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# Separation Anxiety Disorder

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## DESCRIPTION OF SEPARATION ANXIETY DISORDER

### Definition

Separation anxiety disorder (SAD) is defined as developmentally inappropriate and excessive distress or anxiety that involves a fear of separation from those to whom an individual is attached (American Psychiatric Association [APA], 2013, p. 190). The most frequently reported symptoms of SAD include recurrent excessive distress when separated from home or the attachment figure, persistent excessive worry about losing the attachment figure, refusal to go to school, work, or elsewhere due to separation, persistent reluctance or refusal to go to sleep without being near the attachment figure, repeated nightmares involving separation, and repeated complaints of physical symptoms, such as headaches and stomachaches, when separation occurs or is anticipated. This fear or anxiety is persistent and lasts for at least 4 weeks in children and adolescents, and typically 6 months or more in adults (APA, 2013).

### Resources:

Anxiety, Panic & Health: Adult Separation Anxiety Disorder

<http://anxietypanichealth.com/reference/separation-anxiety-disorder-adult/>

Separation Anxiety Disorder

[http://www.childanxiety.net/Separation\\_Anxiety.htm](http://www.childanxiety.net/Separation_Anxiety.htm)

Anxiety BC: Separation Anxiety Disorder

<http://www.anxietybc.com/parent/separation.php>

American Academy of Child and Adolescent Psychiatry: The Anxious Child

[http://www.aacap.org/AACAP/Families\\_and\\_Youth/Facts\\_for\\_Families/Facts\\_for\\_Families\\_Pages/The\\_Anxious\\_Child\\_47.aspx](http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/The_Anxious_Child_47.aspx)

American Academy of Pediatrics: Anxiety

<http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/Pages/Anxiety.aspx>

Anxiety Disorders Association of America

<http://www.adaa.org>

National Institute of Mental Health, Public Information & Communication Branch:

<http://www.nimh.nih.gov>

### Prevalence

SAD affects approximately 4% of children (Cartwright-Hatton, McNicol, & Doubleday, 2006; Pine & Klein, 2008), 1.6% of adolescents (Kessler, Petukhova, Samson, Zaslavsky, & Wittchen, 2012), and 0.9% – 1.9% of adults in the United States (Kessler et al., 2005; Kessler et al., 2012). It is the most prevalent anxiety disorder in children younger than 12 years of age (APA, 2013).

## IDENTIFICATION/ASSESSMENT STRATEGIES

In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; *DSM-5*; APA, 2013), SAD was redefined to include a greater developmental lifespan perspective. Accordingly, counselors must consider assessments that are

developmentally sensitive. According to the American Academy of Child and Adolescent Psychiatry (AACAP; Connolly & Bernstein, 2007), assessment includes three steps. The first step involves the utilization of screening questions during routine mental health examinations, and should include questions related to anxiety. If symptoms of anxiety are present during screening, the counselor should conduct a formal evaluation to determine the presence, severity, and duration of the symptoms, as well as the resulting degree of functional impairment. Finally, the counselor should conduct a broad assessment that goes beyond anxiety for the purposes of differential diagnostics; this is imperative due to the high rates of other mental disorders that are frequently co-morbid with SAD.

Assessment instruments need to be developmentally sensitive to age-related manifestations and differentiate age-appropriate from inappropriate fears. Therefore, an assessment approach that utilizes multiple informants (e.g., child, parent, teacher) and multiple information-gathering methods is recommended. Diagnostic interviews, self-report measures, and observations can all be used to accurately diagnose SAD.

### **Anxiety and Related Disorders Interview Schedule for *DSM-5* (ADIS-5) – Adult and Lifetime Version (Brown & Barlow, 2014)**

The ADIS-5 is a structured interview designed to diagnose anxiety-related disorders according to *DSM-5* criteria. The instrument helps clinicians differentiate among anxiety disorders. The ADIS-5 contains screening questions for a variety of other conditions that may also be present, such as eating disorders, attention-deficit hyperactivity disorder, and impulse control disorders. Sections are also included for the assessment of episodic and ongoing life stressors, individual medical and psychiatric treatment history, and familial psychiatric history (Brown & Barlow, 2014). While there is no data available for the current interview schedule for the *DSM-5*, previous editions of the ADIS (i.e., ADIS, ADIS-R, ADIS-IV) have demonstrated good reliability for the majority of disorders covered. The most recent studies examining the ADIS-IV indicated good-to-excellent interrater agreement for the *DSM-IV* disorders, with the exception of dysthymic disorder (Brown, Di Nardo, Lehman, & Campbell, 2001; Silverman, Saavedra, & Pina, 2001).

### **Diagnostic Interview Schedule for Children, Version IV (DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000)**

The DISC-IV is a structured diagnostic instrument that assesses 34 common psychiatric diagnoses found in children and adolescents. It is organized into six diagnostic sections: Anxiety Disorders, Mood Disorders, Disruptive Disorders, Substance-Use Disorders, Schizophrenia, and Miscellaneous Disorders. To assess SAD, only the Anxiety Disorders section needs to be used. The interview focuses on symptoms presented within the past year and during the past 4 weeks. The parent version is for parents of children ages 6–17, while the child version is for children ages 9–17. Questions are highly structured and are generally limited to “yes” or “no,” and “sometimes” or “somewhat”; there are very few open-ended questions (Shaffer et al., 2000). It is important to keep in mind that this interview schedule specifically addresses the criteria as outlined in the *DSM-IV*. At this point, a revised schedule has not been published that meets the criteria as outlined by the *DSM-5*.

#### **Resources:**

General Documentation: National Institute of Mental Health Diagnostic Interview Schedule for Children (DISC):  
[http://www.cdc.gov/nchs/data/nhanes/limited\\_access/ydq.pdf](http://www.cdc.gov/nchs/data/nhanes/limited_access/ydq.pdf)

DISC-IV Interviewer Manual:

[http://www.cdc.gov/nchs/data/nhanes/limited\\_access/interviewer\\_manual.pdf](http://www.cdc.gov/nchs/data/nhanes/limited_access/interviewer_manual.pdf)

### **Preschool Age Psychiatric Assessment (PAPA; Egger, Ascher, & Angold, 1999)**

The PAPA is a structured parent interview that is used to diagnose psychiatric disorders in children ages 2–5 and is based on the Child and Adolescent Psychiatric Assessment (CAPA; Angold & Costello, 1995, 2000; Angold et al., 1995). This is the first developmentally appropriate structured psychiatric interview to assess family and community risk factors, resiliency and protective factors, and psychopathology in both community and clinical samples of preschool children as young as 2 years old. Trained interviewers interview the parent or other primary caregiver. Both a paper-based version and an electronic version are available. The PAPA assesses symptoms in four domains: a) items based on the *DSM-IV* and the ICD-10 diagnostic criteria; b) items in the Research Diagnostic Criteria-Preschool Age (RDC-PA: Task Force on Research Diagnostic Criteria: Infancy and Preschool, 2003); c) items in the CD:0 0-3 (Zero to Three, 2005); and finally, d) relevant behaviors and symptoms experienced by

preschoolers and their families that are not explicitly in the diagnostic criteria (Egger et al., 2006). Researchers have indicated that the PAPA is reasonably reliable with diagnostic reliability ranging from .36 to .79 and test-retest intraclass correlations ranging from .56 to .89. For the SAD subscale of the PAPA, diagnostic reliability was .60 and the test-retest intraclass correlation was .63 (Egger & Angold, 2006; Egger et al., 2006).

**Resource:**

The Preschool Age Psychiatric Assessment (PAPA): A Structured Parent Interview for Diagnosing Psychiatric Disorders in Preschool Children

<http://devepi.duhs.duke.edu/pubs/papachapter.pdf>

## INTERVENTION STRATEGIES

Counseling, rather than psychopharmacotherapy, is the preferred method of treatment for SAD that is mild in severity. For children and adults who do not respond to counseling alone, present with more severe symptoms, or have other emotional problems in addition to SAD, treatment may consist of a combination of approaches that include the use of psychotropic medications. Individual counseling, medication, and parent counseling have been found to be effective in treating SAD, particularly when these treatments are used in combination. Selective serotonin reuptake inhibitors (SSRIs) may have therapeutic effects for children and adolescents with SAD symptoms who warrant medication (Reinblatt & Riddle, 2007). Cognitive behavioral therapy (CBT) has demonstrated the most efficacy in the treatment of this disorder (In-Albon & Schneider, 2007; James, James, Cowdrey, Soler, & Choce, 2013; Mohr & Schneider, 2013; Silverman, Pina, & Viswesvaran, 2008; Velting, Setzer, & Albano, 2004).

### **Cognitive Behavioral Therapy (CBT)**

CBT is the primary psychosocial treatment used to treat SAD in both children and adults (Mohr & Schneider, 2013). CBT approaches involve gradually exposing clients to feared stimuli. The client learns how to recognize anxious feelings regarding separation and identify his or her physical reactions to anxiety. Clients are taught to identify their thoughts during anxiety provoking situations, and then explore how to develop a plan to cope with the thoughts and reactions to these thoughts.

Because the literature on SAD has focused mostly on children and adolescents, most empirically-based treatment programs have focused on this age group. There are several childhood CBT programs that have been examined in the literature.

**Coping Cat.** The Coping Cat program (Kendall & Hedtke, 2006) is a manualized CBT intervention program for children with anxiety disorders, including SAD. The program combines cognitive restructuring with relaxation training, and is followed by gradual exposure to the anxiety-provoking situation. Clients are encouraged to utilize the coping skills learned in counseling while engaged in exposure exercises. Several studies have suggested that treatment gains associated with the Coping Cat program are maintained over time (Kendall, Safford, Flannery-Schroeder, & Webb, 2004). This program is one of the most widely used and effective anxiety treatment programs for youth (Hirshfeld-Becker et al., 2010; Keeton et al., 2013; Mohr & Schneider, 2012; Pearlman, Schwalbe, & Cloitre, 2010).

**Resources:**

Coping Cat Intervention Summary

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=91>

Promising Practices: Coping Cat

<http://www.promisingpractices.net/program.asp?programid=153>

**FRIENDS.** The FRIENDS program (Barrett, Lowry-Webster, & Turner, 2000) is a 10-session CBT intervention for children with anxiety disorders that is delivered in a group format. FRIENDS is an acronym that stands for F-Feeling worried?; R-Relax and feel good; I-Inner thoughts; E-Explore plans; N-Nice work so reward yourself; D-Don't forget to practice; and S-Stay calm, you know how to cope now. This program also includes family involvement, cognitive restructuring and systematic exposure, and interpersonal therapy. Parents are encouraged to practice the FRIENDS skills with their children on a daily basis and provide positive reinforcement when skills

are used appropriately. The program promotes developing friendships, talking to friends about difficult situations, and learning from peers' experiences. Research has suggested promising results when using the FRIENDS program, and significant treatment gains have been maintained over time (Fjermestad, 2013; Liber et al., 2008; Rodgers & Dunsmuir, 2013; Schoenfield & Morris, 2009; Shortt, Barrett, & Fox, 2001).

**Resources:**

British Columbia Friends for Life

[http://www.mcf.gov.bc.ca/mental\\_health/friends.htm](http://www.mcf.gov.bc.ca/mental_health/friends.htm)

Kids Matter: Friends for Life

<https://www.kidsmatter.edu.au/primary/programs/friends-life>

Friends for Life & My FRIENDS Youth

<http://www.friendsforlife.org.nz/>

**Integrated Cognitive Behavioral Parent-Training Intervention.** Eisen, Raleigh, and Neuhoff (2008) examined the efficacy of an integrated cognitive behavioral parent-training intervention with parents of children diagnosed with SAD. The treatment protocol included 10 parent-only sessions that incorporated traditional CBT techniques such as psychoeducation, practice in session, imaginal exposure, and homework assignments.

**Parent Child Interaction Therapy (PCIT)**

Because cognitive abilities such as metacognitive awareness are required to use CBT approaches, younger children may not benefit from CBT. Parent-Child Interaction Therapy (Brinkmeyer & Eyberg, 2003) has been adapted specifically for use with young children who have SAD (Carpenter, Puliafico, Kurtz, Pincus, & Comer, 2014; Choate, Pincus, & Eyberg, 2005; Pincus, Eyberg, Choate, & Barlow, 2005; Pincus, Santucci, & Ehrenreich, 2008; Puliafico, Comer, & Pincus, 2012). Developed for use with children ages 4-8, the PCIT incorporates three treatment phases: Child-Directed Interaction, Bravery-Directed Interaction, and Parent-Directed Interaction. The first phase focuses on improving the quality of the parent-child relationship. Parents are taught skills that focus on parental warmth, attention, and praise. The second phase includes psychoeducation for parents about the nature of anxiety and explains the rationale for gradual exposure to anxiety-provoking separation situations. The counselor works with the family to develop a fear hierarchy (or bravery ladder) that lists each situation that the child is fearful of and may be currently avoiding. The family also creates a reward list to reinforce the child's positive behaviors when approaching the feared situations. Finally, the third phase of treatment teaches parents how to provide clearly communicated and age-appropriate instructions to the child. Parents are taught to provide consistent positive and negative consequences following the child's obedience or disobedience, and they learn how the social environment can influence the child's behavior.

**Resources:**

PCIT International

<http://www.pcit.org/>

University of Florida: PCIT

<http://pcit.phhp.ufl.edu/>

Parent-Child Interaction Therapy with At-Risk Families

[https://www.childwelfare.gov/pubs/f\\_interactbulletin/f\\_interactbulletin.pdf](https://www.childwelfare.gov/pubs/f_interactbulletin/f_interactbulletin.pdf)

SAMHSA's National Registry of Evidence-based Programs and Practices: Parent-Child Interaction Therapy

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=23>

## REFERENCES

- American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed. [DSM-5]). Washington, DC: Author.
- Angold, A., & Costello, E. J. (1995). A test-retest reliability study of child-reported psychiatric symptoms and diagnoses using the Child and Adolescent Psychiatric Assessment (CAPA-C). *Psychological Medicine, 25*, 755-762. doi:10.1017/S0033291700034991
- Angold, A., & Costello, E. J. (2000). The child and adolescent psychiatric assessment (CAPA). *Journal of the American Academy of Child & Adolescent Psychiatry, 39*, 39-48. doi:10.1097/00004583-200001000-00015
- Angold, A., Prendergast, M., Cox, A., Harrington, R., Simonoff, E., & Rutter, M. (1995). The child and adolescent psychiatric assessment (CAPA). *Psychological Medicine, 25*, 739-753. doi:10.1017/S003329170003498X
- Barrett, P., Lowry-Webster, H., & Turner, G. (2000). *FRIENDS program for children: Group leaders manual*. Brisbane, Australia: Australian Academic Press.
- Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-child interaction therapy for oppositional children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence based psychotherapies for children and adolescents*. New York, NY: The Guilford Press.
- Brown, T. A., & Barlow, D. H. (2014). *Anxiety and related disorders interview schedule for DSM-5 (ADIS-5) – Adult and lifetime version*. New York, NY: Oxford University Press.
- Brown, T. A., Di Nardo, P. A., Lehman, C. L., & Campbell, L. A. (2001). Reliability of DSM-IV anxiety and mood disorders: Implications for the classification of emotional disorders. *Journal of Abnormal Psychology, 110*(1), 49-58. doi:10.1037/0021-843X.110.1.49
- Carpenter, A. L., Puliafico, A. C., Kurtz, S. M. S., Pincus, D. B., & Comer, J. S. (2014). Extending parent-child interaction therapy for early childhood internalizing problems: New advances for an overlooked population. *Clinical Child and Family Psychology Review*. doi:10.1007/s10567-014-0172-4
- Cartwright-Hatton S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review, 26*(7), 817–833. doi:10.1016/j.cpr.2005.12.002
- Choate, M. L., Pincus, D. B., & Eyberg, S. M. (2005). Parent-child interaction therapy for treatment of separation anxiety disorder in young children: A pilot study. *Cognitive and Behavioral Practice, 12*, 126–135. doi:10.1016/S1077-7229(05)80047-1
- Connolly, S. D., & Bernstein, G. A. (2007). Work group on quality issues: Practice paradigm for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of American Academy of Child Adolescent Psychiatry, 46*(2), 267-283. doi:10.1097/01.chi.0000246070.23695.06
- Egger, E. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: Presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry, 47*, 313–337. doi:10.1111/j.1469-7610.2006.01618.x
- Egger, H. L., Ascher, B. H., & Angold, A. (1999). *The preschool age psychiatric assessment: Version 1.1*. Durham, NC: Center for Developmental Epidemiology, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center.
- Egger, H. L., Erkanli, A., Keeler, G., Potts, E., Walter, B. K., & Angold, A. (2006). Test-retest reliability of the preschool age psychiatric assessment (PAPA). *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(5), 538-549. doi:10.1097/01.chi.0000205705.71194.b8
- Eisen, A. R., Raleigh, H., & Neuhoff, C. C. (2008). The unique impact of parent training for separation anxiety disorder in children. *Behavior Therapy, 39*, 195–206. doi:10.1016/j.beth.2007.07.004
- Fjermestad, K. (2013). Effectiveness of cognitive-behavioral anxiety treatments for children and adolescents. *European Psychiatry, 28*, 1. doi:10.1016/S0924-9338(13)77518-7
- Hirshfeld-Becker, D. R., Masek, B., Henin, A., Blakely, L. R., Pollock-Wurman, R. A., McQuade, ... Biederman, J. (2010). Cognitive behavioral therapy for 4- to 7-year-old children with anxiety disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 78*, 498–510.
- In-Albon T., & Schneider, S. (2007). Psychotherapy of childhood anxiety disorders: A meta-analysis. *Psychotherapy and Psychosomatics, 76*, 15-24.
- James, A. C., James, G., Cowdrey, F. A., Soler, A., & Choke, A. (2013). Cognitive behavioral therapy for anxiety disorders in children and adolescents. *Cochrane Database System Review, 3*(6), CD004690. doi:10.1002/14651858.CD004690

- Keeton, C. P., Ginsburg, G. S., Drake, K., Sakolsky, D., Kendall, P. C., Birmaher, B., ... Walkup, J. T. (2013). Benefits of child-focused anxiety treatments for parents and family functioning. *Depression & Anxiety, 30*(9), 865-872. doi:10.1002/da.22055
- Kendall, P. C., & Hedtke, K. A. (2006). *Coping cat workbook* (2nd ed.). Ardmore, PA: Workbook Publishing.
- Kendall, P. C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: Outcomes in adolescence and impact on substance use and depression at 7: 4-year follow-up. *Journal of Consulting and Clinical Psychology, 72*, 276-287. doi:10.1037/0022-006X.72.2.276
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593-602. doi:10.1001/archpsyc.62.6.593
- Kessler, R. C., Petukhova, M., Samson, N. A., Zaslavsky, A. M., & Wittchen, H. U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research, 21*(3), 169-184. doi:10.1002/mpr.1359
- Liber, J. M., Van Widenfelt, B. M. Utens, E. M. W., J., Ferdinand, R. F., Van Der Leeden, A., Adeline, J. M., ... Treffers, P. D. A. (2008). No differences between group versus individual treatment of childhood anxiety disorders in a randomized clinical trial. *Journal of Child Psychology and Psychiatry, 49*(8), 886-893. doi:10.1111/j.1469-7610.2008.01877.x
- Mohr, C., & Schneider, S. (2013). Anxiety disorders. *European Child Adolescent Psychiatry, 22*, 17-22. doi:10.1007/s00787-012-0356-8
- Pearlman, M. Y., Schwalbe, K. D., & Clotre, M. (2010). Treating anxiety symptoms in grieving children. In *Grief in childhood: Fundamentals of treatment in clinical practice* (pp.105-122). Washington, DC: American Psychological Association.
- Pincus, D. B., Eyberg, S. M., Choate, M. L., & Barlow, D. H. (2005). Adapting parent-child interaction therapy for young children with separation anxiety disorder. *Education and Treatment of Children, 28*, 163-181. doi:10.1016/j.cbpra.2007.08.002
- Pincus, D. B., Santucci, L. C., Ehrenreich, J., & Eyberg, S. M. (2008). The implementation of modified parent-child interaction therapy for youth with separation anxiety disorder. *Cognitive and Behavioral Practice, 15*, 118-125. doi:10.1016/j.cbpra.2007.08.002
- Pine, D. S., & Klein, R. G. (2008). Anxiety disorder. In M. Rutter, D. Bishop, D. Pine, S. Scott, J. S., Stevenson, E. A. Taylor, & A. Thapar (Eds.), *Rutter's child and adolescent psychiatry* (5th ed.; pp. 628-648). London, England: Blackwell.
- Puliafico, A. C., Comer, J. S., & Pincus, D. B. (2012). Adapting parent-child interaction therapy to treat anxiety disorders in young children. *Child and Adolescent Psychiatric Clinics of North America, 21*(3), 607-619. doi:10.1016/j.chc.2012.05.005
- Reinblatt, S. P., & Riddle, M.A. (2007). The pharmacological management of childhood anxiety disorders: A review. *Psychopharmacology, 191*, 67-8. doi:10.1007/s00213-006-0644-4
- Reynolds, S., Wilson, C., Austin, J., & Hooper, L. (2012). Effects of psychotherapy for anxiety in children and adolescents: A meta-analytic review. *Clinical Psychology Review, 32*, 251-262. doi:10.1016/j.cpr.2012.01.005
- Rodgers, A., & Dunsmuir, S. (2013). A controlled evaluation of the 'FRIENDS for Life' emotional resiliency programme on overall anxiety levels, anxiety subtype levels, and school adjustment. *Child and Adolescent Mental Health*. Advance online publication. doi:10.1111/camh.12030
- Schoenfield, G., & Morris, R. J. (2009). Cognitive-behavioral treatment for childhood anxiety disorders: Exemplary programs. In M. J. Mayer, J. E. Lochman, & R. Van Acker (Eds.), *Cognitive-behavioral interventions for emotional and behavioral disorders: School-based practice* (pp. 204-232). New York: Guilford Press.
- Shaffer, D., Fisher, P., Lucas, C. Dulcan, M., & Schwab-Stone, M. (2000). NIMH diagnostic interview schedule for children-Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 28-38. doi:10.1097/00004583-200001000-00014
- Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS Program: A cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child Psychology, 30*, 525-535. doi:10.1207/S15374424JCCP3004\_09
- Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child Psychology, 37*, 105-130. doi:10.1080/15374410701817907

- Silverman, W. K., Saavedra, L. M., & Pina, A. A. (2001). Test-retest reliability of anxiety symptoms and diagnoses with the Anxiety Disorders Interview Schedule for DSM-IV: Child and parent versions. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(8), 937-944. doi:10.1097/00004583-200108000-00016
- Task Force on Research Diagnostic Criteria: Infancy and Preschool. (2003). Research diagnostic criteria for infants and preschool children: The process and empirical support. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 1504-1512. doi:10.1097/00004583-200312000-00018
- Velting, O. N., Setzer, N. J., & Albano, A. M. (2004). Update on and advances in assessment of cognitive-behavioral treatment of anxiety disorders in children and adolescents. *Professional Psychology: Research and Practice, 35*, 42-54. doi:10.1037/0735-7028.35.1.42
- Zero to Three. (2005). *Diagnostic classification: 0-3R: Diagnostic classification of mental health and developmental disorders of infancy and early childhood* (Rev. ed.). Washington, DC: Author.