ANXIETY DISORDERS

Separation Anxiety Disorder

SepAD

DSM-5-TR 309.21 | ICD-10-CM F93.0

Developmentally excessive fear of separation from attachment figures, diagnosable across the lifespan since DSM-5.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~4% children; ~6.6% adults	Age 6-12; adult onset occurs	Female predominant in adults	Waxing; may persist to adult

CLINICAL PICTURE

- Children resist school, bedtime, sleepovers, and being left with a sitter, escalating to tears, pleading, bargaining, and physical clinging.
- Somatic complaints cluster on school mornings, with headaches and stomachaches that resolve by mid-morning once separation is avoided.
- Nightmares with explicit separation themes and refusal to sleep alone are common and frequently drive persistent parental co-sleeping.
- Catastrophic worry centers on harm befalling the attachment figure: accidents, illness, kidnapping, or simply never coming back.
- In adults the fear centers on a partner, child, or parent, with excessive checking calls and refusal to travel or sleep away from home.
- Adult presentations are routinely misclassified as dependent personality, panic disorder, or generalized anxiety disorder instead.

DIAGNOSTIC CRITERIA AT A GLANCE

- Developmentally inappropriate and excessive fear about separation from attachment figures, evidenced by at least three of eight characteristic features.
- Features include distress at anticipated or actual separation, persistent worry about losing or harming attachment figures, and refusal to leave home.
- Also included are refusal to be alone, refusal to sleep away or without the figure nearby, separation nightmares, and physical complaints.
- Duration is at least **four weeks in children and adolescents** and typically **six months or more in adults** for the diagnosis to apply.
- The disturbance causes significant distress or impairment and is not better explained by autism, psychosis, agoraphobia, or illness anxiety.

NEUROBIOLOGY & PHYSIOLOGY

- Attachment circuitry spanning amygdala, anterior cingulate, and endogenous opioid signaling mediates the acute separation distress response.
- Animal separation-distress models implicate mu-opioid, oxytocin, and corticotropin-releasing factor systems in isolation calls and reunion relief.
- Heightened CO2 sensitivity is shared with panic disorder and supports a developmental link between childhood separation fear and adult panic.
- Heritability is roughly **40%** in children, with behavioral inhibition and parental anxiety disorder as the strongest predictors of onset.
- HPA axis reactivity to separation challenge is exaggerated, with elevated cortisol measured at school drop-off in affected children.
- Longitudinal cohorts show childhood separation anxiety predicting adult panic disorder, agoraphobia, and major depressive episodes.

PSYCHOLOGICAL MECHANISMS

- Insecure ambivalent or preoccupied attachment yields an internal working model of caregivers as unpredictably and inconsistently available.
- Parental accommodation such as rescuing, early pickup, and co-sleeping negatively reinforces distress and blocks mastery experiences.
- Overprotective or anxious parenting restricts autonomy practice, so the child never accumulates evidence of coping successfully alone.
- Catastrophic cognitions about caregiver harm persist because checking, calling, and refusal keep the prediction from ever being tested.
- Life events including bereavement, illness, relocation, or parental divorce commonly precipitate onset or relapse of separation fear.

DIFFERENTIAL & COMORBIDITY

- Distinguish from **agoraphobia**, which is escape-focused, social anxiety, which is evaluation-focused, and autism-related distress at routine change.
- School refusal is a behavior rather than a diagnosis; screen for bullying, learning disorder, depression, and simple truancy motives.
- Comorbid generalized anxiety, specific phobia, and depression are common in youth, while panic disorder and PTSD predominate in adults.
- Adult separation anxiety frequently coexists with panic disorder and worsens treatment response unless it is targeted specifically.
- Assess parental anxiety disorder directly, since untreated parental anxiety predicts child nonresponse to otherwise adequate treatment.

Treatment

EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **CBT** is first-line; medication is added for moderate-to-severe or nonresponsive presentations rather than used as monotherapy.
- **Sertraline 25-200 mg/day** and **fluoxetine 10-40 mg/day** carry the best pediatric anxiety evidence, including the multisite CAMS trial.
- Start low, titrate every two to four weeks, and monitor for activation, behavioral disinhibition, and suicidality per the FDA boxed warning.
- Benzodiazepines are not recommended in youth given paradoxical disinhibition and the absence of supporting efficacy data.
- In adults, SSRIs and **venlafaxine XR 75-225 mg/day** follow standard anxiety dosing, with close attention to comorbid panic disorder.

PSYCHOTHERAPY

- **CBT** with graded separation exposure, coping skills, and contingency management across **12-16 sessions** is the evidence-based standard.
- Parent-focused treatment such as **SPACE** reduces accommodation and matches child **CBT** outcomes without requiring the child to participate.
- Parent-child interaction therapy adapted for anxiety helps preschoolers who are too young to use cognitive restructuring techniques.
- School reentry plans with graded attendance, a designated safe adult, and a written schedule are essential when school refusal is present.
- The CAMS trial found **CBT** plus **sertraline** superior to either alone in pediatric anxiety, with about an 80% combined response rate.

ADJUNCT & SUPPORTIVE

- Measure with the **SCARED** or the Pediatric Anxiety Rating Scale at baseline and every four to six weeks to guide treatment adjustments.
- Return the child to school quickly, since each additional week of absence measurably lowers the probability of successful reentry.
- Coach graduated sleep independence rather than abrupt removal of co-sleeping, which typically fails and erodes the child's trust.
- Treat parental anxiety concurrently, since parental symptom reduction improves child outcomes independent of the child's own therapy.
- Escalate to intensive outpatient or day treatment when school absence extends past several weeks despite adequate outpatient **CBT**.

CLINICAL PEARLS

- Target parental accommodation first; less rescuing often improves the child before exposure begins.
- DSM-5-TR permits adult onset; ask adults about travel refusal and checking calls to a partner.
- Every missed school day makes reentry harder, so treat school refusal as time-sensitive.

Aligned to DSM-5-TR (APA, 2022) · Educational reference only — not a substitute for clinical judgment or full diagnostic assessment.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Bogels, S. M., Knappe, S., & Clark, L. A. (2013). Adult separation anxiety disorder in DSM-5. *Clinical Psychology Review, 33*(5), 663-674. https://doi.org/10.1016/j.cpr.2013.03.006

Connolly, S. D., & Bernstein, G. A. (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 267-283. https://doi.org/10.1097/01.chi.0000246070.23695.06

Craske, M. G., & Stein, M. B. (2016). Anxiety. *The Lancet, 388*(10063), 3048-3059. https://doi.org/10.1016/S0140-6736(16)30381-6

National Institute of Mental Health. (n.d.). *Anxiety disorders*. U.S. Department of Health and Human Services. https://www.nimh.nih.gov/health/topics/anxiety-disorders

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

Stahl, S. M. (2021). *Stahl's essential psychopharmacology* (5th ed.). Cambridge University Press.

Walkup, J. T., Albano, A. M., Piacentini, J., Birmaher, B., Compton, S. N., Sherrill, J. T., Ginsburg, G. S., Rynn, M. A., McCracken, J., Waslick, B., Iyengar, S., March, J. S., & Kendall, P. C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *The New England Journal of Medicine, 359*(26), 2753-2766. https://doi.org/10.1056/NEJMoa0804633

NOTE

References are formatted in APA 7th edition style with hanging indents. Diagnostic terminology, criteria structure, and coding follow the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; APA, 2022); criteria are paraphrased for instructional use and are not reproduced verbatim. Verify all citations against the original sources before use in academic work, and confirm medication dosing against current prescribing information.