ARTICLE

Separation Anxiety Disorder in School-Age Children: What Health Care Providers Should Know

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ABSTRACT

Separation anxiety disorder (SAD) is the most common childhood anxiety disorder, and it has many consequences, particularly for school-age children. These consequences include excessive worry, sleep problems, distress in social and academic settings, and a variety of physical symptoms that, left untreated, can cause social and academic decline. Pediatric providers routinely see children in the primary care office and have the unique opportunity to diagnose, treat, and manage children with SAD. Despite this, SAD continues to be underdiagnosed and undertreated because of a gap in the literature regarding evidence-based practice guidelines for pediatric providers. The purpose of this article is to discuss the diagnosis and management of SAD in school-age children and highlight the role of pediatric providers in managing separation anxiety. J Pediatr Health Care. (2016) ■, ■-■.

KEY WORDS

Pediatrics, separation anxiety disorder, school-age

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Anxiety conditions including generalized anxiety disorder, social anxiety and phobias, separation anxiety disorder (SAD), and posttraumatic stress disorder are the most common mental health disorders in children. SAD is the most common childhood anxiety disorder and occurs at a mean age of 7 years (Herren, In-Albon, & Schneider, 2013). Some anxiety in children is expected, making it difficult to recognize when the level of anxiety becomes a psychological problem or a disorder. Separation anxiety is developmentally normal for infants and toddlers but becomes a disorder when it continues past toddlerhood. This article focuses on school-age children defined by the National Institutes of Health as children ages 6 to 12 years

(Kliegman, Stanton, Geme, Schor, & Behrman, 2015). There also appears to be underdiagnosing of SAD in school-age children, which leads to children being undertreated.

There are multiple epidemiologic reports on the prevalence of SAD, but it is estimated that between 1.09% and 4.1% of children ages 5 through 11 years have SAD (Lavallee et al., 2011). Another source estimates that between 2% and 13% of children have SAD (Scaini, Ogliari, Eley, Zavos, & Battaglia, 2012). The variations in prevalence rates may be accredited to a variety of assessment methods and lack of reporting.

SAD leads to disturbances for both the child and the caregiver that include excessive worry, sleep problems, distress in social and academic settings, and a variety of physical symptoms (Brand et al., 2011). These disturbances, if not treated, can lead to further psychological problems in adulthood. Furthermore, school-age children who suffer from SAD may have consequences such as poor academic performance, social isolation, and difficulty in social settings. There are several studies that discuss different aspects of SAD, but there is a gap in the literature regarding evidence-based practice guidelines for pediatric providers. The purpose of this article is to discuss the diagnosis and management of SAD in school-age children and to highlight the role of pediatric providers in managing separation anxiety.

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BACKGROUND

The National Institutes of Health (2014, p. 1) define separation anxiety in children as "a developmental stage during which the child experiences anxiety when separated from the primary caregiver." John Bowlby was one of the first theorists to discuss the relationships between parents and children. Bowlby developed the attachment theory, in which he states that children who form an enduring social–emotional relationship are more likely to survive (Kail, 2015). These relationships are formed very early and are usually with the mother, but they can be formed with any responsive and caring person such as a father, grandparent, or other caregiver. Bowlby further described attachment as developing in four stages: preattachment, attachment in the making, true attachment, and reciprocal relationships (Kail, 2015). At around 6 to 8 months of age, an infant has formed a secure relationship with his/her caregiver and also begins to experience distress when separation from this caregiver occurs. Separation anxiety is a normal part of development in children 1 to 3 years old, and as the child continues to develop cognitively, so does the ability to cope with separation anxiety, because the child learns that the caregiver will return (Milrod et al., 2014).

Some children will develop excessive fear and anxiety when separated from their caregivers, leading to SAD. The *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (American Psychiatric Association [APA], 2013), defines the criteria for separation anxiety as developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached. This excessive fear or worry must cause significant impairment in social, academic, or occupational areas of functioning, as well as last longer than 4 weeks to be considered SAD (Box 1).

RISK FACTORS

Several risk factors contribute to the development of SAD. School-age children at higher risk for developing SAD include children with parents with panic disorder or other anxiety disorders (Lavallee et al., 2011). Lavallee et al. (2011) also identify pregnancy and birth factors such as maternal smoking, alcohol consumption, and low birth weight as factors that may increase the risks of developing mental health problems in children. Therefore, family history and birth history are important aspects to consider when evaluating a child for SAD. Scaini et al. (2012) suggest that there are also genetic and environmental factors that significantly increase the risks of developing SAD. Some children may have an inborn anxious propensity, which may inherently lead to SAD (Milrod et al., 2014). Environmental factors and life circumstances that may contribute to the development of SAD include divorce, military leaves such as parental deployments during war, foster care, adoption, incarceration, parental death, and relocation due to occupation. Khadar, Babapour, & Sabourimoghaddam (2013) further expand on environmental factors by identifying that 14% of children of alcoholic parents will develop SAD. Scaini et al. (2012) also conclude that girls are at higher risk, which may be due to internalization of emotions. Lavallee et al. (2011) propose that the process of developing SAD is influenced over time by cognitive maturation, developmental and traumatic events, parenting style, and relationships with others. Anxiety-provoking caretaking such as having a parent who is anxious has also been shown to affect SAD (Milrod et al., 2014). A study by Jansen et al. (2011) suggests that children whose parents stayed with them during the onset of sleep, such as co-sleeping, were at an increased risk of developing anxiety or depressive symptoms. It is also important to note that school-age children have yet to develop the verbal or cognitive skills needed to express their feelings and emotions (Allen, Blatter-Meunier, Ursprung, & Schneider, 2010).

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