Anxiety Disorders

Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. *Fear* is the emotional response to real or perceived imminent threat, whereas *anxiety* is anticipation of future threat. Obviously, these two states overlap, but they also differ, with fear more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors, and anxiety more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors. Sometimes the level of fear or anxiety is reduced by pervasive avoidance behaviors. *Panic attacks* feature prominently within the anxiety disorders as a particular type of fear response. Panic attacks are not limited to anxiety disorders but rather can be seen in other mental disorders as well.

The anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognitive ideation. Thus, while the anxiety disorders tend to be highly comorbid with each other, they can be differentiated by close examination of the types of situations that are feared or avoided and the content of the associated thoughts or beliefs.

Anxiety disorders differ from developmentally normative fear or anxiety by being excessive or persisting beyond developmentally appropriate periods. They differ from transient fear or anxiety, often stress-induced, by being persistent (e.g., typically lasting 6 months or more), although the criterion for duration is intended as a general guide with allowance for some degree of flexibility and is sometimes of shorter duration in children (as in separation anxiety disorder and selective mutism). Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account. Many of the anxiety disorders develop in childhood and tend to persist if not treated. Most occur more frequently in females than in males (approximately 2:1 ratio). Each anxiety disorder is diagnosed only when the symptoms are not attributable to the physiological effects of a substance/medication or to another medical condition or are not better explained by another mental disorder.

The chapter is arranged developmentally, with disorders sequenced according to the typical age at onset. The individual with separation anxiety disorder is fearful or anxious about separation from attachment figures to a degree that is developmentally inappropriate. There is persistent fear or anxiety about harm coming to attachment figures and events that could lead to loss of or separation from attachment figures and reluctance to go away from attachment figures, as well as nightmares and physical symptoms of distress. Although the symptoms often develop in childhood, they can be expressed throughout adulthood as well.

Selective mutism is characterized by a consistent failure to speak in social situations in which there is an expectation to speak (e.g., school) even though the individual speaks in other situations. The failure to speak has significant consequences on achievement in academic or occupational settings or otherwise interferes with normal social communication.

Individuals with specific phobia are fearful or anxious about or avoidant of circumscribed objects or situations. A specific cognitive ideation is not featured in this disorder, as it is in other anxiety disorders. The fear, anxiety, or avoidance is almost always imme-

diately induced by the phobic situation, to a degree that is persistent and out of proportion to the actual risk posed. There are various types of specific phobias: animal; natural environment; blood-injection-injury; situational; and other situations.

In social anxiety disorder (social phobia), the individual is fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized. These include social interactions such as meeting unfamiliar people, situations in which the individual may be observed eating or drinking, and situations in which the individual performs in front of others. The cognitive ideation is of being negatively evaluated by others, by being embarrassed, humiliated, or rejected, or offending others.

In panic disorder, the individual experiences recurrent unexpected panic attacks and is persistently concerned or worried about having more panic attacks or changes his or her behavior in maladaptive ways because of the panic attacks (e.g., avoidance of exercise or of unfamiliar locations). Panic attacks are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms. Limited-symptom panic attacks include fewer than four symptoms. Panic attacks may be *expected*, such as in response to a typically feared object or situation, or *unexpected*, meaning that the panic attack occurs for no apparent reason. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including, but not limited to, the anxiety disorders (e.g., substance use, depressive and psychotic disorders). Panic attack may therefore be used as a descriptive specifier for any anxiety disorder as well as other mental disorders.

Individuals with agoraphobia are fearful and anxious about two or more of the following situations: using public transportation; being in open spaces; being in enclosed places; standing in line or being in a crowd; or being outside of the home alone in other situations. The individual fears these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms. These situations almost always induce fear or anxiety and are often avoided and require the presence of a companion.

The key features of generalized anxiety disorder are persistent and excessive anxiety and worry about various domains, including work and school performance, that the individual finds difficult to control. In addition, the individual experiences physical symptoms, including restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbance.

Substance/medication-induced anxiety disorder involves anxiety due to substance intoxication or withdrawal or to a medication treatment. In anxiety disorder due to another medical condition, anxiety symptoms are the physiological consequence of another medical condition.

Disorder-specific scales are available to better characterize the severity of each anxiety disorder and to capture change in severity over time. For ease of use, particularly for individuals with more than one anxiety disorder, these scales have been developed to have the same format (but different focus) across the anxiety disorders, with ratings of behavioral symptoms, cognitive ideation symptoms, and physical symptoms relevant to each disorder.

Separation Anxiety Disorder

Diagnostic Criteria **309.21 (F93.0)**

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

   1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.

2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

B. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.
C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.

Diagnostic Features

The essential feature of separation anxiety disorder is excessive fear or anxiety concerning separation from home or attachment figures. The anxiety exceeds what may be expected given the person's developmental level (Criterion A). Individuals with separation anxiety disorder have symptoms that meet at least three of the following criteria: They experience recurrent excessive distress when separation from home or major attachment figures is anticipated or occurs (Criterion A1). They worry about the well-being or death of attachment figures, particularly when separated from them, and they need to know the whereabouts of their attachment figures and want to stay in touch with them (Criterion A2). They also worry about untoward events to themselves, such as getting lost, being kidnapped, or having an accident, that would keep them from ever being reunited with their major attachment figure (Criterion A3). Individuals with separation anxiety disorder are reluctant or refuse to go out by themselves because of separation fears (Criterion A4). They have persistent and excessive fear or reluctance about being alone or without major attachment figures at home or in other settings. Children with separation anxiety disorder may be unable to stay or go in a room by themselves and may display "clinging" behavior, staying close to or "shadowing" the parent around the house, or requiring someone to be with them when going to another room in the house (Criterion A5). They have persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home (Criterion A6). Children with this disorder often have difficulty at bedtime and may insist that someone stay with them until they fall asleep. During the night, they may make their way to their parents' bed (or that of a significant other, such as a sibling). Children may be reluctant or refuse to attend camp, to sleep at friends' homes, or to go on errands. Adults may be uncomfortable when traveling independently (e.g., sleeping in a hotel room). There may be repeated nightmares in which the content expresses the in-

dividual's separation anxiety (e.g., destruction of the family through fire, murder, or other catastrophe) (Criterion A7). Physical symptoms (e.g., headaches, abdominal complaints, nausea, vomiting) are common in children when separation from major attachment figures occurs or is anticipated (Criterion A8). Cardiovascular symptoms such as palpitations, dizziness, and feeling faint are rare in younger children but may occur in adolescents and adults.

The disturbance must last for a period of at least 4 weeks in children and adolescents younger than 18 years and is typically 6 months or longer in adults (Criterion B). However, the duration criterion for adults should be used as a general guide, with allowance for some degree of flexibility. The disturbance must cause clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning (Criterion C).

Associated Features Supporting Diagnosis

When separated from major attachment figures, children with separation anxiety disorder may exhibit social withdrawal, apathy, sadness, or difficulty concentrating on work or play. Depending on their age, individuals may have fears of animals, monsters, the dark, muggers, burglars, kidnappers, car accidents, plane travel, and other situations that are perceived as presenting danger to the family or themselves. Some individuals become homesick and uncomfortable to the point of misery when away from home. Separation anxiety disorder in children may lead to school refusal, which in turn may lead to academic difficulties and social isolation. When extremely upset at the prospect of separation, children may show anger or occasionally aggression toward someone who is forcing separation. When alone, especially in the evening or the dark, young children may report unusual perceptual experiences (e.g., seeing people peering into their room, frightening creatures reaching for them, feeling eyes staring at them). Children with this disorder may be described as demanding, intrusive, and in need of constant attention, and, as adults, may appear dependent and overprotective. The individual's excessive demands often become a source of frustration for family members, leading to resentment and conflict in the family.

Prevalence

The 12-month prevalence of separation anxiety disorder among adults in the United States is 0.9%–1.9%. In children, 6- to 12-month prevalence is estimated to be approximately 4%. In adolescents in the United States, the 12-month prevalence is 1.6%. Separation anxiety disorder decreases in prevalence from childhood through adolescence and adulthood and is the most prevalent anxiety disorder in children younger than 12 years. In clinical samples of children, the disorder is equally common in males and females. In the community, the disorder is more frequent in females.

Development and Course

Periods of heightened separation anxiety from attachment figures are part of normal early development and may indicate the development of secure attachment relationships (e.g., around 1 year of age, when infants may suffer from stranger anxiety). Onset of separation anxiety disorder may be as early as preschool age and may occur at any time during childhood and more rarely in adolescence. Typically there are periods of exacerbation and remission. In some cases, both the anxiety about possible separation and the avoidance of situations involving separation from the home or nuclear family (e.g., going away to college, moving away from attachment figures) may persist through adulthood. However, the majority of children with separation anxiety disorder are free of impairing anxiety disorders over their lifetimes. Many adults with separation anxiety disorder do not recall a childhood onset of separation anxiety disorder, although they may recall symptoms.

The manifestations of separation anxiety disorder vary with age. Younger children are more reluctant to go to school or may avoid school altogether. Younger children may not express worries or specific fears of definite threats to parents, home, or themselves, and the anxiety is manifested only when separation is experienced. As children age, worries emerge; these are often worries about specific dangers (e.g., accidents, kidnapping, mugging, death) or vague concerns about not being reunited with attachment figures. In adults, separation anxiety disorder may limit their ability to cope with changes in circumstances (e.g., moving, getting married). Adults with the disorder are typically overconcerned about their offspring and spouses and experience marked discomfort when separated from them. They may also experience significant disruption in work or social experiences because of needing to continuously check on the whereabouts of a significant other.

Risk and Prognostic Factors

Environmental. Separation anxiety disorder often develops after life stress, especially a loss (e.g., the death of a relative or pet; an illness of the individual or a relative; a change of schools; parental divorce; a move to a new neighborhood; immigration; a disaster that involved periods of separation from attachment figures). In young adults, other examples of life stress include leaving the parental home, entering into a romantic relationship, and becoming a parent. Parental overprotection and intrusiveness may be associated with separation anxiety disorder.

Genetic and physiological. Separation anxiety disorder in children may be heritable. Heritability was estimated at 73% in a community sample of 6-year-old twins, with higher rates in girls. Children with separation anxiety disorder display particularly enhanced sensitivity to respiratory stimulation using CO_2-enriched air.

Culture-Related Diagnostic Issues

There are cultural variations in the degree to which it is considered desirable to tolerate separation, so that demands and opportunities for separation between parents and children are avoided in some cultures. For example, there is wide variation across countries and cultures with respect to the age at which it is expected that offspring should leave the parental home. It is important to differentiate separation anxiety disorder from the high value some cultures place on strong interdependence among family members.

Gender-Related Diagnostic Issues

Girls manifest greater reluctance to attend or avoidance of school than boys. Indirect expression of fear of separation may be more common in males than in females, for example, by limited independent activity, reluctance to be away from home alone, or distress when spouse or offspring do things independently or when contact with spouse or offspring is not possible.

Suicide Risk

Separation anxiety disorder in children may be associated with an increased risk for suicide. In a community sample, the presence of mood disorders, anxiety disorders, or substance use has been associated with suicidal ideation and attempts. However, this association is not specific to separation anxiety disorder and is found in several anxiety disorders.

Functional Consequences of Separation Anxiety Disorder

Individuals with separation anxiety disorder often limit independent activities away from home or attachment figures (e.g., in children, avoiding school, not going to camp, having

difficulty sleeping alone; in adolescents, not going away to college; in adults, not leaving the parental home, not traveling, not working outside the home).

Differential Diagnosis

Generalized anxiety disorder. Separation anxiety disorder is distinguished from generalized anxiety disorder in that the anxiety predominantly concerns separation from attachment figures, and if other worries occur, they do not predominate the clinical picture.

Panic disorder. Threats of separation may lead to extreme anxiety and even a panic attack. In separation anxiety disorder, in contrast to panic disorder, the anxiety concerns the possibility of being away from attachment figures and worry about untoward events befalling them, rather than being incapacitated by an unexpected panic attack.

Agoraphobia. Unlike individuals with agoraphobia, those with separation anxiety disorder are not anxious about being trapped or incapacitated in situations from which escape is perceived as difficult in the event of panic-like symptoms or other incapacitating symptoms.

Conduct disorder. School avoidance (truancy) is common in conduct disorder, but anxiety about separation is not responsible for school absences, and the child or adolescent usually stays away from, rather than returns to, the home.

Social anxiety disorder. School refusal may be due to social anxiety disorder (social phobia). In such instances, the school avoidance is due to fear of being judged negatively by others rather than to worries about being separated from the attachment figures.

Posttraumatic stress disorder. Fear of separation from loved ones is common after traumatic events such as a disasters, particularly when periods of separation from loved ones were experienced during the traumatic event. In posttraumatic stress disorder (PTSD), the central symptoms concern intrusions about, and avoidance of, memories associated with the traumatic event itself, whereas in separation anxiety disorder, the worries and avoidance concern the well-being of attachment figures and separation from them.

Illness anxiety disorder. Individuals with illness anxiety disorder worry about specific illnesses they may have, but the main concern is about the medical diagnosis itself, not about being separated from attachment figures.

Bereavement. Intense yearning or longing for the deceased, intense sorrow and emotional pain, and preoccupation with the deceased or the circumstances of the death are expected responses occurring in bereavement, whereas fear of separation from other attachment figures is central in separation anxiety disorder.

Depressive and bipolar disorders. These disorders may be associated with reluctance to leave home, but the main concern is not worry or fear of untoward events befalling attachment figures, but rather low motivation for engaging with the outside world. However, individuals with separation anxiety disorder may become depressed while being separated or in anticipation of separation.

Oppositional defiant disorder. Children and adolescents with separation anxiety disorder may be oppositional in the context of being forced to separate from attachment figures. Oppositional defiant disorder should be considered only when there is persistent oppositional behavior unrelated to the anticipation or occurrence of separation from attachment figures.

Psychotic disorders. Unlike the hallucinations in psychotic disorders, the unusual perceptual experiences that may occur in separation anxiety disorder are usually based on a misperception of an actual stimulus, occur only in certain situations (e.g., nighttime), and are reversed by the presence of an attachment figure.

Personality disorders. Dependent personality disorder is characterized by an indiscriminate tendency to rely on others, whereas separation anxiety disorder involves concern about the proximity and safety of main attachment figures. Borderline personality disorder is characterized by fear of abandonment by loved ones, but problems in identity, self-direction, interpersonal functioning, and impulsivity are additionally central to that disorder, whereas they are not central to separation anxiety disorder.

Comorbidity

In children, separation anxiety disorder is highly comorbid with generalized anxiety disorder and specific phobia. In adults, common comorbidities include specific phobia, PTSD, panic disorder, generalized anxiety disorder, social anxiety disorder, agoraphobia, obsessive-compulsive disorder, and personality disorders. Depressive and bipolar disorders are also comorbid with separation anxiety disorder in adults.

Selective Mutism

Diagnostic Criteria **312.23 (F94.0)**

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.
C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Diagnostic Features

When encountering other individuals in social interactions, children with selective mutism do not initiate speech or reciprocally respond when spoken to by others. Lack of speech occurs in social interactions with children or adults. Children with selective mutism will speak in their home in the presence of immediate family members but often not even in front of close friends or second-degree relatives, such as grandparents or cousins. The disturbance is often marked by high social anxiety. Children with selective mutism often refuse to speak at school, leading to academic or educational impairment, as teachers often find it difficult to assess skills such as reading. The lack of speech may interfere with social communication, although children with this disorder sometimes use nonspoken or nonverbal means (e.g., grunting, pointing, writing) to communicate and may be willing or eager to perform or engage in social encounters when speech is not required (e.g., nonverbal parts in school plays).

Associated Features Supporting Diagnosis

Associated features of selective mutism may include excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or mild oppositional behavior. Although children with this disorder generally have normal language skills, there may occasionally be an associated commu-