Impact of separation anxieties on treatment outcomes in adults with anxiety disorders

Laura T. Kirsten

University of Wollongong
IMPACT OF SEPARATION ANXIETIES ON TREATMENT OUTCOMES
IN ADULTS WITH ANXIETY DISORDERS

Laura T. Kirsten
B.Sc.(Psychology) UNSW
M.App.Sc. (Beh Hlth Sc) USyd

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Dedication

This thesis is dedicated to my grandfather, Andrew Christian Joseph, who has modelled the virtues of being nonjudgmental, generous, and humane and has demonstrated the strength of character of one who possesses these.
ABSTRACT

Despite improvements in treatment for anxiety disorders, many people remain significantly distressed or relapse following treatment. Exploration of specified issues of potential importance in people with anxiety disorders may improve treatment efficacy in those at risk of poorer treatment outcomes. Juvenile and adult separation anxieties have recently been proposed as important factors influencing psychopathology. The aim of the current research was to investigate the effect of juvenile separation anxiety and adult separation anxiety on treatment outcome in an anxious sample following an eight-week cognitive behavioural program.

Method: Clients (aged 18-78 years at intake, mean of 39.22 years) who had been referred to a specialised anxiety clinic were assessed at intake. Participants diagnosed with a primary anxiety disorder were administered the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Separation Anxiety Symptoms Inventory (SASI), and Adult Separation Anxiety Scale (ASA-CL). Those participants who were significantly anxious as assessed at intake on the BAI were included in this study. One hundred and fifty four participants were allocated into one of two eight-week cognitive behavioural group treatment programs as prescribed by their diagnosis. The BDI and BAI were administered again at the conclusion of treatment.

Results: Pre-treatment Results: Both juvenile separation anxiety and adult separation anxiety were significantly related to each other and to pre-treatment levels of depression but only adult separation anxiety was significantly related to pre-treatment
levels of anxiety. Post-treatment Results: Pre-treatment juvenile separation anxiety and adult separation anxiety were able to significantly discriminate between those with and without significant levels of depression whilst only adult separation anxiety was able to significantly discriminate between those with and without significant levels of depression and anxiety.

Conclusion: Adult separation anxiety was significantly associated with post-treatment severity of depression and anxiety whilst reported juvenile separation anxiety seemed to be associated with only post-treatment severity of depression. The findings of this study suggest that further investigation is required into the role of the separation anxieties in psychopathology and their influence on treatment outcome.
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1. Background


The relative contribution of factors proposed as determinants of the common adult psychological disorders, particularly anxiety and depression, remains unclear. Developmental factors have long been proposed as a major contributor, in particular the proposition that aberrant affectional bonding between parent and child may predispose the individual to psychological disorder (Maccoby, 1992; Maccoby & Martin, 1983).

Bowlby (1977a, 1977b) hypothesised that sustained frustration of the child's attachment needs and continued uncertainty about the availability of the attachment figure laid the foundations for childhood separation anxiety (Bowlby, 1973). This theory was based on observations that once infants had become attached to the primary caregiver, usually in the second six months of life, separations caused anxiety and distress which developed into despair and finally withdrawal if the separation was prolonged (Bowlby, 1969; 1973). Such symptoms of separation distress are considered normal at a younger age, with peak separation distress occurring between 9 and 13 months and largely declining by the age of three years (Marks, 1987).
A diagnosis of Juvenile Separation Anxiety Disorder (JSAD) on the other hand is made when the child responds with such symptoms excessively, and at a developmentally inappropriate phase, and / or for an extended period of time or the symptoms produce marked interference with the child's functioning. JSAD has been incorporated in DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) and is characterised by an excessive, pervasive fear of physical or emotional separation from primary attachment figures or from places considered "safe," usually the home (Bowlby, 1969; 1973; Gittleman & Klein, 1985).

The aetiology of this disorder is not clear. A genetic contribution has been proposed (Silove, Manicavasagar, O'Connell & Morris-Yates, 1995). It is also suggested that JSAD develops as a result of aberrant parental bonding experiences (Ollendick, Mattis & King, 1990). Factors that may influence the development of separation anxiety disorder include gender (with higher prevalence rates existing for females: Silove & Manicavasagar, 1993), and temperament (Kagan, Reznick, Clarke, Snidman & Garcia, 1984; Kagan, Reznick & Snidman, 1987). Estimates of community prevalence of JSAD in early adolescents are approximately 3.5% (Anderson, Williams, McGee, & Silva, 1987; Bowen, Offord & Boyle, 1990).

The long-term sequelae of JSAD have been the subject of a relatively small body of research. JSAD has been implicated in later difficulties in adult relationships and parenting (Quinton & Rutter, 1984; Rutter & Quinton, 1984). JSAD has also been linked to the later onset of various adult psychiatric difficulties such as symptoms of depression (Yeragani et al, 1989) and anxiety (Flakierska, Lindstrom & Gillberg, 1988;
Flakierska-Praquin, Lindstrom & Gillberg, 1997; Lipsitz et al, 1994; Manicavasagar, Silove, Curtis & Wagner, 2000; Shear, 1996; van der Molen, van den Hout, van Dieren & Griez, 1989).

In further examining the role of JSAD in the development of psychopathology, some have considered its role as a precursor for specific disorders, namely panic disorder – agoraphobia (Klein, 1964) while others have noted that not all people with panic disorder – agoraphobia report a history of juvenile separation anxiety (de Ruiter & van Ijzendoorn, 1992; Silove, Manicavasagar, Curtis, & Blaszczynski, 1996). Some have suggested that juvenile separation anxiety may in fact be a generic precursor for anxiety disorders (Thyer, Nesse, Cameron & Curtis, 1985; Thyer, Nesse, Curtis & Cameron, 1986; Tyrer & Tyrer, 1974) and if confirmed this would have implications for prevention, recognition and management. Whether it influences the course and outcome of established adult anxiety disorder is largely unknown.

It does however appear that in some children, JSAD remits permanently; whether that be as a result of environmental influences, further cognitive development or personality variables is unknown (Berg, Butler & Hall, 1976; Berg & Jackson, 1985). Recent studies have however suggested that juvenile separation anxiety has the potential to continue into adulthood (Manicavasagar & Silove, 1997; Manicavasagar, Silove & Curtis, 1997; Manicavasagar, Silove, Curtis, & Wagner, 2000).

Adult separation anxiety disorder has been proposed as a distinct diagnostic category (Manicavasagar & Silove, 1997; Manicavasagar, Silove & Curtis, 1997). The symptoms include intense fears of separation from close attachment figures (Coolidge,
Brodie & Feeney, 1964; Klein, Zitrin, Woerner & Ross, 1983). Other features include severe anxiety about harm befalling these attachment figures. These symptoms of adult separation anxiety disorder are said to only differ from those of juvenile separation anxiety disorder in relation to the developmental changes associated with maturation (Manicavasagar, Silove & Curtis, 1997). The description of adult separation anxiety disorder is quite recent and its impact on the severity of psychopathology and its treatment outcomes is largely unexplored.

Given the gaps in research into the putative relationship between separation anxiety and anxiety disorder, this study aimed to investigate the effects of juvenile and adult separation anxiety on outcomes of treatment for anxiety and depression in patients with anxiety disorders undertaking an eight week cognitive behavioural group treatment program.
2. Method

2.1 Participants

Participants in this study were consecutive clients attending a specialist anxiety clinic in one publicly funded Area Health Service of New South Wales, Australia. Clients were either referred or contacted the anxiety clinic of their own accord.

Inclusionary criteria for participation in this study were meeting the diagnostic criteria according to the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV, APA, 1994) for a primary anxiety disorder, and an ability to understand English. People with a psychotic disorder were excluded from the study.

2.2 Instruments

The components of the Structured Clinical Interview for the DSM-IV – Clinician Edition (SCID-IV) (First, Spitzer, Gibbon & Williams, 1997) utilised in this study were for the anxiety disorders. This interview was used purely for diagnostic purposes.

The Beck Anxiety Inventory (BAI: see Appendix C) (Beck & Steer, 1993) is a 21-item self-report scale that assesses the common features of anxiety. Responses are rated on a 4-point scale from 0 to 3 with 0 being “Not at All” to 3 being “Severely – I could barely stand it.” Responses are summed to provide a total anxiety score. A total summed score of 0 to 15 indicated minimal or mild anxiety, and 16 or above indicated moderate to severe anxiety (Beck & Steer, 1993). Participants were excluded from the
current study if they had a BAI score less than 16. The BAI has demonstrated satisfactory reliability with high internal consistency (Beck et al, 1988; Fydrich, Dowdall & Chambless, 1990), satisfactory test-retest reliability over one week (Beck et al, 1988) and has satisfactory validity (Beck et al, 1988; Creamer, Foran & Bell, 1995).

The Beck Depression Inventory (BDI: see Appendix C) (Beck, Steer, & Garbin, 1988) is a self-report scale designed to measure the severity of depression in both adolescents and adults. Scores between 0 and 16 indicated minimal to moderate depression whilst a score of 17 or above indicated moderate or severe depression (Beck, Steer, & Garbin, 1988). Therefore, a score of 17 or above was used as a threshold for significant symptomatic depression. The psychometric properties of the BDI have been reviewed extensively (Beck, Steer, & Garbin, 1988; Boyle, 1985; Edwards, Lambert, Moran, McCully, Smith, & Ellington, 1984; Lips & Ng, 1985; Moran & Lambert, 1983; Steer, Beck, Riskind, & Brown, 1986).

The Separation Anxiety Symptom Inventory (SASI: see Appendix C) (Silove, Manicavasagar, O’Connell, Blaszczynski, Wagner & Henry, 1993) is a 15-item scale developed to assess adults’ memories of symptoms of separation anxiety that they had experienced in the first 18 years of life. Scores are summed and then a square root transformation is used to provide a normal distribution.

The SASI has high internal consistency (Cronbach’s alpha ranging from 0.84 to 0.88) (Silove et al, 1993) and satisfactory test-retest reliability (intraclass correlations ranging from 0.86 to 0.98) (Silove et al, 1993). Scores on the SASI have been found to remain consistent over repeated testing in anxiety patients over an average period of 18
months despite varying anxiety and depression scores (Silove et al, 1993). Further validity has been demonstrated by corroborating sibling observer reports, blind clinical interviews by experienced clinicians, and reports of school absenteeism or school anxieties (Silove et al, 1993).

The Adult Separation Anxiety Self-Report Checklist (ASA-CL: see Appendix C) (Manicavasagar, Silove, Curtis & Wagner, 2000) was developed to assess the severity of symptoms of the proposed adult separation anxiety disorder. The 27 items in the scale ask respondents to rate from 0 ("This has never happened") to 3 ("This happens very often") their experience of symptoms of separation anxiety as an adult. The reliability of the ASA-CL is high (Cronbach's alpha: $\alpha = 0.93$; Spearman-Brown split-half reliability: $Y = 0.90$). The ASA-CL was found to be significantly positively correlated with the SASI ($r=0.51$, $p<.001$) (Manicavasagar et al, 2000). The validity of the ASA-CL was established by using DSM-IV criteria-based diagnoses ($k=0.81$) (Manicavasagar et al, 2000).

2.3 Procedure

Consecutive clients who were diagnosed with a primary anxiety disorder and had significant symptomatic anxiety as assessed by the BAI were recruited to the study. Clients who agreed to participate in the study completed the BDI, BAI, SASI and ASA-CL (Time 1). Participants were offered cognitive behavioural group treatment for general anxiety (the stress management group) or for panic disorder (with or without agoraphobia) as appropriate for their diagnosis. Groups consisted of eight weekly cognitive behavioural treatment sessions that were one and a half-hours in duration.
The manuals for the treatment programs were *Panic Disorder: A Treatment Manual* and *Stress Management: A Practical Guide* (see Appendices A and B respectively for outlines of each session for each manual) (Manicavasagar & Blaszczynski, 1995a; 1995b). Approximately 32 treatment groups were run for the participants of this research. During the last session of the eight-week program participants again completed the BDI and BAI (Time 2).

### 2.4 Statistical Analyses

Statistical analyses were completed using the Statistical Program for Social Sciences (SPSS). The analyses performed included reliability analyses (Cronbach’s alpha), bivariate correlations and Student’s t-tests.

Initial analyses were to assess for accuracy of data entry, missing values, and the normality of the data and the assumptions of multivariate analysis for this sample. Tabachnick and Fidell’s (1996) guidelines for identifying and managing missing data were followed.

Further analyses conducted were to determine the influence of reported juvenile separation anxiety and adult separation anxiety on psychopathology (anxiety and depression) as assessed at intake and following treatment. Severity of anxiety and depression were assessed pre- and post-treatment. Initially, repeated measures t-tests were conducted to determine the degree to which participants improved. Secondly, it was considered of importance to differentiate between those participants who after treatment were still significantly distressed and those who were not, so scores on the
BAI and BDI were dichotomised according to indicators of psychopathology as recommended by the respective manuals of the BAI and BDI. Student t-tests were conducted to determine whether those who were still significantly distressed post-treatment had elevated levels of juvenile separation anxiety and adult separation anxiety.
3. Results

3.1 Sample Characteristics

A total of 241 people who attended the anxiety clinic were invited to, and agreed to participate in the study. After excluding people who did not complete the questionnaire battery (30 people) or those who did not have a primary diagnosis of an Axis I anxiety disorder (11 people), a sample size of 200 participants was obtained. As the missing data identified in the baseline variables was less than twenty five percent and was random, missing data values were estimated using linear trend at point regression as outlined in Tabachnick and Fidell (1996). A final sample of 154 participants with significant symptomatic anxiety was obtained after excluding subjects who scored less than 16 on the BAI at intake.

The primary diagnoses are shown in Table 1 while the comorbid anxiety diagnoses are reported in Table 2. More than half of the sample (63%) met the DSM-IV criteria for a diagnosis of panic disorder with or without agoraphobia. Sixty two (40%) of the sample of 154 people had a comorbid anxiety diagnosis.
### Table 1: Primary Diagnoses of Sample (N = 154)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder with Agoraphobia</td>
<td>60</td>
<td>39</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder (GAD)</td>
<td>39</td>
<td>25.3</td>
</tr>
<tr>
<td>Panic Disorder without Agoraphobia</td>
<td>37</td>
<td>24</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>13</td>
<td>8.4</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Anxiety Disorder Not Otherwise Specified</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### Table 2: Comorbid Anxiety Diagnoses of Sample (N = 62)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalised Anxiety Disorder</td>
<td>45</td>
<td>29.2</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>8</td>
<td>5.2</td>
</tr>
<tr>
<td>Panic Disorder with or without Agoraphobia</td>
<td>3</td>
<td>4.6</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
The average age of the group was 39.22 years (SD = 13.20; age range of 18 to 78 years). Most participants were born in Australia (74%). Seventy two percent of the sample was female, 67.5% were married or in a de facto relationship, and 20.8% had never been married.

3.2 Internal Reliability

Cronbach’s alphas were determined for the scales used in the study. All instruments used in the study demonstrated satisfactory reliability (Anastasi, 1988: α > .8). The internal reliability of the scales ranged from 0.88 (BAI scale) to 0.94 (ASA-CL scale) and are presented in Table 3 below.

Table 3: Internal Reliability for Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAI</td>
<td>0.88</td>
</tr>
<tr>
<td>BDI</td>
<td>0.89</td>
</tr>
<tr>
<td>SASI</td>
<td>0.91</td>
</tr>
<tr>
<td>ASA-CL</td>
<td>0.94</td>
</tr>
</tbody>
</table>
3.3 Relationship between Separation Anxiety and Symptoms of Anxiety and Depression

The relationships between juvenile separation anxiety, adult separation anxiety, intake levels of depression and intake levels of anxiety were investigated using Pearson correlations. Significant correlations (p<.01) were found between all measures with the exception of the relationship between intake levels of anxiety and juvenile separation anxiety (r=.132, p=.102). All correlations are presented below in Table 4.

### Table 4: Relationship between separation anxiety and pre-treatment anxiety and depression

<table>
<thead>
<tr>
<th></th>
<th>SASI</th>
<th>BAI</th>
<th>BDI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA-CL</td>
<td>.38*</td>
<td>.46*</td>
<td>.54*</td>
</tr>
<tr>
<td>SASI</td>
<td>.13</td>
<td>.31*</td>
<td></td>
</tr>
<tr>
<td>BAI</td>
<td></td>
<td>.49*</td>
<td></td>
</tr>
</tbody>
</table>

*p < .01

3.4 Relationship between Treatment Outcomes and Separation Anxiety

Improvement in psychopathology after the CBT programs was assessed by using repeated measures t-tests to detect any significant improvements in levels of anxiety and depression across all participants. There was a significant difference from pre-treatment to post-treatment (M = 31.93 versus M = 21.80) in level of anxiety (t(153) =10.54, p = .000) and level of depression (M = 23.64 versus M = 14.78) (t(153) = 9.90, p = .000).
Thus, following treatment, levels of anxiety and depression decreased significantly. It was apparent though that despite the statistical significance of the decrease, the mean level of anxiety after treatment remained high as detailed in the BAI manual (Beck & Steer, 1993).

Student t-tests were conducted to determine whether pre-treatment juvenile separation anxiety and adult separation anxiety predicted post-treatment levels of anxiety and depression. Dichotomised post-treatment anxiety and depression scores were used as the group variables in student's t-test of juvenile separation anxiety and adult separation anxiety scores. Those people still significantly depressed post-treatment were found to have higher juvenile separation anxiety scores ($M = 4.05$ versus $M = 3.51$) than those who were not still depressed ($t(152) = -1.98$, $p = .049$) (see Figure 1 below). By contrast, after completion of therapy, there was no significant difference in scores on juvenile separation anxiety between people who were still significantly anxious from those who were not significantly anxious post-treatment.
Further, those who remained significantly depressed post-treatment were also found to have higher adult separation anxiety scores ($M = 45.09$ versus $M = 37.07$) than those who were not still depressed ($t (152) = -2.684, p = .008$) (see Figure 2 below). Again it was found that those who were significantly anxious post-treatment reported higher adult separation anxiety scores ($M = 41.53$ versus $M = 30.53$) than those who were not still anxious post-treatment ($t (152) = -3.57, p = .000$) (see Figure 3 below). Thus whilst juvenile separation anxiety appeared to be associated with a poor treatment outcome only for patients with significant symptoms of depression, adult separation anxiety was associated with a poor outcome from these treatment programs in patients with either symptoms of anxiety or symptoms of depression.
Figure 2: Comparison between Severely Depressed and Not Severely Depressed Participants on Mean Adult Separation Anxiety Scores

![Bar chart showing comparison between Severely Depressed and Not Severely Depressed Participants on Mean Adult Separation Anxiety Scores.]

Figure 3: Comparison between Severely Anxious and Not Severely Anxious Participants on Mean Adult Separation Anxiety Scores

![Bar chart showing comparison between Severely Anxious and Not Severely Anxious Participants on Mean Adult Separation Anxiety Scores.]

4. Discussion

The aim of this study was to explore the role of juvenile separation anxiety and adult separation anxiety in treatment outcome in an adult anxiety disordered population. In this study there was a significant positive relationship between juvenile and adult separation anxiety. This suggests a link in perceived separation anxiety at different developmental time points and lends support to the proposal of continuity between the two entities (Manicavasagar et al., 2000).

Juvenile separation anxiety was found to be significantly, positively correlated with the level of depression at intake. A significant, positive relationship was also found between the reporting of adult separation anxiety symptoms and levels of both depression and anxiety at intake. These lend support the growing body of research into the sequelae of juvenile separation anxiety specifically continuation into adulthood (Manicavasagar & Silove, 1997; Manicavasagar et al., 1997, 1999, 2000; Poulton et al., 2001) and also provides some support for an important role for separation anxiety syndromes not only in current anxiety disorder but also in the severity of symptoms of depression and anxiety. Clearly, these findings need further support as they raise implications firstly, for early intervention in children with JSAD to potentially ameliorate adult psychopathology, and secondly, to modify treatment programs for adult anxiety disorders to take into account the influence of separation anxiety syndromes.
Treatment outcome was analysed using repeated measures t-tests. There was a vast improvement in symptomatology from pre-treatment to post-treatment assessments in people who had significant pre-treatment levels of symptomatic depression and anxiety. This suggests that overall the programs of cognitive behavioural treatment utilised in this study for panic disorder and stress management had a significant impact on both depressed and anxious mood in this sample of anxious participants however not all patients benefited.

Many people who remained significantly depressed following cognitive behavioural treatment reported significantly more juvenile separation anxiety symptoms at intake. Those people who were still significantly anxious or those who remained significantly depressed post-treatment reported more adult separation anxiety symptoms. These outcomes have important implications for treatment programs for anxiety adding further emphasis to the need for specific strategies to address separation anxiety in all its manifestations in these programs.

A major strength of this study was the relatively large sample size. Previous studies have been methodologically flawed due to the use of smaller sample sizes (Rapee, 1997). In order to obtain this large sample size this research was conducted in a busy specialised anxiety clinic. The demographics of the sample in this study were very similar to others described in the literature (Mancini et al, 1999; Swinson, Cox, Kerr, Kuch & Fergus, 1992).

Due to the use of a clinical population, and the associated restricted range of symptom scores, it would be expected that the correlations reported would potentially
be lower than would have been obtained had a community sample been used. As such the findings reported are only generalisable to a clinical population and not to the general community.

One of the major limitations of this study is that the measure of juvenile anxiety was retrospective. Although there are reservations about the use of retrospective data, most researchers do not have the resources to conduct the gold standard, prospective, longitudinal developmental studies required to determine if a relationship between juvenile separation anxiety and adult psychopathology exists. Because of the cross-sectional nature of the pre-treatment correlations, it is not clear if separation anxiety scores influenced depression levels, or if depression levels influenced separation anxiety scores, or both influenced each other. Whilst it is clearly preferable to conduct studies of prospective design, Parker (1989) argues that it is the perception itself of earlier relationships that is of value when considering the course of adult development.

Another potential limitation of this study was the incomplete diagnostic evaluation of disorders at intake. This research could potentially have been improved by investigating, as well as the comorbid anxiety disorders, the comorbid depressive disorders and comorbid personality disorders, which are quite prevalent in anxiety samples. This study did not consider these comorbid disorders any further firstly because these disorders were not central to the study, and secondly, consideration was given to the potential for participant burden.

No general measures of early levels of general anxiety were included. These measures would have been of use to determine whether there existed a general
predisposition to higher levels of neuroticism; thus it is necessary to interpret the reported results with caution.

The decision to perform analyses on the complete sample, rather than diagnosis-specific groups may have prevented some other findings from emerging. Perhaps it would be desirable in future studies to consider more specific samples of a particular diagnosis. This would require much larger samples. It was however reasoned that despite the effect of combining diagnoses, some homogeneity in the sample would still be achieved if it was ensured that the sample consisted only of anxiety disorders. This assumption was made based on the use in this study of a specific diagnostic Axis I group in the DSM-IV (APA, 1994).

The sample was assessed according to the severity of anxiety and depression as opposed to just the diagnosis of anxiety or depression. In so doing it was hoped to address some of the issues identified by Rapee (1997) in his review of research that directly assessed developmental factors in depressed and anxious patients. He considered that the relationship between these factors and psychopathology may be more accurately reflected by the severity rather than just the presence of the psychopathology.

This research only partly supports previous findings about a relationship between juvenile separation anxiety, adult separation anxiety and psychopathology. Of interest is the finding that juvenile separation anxiety and adult separation anxiety were of significance in the levels of depressed affect after cognitive behavioural therapy programs. Adult separation anxiety was also related to levels of anxious
symptomatology and treatment. This finding may contribute to thinking about practices in the treatment of people with anxiety disorders; specifically it may be a potential area that clinicians can target to improve treatment outcome and reduce relapse rates.
5. References


Appendix A

Manualised Treatment for Panic Disorder

The eight week cognitive behavioural group program for panic disorder and agoraphobia is based on a treatment manual, Panic Disorder: A Treatment Manual, authored by Manicavasagar and Blaszczynski (1995) from the Psychiatric Research and Teaching Unit at the University of New South Wales.

Session 1

The first session of the program commences as an introduction to the nature of anxiety and anxiety disorders. It outlines the symptoms of a panic attack including the physical symptoms and provides examples of the thoughts that may occur in a panic attack. It differentiates between ‘normal fear’ and panic attacks. The models of Panic disorder and agoraphobia are outlined. Clients are asked to list situations in which they get very anxious or which they avoid. Clients are provided with a monitoring form to monitor their panic attacks.

Session 2

The second session outlines the role of stress in panic attacks and differentiates between stress, stressors (internal and external) and anxiety. The physical and psychological effects of stress are described and the methods that people use to cope with stress are listed. The mind-body relationship is discussed in order to provide a
rationale for maintaining good physical health when coping with stress. Areas of physical health targeted include sleep (with sleep hygiene techniques outlined), exercise, nutrition and relaxation. Clients are asked to list activities that they find relaxing and to identify the frequency with which they engage in these activities. To further the physical component of the mind-body relationship, the “Stress Response” is described so that people can understand the fight or flight response and that individual differences in stress thresholds exist. Clients are provided with instruction on progressive muscle relaxation and are encouraged to monitor their progressive muscle relaxation practice using supplied self-monitoring forms.

Session 3

This session aims to provide practical information on managing panic symptoms and panic attacks. It begins by introducing clients to the role of overbreathing (or hyperventilation) in panic attacks and further explains this in the context of the fight or flight response. Possible causes of hyperventilation are identified and the physical responses to overbreathing are listed. The symptoms of hyperventilation as a trigger for thoughts that one is having a panic attack are discussed. Instruction is given on managing hyperventilation by either using a slow-breathing technique or by using the paper bag technique. Distraction techniques are identified as is the role of medication in the management of panic attacks. Clients are provided with examples of combining techniques described in the session to manage a panic attack or panic symptoms.
Session 4

The focus of session four is on identifying irrational thoughts as the first step in understanding the relationship between irrational thinking styles, panic attacks and anxiety. As an introduction to the cognitive component of therapy for panic disorder, the Activating Situation-Belief-Consequences (A-B-C) model of irrational thinking is described in detail. Possible irrational thoughts that may occur are identified and the definition of automatic thoughts is provided. Clients are provided with a description of the different types of irrational thinking and are asked to identify some of their own irrational thoughts. The role of irrational thinking in anxiety is delineated. Clients are further encouraged to explore their own irrational thoughts by recollecting a situation in which they had experienced a number of irrational thoughts when anxious or afraid. The different types of cognitive distortions, as identified by Albert Ellis, are listed with examples. Clients are encouraged to become more aware of their irrational thoughts and the types and patterns of thoughts that they are displaying.

Session 5

Session five builds on the previous session by providing strategies for challenging irrational thoughts. The relationship between thoughts, feelings and behaviour is explained, specifically the relationship between irrational thoughts, emotions, and anxiety and depression. Clients are asked to identify a situation that they find difficult. They are then asked to list the irrational thoughts they have in this situation as well as their feelings and their behaviour when they have these thoughts.
Following this exercise clients are provided with strategies for challenging irrational thoughts including questioning the evidence for their thoughts, asking others about their perception of the situation and considering other alternatives for interpreting the same situation. Practical techniques for stopping irrational thoughts, namely thought-stopping and distraction techniques are explained. Clients are encouraged to challenge the irrational thoughts that they had identified earlier in the session.

Session 6

This session introduces strategies for changing irrational thoughts held by the individual. Automatic thoughts are explained in more detail with the emphasis on the role of automatic thoughts in the triggering and maintaining of a panic attack. Clients are actively instructed on identifying anxiety-provoking situations and the irrational thoughts associated with them and then challenging these irrational thoughts. The substitution of realistic thoughts for irrational thoughts is done by assessing the degree to which the client believes the original irrational thought to be true and then by using examples of realistic self-statements. One technique encouraged is to use another person as a point of reference to assist the client to generate their own self-statements, that is, clients are encouraged to consider someone who they consider to be quite optimistic and to imagine that person's interpretation of the same situation that the client is negatively evaluating. The relationship between self-esteem and realistic thoughts is considered in relation to the vulnerability of people who have been anxious or depressed for a long period of time and who are holding irrational thoughts about themselves. Clients are prompted to identify a list of things about themselves
(behaviour, personality or physical appearance) that they like and a list of things about themselves that they would like to change.

Session 7

The focus of session seven is to apply the anxiety management techniques outlined thus far to situations identified as anxiety-provoking by the participant. In particular the client is asked to consider the anxiety-provoking situations they identified in the first session. Clients are asked to list the anxiety-provoking situations again but this time to rate them from zero to ten with ten being the highest level of anxiety and zero being no anxiety. Clients are assisted to develop a graded hierarchy of situations. Clients are reminded of the anxiety management techniques outlined in the course thus far and are encouraged to utilise these techniques to assist them to work through their graded hierarchy. Techniques for challenging the irrational thoughts associated with their anxiety are also explicated again so that the client can use both physical and psychological techniques to assist them as they progress through their hierarchy of situations.

Session 8

The final session of the program involves a review of client’s progress with their graded hierarchy as well as a discussion about relapse and relapse prevention. The fact that relapses may occur and should not be interpreted catastrophically is explained as are the possible reasons for these relapses. Techniques for preventing relapses are
outlined. At this point clients are administered the BAI, BDI and SES and are reminded about the two-month follow-up session.

Two-Month Follow-up Session

Clients are mailed a package containing the BAI and BDI prior to the session where they return to the clinic for this follow-up session. In this session the main themes of the group program are revisited. Individual goals that participants set in Session 8 are discussed and achievements or problems are addressed. Maintenance issues are discussed and questions such as those regarding continuance of medication are also addressed.

The follow-up session also reinforces the cognitive-behavioural model as well as revisiting the concept of relapse prevention. Those people who appear to be experiencing a relapse are placed back in the system for further management.

Those people who did not attend the follow-up session or who forgot their follow-up questionnaires are written to and are asked to either mail the completed questionnaires back to the clinic, or if they prefer, to bring them into the clinic.
Manualised Treatment for Stress Management

The eight week cognitive behavioural group program for stress management is based on a treatment manual, *Stress Management: A Practical Guide*, authored by Manicavasagar and Blaszczynski (1995) from the Psychiatric Research and Teaching Unit at the University of New South Wales.

Session 1

Session One of this treatment program involves an introduction to anxiety and anxiety disorders, provides an outline of the anxiety disorders and differentiates these disorders from "normal fear." Clients are asked to identify anxiety-provoking situations. The concepts of stress, stressors (internal and external) and anxiety are delineated. This is followed by a listing of the physical and psychological symptoms of stress as well as positive and negative strategies for coping with stress. The Yerkes-Dodson Law, which explains the relationship between performance and arousal level, is explained to provide clients with an understanding of the difference between harmless and harmful levels of stress in terms of the critical threshold for arousal level.

Session 2

The purpose of this session is to provide clients with strategies to maintain their physical health. The rationale for this is provided with an explanation of the mind-body
connection and the consequences of poor physical health on mental health, specifically irrational thoughts and anxiety. Components of physical health targeted in this session include sleep (sleep hygiene techniques are explained), exercise, nutrition and relaxation. In the relaxation component clients list some activities that they find relaxing and identify the frequency in which they engage in these activities. The stress response is also considered in this session. The notion of the ‘fight or flight’ response is again described. In addition, clients are given instruction on progressive muscle relaxation and an audiotape with a progressive muscle relaxation exercise, which they are encouraged to practice daily.

Session 3

The aim of session three is to provide clients with some practical information about goal setting and time management in order to assist in the management of stress. The rationale for goal setting is presented and clients are encouraged to identify long-term, medium term and short term goals in the realms of personal goals, occupational goals and social / family goals. Following this goal-setting task clients are encouraged to set daily goals in each of the three realms in order to learn the strategy of prioritising tasks. In this goal setting exercise clients are given instruction on how to prioritise tasks and set realistic daily goals by estimating time required to complete each task. Clients are then introduced to unhelpful and helpful problem-solving strategies. Clients are provided with detailed instruction on structured problem-solving techniques and how to evaluate the effectiveness of the problem-solving strategies that they employ.
Session 4

Session four introduces clients to the cognitive therapy component of the treatment program. In this session they are informed about the Activating Situation – Beliefs – Consequences (ABC) model of irrational thinking. In doing so clients are encouraged to identify their own irrational thoughts and to consider their perception of the relationship between the activating situation and consequences and the mediating role of their beliefs. Different types of cognitive distortions, based on the work of Albert Ellis, are explicated and clients are asked to contemplate their own thinking style and identify their cognitive distortions.

Session 5

This session involves clients learning to challenge their irrational thoughts. The relationship between thoughts, feelings and behaviour is explained so that clients are provided with a clear rationale as to why thoughts are being targeted in therapy. Clients are encouraged to identify some of the irrational thoughts they hold. Clients are taught to challenge their irrational thoughts by firstly questioning the evidence for their thoughts. They are also provided with other methods of challenging their thoughts such as asking other people about their perception of the same situation, and by considering the other ways in which the situation can be interpreted before fixating on an irrational conclusion. Other techniques to prevent clients from ruminating about their irrational thoughts are introduced. These include thought-stopping techniques where an imaginal exercise is used in combination with self-talk. Another strategy used is distraction.
Towards the conclusion of the session clients are asked to attempt to challenge the irrational thoughts they identified earlier in the session.

Session 6

The aim of session six is to get clients to challenge and then change their irrational thoughts. Clients are introduced to the concept of automatic thoughts and are encouraged to substitute their irrational thoughts for more realistic thoughts. This substitution of realistic for irrational thoughts are structured such that clients understand each component of the exercise. Examples of realistic thoughts are provided with clients encouraged to develop their own list of realistic thoughts. In order to assist clients further with this component of the therapy, they are encouraged to imagine that they are giving someone in their situation advice or to use a more optimistic person as a point of reference. To encourage clients to think more realistically they are taught about self-esteem and the role of low self-esteem in maintaining irrational thoughts and thus distress. Clients are asked to generate a list of things that they like about themselves, and things that they would like to change. In these lists clients should consider their behaviour, their personality or their physical appearance.

Session 7

Session seven encourages clients to combine the numerous techniques that they have learnt thus far in the treatment program. It begins by asking clients to develop a graded hierarchy of anxiety-provoking situations. In facing these situations the use of the stress management techniques taught thus far is emphasised. Clients are taught to
plan the events that will happen when facing each of their anxiety-provoking situations such that when they are faced with the situation there are a number of strategies, physiological and psychological, they can employ to assist them in achieving success in this confronting exercise. The importance of practice and making sure that clients have reduced their anxiety in each situation as they progress through their hierarchy is emphasised.

Session 8

This session evaluates the success of clients in practicing their stress management techniques in their identified anxiety-provoking situation. It mainly addresses the issue of relapse and relapse prevention. It normalises the fluctuations in the experience of symptoms during recovery and it identifies factors that increase the risk for relapse. At this point, the BAI, BDI and SES are administered and clients are reminded about the two-month follow-up session. In addition a list of further useful references are provided should clients want access to more resources.

Two-Month Follow-up Session

Clients are mailed a package containing the BAI and BDI prior to the session where they return to the clinic for this follow-up session. In this session the main themes of the group program are revisited. Individual goals that participants set in Session 8 are discussed and achievements or problems are addressed. Maintenance issues are discussed and questions such as those regarding continuance of medication are also addressed.
The follow-up session also reinforces the cognitive-behavioural model as well as revisiting the concept of relapse prevention. Those people who appear to be experiencing a relapse are placed back in the system for further management.

Those people who do not attend the follow-up session or who forgot their follow-up questionnaires are written to and asked to either mail the completed questionnaires back to the clinic, or if they prefer, to bring them into the clinic.
Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Numbness or tingling.  
2. Feeling hot.  
3. Wobbliness in legs.  
4. Unable to relax.  
5. Fear of the worst happening.  
6. Dizzy or lightheaded.  
7. Heart pounding or racing.  
8. Unsteady.  
11. Feelings of choking.  
14. Fear of losing control.  
15. Difficulty breathing.  
17. Scared.  
18. Indigestion or discomfort in abdomen.  
19. Faint.  
20. Face flushed.  
21. Sweating (not due to heat).
This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I do not feel sad.</td>
</tr>
<tr>
<td>0</td>
<td>I feel sad.</td>
</tr>
<tr>
<td>1</td>
<td>I am sad all the time and I can't snap out of it.</td>
</tr>
<tr>
<td>2</td>
<td>I am so sad or unhappy that I can't stand it.</td>
</tr>
<tr>
<td>3</td>
<td>I am not particularly discouraged about the future.</td>
</tr>
<tr>
<td>4</td>
<td>I feel discouraged about the future.</td>
</tr>
<tr>
<td>5</td>
<td>I feel that the future is hopeless and that things cannot improve.</td>
</tr>
<tr>
<td>6</td>
<td>I do not feel like a failure.</td>
</tr>
<tr>
<td>7</td>
<td>I feel I have failed more than the average person.</td>
</tr>
<tr>
<td>8</td>
<td>As I look back on my life, all I see is a lot of failures.</td>
</tr>
<tr>
<td>9</td>
<td>I feel I am a complete failure as a person.</td>
</tr>
<tr>
<td>10</td>
<td>I get as much satisfaction out of things as I used to.</td>
</tr>
<tr>
<td>11</td>
<td>I don't enjoy things the way I used to.</td>
</tr>
<tr>
<td>12</td>
<td>I don't get real satisfaction out of anything anymore.</td>
</tr>
<tr>
<td>13</td>
<td>I am dissatisfied or bored with everything.</td>
</tr>
<tr>
<td>14</td>
<td>I don't feel particularly guilty.</td>
</tr>
<tr>
<td>15</td>
<td>I feel guilty a good part of the time.</td>
</tr>
<tr>
<td>16</td>
<td>I feel guilty most of the time.</td>
</tr>
<tr>
<td>17</td>
<td>I feel guilty all of the time.</td>
</tr>
<tr>
<td>18</td>
<td>I don't feel I am being punished.</td>
</tr>
<tr>
<td>19</td>
<td>I feel I may be punished.</td>
</tr>
<tr>
<td>20</td>
<td>I expect to be punished.</td>
</tr>
<tr>
<td>21</td>
<td>I feel I am being punished.</td>
</tr>
<tr>
<td>22</td>
<td>I don't feel disappointed in myself.</td>
</tr>
<tr>
<td>23</td>
<td>I am disappointed in myself.</td>
</tr>
<tr>
<td>24</td>
<td>I am disgusted with myself.</td>
</tr>
<tr>
<td>25</td>
<td>I hate myself.</td>
</tr>
<tr>
<td>26</td>
<td>I don't feel I am any worse than anybody else.</td>
</tr>
<tr>
<td>27</td>
<td>I am critical of myself for my weaknesses or mistakes.</td>
</tr>
<tr>
<td>28</td>
<td>I blame myself all the time for my faults.</td>
</tr>
<tr>
<td>29</td>
<td>I blame myself for everything bad that happens.</td>
</tr>
<tr>
<td>30</td>
<td>I don't have any thoughts of killing myself.</td>
</tr>
<tr>
<td>31</td>
<td>I have thoughts of killing myself, but I would not carry them out.</td>
</tr>
<tr>
<td>32</td>
<td>I would like to kill myself.</td>
</tr>
<tr>
<td>33</td>
<td>I would kill myself if I had the chance.</td>
</tr>
<tr>
<td>34</td>
<td>I don't cry any more than usual.</td>
</tr>
<tr>
<td>35</td>
<td>I cry more now than I used to.</td>
</tr>
<tr>
<td>36</td>
<td>I cry all the time now.</td>
</tr>
<tr>
<td>37</td>
<td>I used to be able to cry, but now I can't cry even though I want to.</td>
</tr>
<tr>
<td>38</td>
<td>I am no more irritated now than I ever was.</td>
</tr>
<tr>
<td>39</td>
<td>I get annoyed or irritated more easily than I used to.</td>
</tr>
<tr>
<td>40</td>
<td>I feel irritated all the time now.</td>
</tr>
<tr>
<td>41</td>
<td>I don't get irritated at all by the things that used to irritate me.</td>
</tr>
<tr>
<td>42</td>
<td>I have not lost interest in other people.</td>
</tr>
<tr>
<td>43</td>
<td>I am less interested in other people than I used to.</td>
</tr>
<tr>
<td>44</td>
<td>I have lost most of my interest in other people.</td>
</tr>
<tr>
<td>45</td>
<td>I have lost all of my interest in other people.</td>
</tr>
<tr>
<td>46</td>
<td>I make decisions about as well as I ever could.</td>
</tr>
<tr>
<td>47</td>
<td>I put off making decisions more than I used to.</td>
</tr>
<tr>
<td>48</td>
<td>I have greater difficulty in making decisions than before.</td>
</tr>
<tr>
<td>49</td>
<td>I can't make decisions at all anymore.</td>
</tr>
</tbody>
</table>
I don't feel I look any worse than I used to.
I am worried that I am looking old or unattractive.
I feel that there are permanent changes in my appearance that make me look unattractive.
I believe that I look ugly.

I can work about as well as before.
It takes an extra effort to get started at doing something.
I have to push myself very hard to do anything.
I can't do any work at all.

I can sleep as well as usual.
I don't sleep as well as I used to.
I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
I wake up several hours earlier than I used to and cannot get back to sleep.

I don't get more tired than usual.
I get tired more easily than I used to.
I get tired from doing almost anything.
I am too tired to do anything.

My appetite is no worse than usual.
My appetite is not as good as it used to be.
My appetite is much worse now.
I have no appetite at all anymore.

I haven't lost much weight, if any, lately.
I have lost more than 5 pounds.
I have lost more than 10 pounds.
I have lost more than 15 pounds.
I am purposely trying to lose weight by eating less. Yes ______ No ______

I am no more worried about my health than usual.
I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
I am worried about physical problems and it's hard to think of much else.
I am so worried about my physical problems that I cannot think about anything else.

I have not noticed any recent change in my interest in sex.
I am less interested in sex than I used to be.
I am much less interested in sex now.
I have lost interest in sex completely.

My appetite is no worse than usual.
My appetite is not as good as it used to be.
My appetite is much worse now.
I have no appetite at all anymore.

Subtotal Page 2
Subtotal Page 3
Total Score
RETROSPECTIVE DIAGNOSIS OF JUVENILE SEPARATION ANXIETY DISORDER

Juvenile separation anxiety is characterized by developmentally inappropriate and excessive anxiety concerning separations from home or from those to whom the individual is attached. Subjects need to fulfill criteria for three or more of the following symptoms, the onset of which has to have been before the age of 18 years:

(1) recurrent excessive distress when separated from home or major attachment figures occurs or is anticipated;

(2) persistent and excessive worry about losing, or about possible harm befalling major attachment figures;

(3) persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g. getting lost or being kidnapped);

(4) persistent reluctance or refusal to go to school or elsewhere because of fear of separation;

(5) persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in settings;

(6) persistent reluctance or refusal to go to sleep without being near a major attachment;

(7) repeated nightmares involving the theme of separation;

(8) repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separated from major attachment figures occurs or is anticipated.

Note that the duration of the disturbance (not individual symptoms) has to be not less than 4 weeks.
The following statements refer to symptoms that you might have experienced as an adult (over the age of 18 years). Please tick the appropriate brackets for each item, according to whether you have experienced any of these symptoms. Please remember to answer all questions.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Very Often</th>
<th>Fairly Often</th>
<th>Occasionally</th>
<th>Never Happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you felt more secure at home when you are with people that are close to you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
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</tr>
<tr>
<td>2</td>
<td>Have you experienced difficulty in staying away from home for several hours at a time?</td>
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<tr>
<td>3</td>
<td>Have you been carrying around something in your purse or wallet that gives you a sense of security or comfort?</td>
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<tr>
<td>4</td>
<td>Have you experienced extreme stress before leaving home to go on a long trip?</td>
<td>( )</td>
<td>( )</td>
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</tr>
<tr>
<td>5</td>
<td>Have you suffered from nightmares or dreams about being separated from someone close to you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>6</td>
<td>Have you experienced extreme stress before leaving someone close to you when going away on a trip?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
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<tr>
<td>7</td>
<td>Have you become very upset when your daily routine is disrupted?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>8</td>
<td>Have you been worried about the intensity of your relationship with people close to you e.g. that you are too strongly attached?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
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<tr>
<td>9</td>
<td>Have you experienced symptoms such as headaches, stomach-aches or nausea (or other) before leaving for work or other regular activity outside the home?</td>
<td>( )</td>
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</tr>
<tr>
<td>10</td>
<td>* Do you find that you talk a lot in order to keep people close to you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>11</td>
<td>Have you been especially concerned about where people close to you are going when you are separated from them, eg when you leave them to go to work or go out of the house?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
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</tr>
<tr>
<td>12</td>
<td>Have you experienced difficulty in sleeping alone at night eg is sleep better if someone is closer to you in the house?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>14</td>
<td>Have you become very distressed when thinking about being away from people that are close to you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>15</td>
<td>Have you suffered from nightmares or dreams about being away from home?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>16</td>
<td>Have you been worrying a lot about people close to you coming to serious harm eg meeting with a care accident, or suffering from a fatal illness?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>17</td>
<td>Have you become very upset with changes to your usual daily routine if they interfere with your contact with persons close to you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>18</td>
<td>Have you been worrying a lot about people you care about leaving you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>This happens very often</td>
<td>This happens fairly often</td>
<td>This happens occasionally</td>
<td>This has never happened</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
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<td>----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>19</td>
<td>Have you found that you sleep better if the lights are on in the house or in the bedroom?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>20</td>
<td>Have you tried to avoid being at home alone especially when people close to you are out?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>21</td>
<td>Have you suffered from sudden bouts of anxiety or panic attacks (eg sudden shaking, sweating, shortness of breath, pounding heart) when thinking about leaving people close to you or about them leaving you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>22</td>
<td>Have you found that you get anxious if you do not speak to people that are close to you on the telephone regularly, eg daily?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>23</td>
<td>Have you been afraid that you would not be able to cope or could not go on if someone you cared about left you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>24</td>
<td>Have you suffered from sudden bouts of anxiety or panic attacks (eg sudden shaking, sweating, shortness of breath, pounding heart) when separated from people close to you?</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>25</td>
<td>Have you been worrying a lot about possible events that may separate you from those close to you eg because of work requirements?</td>
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<tr>
<td>26</td>
<td>*Have people close to you mentioned that you “talk a lot”?</td>
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</tr>
<tr>
<td>27</td>
<td>Have you been worrying that your relationships with some people are so close that it may cause them problems?</td>
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</tbody>
</table>