



DSM-IV criteria for childhood separation anxiety disorder: Informant, age, and sex differences

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ABSTRACT

Background: The present study examines frequency of DSM-IV symptom and diagnostic criteria for separation anxiety disorder (SAD) by informant, age, and sex.

Methods: Children aged 4–15 years with a primary DSM-IV diagnosis of SAD ($N = 106$) were assessed using structured diagnostic interviews (Kinder-DIPS; DSM-IV-TR Version). Frequency of DSM-IV symptom and diagnostic criteria were examined as a function of informant and child characteristics, along with impairment and distress ratings.

Results: The most frequently reported symptoms were separation-related distress, avoidance of being alone/without an adult and sleeping away from caregivers or from home, with nightmares the least frequently endorsed criterion. Child report did not yield any significant sex or age differences. However, parent report revealed greater reluctance or avoidance of school attendance for girls than boys, and for younger children (<8 years). Parent report indicated greater symptom-related impairment than child report, and the number of symptoms was correlated with impairment based on parent report, and with distress based on child report.

Conclusions: The primary indicators of SAD appear to be separation distress, avoidance of being alone, and sleeping away from caregivers. Findings suggest that parents may be best placed to determine impairment, while children may be the most accurate reporters of more covert internal distress. Implications for clinicians are that reports from multiple informants should be used to gain the most comprehensive information about childhood SAD.

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1. Introduction

Separation anxiety disorder (SAD) is characterized by persistent, excessive, and developmentally inappropriate fear of separation from major attachment figures, usually parents. Symptom criteria for SAD, according to the DSM-IV-TR (American Psychiatric Association, 2000) include fearful cognitions, behavioral avoidance, and physiological or somatic symptoms. According to DSM-IV criteria, children must display three of eight symptom criteria for at least 4 weeks for diagnosis. DSM-III criteria indicated three of nine symptoms for at least 2 weeks (APA, 1987). Recurrent excessive distress about anticipated or actual separation were collapsed into one symptom in DSM-IV, with all other symptom criteria remaining unchanged since DSM-III. Further, the presence of significant impairment or distress is also a requirement for a DSM-IV diagnosis. Although the DSM-IV was published 15 years ago (APA, 1994), little is currently known about the frequency of SAD symptom criteria; for example whether certain symptoms are more characteristic

of SAD than others, and whether differences exist according to age, sex, or informant.

There is speculation that the nature and frequency of separation anxiety symptoms may alter as children develop. DSM-IV includes developmental considerations, such that younger children are less likely to experience somatic symptoms or fears of threats to their parents, homes or themselves than older children. However, it is also possible that changes in the behavioral manifestation of SAD may lead to its under-detection in adolescence. One of the few studies to examine the frequency of SAD symptom criteria according to DSM-III criteria ($N = 45$) indicated some developmental variations (Francis, Last, & Strauss, 1987). Children diagnosed with SAD aged 5–8 presented with more symptoms overall than diagnosed children aged 9–12. That is, all young children presented with four or more symptoms but only 69% of children aged 9–12 fulfilled this criterion (31% met diagnostic criteria based only on the minimum of three symptoms). Surprisingly, 78% of adolescents aged 13–16 years presented with four or more symptoms, and as such did not differ from the two younger age groups in the total number of symptoms. Younger children were more likely than older children to report nightmares and excessive distress upon separation, with a trend for adolescents to report more physical symptoms on school

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days than younger children. Some additional evidence also lends support to developmental variations in overall symptom frequency. For example, one examination of both community and clinical samples indicated that children (8–12 years) reported more symptoms overall than adolescents (Compton, Nelson, & March, 2000).

Studies comparing prevalence of SAD in boys and girls have resulted in mixed findings. Some indicate a greater prevalence of SAD for girls than boys in both community (Compton et al., 2000; Foley et al., 2004; Hale, Raaijmakers, Muris, & Meeus, 2005; Hewitt et al., 1997; Ogliari et al., 2006) and clinical samples (Last, Hersen, Kazdin, Finkelstein, & Strauss, 1987). Various explanations, including a stronger interpersonal orientation (Hankin & Abramson, 2001) or a greater genetic susceptibility to SAD in girls (Silberg, Rutter, & Eaves, 2001), have been offered to account for the higher prevalence rate in females. However, other studies have shown relatively equal gender distribution in community (Cohen et al., 1993) and clinical samples (Francis et al., 1987; Last, Perrin, Hersen, & Kazdin, 1992). Compton et al. (2000) even found a reversed gender effect with increased symptoms in boys in a clinical sample, prompting the authors to suggest that parents may be more likely to seek help for boys due to greater societal acceptance of anxiety for females. Finally, the informant may also influence symptom reporting. Research indicates that sex differences in prevalence rates may be more prominent when based on parent as compared to child report, with girls more likely to receive an SAD diagnosis in a community sample of twins (Foley et al., 2004). The informant also influenced the overall rate of SAD, in that child interviews tended to yield a higher prevalence of SAD than interviews with parents.

In addition to symptom criteria, the criterion of impairment or distress is also of interest. Impairment or distress (a child must evidence at least one of the two) has only recently been indicated as a requirement for diagnosis in the DSM-IV (APA, 1994) and appears to be an important factor in identifying SAD. Results of one study indicated that the rate of SAD dropped from 8.6% to 2.4% when impairment was required for diagnosis in preschool-age children (Egger & Angold, 2006). Little else is known about how diagnosis rates change when ratings of impairment and distress are taken into account, their relationship to one another, and how impairment and distress differ according to sex, age, and informant.

The primary aim of the present study is to examine frequency of symptom and diagnostic criteria for SAD as a function of child characteristics (age and sex) and informant (parent and child). On the basis of past findings, younger children are expected to report more distress upon separation and nightmares than older children. Adolescents may report more somatic symptoms than younger children. Girls are expected to evidence more symptoms than boys. An examination of the variation in number of symptoms and specific symptom prevalence by informant is exploratory. As the present study utilized a largely parent-referred clinical sample, parents may be more likely than children to indicate an SAD diagnosis, with more symptoms reported overall. The impairment/distress requirement for diagnosis will also be explored, as very little research exists in this area. Impairment and distress are expected to be highly, but not perfectly, correlated. It is expected that some children will not receive a diagnosis due to low impairment or distress ratings. Rate of diagnosis is expected to decrease when both impairment and distress are required for diagnosis. The correlation between the number of symptoms reported and the degree of impairment/distress will be analyzed on an exploratory basis.

2. Methods

2.1. Participants

Participants were 106 children with a primary diagnosis of SAD, based either on parent or child interview, and their par-

ents. Children were aged 4–15 years (mean age = 8.6, SD = 2.4; 50 boys, 56 girls). Most children (93%) came from two-parent families. All participants were Caucasian, with the majority of children identified as Swiss (82%) followed by “other” European (18%). The sample was predominantly middle to upper middle class, with a median monthly income of 4001–8000 CHF (44%). Participants were recruited through local media advertisements and university-based and community outpatient mental health clinics in the cities of Basel and Zurich, Switzerland. Families formed part of an ongoing randomized trial of CBT for SAD and received subsidized treatment for their participation. Exclusion criteria were insufficient knowledge of the German language, developmental delay, or use of psychotropic medication.

2.1.1. Structured diagnostic interview

The Diagnostic Interview for Children and Youth for DSM-IV-TR: Child and Parent Versions (Kinder-DIPS; DSM-IV-TR Version; Schneider, Unnewehr, & Margraf, 2009) are structured interviews designed to assess mental disorders common in childhood and adolescence according to DSM-IV-TR criteria. The child version is administered only to children 8 years of age and older, as younger children appear unlikely to have developed the verbal and or cognitive skills needed to provide an accurate report of symptoms (Grills & Ollendick, 2003). Clinician-based ratings of symptom frequency are assessed on a 4-point scale from 0 (never/seldom) to 3 (very often). Each symptom criterion is considered fulfilled when a symptom frequency rating of ≥ 2 is awarded. Clinician-based ratings of the degree of distress caused by the presenting symptoms as well as the associated degree of impairment for the child (separately for the home, school, friendship and leisure domains) are provided on a 4-point scale from 0 (not at all) to 3 (very strong). As in structured diagnostic interviews commonly used in English-speaking samples (e.g., ADIS; Silverman & Albano, 1996), the disorder with the highest overall clinician-judged general severity rating (on a scale from 1 to 8, and based on the combined impairment and distress ratings) was considered the child's primary diagnosis, with secondary diagnoses representing all other disorders where DSM-IV criteria were met. The Kinder-DIPS is widely used in German-speaking populations and has demonstrated good retest reliability (child version, $\kappa = .48-.88$; parent version, $\kappa = .85-.94$; all DSM-IV diagnoses) and validity, with moderate parent-child agreement for SAD ($\kappa = .54$). Inter-rater reliability estimates are good for diagnoses of SAD (child version: $\kappa = .81$; parent version: $\kappa = .83$) and moderate to very good for an overall diagnosis of an anxiety disorder (child version: $\kappa = .48$; parent version: $\kappa = .85$; Adornetto, In-Albon, & Schneider, 2008; Schneider et al., 2009).

2.2. Procedure

Families who expressed interest in participating were sent institutional ethics review board-approved information and consent forms. Consenting (parents) and assenting (children) completed the Kinder-DIPS as part of a pretreatment assessment protocol. Diagnostic interviews were administered by qualified, trained, and supervised clinical psychologists and graduate students at a university-based outpatient clinic. Parent interviews were conducted with both parents present (77%), with mothers only (22%), or with fathers only (1%). Parent and child interviews were conducted separately and administered by different clinicians to control for possible bias. Diagnoses for children under 8 years ($n = 43$) are based on information obtained during parent interviews only. Following each interview, clinicians provided diagnoses and severity ratings, producing two separate clinician-based profiles of symptom and diagnostic criteria for each child (over 8 years) based on parent report and child self-report. The diagnosis receiving the highest clinical severity rating on the basis of parent or child interview

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