’s Depression Inventory (CDI; Kovacs, 1992) since there is such a high comorbidity rate between anxiety disorders and depression.

Another method of self-report that has been found to be beneficial is the use of a daily diary (Velting et al., 2002). They have been shown to be useful in providing access to youth’s anxiety intensity levels as well as to antecedents and consequences of anxious behaviors and anxious thoughts for older children (Velting et al., 2002). This makes daily diaries a crucial part of identifying the functional relationships between stimuli, anxiety, and behavioral reactions (Velting et al., 2002). With a daily diary you get information regarding what feelings were brought on by what environmental stimuli and also the ultimate approach/reaction that is used by the individual child in certain stressful
situations. By knowing this, you can begin to understand what is going through a child’s head at the time of anxiety and what function behavioral reactions actually serve for the child.

**Observation**

The third step in the multimethod assessment is behavioral observation. Observations serve as another way of detecting antecedents and consequences that surround the child’s behavior. This may give clues as to what the child is thinking while performing certain behaviors. If the child believes that he or she will be reunited with a parent when complaining of a somatic ailment, he or she is more likely to continue this behavior. Behavioral observations can be done in structured or unstructured situations (Velting et al., 2002). Observations can be done on the individual child or adolescent as well as on the family as a whole or the child and one other individual. Unstructured observation occurs during the interview process when the clinician records the youth’s body language, facial expressions and verbal abilities. Unstructured observations can also be done in a variety of settings constituting the youth’s environment such as school, home and extracurricular activities. An example given by Velting et al. (2002) of a structured behavioral observation approach is the Behavioral Approach Test (BAT). A BAT involves exposing the child or adolescent to a feared object or situation while observing levels of anxiety, physiological reactions and behavioral responses (Velting et al., 2002). For a child with SAD whose primary fear is leaving his or her parent, the
therapist could observe the child while his or her parent is in the room, after the parent leaves the room and while the parent is gone running an errand.

**Alternative Method of Assessment**

Lee and Miltenberger (1996) proposed an alternative method of assessment and diagnosis for youth with school refusal. School refusal can be a symptom of SAD, a specific phobia, truancy, social phobia or depression. Therefore, to be able to correctly identify a child you would need to do a diagnostic assessment. However to be able to correctly treat a youth with school refusal behavior, you must also look at environmental factors that are maintaining the behavior called functional classification. Lee and colleagues present four possible functions for this behavior including avoidance of fear or anxiety producing situations at school, avoidance of aversive social situations at school, attention seeking, and attainment of tangible reinforcers (Lee & Miltenberger, 1996). Two possible functions of behavior for a child with SAD are attention seeking and attainment of tangible reinforcers (Lee & Miltenberger, 1996). Functional analysis, in which potential maintaining variables are manipulated, may also be used with difficult cases of SAD (Lee & Miltenberger, 1996). Then treatment components may be individually selected based on the maintaining variables identified in the functional assessment which will allow for a much more individualized and successful intervention (Lee & Miltenberger, 1996). For example, a child is complaining of stomach pain at school every morning and is therefore removed from the classroom to go to the office and then allowed to call his or her mother. The child has learned that by complaining of
stomach pain he or she will be rewarded with a call home. For treatment of this symptom, the child must learn that he or she will not be rewarded for such behavior.

**Treatment and Interventions**

**Importance of Treatment**

Without treatment Strauss and Todaro (2001) report that the course of SAD is variable with symptoms alternating between periods of exacerbation and remission according to life stressors and developmental transitions. Albano and Kendall (2002) state that the failure to intervene early with effective treatments may cause the youth to be vulnerable to a wide range of impairments in functioning and may have a negative effect on his or her long-term emotional development. It is also noted that a move towards a disorder-specific and evidence based treatment model appears to be the direction in which clinicians are moving in order to best treat youth with anxiety disorders (Albano & Kendall, 2002). Functional analysis and assessment is crucial in deriving the right treatment for the child. Treatment in itself is very important for the future success of the child or adolescent, and it is also important to pick an effective and individualized treatment plan.

**Treatment Outcomes**

Not all youth respond in the same way to the same treatment. Many factors contribute to the successful outcome of a treatment regimen. Southam-Gerow, Kendall and Weersing (2001) report that their study indicates that higher levels of maternal and
teacher reported child-internalizing psychopathology at pretreatment, higher levels of maternal self-reported depressive symptoms, and older-child age are all associated with less favorable treatment outcomes. Southam-Gerow et al. (2001) also report that child ethnicity, child sex, family income, family composition (i.e. dual parent vs. single parent), child-reported symptomatology, and maternal-reported level of child-externalizing behavior problems had no effect on treatment response.

It has also been noted that there is an extremely high comorbidity rate among children with anxiety disorders which may have an effect on the treatment outcomes depending on what disorders are relevant and to what extent. Kendall, Brady & Verduin (2001) did a study on children whose primary diagnoses were that of SAD, generalized anxiety disorder or avoidant disorder/social phobia to investigate the impact of comorbidity on treatment outcomes. They found that comorbidity was associated with greater severity of internalizing symptoms but that pretreatment comorbidity was not associated with treatment outcome. However, it was also found that children who were found to have comorbid diagnoses at the end of the treatment session were significantly less likely to show remission of their primary anxiety diagnosis (Kendall et al., 2001). It has been found that comorbidity is associated with a greater severity of symptoms and more persistent difficulties (Kendall et al., 2001). Kendall et al. (2001) suggest that these findings may mean that comorbidity is mostly a sign of how severe the child's overall anxiety is instead of multiple different problems and that the lines separating one disorder from another may not be quite as clear as was once thought. This approach to anxiety
disorders seems to be the best since all anxiety disorders incorporate many of the same physical and emotional symptoms.

**Empirically-Supported Treatments**

Empirically-Supported Treatment (EST) is the term used to refer to treatments proven effective through rigorous controlled scientific research (Albano & Kendall, 2002). Albano and Kendall (2002) report that CBT for childhood anxiety disorders has emerged as an efficacious psychosocial treatment approach. Velting et al. (2002) report that behavioral and cognitive-behavioral protocols received the only endorsement for having empirical support as being efficacious therapeutic interventions. Traditional interventions such as play therapy and psychodynamic therapies cannot be recommended to treat anxiety disorders as there is no empirical research to support effectiveness. Suggested use of such interventions was not found in the literature even in conjunction with other types of treatment. However, it should also be stressed that although some intervention methods are more effective than others overall, each youth should be assessed individually and treatment methods should be adapted for the specific child or adolescent.

There are many factors that may contribute to the outcome of a treatment method. Poor treatment response is predicted by lower rates of school attendance, a comorbid depression diagnosis, higher levels of internalizing problems, higher levels of maternal depression and older youth age (Layne, Bernstein, Egan & Kushner, 2003). However, there is no significant factor found with a comorbid diagnosis of multiple anxiety
disorders. Layne et al. (2003) also present information suggesting that SAD responds more positively to treatment for children than it does for adolescents. Therefore, these factors should also be taken into consideration when choosing and individualizing treatment plans for children and adolescents.

**Psychoeducation**

Masi et al. (2001) states that psychoeducational intervention is usually the first step in the management of SAD and that in some cases psychoeducational intervention may be adequate alone. However, no studies were done to confirm this assumption. Psychoeducation involves an explanation of the meaning of symptoms, their consequences, quality of the individual’s daily life, prognosis and treatment strategies (Masi et al., 2001). If the child is young and the severity of the symptoms is mild to moderate educating the family may be all that is necessary for the child to overcome SAD (Masi et al., 2001). If symptoms are not too severe, simply being aware of the child’s anxiety and altering his or her environment slightly may be enough to diminish the child’s anxiety to a functional level. The parents must be taught to encourage their child to face new situations despite anxieties they may deal with and to avoid excessive criticism (Masi et al., 2001). Once the child realizes that he or she is more capable of coping in situations than previously thought, the anxiety may remit.

Schlozman (2002) introduces some recommendations for the educators of the youth including avoiding situations that might cause the student public humiliation and respecting the student’s wishes to remain more distant. Also, it is recommended that the
teacher try to give the student choices when it comes to activities that he or she becomes very anxious in so that the student will have a sense of control in the situation. An example that is given by Schlozman (2002) is to give the student who fears public speaking the choice to go first and get a speech over with or to go in the middle as to be more discrete.

**Behavioral Therapy**

Behavioral therapy is supported by Masi et al. (2001). Behavioral approaches focus on the child’s behavior and does not consider causes or psychic/cognitive conflicts (Masi et al., 2001). Behavioral strategies are exposure-based including desensitization, emotive imagery and contingency management (Masi et al., 2001). Functional analysis and functional assessment can directly relate to behavioral recommendations. Once the function of a behavior is found, behavioral therapy can modify the behavior by changing the function. For example, if a child pretends to be sick and stays home from school in order to receive more attention from his or her caregiver, providing this attention outside of school may change the child’s behavior or at least make it easier to be changed.

Masi et al. (2001) report a study done by Blagg and Yule (1984) who applied the behavioral treatment approach to 30 children with school refusal while two other groups received inpatient hospitalization or individual psychotherapy associated with home tutoring. After a year 83% of the children receiving behavioral treatment attended school compared with only 31% of the hospitalized youth and 0% of the children in psychotherapy (Masi et al, 2001). However, Masi et al. (2001) reports that the lack of
randomization limits the interpretation of these data. Also, this study is more dated and further research needs to be done on behavioral approaches.

**Cognitive Behavioral Therapy**

Cognitive Behavior Therapy (CBT) is one of the most common and effective treatments utilized for SAD (Strauss & Todaro, 2001). The terms cognitive behavioral therapy and behavioral therapy are sometimes used interchangeably since CBT has many behavioral components as well as cognitive. Although there is abundant evidence for the efficacy, adaptability and transportability of CBT, one problem that is faced is the fact that relatively few clinicians are trained to mastery in these techniques (Walkup & Ginsburg, 2002). CBT focuses on anxiety as a normal and expected emotion with biological, behavioral and psychological components (Albano & Kendall, 2002). It assumes that an individual’s genetic predisposition, temperament, family history, learning and environmental experiences, parenting styles, and other endogenous and exogenous factors all contribute to the amount of anxiety one experiences as well as how he or she handles this anxiety. Normal or adaptive anxiety is thought of as functioning in protecting the individual from harm. It is assumed to be a construct involving three components: physiological, behavioral, and cognitive (Albano & Kendall, 2002). Cognitive behavioral therapy seems to be the most thorough and encompassing approach to anxiety treatment, building on past approaches and adding new unique components.

Deluty (1996) reports that there are six cognitive-behavioral treatment strategies that have proven to be effective in reducing children’s anxiety including relaxation
training, cognitive restructuring, problem solving, contingent reinforcement, modeling and imaginal and “in vivo” exposure. In a more recent study, Strauss and Todaro (2001) report that there are three main components to CBT including graduated exposure to feared or avoided situations, training in relaxation procedures and instruction in rehearsal of coping self-statements. The CBT components presented by Strauss and Todaro (2001) will be discussed in detail.

The first part of CBT as presented by Strauss and Todaro (2001) is graduated exposure to feared or avoided situations. This component is behavioral and has been used in treating anxiety in patients before. Graduated exposure to feared or avoided situations is intended to gradually increase the child’s or adolescent’s independent activities. If the child is having trouble attending school regularly or going to a friend’s home without experiencing anxiety, this part of CBT will help them to overcome these fears gradually. In order to do this the child and primary caregiver must first each develop a Fear and Avoidance Hierarchy. The hierarchy arranges feared situations from those that elicit mild levels of anxiety to those that provoke extreme anxiety or panic. The hierarchy usually consists of approximately 10 items. Next the hierarchy is implemented through the use of homework assignments. The child should feel in control of the pace at which he or she progresses through the hierarchy, however the homework assignments are negotiated between the child, primary caregiver and therapist. The child is encouraged to practice as many times as possible and keeps a record of the date of the practice and a Likert rating of anxiety experienced during the assigned exposure. The next hierarchy item is introduced only after the child successfully approaches preceding
items with little or no anxiety on a minimum of two consecutive occasions and habituation has occurred (Strauss & Todaro, 2001).

Strauss and Todaro (2001) explain that there has only been a minimum amount of research focused on systematic evaluation of this behavioral procedure in alleviating fear associated with separation. However, the few single-case studies and controlled investigations have provided preliminary evidence to support the effectiveness of in-vivo exposure in reducing SAD symptoms or separation-related school refusal. Strauss and Todaro (2001) state that overall these studies suggest that a graduated in-vivo treatment approach shows promise in treating separation anxiety symptoms, but that more studies are clearly needed in order to establish its efficacy.

The second part of CBT presented by Strauss and Todaro (2001) is relaxation procedures and is intended to teach the child or adolescent how to deal with anxiety when they do experience it in these situations. This part of CBT is also quite behaviorally based and has been used previously to treat anxiety disorders in patients. Relaxation procedures help the child deal with the physiological aspects of anxiety such as increased heart rate, shortness of breath, dizziness, or nausea. The child or adolescent is taught relaxation methods such as deep breathing or deep muscle relaxation techniques modified for children and adolescents (Strauss & Todaro, 2001). Children are also told to focus on a pleasant imagery scene such as eating an ice cream cone or playing on the beach in order to enhance relaxation. The child or adolescent is encouraged to use these procedures during homework assignments in order to deal with his or her anxiety (Strauss & Todaro, 2001).
The third and final part of CBT presented by Strauss and Todaro (2001) is instruction in rehearsal of coping self-statements. This is the cognitive basis of CBT and is a relatively new addition to anxiety treatment. Cognitive rehearsal of coping statements is also used to facilitate the child’s graduated approach to feared or avoided situations (Strauss & Todaro, 2001). The underlying assumption is that the child’s maladaptive thoughts, beliefs, attitudes, and self-statements lead to or maintain anxiety-related behavior. First, the child’s maladaptive self-statements are identified and then more adaptive coping statements are generated that can be used when anticipating or confronting anxiety-provoking situations (Strauss & Todaro, 2001). Masdorf & Lukens provided preliminary evidence for the efficacy of cognitive behavioral techniques in a study of one child showing symptoms of SAD (Strauss & Todaro, 2001). This child was improved by the fourth weekly session of cognitive behavioral treatment and three months after treatment ended there were no signs of relapse (Strauss & Todaro, 2001). The use of small rewards for progress was also used successfully in studies and at times was found to be a critical factor in success (Strauss & Todaro, 2001).

Finding the correct treatment method for the child is more important than finding the correct treatment method in general. Although many studies have shown the efficacy of CBT in general, no studies have shown that CBT is necessarily better than behavioral techniques alone. Also, CBT seems to be more applicable for older students and would be hard to carry out effectively for a young child. However, CBT appears to encompass the important aspects of each treatment method including education, behavioral techniques and cognitive techniques which would make it the primary choice for older
children and adolescents. Ultimately, the function of behaviors exhibited by children with SAD will be the final determiner in what approach is to be used. If school refusal is the primary concern, desensitization and exposure are recommended (Masi et al., 2001). If the avoidance of social and evaluative situations or reoccurring thoughts of negative occurrences due to separation are prevalent, cognitive therapy is suggested (Masi et al., 2001). When there is a problem for the child of attaining attention from the caregiver, parent training may be appropriate (Masi et al., 2001). When abnormal family functioning is involved, family therapy may be best (Masi et al., 2001). Even so, CBT incorporates all of the essential aspects needed for a child to be able to overcome SAD and is also adaptable enough to be able to easily incorporate individualized treatment methods for each child.

**Cognitive Behavioral Therapy-Case Study**

A fictitious case study about a young girl named Darci that partially follows the case study done by Strauss and Todaro (2001) will be used to help explain the details of this treatment method. Darci is a 12-year-old girl who has been diagnosed with SAD. Her primary symptom is that she cannot sleep alone at nights. A Cognitive-Behavioral Treatment is being recommended for Darci. During the first treatment session, progressive muscle relaxation training was begun. She learned muscle groups in sessions and practiced the techniques twice daily at home. She was taught to choose an imagined pleasant scene to facilitate relaxation. Darci chose to picture herself playing with her baby kittens in their garage at home.
Darci kept a daily record of these practice sessions including the date and time of practice as well as the ratings of her tension levels before and after each practice session. She also kept a daily record of situations that induce anxiety, subjective anxiety associated with these situations, and cognitions that precede or accompany anxiety. These records were used to identify that Darci frequently monitored her body and easily contributed changes in heart rate and breathing to physical illness instead of anxiety. It was also used to monitor Darci’s “catastrophic” thinking. Darci frequently had negative thoughts including such things as “What if I am having a heart attack?” and “What if a burglar comes in the house at night and kidnaps me”. Based on these records, Darci was given positive coping statements to rehearse to substitute for these maladaptive cognitions. These include such things as “These are only symptoms of anxiety. They will pass.” or “I know I am being silly. The doors are locked and no one can get in.” Eventually Darci became quite well with identifying maladaptive thoughts and replacing them with these more realistic and adaptive cognitions. Eventually Darci reported that these positive thoughts became automatic for her.

Systematic desensitization using graduated in-vivo exposure was used as the final treatment component for Darci. She used the cognitive self-statements and progressive-muscle relaxation techniques to help cope with each item in her hierarchy. Darci practiced confronting these situations between sessions and recorded her anxiety level during each confrontation on a record form provided by the therapist. Darci was in complete control of the rate at which she did this and her parents and the therapist provided encouragement and praise throughout the procedure.
The treatment hierarchy developed for Darci included her sleeping alone in her own bed for increasingly more nights each week. Darci’s first goal was to sleep alone one of the seven nights of the week. After successfully sleeping by herself for one night out of the week, Darci was to sleep alone two nights, then four, then six and finally all seven nights. Coping strategies were used to help Darci fall asleep each night including her progressive muscle relaxation skills and reading for 15 minutes before turning out the lights. If Darci was unable to sleep within 15 minutes after the lights were turned out she was to resume reading for another 15 minutes until she eventually was successful at falling asleep. Small rewards were provided by Darci’s parents for successfully sleeping in her own bed during the previous night. These rewards included a trip to the ice cream shop or playing a game she liked with her family. Also, when Darci successfully passed one of her weekly hierarchy items she would receive a larger reward such as dinner at a nice family restaurant or a shopping trip with her family. The graduated exposure approach, use of coping strategies and provision of rewards was implemented until Darci reported that she was successfully sleeping by herself nightly without anxiety. This approach took a total of 6 weeks. Darci continued to use her relaxation techniques, rehearsal of positive self-statements and reading to help herself fall asleep. However, these strategies were needed less and less over time. The nightly rewards were discontinued after Darci was sleeping alone nightly for 2 consecutive weeks and the weekly rewards were discontinued after 4 weeks of successfully sleeping by herself each night.
The Coping Cat

A specific model of CBT that is recommended by Velting et al. (2002) is The Coping Cat. This protocol is also recommended by Albano and Kendall (2002) because it incorporates all of the essential elements of CBT as well as allowing for flexibility to be able to modify and individualize it for each specific child. This protocol is designed specifically for children and young adolescents, up to approximately 14 years of age, as a short-term treatment consisting of 8 educational sessions and 8 practice sessions (Velting et al., 2002). It is designed to be individualized for each specific youth (Velting et al., 2002). The therapist must attend to the day-to-day issues that may arise and adapt the protocol as needed (Velting et al., 2002). Also the therapist should use positive regard, warmth, active listening, and a collaborative relationship (Velting et al., 2002). These are all basic components of therapy that involves empathic listening and would be more appropriate for a child than alternate types of therapy that involve harsher methods.

During the first 8 sessions of The Coping Cat program the child or adolescent learns skills that will allow them to recognize and distinguish different emotions and to identify and modify anxious cognitions and somatic responses to anxiety provoking situations (Velting et al., 2002). The children are first taught how to recognize their individual signs of arousal and use these signs to cue them for using learned anxiety management strategies. The children then learn a four-step coping plan to manage their stress, called the FEAR plan. The first step in this plan is affective education in which the children are taught to discriminate between feelings, facial expressions, nonverbal cues and postures. Then children learn physical symptoms that go along with certain
feelings and are trained to use these as early warning signs for their own anxiety. The children are taught to ask themselves "Feeling frightened?". The second step is self-talk in which the child learns how to recognize and challenge distorted anxious cognitions. They are taught to identify their anxious thoughts or beliefs by asking themselves "Expecting bad things to happen?". An accurate assessment and conceptualization of each child’s dysfunctional thought composition are crucial. The therapist encourages the youth to consider the likelihood of alternative possibilities. The therapist also functions as a model for coping skills. The third step encourages the youth to inhibit their initial impulses of avoidance and to create a strategy of "Actions and attitudes that will help." The child will develop alternatives to situations that would initially seem overwhelming and hopeless to the child. The final step involves "Rate and reward." This concept introduces the youth to the idea that perfect performance is not a necessity. The therapist focuses the child on his or her efforts and any aspects of a situation that went well and encourages the child to reward him or herself for this (Velting et al., 2002).

These strategies are then used in the next 8 practice sessions of The Coping Cat program where the child or adolescent is exposed to individualized anxiety provoking situations in which they are able to practice their newly learned skills (Velting et al., 2002). The steps of the FEAR plan can be applied to a variety of anxiety provoking situations that are individually designed for each child. The environmental situations should start out with a low anxiety inducing situation and progress to the most high level anxiety inducing situation for the particular child involved. The same strategies are employed in both training segments including coping models, role playing and homework
assignments. This gradual process will help the youth to acquire a sense of competence that will then be able to be generalized to other areas of the youth’s life that cause stress and anxiety for him or her (Velting et al., 2002).

The Coping Cat program is the first protocol to meet the standards of empirically supported treatment for children and adolescents with anxiety disorders (Velting et al., 2002). Velting et al. (2002) state this it is a good model for developing improved protocols. It demonstrates efficacy in group format and is also transportable to independent settings and different cultures (Velting et al., 2002). Initial support for the Coping Cat Protocol came from two randomized clinical trials performed by Kendall. In 1994, Kendall tested the 16-session manual –based CBT protocol with children who had SAD, Social Phobia or nonspecific worry situations such as Overanxious Disorder and Generalized Anxiety Disorder. The sample included 47 youth ages 9 to 13 years. Approximately 60% were males. The youth were randomly assigned to one of two conditions, either cognitive-behavioral therapy or a wait-list control. At post treatment, children in the CBT group showed significant gains across multiple methods of assessment. Approximately 64% of the children in the CBT group no longer qualified for their principal diagnosis at posttreatment, as evidenced by the ADIS interview. It was found that improvement was maintained at a 1-year follow-up and was generally maintained over a longer time period ranging from 2 to 5 years. In a second randomized trial conducted by Kendall (1997) the previous study was replicated using 94 youth ages 9 to 13 years who all had a principal diagnosis of an anxiety disorder. The children were again assigned to either the CBT group or a wait-list control group. It was again found
that positive treatment gains of the CBT group were evident and maintained on a variety of measures.

The Coping Cat treatment method has many positive aspects including the breadth and depth of treatment, the versatility and flexibility of the protocol and the ability to use it in group formats. The Coping Cat treatment method incorporates the Cognitive Behavioral Methods that have been found to be effective. The treatment is relatively extensive and lengthy. This would make it more difficult to conduct in a school setting and would most likely be more beneficial to a child if done outside of the school. However, the ability to use the protocol flexibly and also to use it in a group context may allow this method to be an option for the school.

**Family Therapy**

Family therapy can also be a good way to address SAD in a child or adolescent. Walkup and Ginsburg (2002) state that one of the most important adaptations of CBT for childhood anxiety is the addition of a family component. Parents may play an important role in the development and maintenance of anxiety symptoms in their youth. Parents may express their own fears about the child’s safety and autonomy which the youth may pick up on (Masi et al., 2001). Also, parents may give contradictory messages about school attendance, independence and separation (Masi et al., 2001). Dia (2001) expresses that parents often fall into traps when trying to raise a child with SAD including overprotectiveness, excessive reassurance, and aversive parent-child interactions.
Dia (2001) stresses the importance of family work and reports that a case study, which used a modification of a CBT protocol for adults with panic disorder with agoraphobia plus a family intervention, worked well for the treatment of a 6-year-old boy with SAD. In this case study a four phase approach was used including psychoeducation, cognitive-behavioral coping strategies, graded exposures and family work, and finally a booster session (Dia, 2001). At the beginning of this treatment, the boy was having at least one panic attack a day, but during the four months after treatment termination, he had only two limited panic attacks (Dia, 2001). Dia (2001) states that a critical factor in the success of this child was involving the parents in treatment. His father had developed an aversive parent-child interaction with the boy as a result of the stress of dealing with the boy's anxiety, and the aversive pattern created more anxiety in the boy and resulted in a reciprocal negative relationship (Dia, 2001). Guided discovery and education were sufficient to address and change the father's beliefs and therefore, help the child become more successful in managing his own anxiety (Dia, 2001).

Addressing issues in the family may be a good start to addressing the issues that go along with SAD. There are also a variety of other factors contributing to the enhancements that family therapy brings to the treatment of SAD. Although there hasn't been much research done directly on the issue of parental and family involvement in the treatment of a child with SAD, indirect evidence points to the potential importance of the family (Barrett et al., 1996). Anxious children are more likely to have parents who also suffer from a variety of disturbances and anxiety problems in their own lives (Barrett et al., 1996). Shortt et al. (2001) indicate that high parental control, parental anxiety and
parental reinforcement of avoidant coping strategies all may have a large role in maintaining anxiety in children. There is also increasing evidence pointing towards a relationship between frequent negative feedback and parental restriction and anxiety in children (Barrett et al., 1996). However, this seems to be more apparent in children with anxiety disorders other than SAD.

The first randomized, controlled trial of CBT including parent training was a study done by Barrett et al. (1996). This study gives more support for family interventions in the treatment of general anxiety problems in children including general anxiety disorder, separation anxiety disorder and social phobia (Barrett et al., 1996). In this study, 79 children from 7 to 14 years of age (45 boys, 34 girls) who were diagnosed with SAD, social phobia or overanxiety disorder were randomly assigned to either CBT, a CBT+Family condition or a waiting-list control group. Afterwards, the children and their parents were interviewed separately using a structured interview schedule. Barret et al. (1996) found that the condition with an added family training component showed significant improvement on a number of measures in the study as compared to the CBT condition without a family component and the wait-list control group. At posttreatment, the percentage of children who no longer met DSM-III-R criteria for a current anxiety disorder was significantly greater for the treatments (69%) than for the waiting list (26%). Also, 84% of the children who received the CBT+family treatment no longer met the DSM-III-R criteria. At the 12-month follow-up, 70% of the children in the CBT group and 96% of the children in the CBT+Family condition no longer met DSM-III-R criteria. Barett et al. (1996) state that there were different success rates found depending on
gender and age. It was reported that younger children (7-10 years of age) responded better to the CBT+family treatment method. However, for older children (11-14 years of age) there was no significant difference found across treatment conditions at posttreatment or at 6 or 12 month follow up sessions (Barett et al., 1996). This may suggest that family components are critical for younger children but that for older children individual child cognitive work and exposure to feared stimuli may be sufficient (Barett et al., 1996). Also, some interesting findings were observed by Barett et al. (1996) regarding gender. It was found that female participants responded better in the CBT+family treatment condition, but that male participants did equally well in both treatment conditions regardless of age. However, due to the small number of participants, no interpretation of this finding is recommended until more studies can be done (Barett et al., 1996).

Cobham and colleagues found that a family component only increased the efficacy of child CBT for children whose parents were suffering from anxiety as well (Shortt, Barrett & Fox, 2001). In this study, Shortt et al. (2001) reported that 67 children ages 7 to 14 years were divided into two groups: child anxiety only and child plus parent anxiety. Children from both groups were randomly assigned to either the child only CBT or the child CBT plus parental-anxiety management (Shortt et al., 2001). Of the children who received child-only CBT, 82% of the children in the child anxiety only group were diagnosis-free at posttreatment compared to 39% of children in the child plus parental anxiety group (Shortt et al., 2001). In the CBT plus parental-anxiety management
condition, 80% of the child anxiety only group and 77% of the child plus parent anxiety group were diagnosis-free (Shortt et al., 2001).

The involvement of parents in a child’s treatment for SAD is beneficial in a variety of ways. Although it is not always possible because of busy schedules or absent parents, parents should be involved in their child’s treatment as much as possible. This is especially true for young children under the age of 11.

**Behavioral Family Treatment**

A family component that has been found to be effective in the treatment of children and adolescents with SAD is the Behavioral Family Treatment (BFT) (Strauss & Todaro, 2001). Instead of focusing mostly on the individual like CBT does, BFT focuses on both the family-child and the teacher-child relationships (Strauss & Todaro, 2001). BFT is not intended to substitute for CBT, but rather it is intended to enhance implementation of traditional CBT strategies (Strauss & Todaro, 2001). When using BFT, there is always an individual capable of managing the child’s SAD symptomatology present even when the therapist is unable to be there (Strauss & Todaro, 2001). Therefore, BFT uses the child, parents and teachers all as active participants in treatment. Strauss and Todaro (2001) report that there are relatively few reported studies investigating the effectiveness of BFT for SAD. However, they also report that there is some evidence to suggest that involving members of the family and teacher in the treatment of the child may enhance traditional CBT interventions (Strauss & Todaro, 2001). BFT seems to be especially important in cases where the primary caregiver also
suffers from some heightened levels of anxiety or where the family systems seems to have contributed to the onset and/or the continuation of SAD symptoms (Strauss & Todaro, 2001).

BFT consists of three components including psychoeducation, contingency management, and parent anxiety management and modeling (Strauss & Todaro, 2001). The first component, psychoeducation, involves educating children, parents, and teachers about what separation anxiety is, precipitating and maintaining factors, and the impact of SAD on familial and academic functioning (Strauss & Todaro, 2001). The clinician describes to the child in age appropriate terms, SAD symptomatology, the model of anxiety including behavioral, physiological and cognitive factors, and factors that may influence the onset and course of SAD (Strauss & Todaro, 2001). Parents and teachers are also educated on how their behavior may impact the anxiety of the child (Strauss and Todaro, 2001). The parents and teachers become aware that they serve as role models for the children regarding how to deal with anxiety provoking situations and coping strategies (Strauss & Todaro, 2001). Also, parents and teachers learn how their responses to the child’s SAD symptoms may have an impact on the continuation of the symptoms (Strauss & Todaro, 2001). For example, sometimes parents and teachers may inadvertently reinforce SAD symptoms by regularly supporting fearful behavior or by allowing the child to avoid anxiety provoking activities and/or environments.

The second component of BFT as presented by Strauss and Todaro (2001), contingency management, includes both parents and teachers playing important roles in managing SAD symptoms. Three primary skills are taught to the parents and teachers
during this component. These include providing positive reinforcement following adaptive coping responses or courageous behavior, ignoring fear-based verbal or non-verbal behavior and limiting avoidance of feared activities/environments (Strauss & Todaro, 2001). In teaching the first skill, parents and teachers are educated about how to select appropriate reinforcers that will increase the frequency of adaptive coping and/or courageous behavior (Strauss & Todaro, 2001). An example of this would be spending some quality time with the child reading his or her favorite book if the child sleeps alone in his or her bed the previous night. The second skill includes educating parents and teachers about how ignoring complaints can positively affect anxious behavior (Strauss & Todaro, 2001). An example of this would be to not give added attention to the child if he or she is complaining about a stomach ache before school. The final skill includes the parents and teachers learning how to encourage the child to participate in activities through the use of both positive reinforcement for approach behavior and ignoring anxious verbalizations (Strauss & Todaro, 2001). An example of this would be to encourage the child to go to school in the mornings by promising a trip to the ice cream shop after school if the entire day is attended. If complaints are made in the morning they should be ignored or downplayed and the child should be told that he or she should go to school and try to stay all day to get his or her reward.

The third component of BFT as presented by Strauss and Todaro (2001) is parent anxiety management and modeling. This component includes the parent, or primary caregiver, learning how to manage his or her own anxiety and then modeling this for his or her own child (Strauss & Todaro, 2001). Once the primary caregiver learns adaptive
coping skills for his or her own anxiety it becomes essential for the caregiver to model these new skills for the child to mimic (Strauss & Todaro, 2001).

BFT is a beneficial program and should be incorporated into the Cognitive Behavioral Treatment plan for each child. It has been shown that if parents are suffering from anxiety themselves, BFT is a positive way to help both the parent and the child with anxiety at the same time. Even if the parents are not suffering from anxiety themselves, they should be educated about it and correct and helpful ways of coping and dealing with anxiety should be reinforced in the parents as well as the child.

**FRIENDS**

Another program that has shown to be effective and incorporates a family component is the FRIENDS program. The FRIENDS program is a Family-Based Group Cognitive Behavioral Treatment (FGCBT) for clinically anxious children (Shortt et al., 2001). FRIENDS is an acronym for the strategies that are taught including the following: Feeling Worried, Relax and feel good, Inner thoughts, Explore plans, Nice work so reward yourself, Don't forget to practice and Stay calm, you know how to cope now (Shortt et al., 2001). The FRIENDS program uses the core concepts from CBT. However, it also has a few unique components including having two parallel forms for children ages 6-11 years and also for youth ages 12-16 years (Shortt et al., 2001). It also incorporates a family-skills component including cognitive restructuring for parents and partner-support training and encourages families to build supportive social networks (Shortt et al., 2001). Families are encouraged to practice the skills learned daily, and
parents are taught the appropriate use of reinforcement strategies (Shortt et al., 2001). The FRIENDS program also has a group component and emphasizes peer support and learning (Shortt et al., 2001). Children are encouraged to make and build social networks while parents are encouraged to facilitate this (Shortt et al., 2001).

In the study done by Shortt et al. (2001) 71 children ranging from 6 to 10 years of age who fulfilled diagnostic criteria for SAD, generalized anxiety disorder or social phobia were randomly assigned to FRIENDS or to a 10-week wait-list control group. The effectiveness of the intervention was evaluated at posttreatment and again at a 12-month follow-up. It was found that anxious children who completed FRIENDS showed greater improvement than children in the control group as evident on the self-report measures completed by the children and their mothers (Shortt et al., 2001). Results indicated that 69% of the children who completed FRIENDS were diagnosis-free compared to only 6% of those who completed the wait-list condition (Shortt et al., 2001). There was also evidence that these improvements were maintained 12 months later. At the 12-month follow-up, 68% of the children were diagnosis-free (Shortt et al., 2001). It also showed a very positive evaluation from parents and children involved. The parents rated the FRIENDS program very highly and recommended it for others, and many of the children rated the FRIENDS program as fun (Shortt et al., 2001).

**Group Cognitive Behavioral Therapy**

Although family and cognitive-behavioral individual psychotherapies have been proven to be very effective in the treatment of youth with anxiety disorders, they are also
costly methods of treatment. A more economical and time effective treatment that is presented by Toren, Wolmer, Rosental, Eldar, Koren, Lask et al. (2000) is the use of group treatments. Toren et al. (2000) tested a brief parent-child group therapy program for youth with a variety of anxiety disorders and found that this intervention was a cost effective and time efficient intervention method (Toren et al., 2000). In this study, 24 children with an anxiety disorder and their parents participated in a 10-session treatment (Toren et al., 2000). The children were evaluated at pretreatment, posttreatment, 12 months after treatment ended and 36 months after treatment ended (Toren et al., 2000). Ten children were assigned to a waiting-list control group (Toren et al., 2000). As expected, no significant changes were found between the waiting list and the pretreatment evaluations; however anxiety symptoms decreased significantly during the treatment and follow-up periods for the children receiving the parent-child group therapy treatment (Toren et al., 2000). The percentage of children who had undergone treatment with no anxiety disorder at posttreatment was 71% and the percentage at 36 months rose to 91% (Toren et al., 2000).

Lumpkin, Silverman, Weems, Markham, & Kurtines (2002) report that a study investigating the efficacy of Group Cognitive Behavioral Therapy (GCBT) in the treatment of a heterogeneous set of anxiety disorders in children and adolescents showed that GCBT was generally efficacious in reducing anxiety symptoms. This study used a partially nonconcurrent multiple-baseline across groups design with 12 youth between 6 and 16 years who met DSM-IV criteria for an anxiety disorder (Lumpkin et al., 2002). Lumpkin et al. (2002) explain that the partially nonconcurrent multiple-baseline across
groups design is an alternative to the original concurrent multiple-baseline across subjects design. In this design participants share a single baseline start date, and treatment is applied in a time-lagged fashion to each participant due to the increasing length of each baseline (Lumpkin et al., 2002). The time-lagged introduction of treatment controls for extraneous factors such as historical effects that might be responsible for observed changes (Lumpkin et al., 2002). The nonconcurrent alternative is useful when participants are only available in succession for practical reasons such as in clinical settings (Lumpkin et al., 2002). A number of baseline lengths are determined prior to the study, and as participants become available, they are randomly assigned to baseline lengths (Lumpkin et al., 2002). In this study, Group 1 (1-week baseline) and Group 3 (3-week baseline) ran concurrently, and Group 2 (2-week baseline) began prior to the last session of Group 3 (Lumpkin et al., 2002). The two concurrent baselines provide control for the effects of history and the third nonconcurrent baseline provides a further replication (Lumpkin et al., 2002). Dependent measures included diagnostic status, daily child and parent ratings of child anxiety severity and child/parent questionnaires (Lumpkin et al., 2002). The youth were treated in diagnostically heterogeneous groups consisting of specific phobias, separation anxiety disorder, social phobia, generalized anxiety disorder, and obsessive-compulsive disorder (Lumpkin et al., 2002). At the completion of treatment, 6 of the 12 youth no longer met diagnostic criteria for their primary diagnosis (Lumpkin et al., 2002). Muris et al. (2001) also report that group and individual CBT were equally effective in reducing children’s anxiety symptoms. This study included 36 children from 8 to 13 years of age who fulfilled the criteria for
generalized anxiety disorder, separation anxiety disorder, and/or social phobia. These children received either group or individual cognitive-behavioral treatment and were assessed using the SCARED-R and the STAIC 6 months prior to treatment, right before treatment started and right after treatment terminated (Muris et al., 2001). As expected, it was found that there was no significant change from 6 months prior to pretreatment assessment, however a significant decline was found from pretreatment to post-treatment assessment (Muris et al., 2001).

Group treatments may be a break through for professionals working with anxious youth in the school system. Although it would be ideal to be able to work extensively and individually with each child or adolescent, it typically is impossible due to time constraints. Therefore, effective group treatment may be the answer to helping a large number of children in a short period of time.

**Medications**

Another intervention method that has shown short-term safety and efficacy is the use of medications. Nonpharmacological treatment strategies should generally be considered first for the treatment of anxiety in youth. Therefore, although CBT and other treatment options should be tried first, there are instances when medications are necessary and Selective Serotonin Reuptake Inhibitors (SSRIs) hold promise as a safe and effective treatment for childhood anxiety (Murphy, Bengtson, Tan, Carbonell & Levin, 2000). It should also be noted that medications work best when used in conjunction with other treatments. Medications as a treatment approach developed as a result of
observations of adult agoraphobic patients suffering from panic attacks who reported that they also had difficulty separating from their families as young children. SSRIs worked well for those adults and therefore, were thought to be potentially successful with children as well (Klein, Koplewicx & Kanner, 1992). Selective serotonin reuptake inhibitors (SSRIs) have been used in the treatment of childhood anxiety disorders due to a broad spectrum of clinical activity, ease of use, and low side-effect profile (Velting et al., 2002). There are, however, very few well-controlled pharmacological studies on treatment of childhood anxiety disorders and up until 1997, studies had only demonstrated significant improvement for youth with Obsessive Compulsive Disorder and adult anxiety disorders.

Although there is a time and place for medication in the treatment of SAD, it should never be the first choice. Sometimes symptoms are so severe or acute that a medical approach needs to be taken to reduce symptoms until cognitive behavioral methods can be put in place. At other times, SAD symptoms may be so severe that a constant use of medications to control symptoms must be used. However, medications should not be used as a quick fix and should not be used alone without the added treatment of cognitive behavioral methods.

**Fluvoxamine**

In 1997 an anxiety study was conducted on RUPP Fluvoxamine (FLV) (Cheer & Figgitt, 2002). Children and adolescents from age 6 to 17 years meeting criteria for separation anxiety disorder, social phobia or generalized anxiety disorder participated in
this study (Cheer & Figitt, 2002). Cheer and Figitt (2002) report that Fluvoxamine improved symptoms of anxiety compared with a placebo in an 8 week well controlled trial of 128 children with social phobia, separation anxiety disorder or generalized anxiety disorder. The results from this study indicate that children and adolescents with anxiety disorders may benefit from medication treatment in the short term. However, long term effects are still unknown (Cheer & Figitt, 2002). The Research Unit on Pediatric Psychopharmacology Anxiety Study Group [PPASG] (2001) performed a randomized, double-blind trial of fluvoxamine and a placebo in children and found that fluvoxamine is an effective treatment for children and adolescents with these disorders (PPASG, 2001). In this study, 128 children ages 6 to 17 years of age who met the diagnostic criteria of the DSM-IV for social phobia, separation anxiety disorder, or generalized anxiety disorder were studied (PPASG, 2001). The children in the fluvoxamine group had greater reductions in symptoms of anxiety and higher rates of clinical response than the children in the placebo group at posttreatment (PPASG, 2001).

**Imipramine**

A study done by Klein, Koplewicx and Kanner (1992) shows results that disagree with previous studies done on the drug imipramine. Although this drug had been found to be beneficial in previous studies, this study showed no improvements in children with SAD who were given imipramine. Klein et al. (1992) investigated the efficacy of imipramine in 20 children ages 6 to 15 with SAD. Each child was treated for a month with an intense behavioral treatment and if they did not respond they were then entered
into a double-blind, randomized 6 week trial of either imipramine or placebo (Klein et al., 1992). Of 45 children who were accepted into the study, only 21 entered this trial (Klein et al., 1992). Approximately half of the children improved with either treatment and no superiority for imipramine was found which had been found previously on similar but larger populations (Klein et al., 1992).

Chapter 3: Summary/Conclusion

Summary

Importance of Early Diagnosis and Intervention

Although for years now educators, parents and professionals have all perceived anxiety disorders as relatively unimportant in childhood, research presented in this paper makes it clear that this is a misperception. Anxiety disorders, specifically SAD, are very real and pervasive disorders of childhood and should be treated as such. Without proper diagnosis and intervention a child with SAD may suffer from many negative effects including short term educational and emotional/behavioral problems as well as more long-term effects spanning into adulthood. The symptoms of SAD can be very intrusive for the youth as well as the family and should be dealt with immediately.

Assessment Methods

In order to diagnose a youth with SAD and to be able to best treat the youth a multimethod assessment approach should be used. This approach includes an interview
given by the clinician to the child and also the primary caregiver as well as any other individual who may be valuable including classroom teachers, school nurse etc (Velting et al., 2002). This approach also includes a self-report and observations of the child within school, at home, and in any other valuable environment (Velting et al., 2002). It also includes a functional analysis in order to determine antecedents and consequences for the youth's behaviors (Schlozman, 2002). The parents and educators should ask themselves what the student might gain from staying at home and what risks he or she takes by attending school (Schlozman, 2002).

**Treatment Options**

There are many options for the treatment and intervention of SAD, and each option for treatment should be individualized for the specific child or adolescent. The most effective treatment available at this time is Cognitive Behavioral Therapy (Strauss & Todaro, 2001). There are many versions of this available including CBT, Group CBT, and CBT with a family component making it very adaptable. Two specific models of CBT that are used and endorsed by many are The Coping Cat and FRIENDS programs (Velting et al., 2002; Shortt et al., 2001).

Alternative methods of treatment include psychoeducation for mild cases and CBT plus medication for severe cases (Masi et al., 2001; Murphy et al., 2000). Medications that are endorsed for the use in treatment of children with SAD include the SSRIs (Velting et al., 2002). Specifically, fluvoxamine has been researched and appears to be beneficial for many children with SAD (Cheer & Figgitt, 2002). However, the best
and first option should always be a form of Cognitive Behavioral Therapy. A thorough assessment and look at etiology for each specific case should contribute to the intervention and treatment of the individual. CBT is flexible and diverse and should be adapted to each individual case using findings from the assessment of the child. CBT has no adverse side-effects and is the most thorough and complete treatment method available.

**Conclusion**

*Need for Research/Future Direction*

Since the study of childhood anxiety disorders is a relatively new phenomenon, there are numerable gaps in all areas of the research. Future studies need to include more comparisons with active control groups rather than only with wait-list control groups. Much more research needs to be done on the use of medications and their safety. Also, more research is needed on Cognitive Behavioral Therapy and variations of CBT including family and group therapies. It has been found that group therapies may be just as effective as individual therapies. More research needs to be done on the effects of the family and possible causes and problems that are apparent there. For instance, how parental anxiety affects the child’s anxiety needs to be studied further. If a positive correlate is found, prevention efforts need to be made in order to break this cycle. Education of the parents and treatment of parental anxiety most likely correlates with positive effects on children, however this needs to be researched more in order to solidify
this finding. The most effective and time efficient therapy should be found which includes group aspects and family components.

**Conclusion**

Cognitive Behavioral Therapy seems to be the most diverse and encompassing treatment approach for SAD. However, cases must be looked at individually and CBT must be modified for each individual. CBT is adaptable and diverse and for the reasons outlined in this paper should be the first treatment approach considered when treating a child or adolescent for SAD.
References


