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Patterns of Family Identification and Self-Congruence in Childhood Separation Anxiety Disorder

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Key Words

Separation anxiety disorder · Family Identification Test

Abstract

Background: Patterns of identification among family members may differ in families with children with separation anxiety disorder (SAD) as compared with healthy children. However, this has not been explored to date. **Method:** The present study examines identification processes in 199 families: 100 families of children with SAD, 43 families of children with other anxiety disorders, and 56 families of nondisordered children, using the Family Identification Test. **Results:** Children with SAD and their parents generally identify significantly less with each other and report less desire to be similar to each other than nondisordered children and their parents. Further, children with SAD are less self-congruent than healthy children. There were no significant differences between children with SAD and with other anxiety disorders. **Conclusions:** Identification and self-congruence distinguish families of children with SAD from families of healthy children. Future studies should aim to determine the direction of effects over time, as well as to determine the contribution of identification and coherence in explaining SAD after accounting for other factors such as attachment and self-esteem.

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Within the context of the family, children compare themselves with their parents, perceiving and noting differences and similarities in a process of identification and self-concept formation. The strength of the identification of one person with another is the degree of congruence, or similarity, between the individual's self-concept and his or her concept of the other person [1], across a spectrum of characteristics, beliefs, and attitudes. Weak identification between a child and his or her parents can impact the development of the self, and is postulated to be related to psychological disorders in childhood [1]. Children with separation anxiety disorder (SAD) may be particularly vulnerable to disturbances in identification, as SAD directly affects multiple aspects of family life, limiting activities of siblings and parents, and elevating parent stress [2, 3]. It is also possible that limited identification contributes to child insecurity and the development of SAD. To date, however, few empirical studies examine identification in families of children with a mental disorder, and no studies have examined identification as it relates to SAD.

SAD is the earliest-emerging and most common anxiety disorder in children, with prevalence rates of about 4% [4, 5]. Further, SAD is a risk factor for the development of anxiety disorders in adulthood [6]. Current theo-

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retical models of the development and maintenance of anxiety point to multiple factors in anxiety disorder etiology [7]. One potentially relevant family factor that has been largely overlooked to date in the development of childhood separation anxiety is the degree to which children and their parents identify with one another. A second factor is the degree to which children perceive themselves to be congruent with their ideal selves.

The study of identification has a long history in psychology, initiated by Freud [8], and is addressed by later proponents of both learning and cognitive theories [9, 10], yet is largely neglected by contemporary psychologists. Poor identification with parents can be impacted by psychosocial stressors, and lead to a negative development of the self, increasing vulnerability to psychological disorders in childhood [1]. Remschmidt and Matthejat [1] have postulated a model of family identification that is closely linked with self-concept, self-congruence and conceptions of others.

Conceptions of the Self

The self-concept is comprised of one's perception of the actual self. Self-congruence is the similarity between the actual self and the ideal self. Both self-concept and self-congruence are important factors in the overall well-being and mental health of children [1, 11], with weaknesses in each related to internalizing emotions such as depression, shame, and guilt in adults [12] and poor self-congruence related to anxiety and social fears [12] and low self-esteem in adults [13]. In addition, ideal-real self-discrepancy is related to social anxiety in adults [14]. These links have not been explored in children.

Family Identification

Children's first conceptions of self develop within the context of their interaction with family [11]. Children compare themselves to others and to others' perceptions of them (i.e., the looking glass self) [15, 16], noting differences and similarities between themselves and others, and thus developing both a self-concept and identification with others. 'Actual' identification is defined as the congruence, or similarity, between an individual's self-concept and his or her concept of a specific other [1] across several domains, including emotional reactivity, personality, intellect, sociability, beliefs, and other characteristics and attitudes. 'Ideal' identification refers to the degree to which the child wants to be similar to the parent. The schemas and representations that children form of themselves in comparison with family members likely provide the basis for later self-concept and identity con-

solidation [17] and contribute to psychological health. Actual identification, ideal identification, and self-congruence are generally lower in families with a disordered child (either with attention deficit hyperactivity disorder or another mental disorder) as compared with the families of healthy children (one exception was no difference in ideal father identification between children with attention-deficit/hyperactivity disorder and healthy children) [18]. Two other studies indicated lower identification in families of children with externalizing versus internalizing disorders [1, 19]. Further, families with children with anxiety disorders [20] tend to be less cohesive than healthy families, and have less healthy patterns of attachment [21]. Early representations of parents involving disconnection and rejection mediate the link between insecure attachment and anxiety [22]. Thus, perceived dissimilarity may lower family cohesion and the security of the parent-child relationships, heightening fears and insecurity surrounding separation. No known studies have examined this hypothesis to date.

The present research aims to contribute to knowledge in this area, by examining identification patterns and self-congruence in families of children with SAD as compared with families of nonclinical controls and children with other anxiety disorders as the primary diagnosis. It was hypothesized that families with children with SAD would report lower real levels of identification between parents and children and lower child self-congruence, but not necessarily lower ideal identification than families with nondisordered children. Differences between families with children with SAD and families of children with other anxiety disorders were examined on an exploratory basis, given the dearth of prior literature in this area.

Method

Participants

Children aged 5–13 and their parents were recruited as part of a randomized controlled trial of cognitive-behavioral family therapy for children with SAD [23]. Children were invited to participate if they fell into one of the following three groups: nondisordered, current primary diagnosis of SAD or current primary diagnosis of another anxiety disorder and no diagnosis of SAD. Exclusion criteria were poor German language skills and intake of psychotropic medication. Participants included 199 families with 94 target boys and 105 target girls. Questionnaires were completed by 187 mothers, 143 fathers, and 122 children (57 boys, 65 girls). For children aged 7 and younger ($n = 68$), only parents were asked to complete the identification assessments. However, children aged 8 or older also completed identification assessments. The mean age of children from all families was 9.20 years ($SD = 2.34$; range = 4.82–14.31). The mean age of the 122 children who com-

pleted assessments was 10.59 years (SD = 1.54; range = 7.98–14.31). The mothers' mean age was 40.35 (SD = 5.03), and the fathers' was 43.18 years (SD = 6.65). Families were generally earning a middle-class wage. All families were Caucasian and living in the German-speaking part of Switzerland or in the southern part of Germany. The SAD group consisted of 100 families (48 boys, 52 girls). Of these children, 51 had another comorbid mental disorder, including 38 with other anxiety disorders. The clinical control group consisted of 56 families with a child (23 boys, 33 girls) with another anxiety disorder as the primary diagnosis. Of these children, 32 had a primary diagnosis of social phobia, 14 specific phobia, 4 general anxiety disorder, 2 panic disorder with agoraphobia, 2 agoraphobia without panic disorder, and 2 obsessive-compulsive disorder. Thirty-one (55%) of the clinical control children had another comorbid mental disorder, including 17 (30%) with another anxiety disorder as a secondary diagnosis. The nondisordered control group included 43 families (23 boys, 20 girls). The groups did not significantly differ on gender composition [$\chi^2(2) = 1.55, p > 0.05$]. A one-way ANOVA indicated that the groups did not significantly differ on mothers' age, fathers' age, maternal anxiety, paternal anxiety, or socioeconomic status. However, the groups did differ on children's age [$F(2, 196) = 4.368, p < 0.05$]. Tukey post hoc comparisons indicated that the SAD group was significantly younger than the nonclinical control group [mean difference $-1.05, p < 0.05$]. The SAD and clinical control groups did not significantly differ from each other in the total percentage of children with comorbid psychological disorders [$\chi^2(1) = 0.27, p > 0.05$], or comorbid anxiety disorders [$\chi^2(1) = 0.92, p > 0.05$].

Measures

Eligibility Determination: Clinical Diagnoses of Children. Structured interviews to determine diagnostic status were conducted by qualified clinical psychologists or graduate students with parents of each child and separately with each child (if 8 years old or older) using the Kinder-DIPS interview [24]. Diagnoses were based on composite information from the parents and children if aged 8 years and older, otherwise on parent interview only. The Kinder-DIPS has good validity and reliability for anxiety disorders (child version: $\kappa = 0.88$; parent version: $\kappa = 0.85$) and other axis I disorders (child version, $\kappa = 0.48$ – 0.88 ; parent version, $\kappa = 0.85$ – 0.94) [24].

Family Identification. The Family Identification Test (FIT) [1] requires individuals to rate themselves ('I am...'), their ideal selves ('I would like to be...'), and their family members ('My mother/father is...'; 'My child is...') on 12 attributes (nervous, moody, content, quick, talkative, calm, confident, independent, understanding, considerate, anxious and friendly), using a 5-point rating scale ranging from 1 (does not fit at all) to 5 (fits very well). Real identification is defined as the correlation between the real self-ratings and that person's ratings of his or her perceptions of another family member. Ideal identification is defined as the correlation between ideal self-ratings and that person's ratings of another family member, and represents how strongly the individual wants to resemble the other family member. Self-congruence is defined as the correlation between the real self-ratings and ideal self-ratings. Parents and children aged 12 and older completed the FIT in a questionnaire format. Children between 8 and 12 completed it in an interactive interview format with 1 of 6 trained clinicians using a board displaying the 5-point rating scale and cards printed with each adjective. Prior research with the FIT indicates good parallel

test reliability (0.78) and retest reliability (2 weeks: 0.78; 4 weeks: 0.75).

Parent Anxiety. Parents completed the Beck Anxiety Inventory [25], German version [26], which consists of 21 items rated on a scale ranging from 0 (not at all) to 3 (strong), with a final sum score ranging from 0 to 63. α values were 0.89 (mothers) and 0.86 (fathers).

Data Analysis

Coherence between pairs of family members was assessed via Pearson correlation coefficients between two ratings on the 9 adjectives from the FIT across pairs, resulting in scores for actual and ideal identification of the child with each parent, actual and ideal identification of each parent with the child, and self-congruence for the child. Due to the limited distribution of these scores, they were transformed into Fisher's Z scores in Microsoft Excel using the following formula:

$$z' = \frac{1}{2} \ln \left(\frac{1+x}{1-x} \right)$$

Initial group (i.e., SAD, clinical control, nonclinical control) comparisons were conducted using one-way ANOVAs. A Bonferroni-adjusted p value was calculated by dividing 0.05 by the 9 primary identification and self-congruence variables of interest (i.e., identification and self-congruence variables listed in table 1), and set at 0.0056. The final analyses were two-way sex by group ANCOVAs including age and parent anxiety as predictors in order to determine the potential explanatory value of these variables in understanding group differences in identification. ANCOVAs on identification with or of the mother included maternal anxiety, ANCOVAs on identification with or of the father included paternal anxiety, and ANCOVAs on self-congruence included both maternal and paternal anxiety.

Results

Descriptive Statistics and Correlations

Table 1 presents means and standard deviations across groups on all predictors and dependent variables. Table 2 presents correlations among variables.

Initial Analyses of Variance

ANOVAs (table 3) indicated group differences on self-congruence and on all identification variables except child ideal identification with mother. Planned comparisons between the SAD group and each comparison group (i.e., nonclinical and clinical) indicated lower identification and self-congruence in children with SAD than in nonclinical controls, with no differences between SAD and clinical control groups.

Analyses of Covariance

ANCOVAs revealed two trend level (in this analysis $p < 0.05$ is considered a trend, as Bonferroni significance

Table 1. Descriptive statistics

		n	Raw scores		Fisher's Z scores	
			mean ± SD	range	mean ± SD	range
Child age	SAD	100	8.72±2.24	4.82 to 13.66		
	Nonclinical control	43	9.77±2.28	5.18 to 13.78		
	Clinical control	56	9.61±2.43	4.97 to 14.31		
	Total	199	9.20±2.34	4.82 to 14.31		
Maternal anxiety	SAD	89	7.89±7.77	0 to 38		
	Nonclinical control	39	5.33±6.87	0 to 36		
	Clinical control	45	6.11±6.02	0 to 21		
	Total	173	6.85±7.20	0 to 38		
Paternal anxiety	SAD	80	4.99±5.59	0 to 28		
	Nonclinical control	29	3.79±5.21	0 to 21		
	Clinical control	39	3.05±3.63	0 to 18		
	Total	148	4.24±5.09	0 to 28		
<i>Real identification</i>						
Child with mother	SAD	52	0.43±0.37	-0.55 to 0.98	0.57±0.56	-0.62 to 2.24
	Nonclinical control	29	0.70±0.25	-0.02 to 0.95	1.00±0.47	-0.02 to 1.87
	Clinical control	40	0.47±0.37	-0.47 to 1.00	0.65±0.63	-0.51 to 2.99
	Total	121	0.51±0.36	-0.55 to 1.00	0.70±0.59	-0.62 to 2.99
Child with father	SAD	50	0.35±0.40	-0.66 to 0.95	0.45±0.53	-0.79 to 1.81
	Nonclinical control	27	0.64±0.29	-0.13 to 0.90	0.90±0.47	-0.13 to 1.50
	Clinical control	40	0.46±0.34	-0.31 to 1.00	0.65±0.62	-0.33 to 2.99
	Total	117	0.46±0.37	-0.66 to 1.00	0.62±0.58	-0.79 to 2.99
Mother with child	SAD	92	0.26±0.38	-0.66 to 0.92	0.33±0.49	-0.79 to 1.61
	Nonclinical control	39	0.69±0.20	0.23 to 0.97	0.98±0.44	0.24 to 2.10
	Clinical control	47	0.32±0.36	-0.46 to 0.95	0.39±0.48	-0.50 to 1.81
	Total	178	0.37±0.38	-0.66 to 0.97	0.49±0.54	-0.79 to 2.10
Father with child	SAD	76	0.22±0.37	-0.68 to 0.78	0.25±0.43	-0.83 to 1.04
	Nonclinical control	21	0.61±0.21	0.00 to 0.91	0.77±0.33	0.00 to 1.53
	Clinical control	37	0.19±0.47	-0.63 to 0.95	0.28±0.64	-0.74 to 1.86
	Total	134	0.27±0.40	-0.68 to 0.95	0.34±0.51	-0.83 to 1.86
<i>Ideal identification</i>						
Child with mother	SAD	52	0.75±0.25	-0.31 to 1.00	1.19±0.62	-0.32 to 2.99
	Nonclinical control	29	0.84±0.17	0.38 to 1.00	1.46±0.59	0.40 to 2.99
	Clinical control	40	0.74±0.24	0.08 to 1.00	1.18±0.63	0.08 to 2.99
	Total	121	0.77±0.23	-0.31 to 1.00	1.25±0.62	-0.32 to 2.99
Child with father	SAD	50	0.70±0.26	-0.38 to 0.98	1.04±0.52	-0.40 to 2.20
	Nonclinical control	27	0.79±0.28	0.00 to 1.00	1.47±0.76	0.00 to 2.99
	Clinical control	40	0.67±0.25	-0.01 to 1.00	0.99±0.58	-0.01 to 2.99
	Total	117	0.71±0.27	-0.38 to 1.00	1.12±0.63	-0.40 to 2.99
Mother with child	SAD	93	0.16±0.43	-0.83 to 0.90	0.20±0.54	-1.20 to 1.45
	Nonclinical control	40	0.72±0.21	0.28 to 0.97	1.05±0.50	0.29 to 2.16
	Clinical control	48	0.22±0.47	-0.80 to 0.95	0.30±0.64	-1.11 to 1.86
	Total	181	0.30±0.46	-0.83 to 0.97	0.42±0.65	-1.20 to 2.16
Father with child	SAD	77	0.21±0.37	-0.79 to 0.90	0.24±0.47	-1.08 to 1.45
	Nonclinical control	21	0.65±0.27	-0.17 to 0.97	0.91±0.50	-0.17 to 2.08
	Clinical control	37	0.15±0.48	-0.68 to 0.93	0.21±0.61	-0.82 to 1.68
	Total	135	0.26±0.42	-0.79 to 0.97	0.34±0.57	-1.08 to 2.08
<i>Self-congruence</i>						
Child	SAD	53	0.45±0.39	-0.60 to 0.95	0.60±0.57	-0.70 to 1.81
	Nonclinical control	29	0.77±0.21	0.03 to 0.96	1.18±0.46	0.03 to 1.90
	Clinical control	40	0.47±0.38	-0.30 to 1.00	0.72±0.75	-0.31 to 2.99
	Total	122	0.53±0.38	-0.60 to 1.00	0.78±0.65	-0.70 to 2.99

Table 2. Correlations among age, sex, parent anxiety and Z-transformed identification and self-congruence

		Potential mediators				Real identification				Ideal identification				Self-congruence child
		child age	sex	maternal anxiety	paternal anxiety	child with mother	child with father	mother with child	father with child	child with mother	child with father	mother with child	father with child	
Child age	r	1												
	n	199												
Covariates														
Sex	r	-0.03	1											
	n	199	199											
Maternal anxiety	r	-0.05	0.02	1										
	n	173	173	173										
Paternal anxiety	r	0.03	0.03	0.14	1									
	n	148	148	136	148									
Real identification														
Child with mother	r	-0.14	-0.12	-0.18	-0.13	1								
	n	121	121	104	88	121								
Child with father	r	-0.09	-0.05	-0.25*	-0.17	0.79**	1							
	n	117	117	101	87	117	117							
Mother with child	r	0.09	0.01	-0.06	-0.12	0.32**	0.22*	1						
	n	178	178	156	133	107	103	178						
Father with child	r	0.19*	0.14	-0.19*	-0.15	0.10	0.21	0.32**	1					
	n	134	134	120	124	74	73	123	134					
Ideal identification														
Child with mother	r	0.02	-0.13	-0.24*	-0.21	0.40**	0.34**	0.27**	0.26*	1				
	n	121	121	104	88	121	117	107	74	121				
Child with father	r	0.05	-0.01	-0.22*	-0.23*	0.41**	0.53**	0.27**	0.10	0.48**	1			
	n	117	117	101	87	117	117	103	73	117	117			
Mother with child	r	0.09	-0.00	-0.15	-0.06	0.34**	0.32**	0.79**	0.45**	0.27**	0.36**	1		
	n	181	181	159	135	108	104	178	125	108	104	181		
Father with child	r	0.08	0.12	-0.21*	-0.13	0.20	0.27*	0.37**	0.85**	0.22	0.15	0.53**	1	
	n	135	135	121	125	74	73	123	134	74	73	125	135	
Self-congruence														
Child	r	-0.19*	-0.06	-0.11	-0.15	0.73**	0.71**	0.24*	0.17	0.29**	0.39**	0.31**	0.21	1
	n	122	122	105	89	121	117	108	75	121	117	109	75	122

* $p < 0.05$; ** $p < 0.01$.

was set at 0.0056) effects of age. These were on father real identification with child (fathers identified more with older children), and on self-congruence (older children reported less self-congruence). There was also a trend level effect of maternal anxiety on child ideal identification with the mother, in that higher maternal anxiety was related to lower identification. There were no other significant effects of age, sex, or maternal or paternal anxiety. All group effects on the outcomes remained significant at the Bonferroni cutoff, or very close to it (i.e., child's real identification with the father, with $p = 0.00597$). An effect of group on child ideal identification with mother reached a trend level, but did not approach the corrected significance level.

Discussion and Conclusions

The aim of the present study was to examine differences between children with SAD and children with no disorders and other anxiety disorders in actual and ideal identification among family members and congruence with the self across family members. The results from the present study indicate patterns of identification that differ between families of children with SAD and families of nondisordered children, and that are similar between families of children with SAD and families of children with other anxiety disorders. Specifically, parents of children with SAD identify significantly less with their chil-

Table 3. ANOVA tests of group differences

	Omnibus effects				Contrasts			
	F	error d.f.	p	partial η^2	nonclinical control vs. SAD		clinical control vs. SAD	
					diff.	p	diff.	p
Real identification								
Child with mother	5.54	118	0.005***	0.086	0.43	0.001***	0.08	0.518
Child with father	5.78	114	0.004***	0.092	0.45	0.001***	0.20	0.094
Mother with child	26.13	175	0.000***	0.230	0.64	0.000***	0.063	0.461
Father with child	9.96	131	0.000***	0.132	0.52	0.000***	0.04	0.719
Ideal identification								
Child with mother	2.23	118	0.112					
Child with father	6.11	114	0.003***	0.097	0.44	0.003***	-0.05	0.679
Mother with child	33.94	178	0.000***	0.276	0.85	0.000***	0.10	0.336
Father with child	15.69	132	0.000***	0.192	0.67	0.000***	-0.03	0.743
Self-congruence								
Child	8.82	119	0.000***	0.129	0.59	0.000***	0.12	0.360

*** $p = 0.0056$: significant at this Bonferroni-adjusted p value (0.05/the 9 identification and self-congruence variables of interest).

Table 4. ANCOVA tests of group differences with age, sex, and relevant parent anxiety included as predictors

	Error d.f.	Child age		Sex		Maternal anxiety		Paternal anxiety		Group	
		F	partial η^2	F	partial η^2	F	partial η^2	F	partial η^2	F	partial η^2
Real identification											
Child with mother	98	3.92	0.04	0.22	0.00	1.80	0.02	-	-	6.70***	0.12
Child with father	81	1.59	0.02	0.21	0.00	-	-	0.93	0.01	5.46**	0.12
Mother with child	150	0.01	0.00	0.66	0.00	0.00	0.00	-	-	22.29***	0.23
Father with child	118	4.21*	0.03	3.16	0.03	-	-	1.94	0.02	10.06***	0.15
Ideal identification											
Child with mother	98	0.01	0.00	0.09	0.00	4.87*	0.05	-	-	3.46*	0.07
Child with father	81	0.06	0.00	0.05	0.00	-	-	3.81	0.05	8.66***	0.18
Mother with child	153	0.05	0.00	0.72	0.01	1.47	0.01	-	-	27.87***	0.27
Father with child	119	0.42	0.00	3.25	0.03	-	-	1.53	0.01	15.39***	0.21
Self-congruence											
Child	75	4.43*	0.06	0.03	0.00	0.20	0.00	0.23	0.00	8.50***	0.19

- = Not included in the model. * $p < 0.05$; ** $p < 0.01$; *** $p = 0.0056$: significant at this Bonferroni-adjusted p value (0.05/the 9 identification and self-congruence variables of interest).

dren than parents of nondisordered children, and report less desire to be like their children as indicated by their lowered ideal identification ratings. In addition, children with SAD also identify less with their parents than nondisordered children, and report less ideal identification with their fathers than nondisordered children. Results remained generally consistent even when child age, sex, and parents' own anxiety were included in the model.

Whether low identification plays a role in the development of SAD or other anxiety disorders, or whether it results from or simply coincides with disorder is yet unclear. Regardless of its role, low real identification among family members of children with SAD could be interpreted as an indicator of disorder awareness and therapy readiness. Evidence for real identification as an epiphenomenon (i.e., merely a co-occurring rather than causal

phenomenon) could lie in the strength of the ideal identification between child and mother across groups, despite differences in real identification. This could mean that mothers serve the same role-modeling function across groups, regardless of disorder status. If that is the case, it may also mean that family relations in families of children with SAD are generally functional with regard to modeling, and that lower real identification is an indicator of the disorder rather than a cause.

In contrast to results on mother ideal identification, analyses indicated a tendency for children with SAD to report lower ideal identification with their fathers than healthy control children, though means of all groups were generally high. Children with SAD may not desire to be more assertive, a trait perhaps perceived as more common in fathers than mothers [27], and thus report less ideal identification with fathers. In addition to the reports of diminished real identification of the parents, parents of children with SAD also reported lowered ideal identification in comparison with parents of nondisordered children, perhaps as a direct response to the child's disorder, as 3 of the adjectives on the FIT are disorder-related (i.e., nervous, independent, and anxious). The repercussions of low ideal identification are unclear, but could result in lower family cohesion or attachment or increased feelings of rejection, contributing to a higher likelihood of SAD. It could thus be important to address identification and mediating factors in therapy. Finally, results indicated lower self-congruence in SAD children than in healthy controls, consistent with research on the importance of self-concept and self-esteem in the development of psychopathology [28], with medium to high (but not extreme) self-congruence seen as functional [1]. In the present study, nondisordered children reported high levels, as evidenced by the mean correlation between actual and ideal self-ratings across characteristics of $r = 0.77$, while children in the SAD ($r = 0.45$) and clinical control ($r = 0.47$) groups evidenced medium levels of self-congruence. While children with anxiety disorders clearly reported diminished self-congruence, levels in the medium range were encouraging, and could be a resource for these children. It may be that medium levels of self-congruence reflect a desire not to have SAD, but otherwise satisfaction with the self. Importantly, present analyses indicate a disorder-specific pattern of identification, and past research shows lower identification and self-congruence across multiple disorders [1, 18, 19] when compared with nondisordered children. A larger-scale longitudinal study comparing distinct disorders would allow for further exploration of possible differences among disorders and

possible mediators of such effects. Future studies should also seek to illuminate the role that identification plays in treatment, if any.

Limitations of the present study include the single time point analysis and the representativeness of the sample, which was largely composed of German-speaking Swiss and German participants. Further, as the present data were collected as part of a larger treatment study of SAD, it was not specifically designed to include all key covariates or potential mediators of the effects. In addition to the substantive theoretical variables of attachment, cohesion, schemas, and self-esteem, other factors that could be important to look at may include age of onset of the disorder, adoption, and sibling characteristics.

In sum, the present study extends knowledge of identification patterns in disordered children to SAD and expands knowledge of factors associated with SAD such as attachment, genetics, cohesion and parent-child interaction patterns [20]. Future research should clarify the specificity of low identification to SAD versus other specific anxiety disorders and should examine directional and mediational effects longitudinally. Finally, clinicians should be aware of potential identification issues in the families of children they treat.

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