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Cognitive Behavioral Therapy for Separation Anxiety Disorder: Three Cases

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ABSTRACT

Separation anxiety disorder (SAD) is characterized by excessive fear and anxiety related to separation from attachment figures. Until relatively recently, SAD was considered exclusively a childhood disorder; however, accumulating evidence indicates that it may persist from childhood into adulthood or emerge for the first time during adulthood, which is referred to as adult separation anxiety disorder (ASAD). High rates of psychiatric comorbidity in individuals with ASAD complicate diagnostic and differential diagnosis processes. Psychotherapy is central to ASAD management. Cognitive behavioral therapy (CBT) is an evidence-based, well-established intervention for anxiety disorders. Nevertheless, ASAD frequently presents with resistance to treatment, as observed in other anxiety disorders. This article examines the therapeutic course and clinical outcomes of three patients diagnosed with ASAD in their twenties who underwent combined pharmacotherapy and CBT. Each case was characterized by substantial psychiatric comorbidities, including anxiety and depression. The CBT protocol for ASAD started with psychoeducation, encompassing case conceptualization, the phenomenology of separation anxiety, adult clinical presentation, and the cognitive, emotional, and behavioral mechanisms that perpetuate anxiety. The formulation was collaboratively constructed and discussed with patients to enhance their autonomy. Dysfunctional responses to perceived separation threats, associated maladaptive schemas, and functional impairments were systematically identified. Catastrophic cognitions related to separation, inadequacy, and abandonment were modified. Treatment proceeded with graded exposure designed to facilitate independent functioning apart from the primary attachment figures. In all three patients, the treatment process ended with remission. Pharmacotherapy was discontinued. Taken together, these observations highlight important clinical implications. When SAD appears in adulthood, the diagnosis is often delayed. Symptoms may be mistaken for other anxiety disorders, which can lead to an insufficient response to psychotherapy. If treatment response is poor, comorbid or primary SAD should be considered. CBT should be considered an effective treatment option.

Keywords: Adult separation anxiety disorder, case report, cognitive behavioral therapy, diagnosis, intervention, separation anxiety, therapeutic alliance.

ÖZ

Ayrılma Kaygısı Bozukluğunda Bilişsel Davranışçı Terapi: Üç Olgu

Ayrılma kaygısı bozukluğu (AKB), bağlanma figürlerinden ayrılmaya ilişkin aşırı korku ve kaygı ile karakterizedir. Yakın zamana kadar AKB yalnızca çocukluk çağına özgü bir bozukluk olarak kabul edilmekteydi ancak artan kanıtlar, bu bozukluğun çocukluktan yetişkinliğe kadar devam edebileceğini ya da ilk kez yetişkinlikte ortaya çıkabileceğini göstermektedir. Bu durum, yetişkin ayrılma kaygısı bozukluğu (YAKB) olarak adlandırılmaktadır. YAKB olan bireylerde yüksek oranda görülen komorbid psikiyatrik tanılar, tanı ve ayırıcı tanı süreçlerini zorlaştırmaktadır. Psikoterapiler, YAKB'nin yönetiminde merkezi bir

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rol oynamaktadır. Bilişsel davranışçı terapi (BDT), anksiyete bozuklukları için kanıta dayalı ve iyi uygulanabilen bir tedavi yöntemidir. Bununla birlikte, YAKB, diğer anksiyete bozukluklarında da görüldüğü gibi, sıklıkla tedaviye direnç gösterebilmektedir. Bu makale, YAKB tanısı alan ve yirmili yaşlarında olan üç hastanın farmakoterapi ve BDT kombine tedavisiyle terapötik seyirlerini ve klinik sonuçlarını incelemektedir. Her bir olgu, ek anksiyete ve depresif bozukluklar dahil olmak üzere belirgin komorbid tanılarla karakterizedir. YAKB için uygulanan BDT protokolü, olgu formülasyonu, ayrılma kaygısının fenomenolojisi, yetişkinlikteki klinik görünümü ve kaygıyı sürdüren bilişsel, duygusal ve davranışsal mekanizmaları içeren psikoeğitimle başladı. Formülasyon, hastalarla iş birliği içinde oluşturuldu ve hastaların özerkliğini artırmak amacıyla birlikte tartışıldı. Ayrılma tehdidine yönelik işlevsiz tepkiler, buna eşlik eden uyumsuz şemalar ve işlevsel bozulmalar sistematik olarak belirlendi. Ayrılmaya, yetersizlik duygularına ve terk edilme korkusuna ilişkin felaketleştiren bilişler modifiye edilmeye çalışıldı. Tedavi, hastaların birincil bağlanma figürlerinden bağımsız işlevsellik kazanmasını sağlamak amacıyla dereceli maruz bırakma teknikleriyle sürdürüldü. Üç olgunun tamamında tedavi süreci remisyon ile sonuçlandı. Farmakoterapi sonlandırıldı. Tüm bu bulgular değerlendirildiğinde önemli klinik sonuçlar ortaya koymaktadır. AKB yetişkinlikte ortaya çıktığında tanı sıklıkla gecikmektedir. Belirtiler diğer anksiyete bozukluklarıyla karıştırılabilmektedir. Bu durum psikoterapiye yetersiz yanıt verilmesine neden olabilir. Tedaviye yanıtın düşük olduğu durumlarda, klinisyenler eşlik eden ya da birincil AKB olasılığını göz önünde bulundurmalıdır. BDT, etkili bir tedavi seçeneği olarak değerlendirilmelidir.

Anahtar Kelimeler: Yetişkin ayrılma kaygısı bozukluğu, olgu sunumu, bilişsel davranışçı terapi, tanı, müdahale, ayrılma kaygısı, terapötik iş birliği.

INTRODUCTION

Separation anxiety disorder (SAD) is characterized by excessive fear and anxiety linked to separation from attachment figures (Manicavasagar & Silove, 1997). This diagnosis was viewed as a childhood disorder until two decades ago (American Psychiatric Association, 1994). However, research shows that childhood-onset SAD may persist into adulthood, and the disorder can also begin in adulthood (Manicavasagar & Silove, 1997). The age restriction requiring onset before 18 years was removed, so adult separation anxiety disorder (ASAD) was added to the DSM-5 diagnostic system (American Psychiatric Association, 2013).

Common features of ASAD include persistent worries that harm may come to attachment figures or that events like abduction may result in permanent separation. Patients often resist attending work or school and show pronounced somatic symptoms during separation (Manicavasagar et al., 1997; Silove et al., 2010). Apart from attachment figures, they may experience recurrent and excessive distress, which can manifest as anger outbursts, social withdrawal, panic attacks, or intense grief. Many refuse to sleep without attachment figures and report frequent nightmares with separation themes (American Psychiatric Association, 2013). Physical symptoms—such as nausea, vomiting, abdominal pain, and headaches—also frequently occur with separation (Bögels et al., 2013).

The comorbidity rates among patients with adult SAD are notably high. The lifetime probability of receiving another comorbid diagnosis of an anxiety disorder is 67% (Beck, 2011). In a clinical study, lifetime comorbidity rates in patients with separation anxiety disorder were found to be 69% for major depressive disorder and 67% for agoraphobia and panic disorder (Manicavasagar et al., 1997; Silove et al., 2015). Recent research further indicates that the substantial symptomatic overlap with other anxiety and mood disorders contributes to delayed diagnosis in adult populations (Manicavasagar et al., 2010; Silove et al., 2010). In this context, ASAD with comorbid psychiatric conditions is linked to more severe clinical profiles and is associated with poorer treatment response and increased emotional dysregulation (Milrod et al., 2014, Pini et al., 2025). The disorder carries a high risk of chronicity and leads to significant functional impairment if left untreated (Silove et al., 2015).

Given the clinical burden, high comorbidity, risk of chronicity, and potential for treatment resistance associated with ASAD, it is essential to consider effective evidence-based treatment approaches (Beck, 2011; Milrod et al., 2014; Pini et al., 2025). Cognitive behavioral therapy (CBT) is a structured approach to psychotherapy that has been used on an evidence-based basis since the 1980s for mental disorders, particularly anxiety and depressive disorders (Beck, 2011). The effectiveness of CBT, which aims to understand belief and behavior systems through conceptualization, has been demonstrated in anxiety disorders

Table 1. Clinical characteristics of the cases

Cases	Case 1	Case 2	Case 3
Medical diagnosis	Adult separation anxiety disorder	Adult separation anxiety disorder	Adult separation anxiety disorder
Comorbid disorder	Panic disorder	Generalized anxiety disorder depression	Generalized anxiety disorder depression
Total number of sessions	28	34	29
Baseline Hamilton Anxiety rating scale score	42	28	22
Post-treatment Hamilton Anxiety rating scale score	4	1	3
Baseline Adult Separation Anxiety questionnaire score	68	56	52
Post-treatment Adult Separation Anxiety questionnaire score	14	7	7
Baseline Beck Depression inventory scale score	7	19	18
Post-treatment Beck Depression inventory score	5	4	4

and is recommended as the first-line treatment (Ströhle et al., 2018, Butler et al., 2006). Studies have demonstrated that CBT is highly effective in reducing symptoms of ASAD and improving patients' levels of functioning; moreover, CBT has been shown to accelerate clinical improvement when it is addressed as a primary therapeutic focus in treatment-resistant cases comorbid with other anxiety disorders (Milrod et al., 2014, Silove et al., 2015, Manicavasagar et al., 2010, Pini et al., 2014, Namlı et al., 2022).

In this context, targeted psychotherapeutic approaches may be particularly relevant for addressing the clinical features of ASAD. CBT offers a structured and theory-driven framework that directly addresses maladaptive cognitions, behavioral avoidance, and attachment-related fears underlying ASAD, thereby facilitating symptom reduction and functional recovery (Wheaton & Kaiser, 2021, Namlı et al., 2022). Accordingly, this study aims to illustrate the applicability and clinical effectiveness of CBT by presenting the therapy process of three patients diagnosed with ASAD.

Clinical Characteristics of the Cases

This case report describes the treatment process and outcomes of three patients in their twenties diagnosed with ASAD. A psychiatrist established the patients' diagnoses according to the DSM-5 criteria. The Structured Clinical Interview for DSM-5 (SCID-5) was administered (Bayad et al., 2021). Psychometric instruments possessing established reliability and validity in the participants' native language were systematically employed in the clinical assessment and longitudinal monitoring of patients. The Hamilton Anxiety Rating Scale (HAM-A), Adult Separation Anxiety Questionnaire (ASA-27), and Beck Depression Inventory (BDI) were administered as standardized measures to evaluate symptom severity and track treatment-related changes. Clinical interpretation was facilitated by established cut-off thresholds (HAM-A ≥ 18 for moderate anxiety, ASA-27 ≥ 22 for separation anxiety, and BDI ≥ 17 for moderate depression) (Yazıcı et al., 1998, Diriöz et al., 2011, Hisli, 1989). Two patients received a combination of pharmacotherapy and CBT, whereas one received CBT alone; these treatment variations were determined by clinical circumstances rather than by design. Table 1 presents the clinical diagnoses of the cases, the number of therapy sessions, and baseline and post-treatment scale scores. In all three cases, CBT was delivered by a psychotherapist who holds diplomate status from the Academy of Cognitive Therapy and is accredited by the European Association for Behavioral and Cognitive Therapies. The therapy was conducted by the first author. All participants provided informed consent. This report aims to contribute to the clinical management of ASAD by presenting the techniques and treatment algorithm employed in ASAD, a condition often associated with features predictive of poorer treatment response (Miniati et al., 2012).

CASE REPORTS

Case 1

A 22-year-old male patient, living with his parents, had attended university but was unable to continue due to panic attacks. He reported experiencing panic attacks when he was away from home, and he sometimes woke up at night experiencing panic attacks when he was home alone. The patient, whose anticipatory anxiety was prominent, had been taking 40 mg/day of paroxetine for approximately 1 year with a diagnosis of panic disorder. The patient's HAM-A score was 42, and there was an inadequate response to treatment. CBT was initiated while pharmacotherapy was continued, and a decrease in symptoms was noted from the initial sessions.

Although anticipatory anxiety persisted, the frequency of panic attacks decreased substantially from 7–8 to 2–3 episodes per week. The patient could leave the house more easily and could sleep through most nights without experiencing panic attacks; however, anticipatory anxiety continued.

The anticipatory anxiety persisted despite these improvements. The patient initially benefited from CBT, but no further improvement was observed after the 10th session. The patient came to all sessions with his mother and had panic attacks when she was not with him. The patient was classified as having ASAD based on his life history, medical history, CBT process, and current symptoms. His ASA-27 score was 68, and his BDI score was 7. Symptoms had started 1.5 years prior when the patient was admitted to university and faced independent living. The absence of childhood symptoms and overlapping panic disorder criteria were attributed to the delayed diagnosis. The diagnosis was updated to include panic disorder and ASAD, and psychotherapy was replanned accordingly. In this case, the primary attachment figure was his mother, and he structured his life around her presence. Safety behaviors included ensuring that his mother was within reach and that he was close to home. He avoided any action that might trigger anxiety, including moving quickly. Because the physiological and cognitive aspects of anxiety had already been addressed, psychoeducation specific to ASAD was provided. Longitudinal case formulation identified intervention areas, and a hierarchical list of avoidance and safety behaviors was created. A rapid decrease in symptoms was observed afterward. Exposure and response prevention techniques were frequently used along with behavioral experiments. Therapy focused on emotional regulation, distress tolerance, self-compassion, and self-identity. As symptoms decreased, the medication was tapered off. A total of 28 therapy sessions were conducted, and following the initiation of targeted interventions for ASAD after the 10th session, the patient demonstrated remission, with a HAM-A score of 4, a BDI score of 5, and an ASA-27 score of 14 at the conclusion of treatment. Pharmacological treatment was tapered and discontinued during the remission phase, and no relapse of separation anxiety symptoms was documented over an 18-month follow-up.

Case 2

A 26-year-old pregnant woman presented with persistent sadness and anxiety, worrying about her financial future, health, and motherhood. These concerns had been present for years and occupied most of her day. She was in her 21st week of pregnancy and spent much of her time imagining worst-case scenarios about raising her baby alone or losing her child, often crying. She stated that she began her days with these thoughts. She reported experiencing a severe depressive episode when she first moved away from home for university, during which she and her mother frequently cried over the phone. Psychiatric evaluation diagnosed her with generalized anxiety disorder (GAD) and ASAD according to DSM-5. Her HAM-A score was 28, her BDI score was 19, and ASA-27 score was 56. The patient refused pharmacotherapy because of her pregnancy.

Psychotherapy was planned primarily for depressive symptoms and GAD. The initial therapy targeted depressive symptoms using behavioral interventions. Rumination was addressed using cognitive distancing techniques. When the patient's HAM-A score decreased below 20, ASAD-focused psychotherapy was introduced. Her primary attachment figure had shifted from her mother to her husband, and ASAD was impacting her anxiety levels and her marital relationship, leading to frequent conflicts. First, the patient underwent a motivational interview.

Psychoeducation about the disease was provided along with a longitudinal formulation. Intervention areas were identified and a hierarchical list of avoidance and safety behaviors was developed. Rumination was addressed again. Exposure and response prevention and behavioral experiments were frequently implemented in this patient. The therapy emphasized emotional regulation, distress tolerance, self-compassion, self-efficacy, role perception, and schema work. Courses and training were planned to address areas of perceived inadequacy. Since she avoided responsibility due to fear of making mistakes, therapy focused on developing her competence. No pharmacotherapy was provided because of pregnancy. Following 34 therapy sessions, during which depressive symptoms and GAD were initially addressed at the level of automatic thoughts and behavioral activation over the first 17 sessions before initiating targeted interventions for separation anxiety, her HAM-A score was reduced to 1, her BDI score to 4, and ASA-27 score to 7, achieving remission. No relapse was detected during the 18-month follow-up after the conclusion of therapy.

Case 3

A 20-year-old female university student presented with complaints of reluctance to attend school, feelings of worthlessness and guilt, excessive anxiety, frequent phone calls to her mother, fear of earthquakes, obsessive research on earthquake risks, and crying spells triggered by catastrophic thoughts. She reported experiencing intense distress when away from her mother or home, having difficulty coping with her emotions, and occasionally feeling relieved by eating, which had resulted in weight gain in recent years. She also recalled experiencing brief separations from her mother during childhood, during which she believed her mother had died when she was out of sight.

Based on clinical evaluation, developmental history, and current symptoms, the patient was diagnosed with depressive disorder, GAD, and ASAD. At baseline assessment, her Hamilton Anxiety Rating Scale (HAM-A) score was 22, her BDI score was 18, and her ASA-27 score was 52.

In the initial treatment phase, depressive symptoms and GAD were prioritized. During the first 10 sessions, the interventions focused on behavioral activation and automatic thoughts. Subsequently, following work on maladaptive metacognitive beliefs, approximately a 50% reduction in symptoms was achieved, accompanied by an improvement in overall functioning. After the 15th session, the treatment shifted to interventions targeting ASAD. At this stage, disorder-specific psychoeducation was provided, a longitudinal case formulation was developed, and a hierarchical list of avoidance and safety behaviors was constructed. Given the patient's pronounced difficulties with distress tolerance and emotion regulation, longer-duration exposure exercises were incorporated into behavioral experiments.

The therapeutic process was terminated after 29 therapy sessions. At the conclusion of treatment, the patient's HAM-A score decreased to 3, her BDI score to 4, and her ASA-27 score to 7. No relapse was observed during the 18-month follow-up period.

Cognitive Behavioral Therapy Process for Adult Separation Anxiety Disorder

In anxiety disorders, CBT, which is considered a first-line treatment, begins with psychoeducation focusing on the introduction of the therapeutic model, the nature of separation anxiety, the clinical features specific to its adult presentation, and the cognitive–emotional–behavioral processes that maintain anxiety (National Institute for Health and Care Excellence [NICE], 2024, NICE, 2024, Majidli et al., 2026).

The foundation of the therapeutic process is the presentation of disorder-specific psychoeducation through individualized case formulations. Psychoeducation not only enhances patients' understanding of the disorder but also facilitates their ability to observe their own behavioral patterns from a more objective, external perspective, thereby increasing insight and treatment motivation (Oliveira & Dias, 2023). Psychoeducation also serves a critical function in helping patients comprehend the rationale for tolerating anxiety and distress encountered during treatment in this patient group, where difficulties in emotion regulation are prominent.

The therapeutic process begins with longitudinal case formulations, which serve as the starting point for identifying dysfunctional behavioral patterns triggered by perceived separation threats, underlying maladaptive schemas, and domains of impaired functioning. As illustrated in the

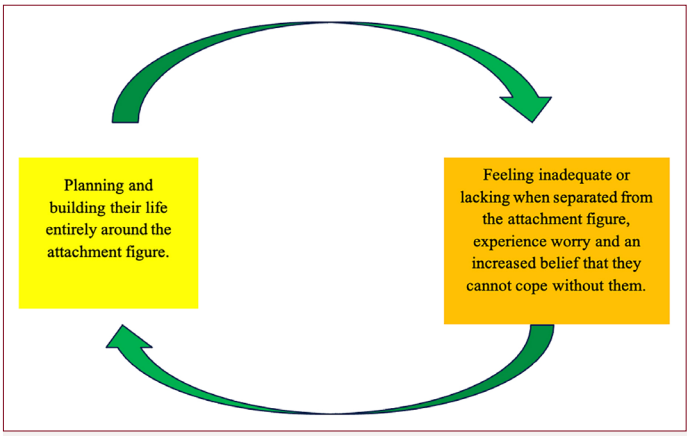

Figure 1. Formulation model a.

conceptual models presented in Figure 1 (Formulation Model a) and Figure 2 (Formulation Model b), these formulations guide the identification of separation-specific catastrophic cognitions and schemas related to inadequacy and abandonment, which are addressed through cognitive interventions. The therapeutic process is then continued with graduated exposure interventions aimed at facilitating experiences independent of attachment figures in patients whose lives have been largely structured around these relationships. During this phase, patients are encouraged to confront separation-related situations, reduce safety behaviors (e.g., frequent phone calls, reassurance seeking, and monitoring physical proximity), and develop tolerance for negative emotional states. In parallel, strengthening emotion regulation capacities, enhancing self-esteem, and fostering self-compassion skills constitute key treatment targets.

In some cases, additional difficulties may emerge even after initial therapeutic progress. If managing the strong anxiety and distress from separation-related thoughts is particularly difficult, it may be beneficial to first focus on treating comorbid conditions such as depression or GAD. This step-by-step approach helps patients better regulate their emotions and maintain engagement with subsequent interventions for separation anxiety. Following the management of these comorbid conditions, therapy focuses on behavioral experiments, which help test negative expectations and support patients in managing difficult emotions during exposure, thereby building practical coping skills. The therapeutic process concludes with a structured and planned termination phase during which patients experience a healthy separation, are supported in developing independence, and collaboratively engage in relapse prevention. This approach targets the core issues of ASAD and contributes to sustained improvement in daily functioning and well-being.

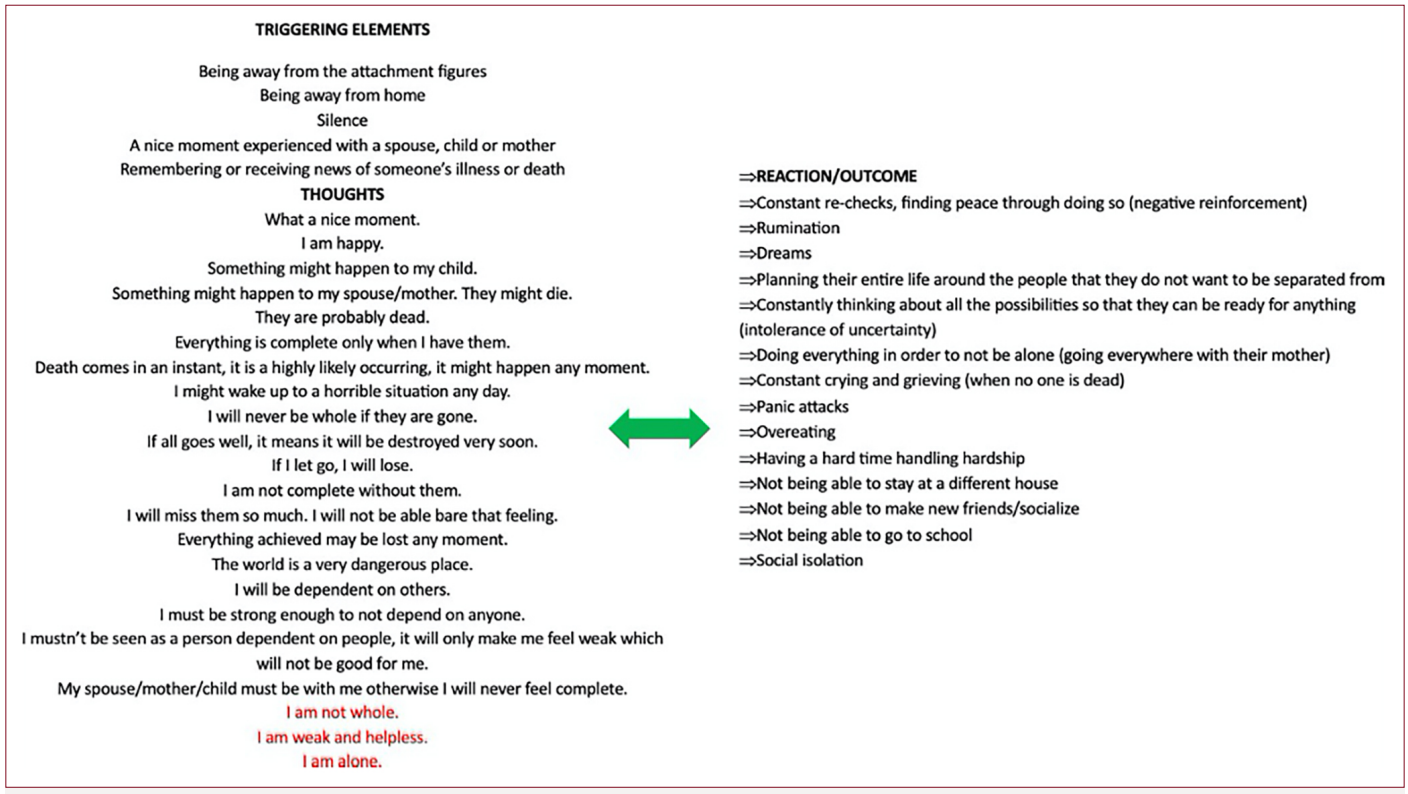

Figure 2. Formulation model b.

In all three cases presented in this study, the therapy process was conducted following standard CBT session structures. Nevertheless, as described above, particular emphasis was placed on psychoeducation, collaborative sharing of case formulations with patients, and the promotion of therapeutic autonomy. These processes, including joint case formulation, enabled patients to evaluate their difficulties from a more objective perspective and identify specific targets for intervention (Figs 1 and 2).

Patients assumed responsibility for between-session assignments throughout the treatment process, and therapy progressed within a collaborative framework. CBT not only facilitated cognitive change but also enhanced patients' abilities to identify emotions, maintain focus on session agendas, and recognize tangible therapeutic gains, thereby strengthening their sense of competence. These developments support individuation processes and contribute to more effective therapeutic progress. Treatment resulted in multi-level cognitive restructuring across automatic thoughts, intermediate beliefs, rules and assumptions, and core beliefs.

Overall, CBT is associated with increased tolerance for negative emotions and functional outcomes. The integrated use of exposure-based techniques and behavioral experiments appears to be instrumental in promoting adaptive coping and reducing maladaptive responses to separation-related distress. As summarized in Table 2, a range of CBT techniques spanning cognitive, behavioral, and emotion-focused domains was systematically applied across different therapeutic phases, reflecting a structured and individualized treatment approach.

Adult Separation Anxiety and Therapeutic Alliances

The therapeutic alliance is regarded not only as a supportive element but also as a fundamental mechanism that substantially enhances the effectiveness of CBT within the context of ASAD. Deep-rooted fears of separation from attachment figures may hinder engagement in exposure-based interventions and cognitive restructuring; therefore, establishing a secure and consistent therapist–client relationship is critical for strengthening these interventions' feasibility and clinical impact. The sense of safety fostered within the therapeutic relationship enables clients to develop tolerance for previously avoided emotions, confront separation-related triggers, and apply CBT techniques more effectively.

In this framework, the therapeutic relationship functions both as a context in which attachment-related vulnerabilities can be addressed and as a catalytic process that potentiates CBT's cognitive and behavioral components. Consequently,

Table 2. Cognitive behavioral therapy processes

Sessions	Content	Aim
Psychoeducation	Disorder, cognitive behavioral model, and physiology of anxiety.	The patient understands their mental disorder, the therapy model, and the effects of anxiety on the mind and body
Cognitive and metacognitive interventions	Automatic thoughts, cognitive qualities (catastrophizing, inference from emotion, etc.).	Recognizing automatic thoughts, objectively evaluating thoughts, and initiating the process of cognitive processing restructuring
Case formulation	Pschoeducation for the disorder is repeated and established with the patient; intolerance of uncertainty, rumination, excessive control, planning life according to the attachment figure, etc.	Identifying the factors that sustain the disease and determining the intervention areas
Exposure therapy for avoidance issues and cognitive intervention continuation	Behavior experiments Exposure-response prevention. Automatic thoughts and beliefs continue to be addressed using cross-sectional formulations in accordance with the goalsthat were set.	Cognitive restructuring and habituation
Sessions for achieving autonomy	Developing emotional regulation, self-compassion, and daily life skills.	Realizing that negative emotions are bearable, gaining the ability to regulate their own emotions, and acquiring or strengthening skills needed in daily life (such as at work, increasing financial resources, obtaining a driver's license, etc.), taking responsibility (for their work or mistakes).
Self-respect and schema focused interventions	Psychoeducation on the concepts. Behavior experiments.	Strengthening a balanced self-concept.
Coping strategies	Coping attitudes that increase dependence on others rather than developing independent skills.	Healthy and functional coping strategies are discussed.

more robust and enduring clinical change can be achieved. As clients' autonomy develops, their capacity to experience a healthy separation from the therapist further consolidates these therapeutic gains and supports a secure termination of treatment.

In the present study, the therapeutic process was conducted in accordance with the importance attributed to the therapist–patient relationship and attachment in the literature (Milrod et al., 2016), with session content and between-session tasks determined collaboratively with the patient. Despite the technical and structured nature of CBT, numerous studies have demonstrated that the therapeutic alliance is an indispensable determinant of treatment efficacy (Langhoff et al., 2008). The strategic use of the therapeutic relationship and therapist–patient attachment within the intervention process in ASAD appears to elevate the effectiveness of therapy to a more advanced level.

Sample Behavioral Experiment

A behavioral experiment, the details of which are provided in Table 3, was planned for the patient who was experiencing intense anxiety and worry as a result of his mother leaving the country for a week. Table 4 presents examples of automatic thoughts and core beliefs identified in these three cases, as well as the new beliefs that emerged following cognitive change at the end of therapy.

DISCUSSION

This case series aimed to present a clinical perspective that considers the clinical presentation and diagnostic challenges of ASAD and to outline a partially structured CBT process tailored for ASAD. The clinical features observed across the three cases were consistent with the literature on SAD in adulthood, which often includes fears of separation from various loved ones, concerns about their safety, and avoidance behaviors such as reluctance to attend work or study in another city. Unlike children

Table 3. Sample behavioral experiment

Target cognitions	Level of belief	Experiment content	Prediction	Conclusion	New cognition
I must not be separated from my mother. I cannot possibly take it.	%90	He will call his mother once a day. He will not engage in behaviors to relieve distress in situations of increased uncertainty. He will continue going to school.	I will not be able to stop myself from crying. I will not be able to stay at home. I will go mad. I will spend every second thinking about her. I will not be able to take care of myself.	He did not experience any crying spells in the absence of his mother. He managed to go to school. He managed to cook and clean. He was able spend time with his friends.	I can bear negative emotions and do not lose it. I miss my mother, but that does not mean I am helpless. It would be better if she is with me but I have realized that I can take care of myself in her absence. Loneliness does not necessarily mean helplessness.

Table 4. Thought–alternative thought

Thought	Alternative thought
Everything is complete with them.	Their presence is important in many ways, but even without them, I still have many good things in my life.
I will not be able to cope without them.	If they are not in my life, I may feel their absence, but that does not mean that I cannot function or be whole.
If all is well, it means that it will all be destroyed someday.	I can be up against the good and the bad in life. The fact that all is well in a moment does not mean that it will be destroyed later.
If I let go, I will lose everything.	When I need support, if she is absent, I might have her by my side or others.
I will miss her too much. I cannot bear being apart.	Separation may not be easy, but I can adapt and learn to tolerate it when the time comes. Perhaps I am more resilient than I think I am.
I cannot do things on my own.	Some things may be difficult to do alone, but I can always ask for help.
The world is dangerous.	The world might be dangerous, but I can handle challenges like others.
I will depend on others.	Sometimes I may need support. If in need, I can ask for help and find it. Asking for help is not a bad thing.
If my parents, partner, or child are not with me, I will feel incomplete.	Being without someone does not make me incomplete.
I am not enough on my own.	I am a capable and sufficient individual.
I am weak and helpless.	I do not have to be incredibly strong; I can find ways to cope and solve problems.
I am alone.	When I feel lonely, I can reach out to people for support and connection.

with SAD, in whom overt behaviors like crying or clinging are more common, adults more frequently exhibit subtle avoidance or safety behaviors; these patterns were evident across the cases presented. For example, the first and third cases showed avoidance of studying in another city, and the second case demonstrated frequent phone calls to loved ones. One study

reported that 69% of individuals felt safer with loved ones (Seligman & Wuyek, 2007), a feature evident in all cases.

ASAD has received relatively limited attention in clinical settings. Manicavasagar et al. suggested that ASAD is among the least recognized disorders in clinical settings, largely because its symptoms are often overshadowed by those of panic disorder, agoraphobia, or GAD. The high prevalence of psychiatric comorbidities—particularly other anxiety disorders and depression—among patients with ASAD further complicates the diagnostic process and may lead to the disorder being overlooked as a primary diagnosis and instead misinterpreted as a "secondary feature" or attributed to a "dependent personality structure" (Silove et al., 2010, Manicavasagar et al., 2010).

A review of the treatment histories revealed that the presence of significant psychiatric comorbidities contributed to diagnostic overshadowing and delayed the implementation of ASAD-specific interventions in all three cases. This finding is consistent with Manicavasagar et al. (2010), who reported that separation-related symptoms in adults are often masked by atypical presentations, such as somatic complaints or anger outbursts, leading clinicians to conceptualize them within the broader anxiety spectrum rather than recognizing ASAD as a distinct condition (Manicavasagar et al., 2010).

Current evidence suggests that the presence of comorbid ASAD may predict non-response to standard CBT. Although anxiety disorders generally show high remission rates with CBT, the presence of SAD as a comorbid condition has been associated with resistance to treatment (Aaronson et al., 2008; Milrod et al., 2014). Studies have reported that adult patients who fail to benefit from standard psychotherapy or pharmacological treatment for an anxiety disorder are often subsequently diagnosed with SAD (Milrod et al., 2016, Dogan et al., 2021). In accordance with these findings, the first case in this series was initially diagnosed with panic disorder, whereas the second and third cases were diagnosed with GAD. However, none of the patients achieved the expected therapeutic benefit from CBT before receiving an ASAD diagnosis.

Although a standardized CBT protocol specifically designed for ASAD has not yet been established, the literature emphasizes the need to adapt classical CBT approaches to address disorder-specific vulnerabilities (Kirsten et al., 2008, Manicavasagar & Silove, 2020). Individuals with ASAD frequently exhibit elevated anxiety sensitivity, intolerance of uncertainty, and separation-focused catastrophic cognitions, all of which have been shown to reduce responsiveness to standard exposure-based CBT (Kirsten et al., 2008, Wheaton & Kaiser, 2021). Consequently, several tailored interventions have been recommended, including cognitive restructuring of catastrophic interpretations related to separation and bodily sensations (Schiele et al., 2021, Wheaton & Kaiser, 2021), interoceptive exposure to reduce the avoidance of anxiety related somatic cues (Schiele et al., 2021), and systematic *in vivo* and imaginal exposure to separation-related triggers (Manicavasagar & Silove, 2020). In addition, relationally adapted interventions—such as strengthening the therapeutic alliance, addressing attachment-based fears within the therapeutic relationship, and using the therapist as a secure base—have been shown to improve treatment outcomes in adults with pronounced separation anxiety (Kirsten et al., 2008). Taken together, these findings suggest that CBT for ASAD is most effective when disorder-specific cognitive and behavioral interventions are integrated with attachment-sensitive relational strategies.

Several limitations of this case series should be noted. The inclusion of only three cases, the lack of data on family characteristics, and the absence of family sessions during the psychotherapy process constitute important limitations. Future studies and clinical applications would benefit from a larger sample size and the inclusion of additional domains, such as family involvement.

CONCLUSION

In conclusion, when SAD emerges in adulthood, diagnosis is often delayed, and symptoms are frequently misattributed to other anxiety disorders, which may result in insufficient response to psychotherapy. In cases where adequate treatment response is not achieved, the possibility of comorbid or primary SAD should be carefully considered. When SAD is identified in adulthood, CBT—when appropriately adapted—should be regarded as an effective and feasible treatment option, similar to its application in other anxiety disorders.

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Informed Consent: In this study informed consent was taken from each patient.

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REFERENCES

Aaronson, C. J., Shear, M. K., Goetz, R. R., Allen, L. B., Barlow, D. H., White, K. S., Ray, S., Money, R., Saksa, J. R., Woods, S. W., & Gorman, J. M. (2008). Predictors and time course of response among panic disorder patients treated with cognitive-behavioral therapy. *The Journal of Clinical Psychiatry, 69*(3), 418–424. [CrossRef]

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. [CrossRef]

Bayad, S., Alp Topbaş, Ö., Kocabaş, T., Elbir, M., Gökten-Ulusoy, D., Korkmaz, U., … Aydemir, Ö. (2021). DSM-5 Kişilik Bozuklukları için Yapılandırılmış Klinik Görüşme (SCID-5-PD)'nin Türkçeye uyarlanması ve psikometrik özellikleri. *Türk Psikiyatri Dergisi, 32*(4), 1–10. [Article in Turkish]

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). Guilford Press.

Bögels, S. M., Knappe, S., & Clark, L. A. (2013). Adult separation anxiety disorder in DSM-5. *Clinical Psychology Review, 33*(5), 663–674. [CrossRef]

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*(1), 17–31. [CrossRef]

Diriöz, M., Kılıç, C., & Kılıç, E. Z. (2011). Yetişkin Ayrılık Anksiyetesi Ölçeği (ASA-27)'nin Türkçe formunun geçerlik ve güvenirliği. *Anadolu Psikiyatri Dergisi, 12*(3), 218–224. [Article in Turkish]

Dogan, B., Kocabas, O., Sevincok, D., Baygin, C., Memis, C. O., & Sevincok, L. (2021). Separation anxiety disorder in panic disorder patients with and without comorbid agoraphobia. *Psychiatry, 84*(1), 68–80. [CrossRef]

Hisli, N. (1989). Beck depresyon envanteri'nin geçerliği üzerine bir çalışma. *Türk Psikoloji Dergisi, 7*(23), 3–13. [Article in Turkish]

Kirsten, L. T., Grenyer, B. F. S., Wagner, R., & Manicavasagar, V. (2008). Impact of separation anxiety on psychotherapy outcomes for adults with anxiety disorders. *Counselling and Psychotherapy Research, 8*(1), 36–42. [CrossRef]

Langhoff, C., Baer, T., Zubraegel, D., & Linden, M. (2008). Therapist–patient alliance, patient–therapist alliance, mutual therapeutic alliance, therapist–patient concordance, and outcome of CBT in GAD. *Journal of Cognitive Psychotherapy, 22*(1), 68–79. [CrossRef]

Majidli, S., Mammadova, S., Mammadova, G., & Aliyeva, G. (2026). Effectiveness of cognitive-behavioral therapy (CBT) in reducing anxiety symptoms across different anxiety disorders compared to control conditions and alternative treatments: A systematic literature review.

Manicavasagar, V., & Silove, D. (1997). Is there an adult form of separation anxiety disorder? A brief clinical report. *The Australian and New Zealand Journal of Psychiatry, 31*(2), 299–303. [CrossRef]

Manicavasagar, V., & Silove, D. (2020). *Separation anxiety disorder in adults: Clinical features, diagnostic dilemmas and treatment guidelines*. Academic Press.

Manicavasagar, V., Marnane, C., Pini, S., Abelli, M., Rees, S., Eapen, V., & Silove, D. (2010). Adult separation anxiety disorder: A disorder comes of age. *Current Psychiatry Reports, 12*, 290–297. [CrossRef]

Manicavasagar, V., Silove, D., & Curtis, J. (1997). Separation anxiety in adulthood: A phenomenological investigation. *Comprehensive Psychiatry, 38*(5), 274–282. [CrossRef]

Milrod, B., Altemus, M., Gross, C., Busch, F., Silver, G., Christos, P., Stieber, J., & Schneier, F. (2016). Adult separation anxiety in treatment nonresponders with anxiety disorders: Delineation of the syndrome and exploration of attachment-based psychotherapy and biomarkers. *Comprehensive Psychiatry, 66*, 139–145. [CrossRef]

Milrod, B., Markowitz, J. C., Gerber, A. J., Cyranowski, J., Altemus, M., Shapiro, T., Hofer, M., & Glatt, C. (2014). Childhood separation anxiety and the pathogenesis and treatment of adult anxiety. *The American Journal of Psychiatry, 171*(1), 34–43. [CrossRef]

Miniati, M., Calugi, S., Rucci, P., Shear, M. K., Benvenuti, A., Santoro, D., Mauri, M., & Cassano, G. B. (2012). Predictors of response among patients with panic disorder treated with medications in a naturalistic follow-up: The role of adult separation anxiety. *Journal of Affective Disorders, 136*(3), 675–679. [CrossRef]

Namlı, Z., Özbay, A., & Tamam, L. (2022). Yetişkin Ayrılma Anksiyetesi Bozukluğu: Bir Gözden Geçirme.. *Psikiyatride Güncel Yaklaşımlar, 14*(1), 46–56. [Article in Turkish] [CrossRef]

National Institute for Health and Care Excellence. (2024). *Generalised anxiety disorder and panic disorder in adults: Management* (Clinical guideline CG113). Retrived from https://www.nice.org.uk/guidance/cg113 (Original work published 2011)

National Institute for Health and Care Excellence. (2024). *Social anxiety disorder: Recognition, assessment and treatment* (Clinical guideline CG159). Retrived from https://www.nice.org.uk/guidance/cg159 (Original work published 2013)

Oliveira, C. T. D., & Dias, A. C. G. (2023). How can psychoeducation help in the treatment of mental disorders? *Estudos de Psicologia (Campinas)*, 40, e190183. [CrossRef]

Pini, S., Abelli, M., Troisi, A., Siracusano, A., Cassano, G. B., Shear, K. M., & Baldwin, D. S. (2014). The relationships among separation anxiety disorder, adult attachment style and agoraphobia in patients with panic disorder. *Journal of Anxiety Disorders, 28*(8), 741–746. [CrossRef]

Pini, S., Nardi, B., Carpita, B., Lorenzi, G., Mula, M., Milrod, B., … Baldwin, D. S. (2025). Relationships between depersonalization–derealization symptoms and separation anxiety in adult patients with mood and anxiety disorders. *Frontiers in Psychiatry, 16*, Article 1565217. [CrossRef]

Schiele, M. A., Vietz, M., Gajewska, A., Unterecker, S., Gottschalk, M. G., Deckert, J., Neufang, S., Schmidt, N. B., & Domschke, K. (2021). The cognitive anxiety sensitivity treatment (CAST) in anxiety prevention: Focus on separation anxiety and interoception. *European Neuropsychopharmacology: The Journal of the European College of Neuropsychopharmacology, 53*, 104–113. [CrossRef]

Seligman, L. D., & Wuyek, L. A. (2007). Correlates of separation anxiety symptoms among first-semester college students: An exploratory study. *The Journal of Psychology, 141*(2), 135–145. [CrossRef]

Silove, D. M., Marnane, C. L., Wagner, R., Manicavasagar, V., & Rees, S. (2010). The prevalence and correlates of adult separation anxiety disorder in an anxiety clinic. *BMC Psychiatry, 10*, Article 21. [CrossRef]

Silove, D., Alonso, J., Bromet, E., Gruber, M., Sampson, N., Scott, K., … Kessler, R. C. (2015). Pediatric-onset and adult-onset separation anxiety disorder across countries in the World Mental Health Survey. *American Journal of Psychiatry, 172*(7), 647–656. [CrossRef]

Ströhle, A., Gensichen, J., & Domschke, K. (2018). Diagnostik und Therapie von Angsterkrankungen. *Dtsch Arztebl Int, 115*(37), 611–620.

Wheaton, M. G., & Kaiser, N. (2021). Anxiety sensitivity and intolerance of uncertainty as factors related to adult separation anxiety disorder symptoms. *International Journal of Cognitive Therapy, 14*, 473–484. [CrossRef]

Yazıcı, M. K., Demir, B., Tanrıverdi, N., Karaağaç, N., Yolaç, P., & Köroğlu, E. (1998). Hamilton Anksiyete Değerlendirme Ölçeği'nin geçerlik ve güvenirliği. *Türk Psikiyatri Dergisi, 9*(2), 114–120. [Article in Turkish]