



# Separation anxiety disorder across the lifespan: DSM-5 lifts age restriction on diagnosis



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## ABSTRACT

DSM-5 has lifted the age criterion in the definition of separation anxiety disorder thereby overturning the long-standing convention of restricting the diagnosis to childhood. Previously, adults with separation anxiety symptoms were assigned to other conventional categories such as panic disorder, agoraphobia or generalized anxiety disorder. Over the past two decades, an evolving body of research has identified separation anxiety disorder in adulthood, with 20–40% of adult psychiatric outpatients being assigned that diagnosis. In the US, the lifetime prevalence of the disorder in adulthood is 6.6%. The removal of the age restriction on diagnosis has important implications for clinical practice. Whereas parents (particularly mothers) of children with separation anxiety disorder commonly attracted the diagnosis of agoraphobia, the latter are more likely now to be diagnosed with the adult form of separation anxiety disorder, focusing attention on the importance of intervening with both members of the dyad to overcome mutual reinforcement of symptoms. In addition, adults with separation anxiety disorder have been found to manifest high levels of disability and they tend to show a poor response to conventional psychological and pharmacological treatments. There is an urgent need therefore to devise novel psychological and pharmacological interventions for the adult form of the disorder. The reformulation of separation anxiety disorder in DSM-5 therefore requires a paradigm shift in which clinicians are alerted to identifying and treating the condition in all age groups. Research across countries is needed to examine the new formulation of separation anxiety disorder amongst populations of diverse ethnic and cultural backgrounds.

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## 1. Introduction

DSM-5 has introduced key changes to the criteria for diagnosing separation anxiety disorder, lifting the age of onset restriction and modifying symptom descriptors to facilitate their application to adults as well as children and adolescents (APA, 2013). In addition, the category has been re-assigned to the general section of the anxiety disorders, giving it equal status with other common lifetime anxiety subtypes such as generalized anxiety disorder, social phobia and panic disorder. This shift advances the process of reconciling childhood and adult subtypes of anxiety, bringing symmetry to the classification of the anxiety disorders across the

lifespan. The present article considers the historical and theoretical factors that may have delayed recognition of separation anxiety disorder as a condition that can occur in adulthood; evidence supporting the changes in the criteria for the disorder in DSM-5; implications of the new formulation to theories of developmental psychopathology; and the impact of these changes on the assessment and treatment of children and adults.

## 2. Classification and developmental theory

DSM-III established the era of operationalized diagnoses, the overarching principle being to distinguish empirically derived clinical diagnosis from their theoretical underpinnings (APA, 1984). Detaching separation anxiety disorder from its theoretical roots has proven difficult however. Traditionally, the construct of separation anxiety has been central to psychodynamic and attachment theories of psychopathology (Bowlby, 1960). Within that framework, there has been a blurring between the idiographic (notions of the development of the response and

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related intra-psychic/interpersonal mechanisms) and the nomothetic (empirical description of overt symptoms and behaviours). The influence of attachment theory has meant that professionals working in child psychiatry assumed that typical symptoms of separation anxiety (excessive clinging, overt distress when separated from primary attachment figures, nightmares of separation, fear of harm befalling attachment figures or the self, and school refusal) are linked to an underlying “anxious attachment” arising from disruptions or disturbances in the child’s primary bonds (Bowlby, 1960). A strongly held corollary of this model is that typical separation anxiety symptoms are characteristic of early development when the child is wholly reliant (psychologically and physically) on adult attachment figures. Older children can also show the pattern as a form of “regression” when confronting the individuation challenges of early adolescence. Bowlby argued however that adults with underlying separation anxiety disorder tend to manifest their anxieties in the form of agoraphobia (Bowlby, 1960). In this formulation, agoraphobia was regarded as a covert form or *forme fruste* of separation anxiety, in essence representing the adults’ more sophisticated way of coping with underlying attachment fears.

Bowlby’s model was elaborated further into what has become a long-standing and widely accepted separation anxiety–agoraphobia (SA–Ag) hypothesis (Klein, 1964; Gittelman and Klein, 1984; Silove et al., 1995a, 1996). The model was extended to include panic disorder which in DSM-III was closely linked to agoraphobia. The prevailing model was that panic disorder–agoraphobia (PD–Ag) linked to early separation anxiety formed a distinctive “endogenous” type of anxiety (Klein, 1964; Sheehan et al., 1980). The formulation was supported by family aggregation and twin studies, the latter suggesting a common heredity pattern underlying PD–Ag and separation anxiety disorder (Weissman et al., 1984; Battaglia et al., 2009; D’Amato et al., 2011; Roberson-Nay et al., 2012). In addition, adults with PD–Ag and children with separation anxiety disorder have been shown to exhibit a common and distinctive psychophysiological response to laboratory induced CO<sub>2</sub> inhalation (Battaglia et al., 2009; D’Amato et al., 2011; Roberson-Nay et al., 2010; Atli et al., 2012). This tradition, supported by some empirical evidence, has entrenched the notion that children with separation anxiety disorder who experience persisting or recurrent symptoms in adulthood are most likely to manifest PD–Ag. For these reasons, clinicians have been reluctant to make a diagnosis of separation anxiety disorder in adulthood as indicated by the following case vignette.

A 7-year-old girl is accompanied by her mother to consult a clinical psychologist. The referral was made by the principal of the girl’s school. The mother reports that the daughter is “extremely stressed and worried” and avoids going to school. The daughter is rather vague in her account, reporting at first that she “worries about school and it makes me tired so I can’t go.” According to the mother, on school days, the daughter has bouts of crying and screaming prior to leaving home, insisting she cannot go to school because she is tired or sick. She complains of headache, stomach-ache, and often begins vomiting if compelled to go to school. The mother generally relents but the father insists that the daughter attend school, lack of agreement that leads to conflict in the household. When the daughter does attend school, teachers report that she always looks stressed and that she repeatedly requests to return home. The school authorities frequently phone the mother who then brings the daughter home. According to the mother, the daughter’s anxiety has escalated in recent months since her maternal grandmother died. The mother recalled that her daughter had a previous episode of being very “clingy” during her preschool years (3–4 years old), crying, screaming and at times vomiting when dropped off at preschool.

When interviewed alone, the daughter repeatedly refer to her fears for her mother’s health and safety. She reports having repetitive nightmares about her mother falling ill or dying. She also fears being left alone because she may be kidnapped or harmed by intruders. When the mother is interviewed alone, she admits that she experiences persistent fears and anxieties about her own health and the safety and health of the child. The mother has a longstanding pattern of broken sleep that began after her daughter’s birth, when she formed a “habit” of checking repeatedly to make sure the infant was “alive and breathing”. Throughout the child’s life, the mother has worried that her daughter may be suffering from undisclosed illnesses of a life threatening nature. She admits keeping the daughter away from other children to protect her from infections. Whenever the child attends school, the mother worries incessantly about her well-being, calling the school repeatedly during the day to “check” that the daughter is “OK”. The mother admits that she avoids leaving home (except to pick up the daughter), and rarely goes shopping. She feels anxious in shopping centres or other noisy and crowded places “in case I can’t get away quickly enough or hear my mobile ring.” More recently, the mother has relied on on-line shopping, avoiding leaving the house almost entirely. When the phone rings, it causes the mother to “panic”, provoking immediate fear, palpitations, sweating and difficulty “catching” her breath.

The psychologist refers the mother to a psychiatrist who “confirms” a diagnosis of panic–agoraphobia with related symptoms of generalized anxiety and hypochondriasis. The psychiatrist commences a programme of general stress management and graded exposure, encouraging the mother to increase the distance she travels from home in a stepwise manner. After three sessions however, the mother discontinues treatment, reporting back to the psychologist that the focus of the exposure programme is not “relevant” to her problem. When asked why, the mother explains that her primary fears are centred on threats to the health and survival of her daughter, not on going out alone to shopping centres.

### 3. Identifying separation anxiety disorder in adulthood

In the early 1990s, our group at the University of New South Wales, Sydney, Australia, pursued a research programme examining the prevailing SA–PD/Ag hypothesis (Silove et al., 1993, 1995b, 1996). Although our studies offered tentative support for the model, the findings were counterbalanced by other clinical and community-based studies suggesting that early separation anxiety is a generic risk factor for a range of adult anxiety (and depressive) disorders in later life (Flakierska-Praquin et al., 1997; Silove et al., 1993, 1995a; Aschenbrand et al., 2003; Brückl et al., 2006; Lewinsohn et al., 2008; Kossowsky et al., 2013). Detailed interviewing of our adult anxiety patients revealed that many experienced separation anxiety symptoms that were analogous to those of children but manifested as behaviours such as repeated phone calls to attachment figures throughout the day; ordering arrangements to avert or delay separations; non-verbal cues designed to signal the person’s distress when there was a perceived threat of separation from attachment figures; and other subtle ways of ensuring proximity to or maintenance of close contact with these key figures. Some tried to rationalize their behaviours by passing them off as “normal”, but most were quick to acknowledge that separation anxiety was their core problem, the cause of severe suffering and ongoing dysfunction (Manicasagar and Silove, 1997). In all these persons, referring clinicians had made primary diagnoses of panic disorder, agoraphobia, generalized anxiety disorder (GAD) or other disorders. Documentation of these cases of a putative adult separation anxiety disorder (ASAD), laid the foundation for a programme of research aimed at

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