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Intensive Treatments for Separation Anxiety Disorder in Children and Adolescents

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Abstract

Childhood separation anxiety disorder (SepAD) has only recently been recognized as a highly frequent disorder, precursor of panic disorder, and pacemaker of anxiety and other mental disorders. Although cognitive-behavioral therapy (CBT) has proven effective for the treatment of anxiety disorders in children, including SepAD, intensive forms of treatments have been developed recently to further improve treatment efficacy. This brief article describes a rationale for the development of intensive, disorder-specific treatments for SepAD, focusing on extinction learning and parental involvement in the child's therapy. We further provide an overview of three cognitive-behavioral and one psychodynamic intensive treatment programs for SepAD and review the empirical evidence for each of these programs. In conclusion, one promising treatment-intensification strategy is to deliver exposure in high doses and in multiple contexts. Parents can be coached to conduct such exposure in-between treatment sessions. In the light of initial findings from RCTs, the involvement of parents seems to benefit younger children more so than older ones.

Keywords: Separation anxiety; children; disorder-specific CBT; family-based CBT; intensive treatments; brief treatments

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Introduction

After being viewed as a transient phenomenon for some time, separation anxiety disorder (SepAD) is now recognized as a wide-spread and highly debilitating disorder that may continue into adulthood (Shear, Jin, Ruscio, Walters, & Kessler, 2006), has a “pacemaker” function (i.e., it increases the risk or “paves the way”) for anxiety and other mental disorders in later developmental phases (Kossowsky et al., 2013), and has been shown to be a precursor to panic disorder in many instances (for a meta-analysis see Kossowsky et al., 2013). SepAD is characterized by developmentally inappropriate, excessive, and lasting anxiety of separation from the child’s major attachment figures. The most frequently reported symptoms are separation-related distress, avoidance of being alone/without an attachment figure, and sleeping away from caregivers or from home (Allen, Lavallee, Herren, Ruhe, & Schneider, 2010; Mohr & Schneider, 2012).

Given the lifetime prevalence rates of 3 to 4.1% (Cartwright-Hatton, McNicol, & Doubleday, 2006; Shear et al., 2006), therapeutic coverage of SepAD is far from satisfying. In the National Comorbidity Survey Replication (NCS-R) study conducted in the United States, only about half of the children diagnosed with SepAD in the 12 months before the NCS-R diagnostic interview reportedly received treatment for emotional problems, and of those who underwent therapy less than one third (28.5%) reported that SepAD was a focus of their treatment (Shear et al., 2006). Of the adult respondents with retrospectively estimated childhood SepAD, only about 20% reported they had received treatment for emotional problems before the age of 18, with SepAD being a focus of treatment in only one fourth (24.3%) of these patients.

Reviews and meta-analyses on RCTs comparing CBT against a passive or active control condition support CBT as an effective treatment for several anxiety disorders including SepAD (e.g., In-Albon & Schneider, 2007; Reynolds, Wilson, Austin, & Hooper, 2012). Although general (“catch-all”) treatment programs for childhood anxiety disorders have been successfully used with children who have SepAD (e.g., the *Coping Cat* program [CC]; Kendall, 1994), not all youth respond and, as a result, disorder-specific treatments have been developed to better meet the distinctive characteristics of SepAD (i.e., the early age of onset and dyadic, caregiver-child nature of the disorder).

Rationale for Developing Brief Treatments and the Potential Benefits for Doing So

In general, treatments can be intensified either by manipulating the time element (i.e., shortening the time span over which the treatment is delivered) or by delivering the treatment within fewer sessions (Albano, 2009), or in a combined short-term treatment with a low number of sessions. A necessary prerequisite for reducing the number of sessions is to have empirically supported evidence of the active treatment ingredients, i.e., the mediators of treatment success. Meta-analyses show that in 90.5% of successful treatment programs, exposure techniques were applied (In-Albon & Schneider, 2007), indicating that exposure may be the essential ingredient for successful treatment.

Mediators of Treatment Outcome: Extinction Learning

Exposure intervention and thus extinction learning is a "hot" candidate for the mediation of successful anxiety treatment. Although this assumption has not yet been explicitly tested in childhood anxiety (e.g., by comparing pure exposure vs. pure psychoeducation or pure cognitive restructuring), results from both animal and preclinical research give insight into a better understanding of successful anxiety treatment (for reviews see Craske, Liao, Brown, & Vervliet, 2012; and Vervliet, Craske, & Hermans, 2013). A widely accepted view in this line of research is that of an inhibitory model of fear reduction (Bouton, 1993), wherein the original feared association (CS-US) remains but is inhibited by a newly formed association (CS-no US) representing safety. This process may help explain the long-term attenuation of fear and anxiety. Importantly, fear memories are thus not erased, and they can be retrieved under certain circumstances. This phenomenon, also known as return of fear, is clinically well-known and associated with the reoccurrence of anxiety symptoms or relapse. Preclinical research has studied the conditions under which return of fear can be observed and emphasises the key role of context variables during fear extinction (Vervliet et al., 2013; Craske et al., 2012). Context information is critically linked to extinction memory and acts as a gating mechanism as to whether the fear memory is inhibited or not. Translating these results into clinical practice, the following recommendation for the implementation of successful exposure and thus extinction learning can be made: To support safety learning (i.e., the formation of inhibitory CS-no US associations) in the child, exposure training should best be repeated in *close succession* and in *multiple situations* (contexts). In SepAD, different separation situations can be practiced with the child (e.g., staying at home without the parents, going to school, attending a schoolmate's birthday party, staying over with grandparents, sleeping alone in own bedroom) and each situation should be repeated several times to optimize inhibitory / extinction learning.

Moderators of Treatment Outcome: Child Age and Parental Involvement

An additional prerequisite for developing intensive treatments is the identification of moderators of treatment outcome, i.e., for whom and under what circumstances therapy programs are effective. Two moderator candidates seem intuitive with SepAD: Chronological age and caregiver involvement. With regard to parental involvement as a potential moderating variable in the treatment of SepAD, no differences in outcome have been shown between child- and family-based treatments (e.g., In-Albon & Schneider, 2007; Reynolds et al. 2012). For age, however, there are some data indicating that younger children and children with parents who suffer from anxiety disorders themselves may benefit more from a combined parent-child than child-alone treatment (Cobham, Dadds, & Spence, 1998). Targeting parent cognitions, fears, and behaviors might indirectly improve separation anxiety symptoms in the child by removing, or attenuating, parent-related maintaining factors of the disorder. Beyond that, with appropriate coaching and sufficient practice, parents appear to be able to assist in / conduct their child's exposure training (i.e., act as coaches for their children; Pincus, Santucci, Ehrenreich, & Eyberg, 2008). Given the importance of repeated and closely spaced exposure practice as described above, parents' role might be especially important in younger children's therapy because of their responsibility for providing the child with opportunities for practice in daily life and motivating the child to seek out such opportunities.

The potential benefit of parental involvement in children's therapy was investigated in different age groups by the TAFF ("TrennungsAngstprogramm Für Familien"; English: Separation Anxiety Program for Families) treatment project that consisted of two separate RCTs and was conducted at the University of Basel from 2004 to 2009. In the first RCT (Schneider et al., 2011), which was realized in a sample of 43 children between 5 and 7 years of age, the TAFF parent-child treatment program obtained large pre-post effect sizes (d = 1.26-1.46) as well as large time by treatment interaction effect sizes (d = 0.98-1.41) for reduction of avoidance in separation situations (as assessed by the Separation Anxiety Inventory for Children, SAI; Scalbert, In-Albon, & Schneider, 2006) across informants (child, mother, father) when compared to a waitlist control condition. In the second RCT (Schneider et al., 2013), the TAFF program was compared to the Coping Cat program in a sample of older children 8 to 13 years of age (N = 64; completers: 52). Again, the TAFF program obtained large pre-post treatment effect sizes (d = 0.96-1.66) for reduction of avoidance as reported by multiple informants (child, mother, father). However, the CC program also obtained large pre-post effect sizes (d = 0.84-1.34) and with regard to remittance rates no significant difference was found between the TAFF and CC programs at the 4-weeks (TAFF: 87.5%; CC: 82.1%; intent-to-treat: 67.7% vs. 69.7%) and 1-year follow-ups (TAFF: 83.3%; CC: 75%; intent-to-treat: 64.5% vs. 63.6%). Results

from primary and secondary outcome measures (multiple-informant ratings of the child's anxiety and avoidance, functional impairment and disability, general anxiety, and quality of life) indicated improvement for both treatment groups across time points, with some small but significant between-group differences in favor of the TAFF program. Taken together, these results show that the disorder-specific, family-based TAFF treatment program is successful with the age group in which SepAD is most prevalent (5-13 years). The results also point to a clear advantage of the TAFF program over a waitlist control condition in young children (5-7 years), but when compared to a general treatment program (CC) in older children (8-13 years) only a small advantage of TAFF was found. Thus, it remains an open question if young children may profit more from a family-based intervention like TAFF than older children. For clarification of this important question, future research should compare the TAFF program with an established treatment program in young children.

Description of Brief Treatments for SepAD and Evidence Base Associated With Their Use

This section briefly outlines and compares four intensive parent-child treatment programs that have specifically been tailored to SepAD children and have received empirical evidence through RCTs, multiple-baseline, or case series studies (for an overview, see Table 1). There is one psychodynamic time-limited therapy program for children with SepAD (Muratori et al., 2005). The psychodynamic program (PP) was delivered to 14 children (treatment group, TG) and compared against a control group (CG) of 10 children who received "usual care", using a nonrandomized design. CBCL (Child Behavior Checklist) and C-GAS (Children's Global Assessment Scale) scores were assessed at baseline (T1), after 6 months (T2, which corresponded with the end of treatment for TG), and at 2-year follow-up (T3). C-GAS scores improved significantly from T1 to T2 in both groups, but the improvement continued from T2 to T3 and reached non-clinical levels of functioning only in TG. On the CBCL, both groups moved to normal levels at T2 but a progressive reduction over the whole two-year period was observed only in TG. Effect sizes were 1.4 for C-GAS and 0.7 for CBCL. Table 1 provides an overview of key features of this program as well as the other intensive treatment programs for childhood SepAD.

Second, although Parent-Child Interaction Therapy (PCIT) was originally developed and evaluated for reducing disruptive behaviors in children, it has recently been applied to children with SepAD as well (Choate, Pincus, Eyberg, & Barlow, 2005; Pincus et al., 2008). Standard PCIT for SepAD has been pilot-tested with regard to feasibility and efficacy using a multiple-baseline design in a sample of three families with children 4 to 8 years of age (Choate et al., 2005) and in a separate study with ten pilot participants in the same age group (Pincus et al., 2008). Although the pilot results demonstrated some improvement in SepAD severity as indexed by a reduction in Clinician Severity Ratings (CSRs) on the Anxiety Disorders Interview Schedule (ADIS; Silverman & Albano, 1996) from M = 5.8 pre- to 4.2 post-treatment on the 8-point CSR scale, the improvement did not reach non-clinical levels. Thus, a modified version of PCIT was developed and is being currently tested in a RCT against a waitlist control (WLC) group. One of the central elements newly introduced into the PCIT program is exposure training. Still, PCIT does not include therapist-led exposure in vivo, but instead parents are coached and encouraged to conduct exposure sessions with the child during the week.

Third, the Child-Anxiety Multi-Day Program (CAMP) is a 1-week summer treatment for school-aged girls with SepAD that has been pilot-tested using a case-series design in a sample of five girls aged 8 to 11 years (Santucci, Ehrenreich, Trosper, Bennett, & Pincus, 2009). CAMP was also recently evaluated in a RCT study against a WLC group in a sample of 28 girls aged 7 to 12 years (Santucci & Ehrenreich-May, 2013). At post-treatment one week following treatment, severity ratings of SepAD, functional impairment, and parent-reported child anxiety symptoms were significantly lower in the treatment group (n = 14) than in the WLC group (n = 14). However, reductions in SepAD severity and functional impairment were significant for both groups, and contrary to hypotheses no difference between groups was observed in self-reported anxiety symptoms of the child. Children from the WL received treatment after a waiting period of 8 weeks (delayed treatment). Data were collapsed across the immediate and delayed treatment groups to determine the percentage of treatment responders. At post-treatment 43% and at 6-week follow-up 61% of the full sample (N = 28) no longer met diagnostic criteria for SepAD as assessed by the ADIS.

Fourth, the TAFF treatment program, mentioned above, is a cognitive-behavioral family therapy program for children between 4 and 13 years of age. Of the four treatment programs for children with SepAD described in this section, only the TAFF program has been evaluated in two RCT studies, using manuals and a multi-informant approach to test efficacy. It is therefore described in more detail in the next section (for a comprehensive overview of the TAFF program see Schneider & Lavallee, 2013).

Table 1: Overview of intensive treatments for childhood SepAD

	PP	PCIT	CAMP	TAFF
Duration / number of sessions	11 sessions delivered within routine clinical contexts	minimum of 9 50-min sessions	1-week summer camp	16 50-min sessions
Exposure	not mentioned	modified PCIT: parent-led exposure practices in-between sessions	daily exposure practice	9 exposure sessions and parent-led exposure practices in-between sessions
Parental involvement	combines 5 parent-child sessions with 5 child-alone sessions and closes with a joint treatment termination session	aims at improving parent-child interactions through “teach” and “coach” sessions with the parents	separate and joint child and parent groups; parental involvement is gradually faded out	50% separate psychoeducational parent- and child-sessions; 50% joint parent-child practice sessions
Empirical evidence	pilot-tested in a study (nonrandomized design) with 14 children, compared against a control group of 10 children who received “usual care”	standard PCIT was pilot-tested in a study with 3 families and in a separate sample of 10 children; modified PCIT is currently tested against WLC in a first RCT; all children aged 4 to 8	pilot-tested in a study with 5 girls aged 8 to 11; a first RCT study comparing CAMP against WLC in a sample of 28 girls aged 7 to 12 is currently conducted	two RCT studies, one against WLC (N=43, aged 5-7) and the other against an established general child-only CBT (“Coping Cat”, N=64, aged 8-13)

PP: Psychodynamic psychotherapy; PCIT: Parent-Child Intensive Treatment; CAMP: Child-Anxiety Multi-Day Program; TAFF: TrennungsAngstprogramm Für Familien; RCT: randomized controlled trial; WLC: waitlist control

The TAFF Treatment Program for SepAD in Children Aged 4-13 Years

Psychoeducational sessions 1 to 8.

Of the 16 TAFF sessions, the first 8 are partitioned into 4 child-alone sessions alternating with 4 parent-alone sessions. The content of the child- and parent-alone sessions is similar – consisting of psychoeducation, cognitive restructuring, and exposure preparation – but are delivered in an age- and role-tailored way. In the exposure-preparatory session, the child learns how avoidance acts as a fear strengthener and how one can conquer and permanently overcome fear by engaging in “TAFF thoughts” and coping strategies acquired in the previous sessions. The therapist conveys the rationale and graduated plan for exposure, using the metaphor of a mountain (“defeating anxiety is like climbing a mountain”). Child and therapist jointly develop a hierarchy of feared situations. The fear thermometer for on-site ratings of fear is introduced and the child chooses rewards for each step up the mountain. Parents are coached to use reinforcement to promote desired, courageous behaviors and to ignore unwanted, anxious behaviors.

Throughout sessions 1 to 8, the therapist uses guided discovery to convey new information and provides the child with frequent “recognition points” that connect to the child's own experiences. Structured materials like strategy and index cards are used to aid the child in rehearsing and practicing TAFF thoughts and coping strategies. Between sessions, the child and parents regularly write in the TAFF daily diary. All child materials are designed in a child-friendly way (e.g., little potato head figurines, thought bubbles).

Exposure practice sessions 9 to 16.

The exposure practice sessions are preceded by a parent-child joint preparatory session where the child explains the exposure rationale to the parents, and together they create a mutually shared fear hierarchy. Because exposure exercises must follow each other closely, it is important that the family commits to daily exposure. After successful completion of the first therapist-led exposure exercise in session 10, the situation is repeatedly practiced up to 4 times in a block. After 2-3 successful practice trials, parents are asked to perform the exercise on their own with the therapist present. The first exposure session block is ended when the parents are confident they can conduct the exercises on their own. From that point on, the involvement of the therapist is on an as-needed-basis. Extinction learning during exposure is assisted by applying strategies and materials that are based on new knowledge on the enhancement of inhibitory learning during extinction (e.g., variable practice, expectation violation, or retrieval cues like note-cards).

The TAFF treatment program ends with two sessions on relapse prevention and reflection on the course of therapy. The child and parents are encouraged to continue practicing TAFF thoughts and strategies in new situations because a well-practiced set of skills and a wide variety of successfully mastered (potential) fear situations is the best protection against setbacks.

Summary and Future Directions – Clinical and Research Implication

With the acknowledgement of SepAD as a highly prevalent, debilitating disorder and as a risk factor for anxiety and other mental disorders in adulthood, the development and dissemination of efficacious treatments for SepAD has become an important issue. CBT is supported as the most effective treatment for childhood anxiety disorders, including SepAD, and exposure (extinction) is the most promising candidate for mediating CBT efficacy. While animal and preclinical research on extinction learning and “return of fear” through context conditioning is thriving, results have not yet been sufficiently translated into treatment studies with children.

Recently, intensive treatments have been specifically developed for child patients with SepAD. Each of these disorder-specific treatment programs has received empirical support, either preliminarily through pilot studies or more substantially through RCTs, thus supporting intensive treatments for SepAD in general. The rationale of intensive treatments as outlined in this paper is to improve the efficacy of CBT by optimizing inhibitory / extinction learning in children with the aim of helping them form lasting and stronger inhibitory (CS-no US) associations. As a common denominator, all intensive treatments for SepAD involve parents and all but one rely on highly frequent exposure training as a key ingredient. The most empirical support so far has been accumulated for the family-based TAFF treatment program. Results from two separate RCTs in children aged 5-7 (RCT 1) and 8-13 (RCT 2) support the TAFF program as an effective treatment for SepAD. With regard to parental involvement, results point to a better benefit for younger children. Despite these promising results, the need for parental participation and the potential moderating role of age still lack a final answer. Future studies with larger samples and increased power should identify the mediators and moderators of treatment outcome in children and parse out the essential ingredients of treatment. Having identified the mechanisms and moderators of treatment success, treatments can be tailored to subgroups of patients and all redundant elements can be removed from treatment protocols, thereby further strengthening intensive treatments for SepAD.

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