Should OCD Be Recognized as a Differential Diagnosis for Separation Anxiety Disorder?

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There are topographical similarities between separation anxiety disorder (SAD) and certain forms of obsessive-compulsive disorder (OCD), particularly in terms of excessive, persistent, and recurrent fears of losing a major attachment figure and/or harm befalling a loved one. The DSM-5 (APA, 2013) included anxiety disorders as a differential diagnosis for OCD. However, OCD is not listed as a differential diagnosis for SAD. This discrepancy is concerning for different reasons. First, OCD and the OC spectrum disorders (e.g., trichotillomania, excoriation disorder, body dysmorphic disorder) have now been independently classified in the DSM-5 away from anxiety disorders (Regier, Kuhl, & Kupfer, 2013). As such, it is inconsistent that OCD is not listed as a rule-out for SAD. Second, the differential diagnosis section of the DSM-5 is intended to be helpful in guiding diagnostic decisions in clinical and/or research settings. Without a comprehensive reference of rule-out diagnoses, misdiagnosis can occur, to the detriment of treatment effectiveness and reliable research.

In this article, we compared diagnostic features of SAD and certain forms of OCD, and discussed a case example, in order to explore whether OCD should be recognized as a differential diagnosis for SAD. Our approach is consistent with functional analysis (Holman, Rohl, & Andover, 2017), which involves determining antecedent internal and external events that precede target behaviors, as well as the consequences of those behaviors (for a case example, see May et al., 2008).

Diagnostic Features of SAD

According to the DSM-5 (APA, 2013), SAD is characterized by excessive, developmentally inappropriate fear or anxiety about being separated from the home or major attachment figures (for children, typically the parent[s]; for adults, typically the spouse or a close friend) that causes clinically significant distress or functional impairment. Individuals with SAD experience distress with actual or anticipated separation. They worry about harm or death occurring to their loved ones, and feel the need to stay in contact with them. They also worry about untoward events occurring to themselves that would keep them from reuniting with their loved ones. These worries are linked to the core fear of separation from and abandonment by attachment figures (see Krain, Hudson, Coles, & Kendall, 2002).

Typically accompanying this fear are ritualistic checking and reassurance-seeking behaviors (Blunden & Nair, 2009; Phillips & Wolpe, 1981). Individuals with SAD may be reluctant or refuse outright to enter or stay in settings independently. There may also be repeated nightmares about separation from attachment figures, and unpleasant somatic symptoms. SAD can be diagnosed in children and adolescents if these symptoms last for at least 4 weeks. SAD is often perceived as a childhood disorder because most symptoms remit with age (Shear, Jin, Ruscio, Walters, & Kessler, 2006). However, SAD can also be diagnosed in adults if symptoms persist for at least 6 months (i.e., Criterion B; APA, 2013, p. 191).

These clinical characteristics of SAD are well-documented in the literature (for reviews, see Bügels, Knappe, & Clark, 2013; Vaughan, Coddington, Ahmed, & Ertel, 2017). Kossowsky, Wilhelm, Roth, and Schneider (2012) found that children with SAD reported elevated anxiety and demonstrated increased sympathetic reactivity, specifically in response to separation from their attachment figures (in all cases, the mother), compared with children with other anxiety disorders and nonclinical controls. Pini et al. (2012) showed that adult psychiatric outpatients who have suffered bereavement reported elevated levels of complicated grief reactions if they also had a primary diagnosis of SAD (as opposed to mood disorders or other anxiety disorders). These findings were discussed in the context of the fear of a significant disruption in an attachment relationship, or, in other words, fear of abandonment by attachment figures.

The functional consequences of SAD can be severe, often as a result of avoidance or safety behaviors that reinforce separation fears. There is limited engagement in independent activities away from the home or attachment figures (e.g., school refusal, or remote employment, if at all; Manicasagar & Silove, 1997). At home, restrictions may be imposed on how often/long attachment figures are away from their loved ones. These accommodation behaviors can paradoxically exacerbate symptoms (Lebowitz et al., 2013), leading to academic/occupational difficulties, social isolation, and familial stress and conflict (Masi, Mucci, & Millepiedi, 2001).

Diagnostic Features of OCD and Overlap With SAD

OCD is defined in the DSM-5 by the presence of distressing obsessions, and/or behavioral and mental compulsions, typically performed to neutralize the obsessions themselves and/or the induced anxiety (APA, 2013). OCD can be functionally impairing, due to the inordinate time consumed by symptoms, and dysfunctional avoidance of triggering situations/stimuli. Therefore, shame, strained interpersonal relationships, social isolation, and an overall reduction in quality of life can similarly result (Ruscio, Stein, Chiu, & Kessler, 2010; Singh, Wetterneck, Williams, & Knott, 2016). If left untreated, OCD can be chronic, with waxing and waning of symptoms (Ruscio et al., 2010).

OCD overlaps topographically with SAD in several ways. Obsessive fears and separation anxiety are functionally linked to compulsions and separation-prevention behaviors (and avoidance behaviors), respectively, in a negatively reinforcing manner (Gillan et al., 2014; Starcevic et al., 2011). Family accommodation is a symptom maintenance factor common to both (and other anxiety) disorders too (Storch et al., 2007; Strauss, Hale, & Stobie, 2015).
Because the processes of negative reinforcement and family accommodation of symptoms are common to both SAD and OCD, they obscure differential diagnosis, if just attending to behavioral observations. Furthermore, SAD can be diagnosed in adults with nonparental attachment figures (e.g., spouse). Thus, neither the patient’s age nor type of attachment figure are useful for differentiating between diagnoses.

Harm OCD Versus SAD

OCD can manifest in several symptom dimensions, such as contamination concerns, harm occurring to the self or others, violent, sexual, or religious/immoral concerns, and symmetry/ordering or “just-right” concerns (Williams, Mugno, Franklin, & Faber, 2013). Particularly, individuals with OCD involving egodystonic concerns about harm occurring to themselves or their loved ones (i.e., harm OCD) can present compulsive harm avoidance behaviors topographically similar to SAD.

In harm OCD, however, there is typically an inflated sense of responsibility for causing harm, accompanied by excessive doubt/uncertainty about harm occurring (McKay et al., 2004), or even distorted beliefs about thoughts increasing the likelihood of harm (i.e., thought-action fusion [TAF]; Berle & Starcevic, 2005; Shafran & Rachman, 2004; for children with OCD, see Barrett & Healy, 2003). In fact, harm avoidance (specifically, the avoidance of feeling responsible for harm) has been shown to be a strong motivational factor for compulsions in OCD (e.g., Ecker & Gönner, 2008; Pietrefesa & Coles, 2009), which is distinct from the core fear of separation and abandonment in SAD (Kramp et al., 2002). Individuals with harm OCD engage in compulsive checking behaviors, excessive reassurance-seeking, and other verbal or mental rituals topographically similar to separation-prevention behaviors in SAD. For example, children with harm OCD can also impose rigid and unreasonable rules within the home and demand constant physical proximity to their parents (Wu & Storch, 2016). However, individuals with harm OCD irrationally believe that by performing these rituals, they will prevent harm from happening to themselves and others. Research shows that the greater the level of perceived responsibility for preventing harm, the more time-consuming rituals become (Bucarelli & Purdon, 2016). The main function of harm-prevention compulsions in OCD therefore involves the reduction of anxiety stemming from perceived responsibility for safety (Kobori, Salkovskis, Read, Lounes, & Wong, 2012), even though compulsions in harm OCD tend to backfire by paradoxically reinforcing and increasing doubt about the checking (Woods, Vevea, Chambless, & Bayen, 2002). More importantly, harm OCD does not necessarily stem from fears of abandonment characteristic of SAD. In fact, Cooper-Vince, Emmert-Aronson, Pincus, and Comer (2014) found that separation distress and fear of being alone without major attachment figures (i.e., fear of abandonment) best discriminated children with severe SAD symptoms from those with mild SAD symptoms. However, worry about harm befalling attachment figures was the poorest discriminative factor. This implies that uncovering the core fears of abandonment versus responsibility for harm might best discriminate between SAD and harm OCD.

When weighing the differential diagnosis between OCD and SAD, it would help for clinicians to consider the following question: “Are there differences in the function(s) and goal(s) of worries and behaviors in SAD and compulsions in OCD?” To improve diagnostic accuracy, clinicians should carefully examine the precise function(s) of behaviors that accompany the client’s presenting concerns. In the following, we demonstrate differentiation between harm OCD and SAD with a detailed case example.

Case Example

Finn was a 13-year-old non-Hispanic White male who was referred for therapy with one of the authors in a specialized OCD treatment clinic in the Midwest by his parents for concerns related to anxiety and repetitive behaviors. Finn had no history of neurodevelopmental disorders. Finn was accompanied by his mother for all sessions. According to her report, Finn was anxious throughout childhood and would worry excessively and become frightened when separated from her. His school attendance was consistent until the sixth grade when there was a gradual increase in worries and a sense of urgency to be close to his mother. He would often scream in class, tense his muscles, jerk his body, and spend most of his class time in the school counselor’s office, anxiously waiting for his mother to leave work to pick him up. His mother eventually decreased her hours at work and removed Finn from school permanently. His mother reported that he no longer slept in his bedroom at night; instead, he would sleep on a small mattress at the end of his parents’ bed to be close to his mother.

Finn’s symptoms in sessions included pressured speech, panic-like symptoms, screaming, hyperawareness of his mother’s location in the room, unusual body contortion and jerking movements, muscle tensing, and frequent reassurance-seeking behaviors. Eye contact with the therapist was infrequent, as Finn tended to look downward, hide under a blanket, or gaze in his mother’s direction. In sessions, Finn would often want to be close to his mother in ways that were developmentally atypical. For example, despite his mother’s protests, Finn would sometimes press his forehead against hers, and hold her cheeks in the palms of his hands. He would also sometimes get onto her lap or cover her in his blanket while the therapist was asking questions. In sessions, Finn often looked in his mother’s direction to answer questions. Occasionally, Finn elected to discuss fears with his mother in the therapist’s presence, but not directly to the therapist. He expressed fears about something bad happening to his mother, and therefore needed to stay with her at all times. Finn would frequently ask his mother if she loves him and for her to promise that they will be safe, telling her that he was scared and wanting reassurance that she would not leave his sight. Despite these frequent reassurances, Finn would ask her to repeat them, becoming more anxious while awaiting each reply. Finn’s anxiety and disruptive behaviors (e.g., screaming, flailing on the ground, storming in and out of the therapy room, hiding under couches, blankets, and chairs while calling out for his mother) worsened with repeated assurances over time, more so when his mother, as instructed by the therapist, withheld reassurance about his fears of separation. It became apparent that the function of Finn’s disruptive behaviors was to increase the frequency of reassurances by his mother about her safety.

Achieving Differential Diagnosis in Finn’s Case

The OCD-SAD differential diagnosis may be challenging in children because they tend to have less well-formed and well-articulated obsessions, making the function of compulsive rituals and avoidance behaviors potentially difficult to decipher (Geller et al., 2001). Indeed, there was significant overlap between OCD and SAD symptoms in Finn’s case. On the Separa-
tion Anxiety module of the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1997), Finn endorsed sufficient criteria to screen positive for a diagnosis of SAD. Finn’s excessive fear of separation from his mother seemed to fulfill at least three symptoms listed under Criterion A in the DSM-5 for SAD: (1) recurrent excessive distress when anticipating separation from major attachment figure; (2) persistent and excessive worry about harm coming to a major attachment figure; (3) persistent reluctance to go out or to be alone; and (4) reluctance or refusal to sleep without being near a major attachment figure. Finn also met Criteria B (i.e., symptoms of separation fear lasting at least 4 weeks) and C (i.e., clinically significant distress and functional impairment across settings as a result of his symptoms).

The therapist considered several pieces of evidence in making the differential diagnosis of OCD, instead of SAD. First, self- and parent-report responses on several intake measures suggest the possibility of OCD as an alternative framework for understanding Finn’s presenting symptoms. On the Children’s Yale-Brown Obsessive-Compulsive Scale checklist (CY-BOCS; Schallil et al., 1997), Finn endorsed primary obsessions of harm occurring to his mother, accompanied by primary compulsions involving reassurance-seeking from his mother about her safety, and several other repetitive behavioral and mental acts. Finn also reported a CY-BOCS total severity score of 30 (“severe” range). On the parent-report version of the Spence Children’s Anxiety Scale (SCAS-P; Nauta et al., 2004), Finn’s mother reported that he would “often” or “always” be bothered by “bad thoughts in his head,” and “has to do certain things in just the right way to stop bad things from happening.” Additionally, on the parent-report version of the Family Accommodation Scale for OCD (FAS-PR; Flessner et al., 2009), Finn’s mother endorsed several accommodative behaviors toward Finn’s compulsions (e.g., providing reassurance whenever asked, helping him complete his behavioral rituals, modifying family responsibilities around his symptoms, etc.). Although family accommodation is also common in SAD (as discussed above), these responses provided a more comprehensive picture of how Finn’s disordered behaviors were negatively reinforced in the family.

With the help of these assessment data, the therapist became cognizant of the topographical overlap in symptoms of OCD and SAD that were highly descriptive of Finn’s presentation. As such, the therapist probed deeper into Finn’s core underlying fears, which mainly focused on being wholly responsible for his mother’s safety (e.g., “What if something bad happens to my mom that I could have stopped?”), as is typical of harm OCD, as opposed to the core fears of abandonment that are more typical of SAD. Upon further inquiry into the functions of Finn’s compulsions, the therapist was also able to determine that his compulsive rituals (e.g., making bids for reassurance from his mother; mentally reviewing interactions with her to ensure that no harm has occurred) were performed largely to assuage the distress he feels with an inflated sense of responsibility for his mother’s safety in a way typical, again, of harm OCD, instead of SAD. Further, in addition to making sure he slept near his mother at night, and exhibiting disruptive behaviors to obtain his mother’s reassurances about her safety, he also engaged in other outward compulsive behaviors such as ritualistic blinking, tensing, jerking movements, rapid breaths, and walking through doorways and hallways in a “just right” manner to neutralize his intrusive thoughts. These behaviors were all functionally bound to his inflated sense of responsibility for his mother’s safety, which are different than the separation-prevention behaviors in SAD that are enacted to mitigate separation and abandonment fears. Further assessment revealed avoidance behaviors to temper inflated responsibility for harm, instead of fears of abandonment. The aforementioned information converged on the core fear of inflated responsibility for harm (instead of abandonment), as distinctive of a differential diagnosis of OCD (instead of SAD). Indeed, Finn has received a consistent diagnosis of OCD from five other clinicians (three of whom specialized in OCD treatment) since his original diagnosis from his therapist.

**Recognizing OCD as a Differential Diagnosis for SAD**

There is consensus that explicitly recognizing OCD as a differential diagnosis for SAD can better guide the assessment process for a wider audience of health care professionals (Baldwin, Gordon, Abelli, & Pini, 2016; Ivarsson, Melin, & Wallin, 2008), although this is not reflected in the current version of the DSM. We recommend that this be rectified in the next update of the DSM. This is pertinent in light of the fact that OCD is frequently mis-diagnosed by professionals such as primary care physicians, who are often the first point of contact (Glazier, Swing, & McGinn, 2015; Glazier, Wetterneck, Singh, & Williams, 2015). From our discussion, it appears that the core element of an inflated sense of responsibility for harm, as opposed to fears of separation from and abandonment by attachment figures, is a good differentiating factor for a diagnosis of harm OCD, rather than SAD.

Accurate differentiation between SAD and OCD is important because there can be differences in specific treatment targets, with implications for treatment efficacy, for these two disorders. To maximize treatment efficacy, the correct core fears and primary beliefs should be targeted. Cognitive challenging in harm OCD may aim to reduce inflated responsibility for harm by having the patient recollect instances in which harm did not befall loved ones when compulsions were resisted. On the other hand, cognitive challenging in SAD may target fears or abandonment by asking patients to identify evidence of positive outcomes in instances in which they were separated from their attachment figure. In terms of behavioral targets, rituals in OCD are not limited to simple reassurance-seeking, and may even seem elaborate, bizarre, or not clearly connected to a harm avoidance function in a causal manner (especially in young children; Adelman & Lebowitz, 2012), which might not be expected in SAD. For example, individuals with harm OCD may perform rituals to prevent harm along the lines of “magical thinking” (e.g., Finn walking through doorways and hallways in a “just-right” manner so that his mother “would not die”; Einstein & Menzies, 2004). As such, exposure therapy can also proceed in very different directions for OCD versus SAD. Individuals with harm OCD may be guided in retraining from, or intentionally spoiling, these compulsions to show that harm will not happen to loved ones, while individuals with SAD may be tasked to tolerate distress upon separation to demonstrate that secure attachments would not be disrupted, and that parental abandonment would not occur. Exposure and response prevention (Ex/RP) for harm OCD may involve having the patient risk harming someone (e.g., not locking the door), while resisting urges to engage in safety behaviors and reassurance-seeking/checking. These exercises can also be paired with imaginal scripts depicting the patient being responsible for harm in similar scenarios. On the other hand, exposure therapy for SAD may
may also compulsively seek reassurance about their safety and knowledge of their whereabouts. However, these behaviors serve the function of reducing inflated responsibility for harm, instead of allaying the fear of separation and abandonment characteristic of SAD. Both diagnoses can be considered only when there is incremental and functionally distinct separation fear/anxiety that is not related to OCD, and which is distressing and impairing to a clinically significant extent.”


### Table 1. Overlapping Features and Underlying Distinction for SAD and Harm OCD

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<tr>
<th>SAD</th>
<th>Harm OCD</th>
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<tr>
<td><strong>Overlapping Features</strong></td>
<td><strong>Underlying Distinction</strong></td>
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<tr>
<td>• Worries about harm occurring to the self or loved ones</td>
<td>• Symptoms are linked to the core fear of abandonment by attachment figures</td>
</tr>
<tr>
<td>• Distress with actual or anticipated separation from loved ones</td>
<td>• Symptoms are linked to the core fear of responsibility for harm</td>
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<tr>
<td>• Excessive reassurance-seeking/checking (and other separation-prevention behaviors) to reduce separation anxiety</td>
<td>• Obsessions about harm to the self or others (typically, loved ones) that are experienced as distressing</td>
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### References


SAD or OCD?


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