from normal variation in characteristics that may underlie or be similar to the disorder. *Additional information* provides a description of other features that are relevant in helping the clinician to recognize variations in presentation of the disorder, but are not diagnostically determinative. The final, published version of the guidelines will include additional information (e.g., information on features related to culture, gender and development).

The WHO Department of Mental Health and Substance Abuse is interested in receiving comments on the proposed diagnostic guidelines from their intended users. To receive these comments, the Department has created a new Internet platform for members of the GCPN, called GCP.Network (http://gcp.network). This platform will make several sets of guidelines available per month until all of them are included. All mental health or primary care professionals who are legally authorized to provide services to people with mental and behavioural disorders in their countries are eligible to join the GCPN and to provide comments on the proposed diagnostic guidelines. At a later time, the draft guidelines will also be made available for review by the general public.

A variety of additional resources for registered GCPN members are available at GCP.Network. These include brief reports on the results of GCPN field studies, access to articles related to the development of ICD-11 mental and behavioural disorders, and a variety of relevant training resources. We invite you to visit http://gcp.network, to register if you are not already a member, to provide comments on the proposed ICD-11 guidelines, and to take advantage of the other resources we have and will continue to develop.

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DOI:10.1002/wps.20322

Can separation anxiety disorder escape its attachment to childhood?

The definition of separation anxiety disorder (SEPAD) has undergone significant changes in DSM-5, the most important being the lifting of the age restriction (18 years of age in DSM-IV) for assigning the diagnosis. There may be resistance, however, amongst some clinicians and researchers to extending the diagnosis to adulthood. We consider the arguments in favour and against this change in the hope of stimulating debate and research aimed at achieving a consensus on this issue.

Why do clinicians traditionally restrict the diagnosis of SEPAD to childhood (here used broadly to cover the period from infancy to early adolescence)? The main reason is that the construct of separation anxiety (SA) has long been central to developmental theories that exert a strong influence in guiding clinical practice. Within the broad developmental framework of psychoanalytic and attachment theories, SA is regarded as representing a repertoire of neurophysiological, intrapsychic and behavioural responses specifically designed to protect children from danger by ensuring the maintenance of close proximity to an adult caregiver, typically the mother. The SA mechanism is of particular importance to our species because of the prolonged period of dependency of the child on the caregiver[1]. In attachment theory, heightened expressions of SA are regarded as indicating disturbances in the child's working models or internal representations of attachment figures, shaped by past and ongoing bonding experiences with primary caretakers[2]. SEPAD as a diagnosis therefore lies at the extreme end of a spectrum of responses that extend from the normative to the pathological, its presence signifying that the child has been exposed to severe disruptions and/or disturbances in his/her primary bonds[2]. Classical symptoms of SEPAD (excessive clinging, tantrums, school refusal, abdominal pain and headaches, refusal to sleep alone, and nightmares of being attacked or abducted) reinforce further the phase-specific nature of the response.

Yet attachment theory has long acknowledged that the drive to form and maintain close bonds is fundamental to humans throughout the life course[3]. The corollary must be that the SA response can occur in persons of all ages. Indeed, reciprocity in the SA response between the mother and the child is critical to the mechanism's protective function; by mirroring the alarm signals of the lost child, the mother's anxiety ensures that she engages in intensive searching behaviour to rescue the young person from potential harm. More generally, in collective species

such as *homo sapiens*, the drive to maintain proximity to close others is fundamental to ensuring the survival of individual members[1].

In summary, there is an evident tension within attachment theory between the tendency to regard SA as a specific characteristic of childhood and the recognition that attachment anxiety extends throughout the life course. From a clinical perspective, Bowlby's developmental model of agoraphobia provided a partial resolution for this problem. He proposed that, if high levels of SA persisted into later years, they manifested as typical symptoms of agoraphobia[4]. According to this model, symptoms such as carrying transitional objects, reliance on phobic companions, and the preference for staying at home (as a symbol of a secure base) reveal the underlying SA roots of adult agoraphobia[4].

Initially, empirical research provided support for the SA-agoraphobia model; in a series of studies, adult patients with agoraphobia reported much higher levels of early SEPAD (assessed by the proxy indicator of school phobia) in their early lives compared to those with other anxiety or depressive disorders[5]. The SA-agoraphobia model became firmly embedded in developmental theory over time, incorporating panic disorder as an adult outcome when DSM-III linked that category to agoraphobia. Since then, researchers have searched for evidence of a common biological substrate underlying SEPAD, panic disorder and agoraphobia, by examining the family aggregation, shared pattern of genetic inheritance and distinctive psychophysiological responses associated with the three constellations[6,7].

In parallel, however, other studies have produced evidence that calls into question the SA-agoraphobia model. In particular, several studies have found that the link between early SA and panic disorder/agoraphobia is not specific, but represents a general characteristic of adults with a range of anxiety and depressive disorders[8]. Two decades ago, observations at a clinic for anxiety patients at the University of New South Wales led to the formulation of an alternative developmental model of SEPAD[9]. The team found that, when symptoms were specifically inquired into, many adult anxiety patients revealed the presence of SEPAD, commonly dating the onset of the problem to childhood[9]. This discovery suggested a continuity model in which SEPAD was a disorder that extended across the life course, although symptoms showed pathoplastic changes commensurate with maturation. For example, adults feared for the safety and whereabouts of a wider range of attachment figures, including parents, romantic partners and spouses. Moreover, symptoms manifested in more subtle ways: for example, adults employed complex rationalizations to avoid work or travel and tended to find pretexts to make repeated phone contact with attachment figures throughout the day.

Following these observations, several measures were developed to assess SEPAD in adulthood[9,10]. The clinic-based studies that followed indicated that 20-40% of patients attending ambulatory facilities met criteria for SEPAD[10,11]. The relationship between reported early SA symptoms and adult SEPAD proved to be highly specific; once that relationship was accounted for, there was no evidence to support a specific link between SA and panic disorder or agoraphobia.

A recent analysis of the World Mental Health Survey dataset indicated that the lifetime prevalence of SEPAD across countries approximated 5%; persistence of the disorder into adulthood was common; and adult onset occurred in 40% of all cases[12]. SEPAD showed a high level of comorbidity with a range of common mental disorders, not specifically with panic disorder and agoraphobia. Adults and children with SEPAD reported a consistent pattern of disturbances in their early family lives and high levels of exposure to a wide range of traumas[12]. Taken together, these findings offer support for the model of SEPAD proposing that symptoms in adulthood commonly represent the continuation or recurrence of those experienced in childhood.

Why, in the face of these recent findings, has the SA-agoraphobia model persisted? Several factors are likely to be at play. The overriding reason is that adherence to established developmental theory discourages clinicians from recognizing SEPAD symptoms in adults. Also, by its very nature, SEPAD occurs within an interpersonal field, involving the family and close attachments. It is common in clinical practice to find that close attachments accommodate and adapt to the person's SEPAD-related fears, particularly as the anxieties are directed at safeguarding others[13]. A pattern of collusion therefore may arise in which the person with SEPAD, the family, and ultimately the clinician, all underestimate the role of SEPAD symptoms as a source of dysfunction in the patient. Definitional overlap in symptoms, particularly between agoraphobia and SEPAD, may further confound the picture. SEPAD may also occur in response to the disruptions and losses associated with other severe mental disorders, such as bipolar disorder[14]. In these contexts, the mood-related symptoms will often overshadow those of SEPAD which, as a consequence, will go undetected, even though they add to the person's overall disability. Severe SEPAD may also present in a variety of ways – for example, as suicidal behaviour or stalking in response to actual or threatened separations – which are not indicated in the DSM-5 criteria for the disorder.

In the end, only one of the two developmental models outlined herein, the SA-agoraphobia model and the continuity model, can be valid. Resolution of this issue is not merely one of theoretical importance. SEPAD in adulthood is associated with high levels of disability and signifies a poor response to treatment when conventional pharmacological or cognitive behavioural therapies are used to treat comorbid anxiety disorders[11,12]. As a consequence, there may be a substantial cost in disability and suffering by overlooking the diagnosis of adult SEPAD. The critical question, therefore, is whether the DSM-5 reformulation of SEPAD is a turning point that will release SEPAD from its over-attachment to childhood.

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DOI:10.1002/wps.20336

The many faces of narcissism

Although the term narcissism is widely used in psychiatric discourse, there is much confusion about its precise meaning. The term is most often used pejoratively to refer to someone with excessive vanity or an urgent need for validation and praise. There is a continuum of narcissism, and the point where healthy self-esteem ends and pathological narcissism begins is highly arbitrary. A further complication is that some individuals who have elements of pathological narcissism may have sectors of their personalities that are characterized by generosity towards others.

It is unfortunate that a false dialectic between narcissism and altruism is in common usage. The two entities regularly co-exist. Vaillant[1], in his longitudinal study of healthy males, found that altruism increases significantly in the second half of life – not simply because we become more selfless as we age, but rather because helping others becomes more rewarding to us. A neuroimaging study[2] demonstrated that those who are altruistic directly benefit from their altruism. Participants had to choose to endorse or oppose societal causes by anonymous decisions to donate or refrain from donating to real charitable organizations. The mesolimbic reward system was engaged when one *donated* money in the same way as it was when one *received* monetary awards. In other words, altruism activates brain centers that are associated with selfish pleasures like sex or eating.

A further complication is that the term narcissism is used as a clinical entity as well as a way of denoting cultural trends, as in C. Lasch's book *The Culture of Narcissism*[3], describing a cultural phenomenon in the 1970s in which the growing role of the media promoted a lack of substance and depth in the culture. In our decade, we are in the midst of another cultural awakening as the constant interaction with technology and social media is impacting the cultural perspective of the self. Members of the millennial generation live in a constantly connected, technologically visible, self-oriented public space. *Time* captured this cultural moment by referring to the "Me Me Me Generation". S. Turkle[4] described how the smartphone generation is populated by people who are losing the art of human interaction. A radical new self is emerging, one that is shaped by what we want others to see. One can receive validation, praise and self-esteem enhancement within seconds after pressing "send" or posting a "selfie".

In a study by Stinson et al[5], there were nearly three times the number of persons in their twenties meeting criteria for narcissistic personality disorder than in the age group over 65. However, we must question the idea that the current generation is developing such a vastly higher number of narcissists. The overlap between cultural shifts and individual pathology must be more complex than simply following a list of diagnostic criteria. Moreover, the constant connection to social media has also led to altruism in this new generation. Indeed, they are dedicated to service projects, are socially aware and contribute to charity at a higher rate than their elders[6]. Not only do we need to consider the false dialectic between narcissism and altruism in individuals; we must also consider it more broadly in the culture.

In the midst of this confusion, how do we distinguish healthy self-interest from pathological narcissism, usually referred to as narcissistic personality disorder? The time-honored indices of "to love and to work" are problematic in this context, because some of the most successful individuals from an economic perspective are also highly narcissistic[7]. Their narcissistic need for acclaim and recognition may motivate them to succeed. On the other hand, the capacity for mutuality and reciprocity in love relationships may be useful in identifying narcissistic personality disorder. Others are often used up and discarded, existing only to serve the narcissistic individual's needs.

While problems in human relatedness are central to narcissistic personality disorder, clinicians must be alert to the fact that narcissistic individuals may have considerable variability in their ways of relating to others. There is a spectrum of narcissistic personality disorder, not necessarily reflected in the official nomenclature. Psychoanalytic debates about narcissistic patients stemmed from differences noted by Kohut[8] and Kernberg[9]. While Kohut's formulation was based on a self-deficit model, causing patients to be highly sensitive to narcissistic injury, Kernberg emphasized the aggressive and destructive aspects of these patients. Further research has documented the existence of two subtypes of narcissistic personality disorder: the grandiose and oblivious variant and the hypervigilant or fragile subtype[7]. More recent research[10] detected a further high-functioning variant, which is outgoing, energetic and articulate, with an exaggerated sense of self-importance.

The fact that narcissistic personality disorder is not a monolithic entity creates challenges for the diagnostician and the psychotherapist. In keeping with the notion that the key to