Separation Anxiety in Adulthood: A Phenomenological Investigation

V. Manicavasagar, D. Silove, and J. Curtis

Separation anxiety disorder is well recognized as a juvenile psychiatric disorder, but it appears to be rarely diagnosed in adulthood. Drawing on our clinical impressions and a review of the relevant literature, we sought to investigate whether separation anxiety symptoms could be identified in adulthood. Forty-four subjects recruited by a media campaign were administered a semistructured interview and a self-report checklist for adult separation anxiety (ASA) symptoms, as well as the Separation Anxiety Symptom Inventory (SASI), a retrospective measure of early separation anxiety symptoms. Diagnoses of major depressive disorder (MDD), panic disorder (PD), agoraphobia (Ag), and dependent personality disorder were made using the SCID-P and SCID-II. Thirty-six subjects met criteria for a putative diagnosis of ASA based on a global clinical rating and/or endorsement of DSM-IV–derived criteria. Although most subjects dated the separation anxiety symptoms to their juvenile years, it was notable that one third reported the first onset of separation anxiety symptoms in adulthood. Although comorbid lifetime anxiety or depressive disorders were common, the majority of subjects reported that the separation anxiety symptoms predated other axis I disorders. Only six subjects (17%) were diagnosed with dependent personality disorder. Although limited by the method of sampling, this preliminary study suggests the need to examine more systematically whether a form of separation anxiety disorder may occur in adulthood.

SEPARATION ANXIETY DISORDER is now well established as a juvenile-onset anxiety disorder, with an estimated prevalence rate of 4% among children and adolescents.[1] For the diagnosis to be made, DSM-IV and ICD-10 both require that the onset of symptoms occurs before 18 years of age. DSM-IV further states that separation anxiety disorder in adulthood is rare and that the diagnosis should not be made if the symptoms are better accounted for by panic disorder (PD) or agoraphobia (Ag). However, no criteria are specified for a diagnosis of separation anxiety disorder in adulthood, the implication being that the juvenile criteria are adequate. This report explores the possibility that separation anxiety symptoms may be identified in adulthood and that they may aggregate to form a distinct syndrome with symptoms that vary from the juvenile form according to the developmental changes accompanying maturation.

There are several lines of evidence that suggest such a possibility. Longitudinal studies of children with school phobia have shown high rates of ongoing psychosocial disability in later life.[2,3] However, limitations in sampling and assessment procedures have prevented clarification of the precise diagnostic outcomes in adulthood.[4-6] Retrospective studies, on the other hand, have suggested that juvenile separation anxiety disorder (JSAD) is linked to the risk of PD, Ag, or both (PD-Ag) in adulthood,[7-10] but the specificity of that link remains in doubt.[11] For example, a recent study by Lipsitz et al.[12] suggested that early separation anxiety may constitute a nonspecific vulnerability to a wide range of anxiety disorders in adulthood in addition to PD. In contrast, a recent community study supports the hypothesis that heightened levels of early separation anxiety are linked specifically to adult PD-Ag.[10] Uncertainty about the long-term outcome of JSAD is increased by methodological limitations of several previous studies, which include problems such as small sample size, variability in the retrospective measurement of JSAD, and use of inappropriate control groups.[13]

At the same time, studies arising from attachment theory increasingly have emphasized the continuities between attachment insecurities in early and later life,[14,15] with terms like "rejection sensitivity"[16] or "interpersonal sensitivity"[17] used to denote forms of attachment anxiety that persist into adulthood. In his early study, Bowlby[18] suggested that Ag was an expression of separation anxiety originating in early life that re-emerged under conditions of interpersonal stress in adulthood. Such a developmental formulation is consistent with the observations of several researchers that some children with severe separation anxiety may have a constitutional vulnerability that persists

From the Psychiatry Research and Teaching Unit, School of Psychiatry, University of New South Wales at Liverpool Hospital, Liverpool, New South Wales, Australia.

Address reprint requests to V. Manicavasagar, M. Psychol., Psychiatry Research and Teaching Unit, Level 4, Health Services Building, Liverpool Hospital, Liverpool, NSW, 2170, Australia.

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throughout life.[2,19-21] One possibility therefore is that symptoms of JSAD may progress into an adult equivalent of the disorder,[13] but the symptoms are overlooked in the clinical setting either because contemporary diagnostic conventions discourage making such a diagnosis or because supervening symptoms of PD or Ag obscure the underlying disorder. Adding to the complexity is the need to distinguish between symptoms of separation anxiety and dependency as a personality trait. Bowlby[22] pointed out that dependency is a pervasive and indiscriminate tendency to rely excessively on others, whereas separation anxiety refers to a limited array of concerns about the proximity and safety of key attachment figures.

The present study represents a preliminary attempt to identify separation anxiety symptoms in adulthood. We aimed to describe the phenomenology, onset, and course of such anxieties and to study the pattern of comorbidity with other affective disorders and dependent personality disorder. By recruiting subjects from the community rather than from established anxiety clinics, we sought to reduce the possible confounding influence of a prior diagnosis on the subjects' accounts of separation anxiety symptoms.

METHOD

Subjects

A limited media campaign was undertaken to recruit adults whose major concerns were anxieties about separation from key attachment figures. Advertisements were placed in newspapers, and these led to a series of radio interviews. A brief account of the typical fears associated with separation anxiety was given without emphasizing details. The newspaper advertisements stated that the research team was interested in interviewing adults who were troubled by excessive anxieties or fears about being separated from persons close to them.

All respondents were initially screened by telephone. For inclusion, subjects had to be over 18 years of age and not suffering from an obvious psychotic or organic disorder. Subjects were then mailed a set of self-report questionnaires including a consent form approved by the University of New South Wales Ethics Committee. The consent form emphasized the voluntary nature of the study and the right of subjects to withdraw consent at any point. Consenting subjects were asked to nominate a convenient time and location to be interviewed. Interviews took place, on average, 2 to 3 weeks after the questionnaires were returned.

Measures

Symptoms of separation anxiety in adulthood were assessed by three different methods: (1) a semistructured interview, (2) a global clinical rating, and (3) a self-report symptom checklist.

An adult separation anxiety (ASA) semistructured interview (ASA-SI) consisting of 27 questions was devised to assess the extent of the subjects' anxieties about attachments to persons identified as close to them, with responses focusing on the preceding 3 months. Items were derived from several sources, including DSM-IV criteria for JSAD with symptoms modified to apply more appropriately to adults; a review of the relevant literature on attachment theory and research; our own additional clinical impressions, for example, that adults with separation anxiety "cling" by excessive talking; and the results of a qualitative study on clinic patients with suspected ASA. In the preliminary investigation, open-ended interviews were conducted with nine patients referred to us by psychologists and psychiatrists who were informed in broad terms of the type of patients we sought to study. Interviews lasted approximately 1.5 to 2 hours and were audiotaped. Content analysis[23] of the tapes was undertaken to identify the range of symptoms that appeared to relate to ASA. The qualitative study was terminated when the content yielded by successive interviews became repetitive, suggesting that the themes and symptoms documented were exhaustive.[24]

Based on these sources, items were generated in an interview format. Items were assigned a score of 3 (threshold) when responses were judged to be positive. Responses of 1 (absent) or 2 (subthreshold) were regarded as clinically unimportant. DSM-IV criteria for separation anxiety disorder (modified for adulthood) were reflected in 13 items, with some redundancy in such items. Following the interview, a global assessment was made (present or absent) as to whether the respondent suffered from a clinically significant problem of separation anxiety. This global rating was made before systematic analysis of the ASA-SI items. A 27-item self-report checklist (ASA-CL) for assessing separation anxiety symptoms in adulthood was devised with items identical to those of the ASA-SI. Items on the ASA-CL were rated on a four-point scale ranging from 0 ("this has never happened") to 3 ("this happens very often").

Subjects were also asked to complete a retrospective questionnaire to assess the frequency of separation anxiety symptoms occurring before 18 years of age (the SASI).[25] The psychometric properties of the measure, including its factorial structure, test-retest and internal reliability, and concurrent validity, have been reported previously.[25]

Subjects were screened for major depressive disorder (MDD), PD, Ag, and dependent personality disorder using the SCID-P[26] and SCID-II.[27] (Note that these diagnoses were based on DSM-III-R, since the SCID for DSM-IV was not available at the time of study.) A brief DSM-IV–derived checklist was used to assess past history of JSAD. A short questionnaire was included to obtain information about losses or distressing separations from caregivers in early life. In addition, a patient-rated scale (0, no impact; 10, maximum disruption) was devised to determine the extent to which each identified axis I disorder affected the subject's life-style.

All interviews were conducted by the first author. Most of the interviews were conducted (and audiotaped) in the subject's home. In a minority of subjects who lived in another state or beyond the metropolitan region of Sydney, interviews were conducted over the telephone.

RESULTS

Fifty-eight subjects responded to our media campaign. Fourteen subjects either did not return