



Overlap of symptom domains of separation anxiety disorder in adulthood with panic disorder–agoraphobia

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ABSTRACT

There is a need to explain the high level of comorbidity between separation anxiety disorder (SAD) in adulthood and panic disorder with agoraphobia (Pd-Ag). One possibility is that inadequate specification of symptom domains and/or diagnostic questions accounts for some of the comorbidity. The present anxiety clinic study examined responses of adult patients ($n=646$) with SAD and/or Pd-Ag on eight symptom domains based on a previous factor analysis of a commonly used separation anxiety measure, the ASA-27, as well as on the Anxiety Sensitivity Index. We also examined questionnaire items that did not load on the factor structure. All separation anxiety domains distinguished strongly between SAD and Pd-Ag. Comparisons across three groups (SAD alone, Pd-Ag alone and comorbid SAD/Pd-Ag) revealed that two symptom domains (anxiety about embarking on trips, and sleep disturbances) showed some overlap between Pd-Ag and SAD. Two of the items of the ASA-27 that did not load with other items in the factor analysis also showed overlap with Pd-Ag, with both referring to anxieties about leaving home. Patients with SAD (with or without Pd-Ag) returned higher scores on anxiety sensitivity than those with Pd-Ag alone. The findings support the distinctiveness of the construct of SAD and the capacity of the ASA-27 to discriminate between that disorder and Pd-Ag. SAD appears to be a more severe form of anxiety than Pd-Ag. There may be a need to refine items to include the reasons for avoiding leaving home, reluctance to sleep alone and to embark on trips, to ensure accurate discrimination between Pd-Ag and SAD in adulthood.

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1. Introduction

There is growing evidence that separation anxiety disorder (SAD) can occur in adulthood, with epidemiological and clinical data indicating that the constellation is common and disabling (Manicavasagar, Silove, & Curtis, 1997; Shear, Jin, Ruscio, Walters, & Kessler, 2006). According to the National Comorbidity Survey Replication (NCS-R), SAD has a lifetime prevalence of 6.6% in adulthood and 4.1% in childhood (Shear et al., 2006). In accordance with the above research findings, the proposed criteria for SAD for DSM-5 have been modified to ensure that symptoms are worded to make them equally applicable to adulthood and childhood (DSM-5; American Psychiatric Association, 2011).

Adult SAD is relatively distinct from dependent personality disorder, with Manicavasagar et al. (1997) reporting only a 17% rate of comorbidity between the two disorders. A separate study

reported that adult SAD showed lower rates of comorbidity with dependent personality disorder than with several other personality subtypes, including avoidant and borderline (Silove, Marnane, Wagner, & Manicavasagar, 2011). A consistent finding in the recent literature, however, is the high level of comorbidity observed between adult SAD and agoraphobia (commonly represented as panic disorder–agoraphobia or Pd-Ag). For example, in the clinic sample on which the present analysis is based, we found that adult patients with SAD were more likely to have comorbid Pd-Ag than any other anxiety subtype (Silove, Marnane, Wagner, Manicavasagar, & Rees, 2010), whereas a previous study of a mixed community and clinic sample found Pd-Ag to be the only anxiety disorder strongly associated with SAD (Manicavasagar, Silove, & Hadzi-Pavlovic, 1998). The pattern of comorbidity is clinically relevant in that it appears to be associated with a poor prognosis following treatment with cognitive behavioural therapy (Aarons et al., 2008; Kirsten, Grenver, Wagner, & Manicavasagar, 2008).

It is important, therefore, to shed further light on the reasons for the high level of comorbidity between SAD and Pd-Ag. The notion that the two constellations represent developmentally determined variants of a common diathesis is a longstanding hypothesis of attachment theory (Bowlby, 1969, 1973). Such a model suggests

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that a combination of biological and developmental factors generate persisting attachment anxieties that manifest as SAD in earlier life and agoraphobia in adulthood (Klein, 1980). If that model is correct, then patients with adult SAD and Pd-Ag should show substantial overlap in their responses to items on a separation anxiety symptom measure. The recent formulation of the construct of a Pd-Ag spectrum disorder represents a variation of this theme, in which separation anxiety forms one component of the proposed broader constellation (Rucci et al., 2009). Early genetic data offers some supportive evidence for that model (Roberson-Nay, Eaves, Hetttema, Kendler, & Silberg, 2012). Again, if that model is correct, persons with Pd-Ag should score high on the range of separation anxiety symptoms.

It is possible, however, that the two disorders are distinct and that there is a genuine pattern of comorbidity between them, although the observed level of comorbidity might be accentuated by inadequate specification of some symptoms. For example, it is common for patients with Pd-Ag or SAD to be reluctant to leave home. Nevertheless, those with Pd-Ag typically are constrained by fears of experiencing panic in specific situations outside the home, whereas persons with SAD are primarily anxious about losing contact with attachment figures. Failure to make these distinctions in the wording of relevant items may lead to spurious overlap of Pd-Ag and SAD, with patients with either diagnosis endorsing the same symptoms. Examining the symptom domains in which the two diagnostic groups overlap therefore may assist in defining items that require further refinement in order to achieve clearer boundaries between the two disorders.

The present study drew on a large database of patients attending an anxiety disorders clinic who were assigned to diagnoses of SAD, Pd-Ag or both. We based the analysis on a previous factor analysis of the items of the Adult Separation Anxiety Questionnaire, ASA-27 (Manicavasagar, Silove, Wagner, & Drobny, 2003). In the present report, we aimed to examine the extent to which symptom domains of separation anxiety discriminated between SAD and Pd-Ag. Specifically, we sought to identify domains specific to separation anxiety disorder, that is, where the presence of comorbid Pd-Ag made no difference to the separation anxiety scores of those with SAD. Conversely, we sought to identify symptom clusters where the presence of comorbid Pd-Ag increased scoring for those with adult SAD, a pattern that would suggest symptom overlap in responses. Finally, we examined the few individual ASA-27 items that failed to load on the factor analysis to assess whether they were particularly poor at discriminating between Pd-Ag and SAD.

2. Materials and methods

2.1. Participants

Participants were consecutive patients attending an ambulatory public facility for treating anxiety disorders in South West Sydney, Australia. Included were those who met criteria for either SAD in adulthood, Pd-Ag, or agoraphobia alone (the latter two diagnoses were aggregated into a single “Pd-Ag” grouping). Patients could have other comorbid anxiety or depressive diagnoses. Patients provided informed consent in accordance with the South Western Sydney Area Health Service Ethics Committee.

2.2. Measures

Pd-Ag was diagnosed by clinical psychologists using the Structured Clinical Interview for the DSM-IV-TR (SCID) (First, Spitzer, Gibbon, & Williams, 1997), a clinician-administered semi-structured interview. All psychologists were required to achieve

100% agreement in the use of this measure with the senior psychologist at the clinic before using the measure independently. Diagnoses of SAD were made using the Adult Separation Anxiety Questionnaire (ASA-27) (Manicavasagar et al., 2003), a self-report questionnaire containing 27 items assessing symptoms in adulthood. Participants responded to items on a four-point frequency scale, ranging from “This has never happened” to “This happens very often”. Item scores (0–3) are added to yield a total instrument score ranging from 0 to 81. The measure has shown a high level of internal consistency (Cronbach’s alpha = .89), and test–retest reliability ($r = .86, p < .001$) (Manicavasagar et al., 1997). A total score of 22 or higher provides a threshold for SAD caseness based on a previous calibration of the measure against a structured clinical interview (Manicavasagar et al., 2003).

The factor structure of the ASA-27 was established in an earlier analysis using a principal components factor analysis (Silove et al., 2007). That study reported an eight factor model with a single second order factor that included 23 of the 27 questionnaire items. The eight factors were readily interpretable as reflecting: nightmares, anxiety about trips, a need to maintain strict routines, excessive talking to ensure continuity of contact with attachment figures, concerns about harm befalling attachment figures, sleep disturbances, separation distress, and insecurity about relationships (Table 1). Factor loadings ranged between 0.59 and 0.98 on the second order general separation anxiety factor. Four items (1, 2, 3 and 9, pertaining to feeling secure at home with loved ones, experiencing difficulty staying away from home, carrying an object for security, and experiencing somatic symptoms before leaving home, respectively) failed to load highly on any of the factors.

The Anxiety Sensitivity Index (ASI; Reiss, Peterson, Gursky, & McNally, 1986) is a 16 item self-report questionnaire measuring the degree that respondents interpret anxiety as having negative consequences, that is, the fear of fear. The measure has been found to be strongly associated with Ag, as well as with more severe anxiety in general. The test–retest reliability and construct validity of the measure have been demonstrated (Reiss et al., 1986).

2.3. Procedure

Three mutually exclusive diagnostic groups were derived: comorbid SAD and Pd-Ag (SAD + Pd-Ag), SAD without comorbid Pd-Ag (SAD/no Pd-Ag), and Pd-Ag with no comorbid SAD (Pd-Ag/no SAD). We compared the average scores of items comprising each factor across the derived diagnostic groupings by applying ANOVAs with post hoc comparisons using SPSS (version 18; PASW Statistics, 2009), the level of significance being set at $p < .01$.

3. Results

Six hundred and forty-six patients fulfilled criteria for inclusion in the study. Three hundred and eighty-three patients (59.3%) had SAD without comorbid Pd-Ag, 211 (32.7%) had SAD with comorbid Pd-Ag, and 52 (8.0%) had Pd-Ag with no comorbid SAD. Of those classified in the Pd-Ag group ($n = 263$), the majority had Pd-Ag ($n = 250, 95\%$), while 13 had Ag without panic disorder (5%).

The demographic characteristics of the sample are summarised in Table 2, with no statistical differences being evident. Patients ranged in age from 15 to 78. An analysis of the number of comorbid disorders (excluding SAD and Pd-Ag) exhibited by each group showed the SAD + Pd-Ag group had a somewhat higher level of comorbidity ($\mu = 2.16$ disorders, $SD = 1.06$) compared to SAD/no Pd-Ag ($\mu = 1.80, SD = 0.88$) and Pd-Ag/no SAD ($\mu = 1.52, SD = 0.6$). We note, however, that when the number of comorbid disorders was rounded off, all groups had an average of two additional diagnoses.

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