A New Framework for Diagnosing and Treating Separation-Related Disorders

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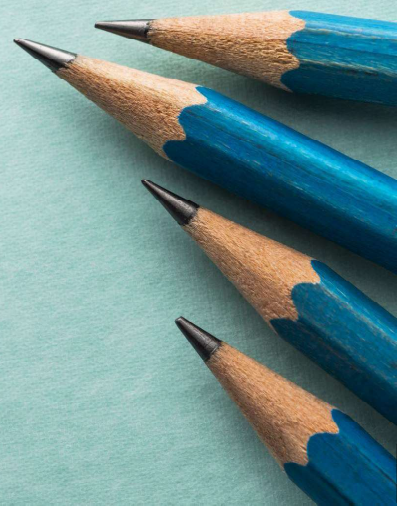
July 14, 2022

Agenda

- Taking a Good History
- Diagnosing SRD
- Treating SRD



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Clinical Signs

- Vocalization
- Destructiveness
- Increased or decreased motor activity
- House soiling
- Escape-seeking
- Anorexia
- Hypersalivation and/or panting
- Self-injury, repetitive behaviors
- Aggression with departure
- Excited greeting behavior >2 minutes upon return

Taking a Good Behavior History:

FREQUENCY | LATENCY | TRIGGERS | INTENSITY | RECOVERY TIME

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Taking a Good Behavior History:

How frequently is the behavior occurring?

--> To be SRD needs to be nearly 100% of departures in a given condition; if not, seriously look at other diagnoses

How frequently does the client need to leave and for how long?

FREQUENCY

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Taking a Good Behavior History:

When do the behaviors first start?

e.g. moment person out of sight
e.g. putting on shoes
e.g. morning alarm

LATENCY

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Taking a Good Behavior History:

What are the problem triggers?

E.g. a specific person leaving
E.g. only when the dog is totally alone
E.g. placement in the crate

TRIGGERS

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Taking a Good Behavior History:

Getting worse?
Getting better?
Plateaued?

Mild/moderate/severe

INTENSITY

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Taking a Good Behavior History:

When does the pet calm down again?
e.g. 20 minutes after departed
e.g. only when sees person again

What does the pattern look like while gone?

RECOVERY TIME

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Taking a Good Behavior History:

Understand if there are signs of generalized anxiety as well:

- ❑ Persistent shadowing
- ❑ Chronic hypervigilance
- ❑ Excessive startle response
- ❑ Difficulty settling
- ❑ Neophobia
- ❑ Difficulty adjusting to novel environments
- ❑ Difficulty adjusting to novel routines

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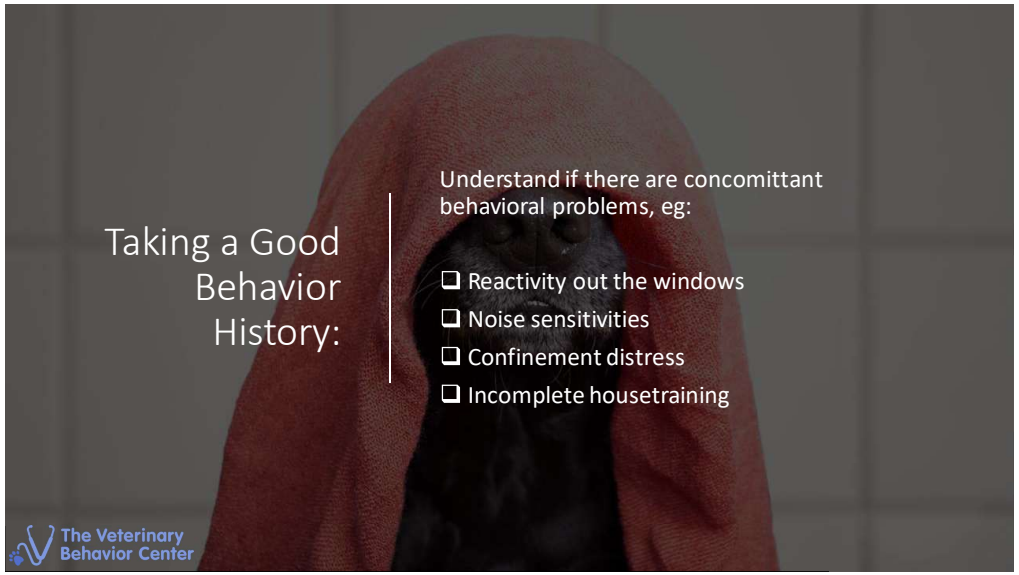

Taking a Good Behavior History:

Know what the client needs

- How many departures a week?
- How long are the departures?
- What resources do they have to avoid departures?
- What is sustainable, what is not?
- Can they pre-medicate before departures?
- Do they have bandwidth to commit to a behavioral therapy program?
- What is their comfort level with the dog being out in the house from a destruction perspective?
- What is the clients emotional state?

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Rule out medical problems

- Inappropriate urination – PU/PD, UTI, spay incontinence, unobserved seizures, etc.
- Inappropriate defecation – diarrhea, constipation, work up as appropriate
- Pacing, difficulty settling – encephalopathy, any source of pain/discomfort
- Self-injury or repetitive behavior – dermatologic, orthopedic, GI

Minimum database: CBC, Chem, UA, full PE +/- ortho exam +/- additional diagnostics as warranted

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Rule out other behavioral problems

Destructive behavior:
- Exploration/object play
- Activity/energy
- Scavenging
- Territorial
- Other fears or phobias
- Predation
- Confinement distress

Vocalization:
- Alarm/outside stimuli
- Other fears or phobias
- Confinement distress
- Frustration
- Physical

Housesoiling:
- Inadequate housetraining
- Insufficient elimination opportunities
- Physical limitations
- Excitement, conflict or anxiety
- Other fears or phobias

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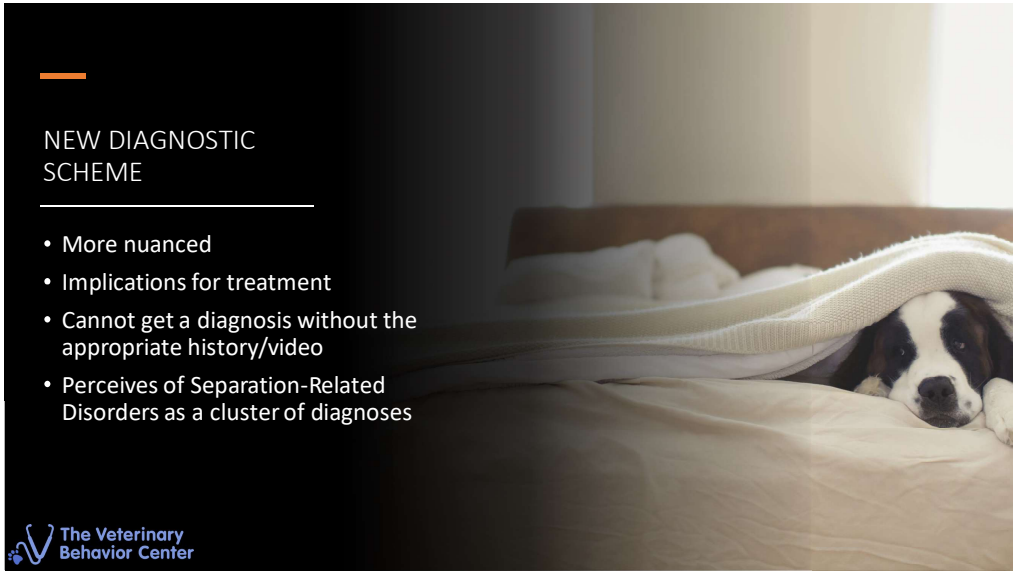
NEW DIAGNOSTIC SCHEME



- More nuanced
- Implications for treatment
- Cannot get a diagnosis without the appropriate history/video
- Perceives of Separation-Related Disorders as a cluster of diagnoses

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Categories

Fear

Behavioral, physiologic signs of distress

At time of separation

Anxiety

Behavioral, physiologic signs of distress

Anticipatory

Phobia

Profound

Non-graded response

Panic

Often with anticipatory response

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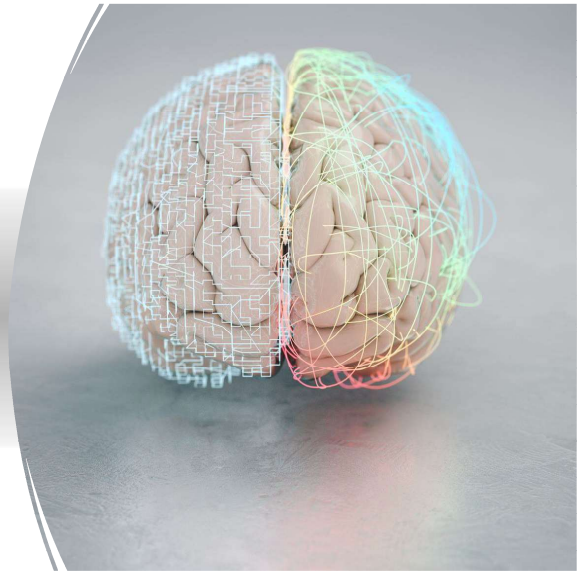
Different brain circuits involved

Fear and anxiety are processed differently in the brain



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Determination made from history and video:

- Clinical signs --> phobia vs. fear/anxiety
- Intensity/severity --> phobia vs. not
- Latency --> anxiety vs. fear
- Signs of GAD --> anxiety

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Look at trigger to determine..

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Separation

- Preferred person
- Preferred pet

Isolation

- Being alone

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6 Distinct Diagnoses

	Fear	Anxiety	Phobia
Separation Distress	**Separation Fear** physiological, physical and/or behavioral signs of distress associated with separation from preferred social companions, such as specific family members	**Separation Anxiety** physiological, physical and/or behavioral signs of distress in anticipation of and with separation from preferred social companions	**Separation Phobia** Profound, non-graded, physiological, physical and behavior signs of panic with separation from preferred social companions, along with physiological, physical and/or behavioral signs of distress in anticipation of separation from preferred social companions
Isolation Distress	**Isolation Fear** physiological, physical and/or behavioral signs of distress associated with being alone	**Isolation Anxiety** physiological, physical and/or behavioral signs of distress in anticipation of and with being alone	**Isolation Phobia** Profound, non-graded, physiological, physical and behavioral signs of panic associated with being alone, along with physiological, physical and/or behavioral signs of distress in anticipation of being alone

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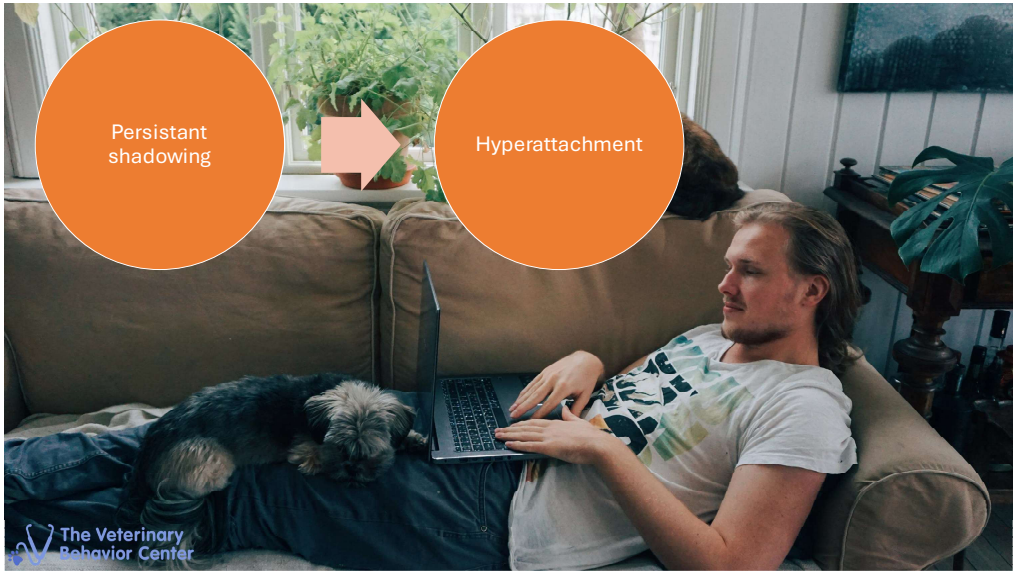

Diagnoses

Separation-Related Disorders

- Hyperattachment
- Separation Distress (unspecified)
  - Separation Fear
  - Separation Anxiety
  - Separation Phobia
- Isolation Distress (unspecified)
  - Isolation Fear
  - Isolation Anxiety
  - Isolation Phobia

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Treatment

NEUROCHEMICAL MODULATION

MANAGEMENT

BEHAVIORAL TREATMENTS

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Management

- Stop punishment
- Avoid separations
- Ensure psychological and physical needs are met
- Confinement or limited access to protect the home
- Sanctuary space

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Stop Punishment

- Punishment often implemented in effort to reduce housesoiling and destruction
- More likely to increase fear and anxiety
- Long latency between behavior and punishment = unlikely to make desired connection

Instead: clean soiled areas and change setup to prevent or limit destruction and housesoiling next time

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Avoid Departures

- Prevents negative learning experiences
- Utilize resources: doggie daycare or pet sitter, bring to work, etc.
- If not possible, use fast-acting anxiolytics to reduce distress

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Address Basic Physical and Social Needs

- **Nutritious, well-balanced diet**
- **Exercise and enrichment**
- **Foster healthy attachment style**
  - Structure and predictability
  - Coach clients on dog body language

Protect the Home

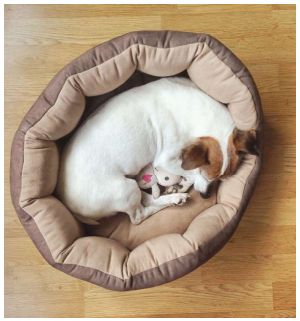
- **Confinement - often contraindicated**
  - Confinement distress common in dogs with SRD
  - If necessary, soften experience – food reinforcers, anxiolytics
- **Limit access with barriers** (e.g. baby gates)
- Install **disposable materials to protect walls and doors**
- **Leave pet in easy-to-clean areas** or protect floor with puppy pads or tarps

Sanctuary Space

- preconditioned space of comfort to utilize for departures
- daily practice with attachment figure initially present and high value long lasting chew/stuffed Kong
- provide something that smells like attachment figure

Behavior Modification

- Relaxation therapy
- Independence therapies
- Departure training
- Pre-departure cues



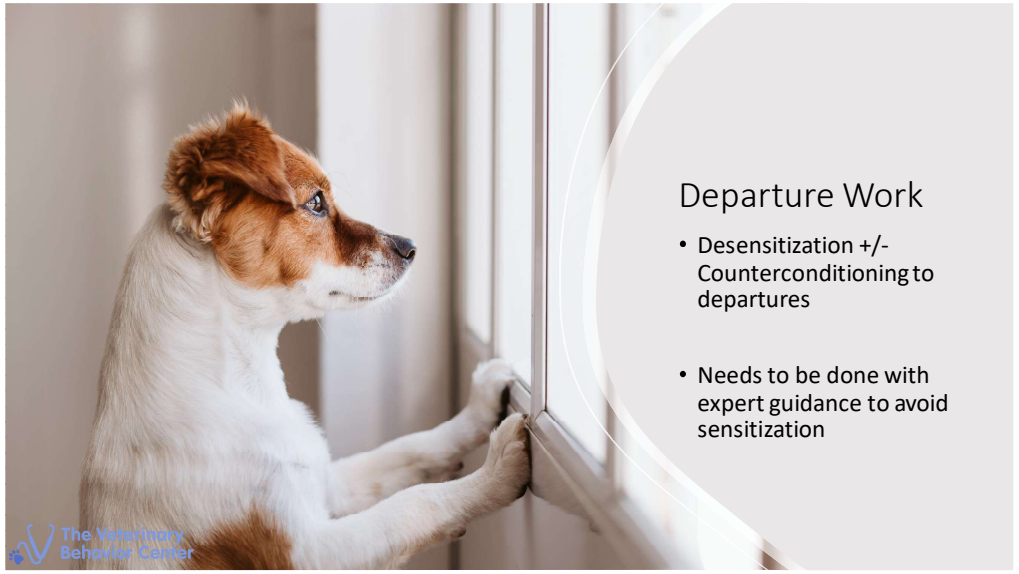
Relaxation Therapy

- Scaffolded conditioned emotional response of relaxation on cue
- Mobile and presentable when needed
- Super helpful skill

We do have virtual relaxation classes
Open to the public.
www.vetbehaviorcenter.com/classes

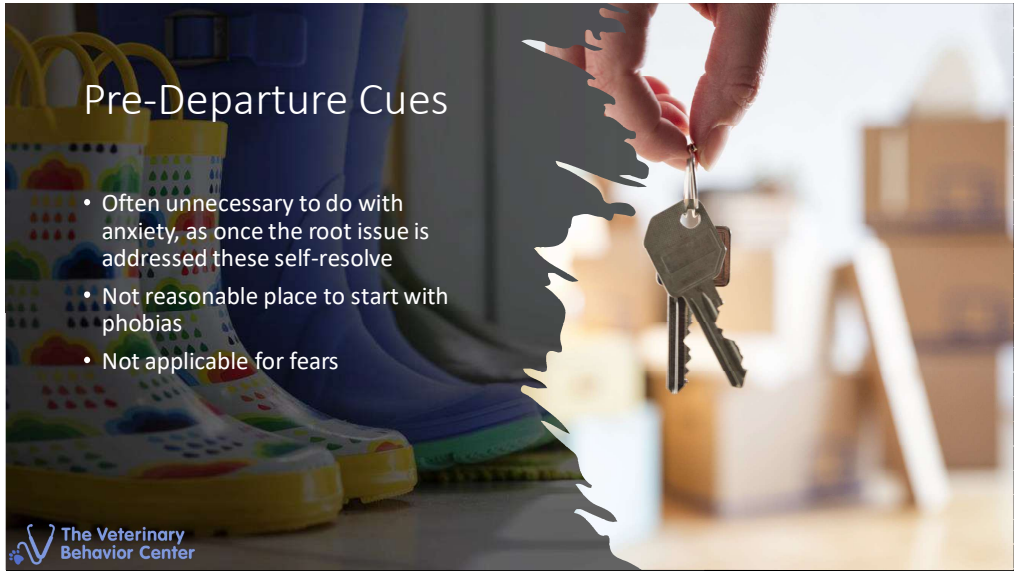
Independence Therapies

- Helpful for patients with hyperattachment
- Not helpful for patients without hyperattachment
- Learning to be OK not next to attachment figure



Departure Work

- Desensitization +/- Counterconditioning to departures
- Needs to be done with expert guidance to avoid sensitization



Pre-Departure Cues

- Often unnecessary to do with anxiety, as once the root issue is addressed these self-resolve
- Not reasonable place to start with phobias
- Not applicable for fears

Psychopharmacology

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Psychopharmacology

1. Fear: Should be considered in all moderate and severe cases, could be considered in mild fear cases
2. Anxiety: Should be utilized in all moderate and severe cases, should be considered in mild anxiety cases
3. Phobia: Must be utilized in all phobia cases, unless medical contraindication – inhumane not to

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Fast-Acting Medications

- **Short term:** for cases with suffering where departures cannot be avoided before daily medications kick in. Attempt wean once daily medication is working.
- **Long term in addition to daily**: for many severe cases and some moderate cases, for most phobia cases
- **Long term without a daily**: for cases where clients can pre-medicate for all departures and/or want to avoid daily medications

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How to choose fast acting medications:

- Time to effect – ranges from 20 min – 3 hours
- Duration of action – ranges from 2 hours – 12 hours
- Severity of clinical signs
- Type of clinical signs
- Mechanism of action
- Evidence-base
- Tolerability of side effects

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Most commonly used fast acting medications:

- Benzodiazepines
  - Alprazolam – fastest onset (~30min), shortest duration (~3-4 hours)
  - Diazepam
  - Lorazepam
  - Clonazepam – longest duration (closest to 12 hours), most likely to cause side effects
  - Oxazepam

Reasons to consider: muscular relaxation, increase appetite, amnestic effects, panicolytics

Indications: phobia or severe fear/anxiety

Reasons to avoid: controlled substance, withdrawal effects if suddenly d/c with persistent use, paradoxical effect, resource guarders, food seeking already a problem

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Most commonly used fast acting medications:

- Alpha 2 agonists
  - Clonidine – TTE: 2 hr, DOA: 6-8 hours, affordable
  - Sileo – on label for noise aversions, shortest TTE 20 min, DOA 2-3 hrs, expensive, OTM gel
  - Guanfacine – very new to using in animals, theoretically more selective for anti-anxiety effects than clonidine, no clinical studies yet, wide published dose range

Reasons to consider: sympatholytics, mild anti-pain effects

Indications: phobia or severe fear/anxiety, high SNS observed

Reasons to avoid: any patient you would be concerned about hypotension or bradycardia, pregnant animals

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Most commonly used fast acting medications:

- Voltage gated sodium channel blockers
  - Gabapentin– TTE: 2 hr, DOA: 8-12 hours – up to 60 mg/kg/day published; not uncommon don't recruit anti-anxiety effects until 30 mg/kg plus
  - Pregabalin – TTE: 2 hr, DOA: 8-12 hours

Reasons to consider: very safe medication, concommitant generalized anxiety, concommittant pain or seizure disorder

Indications: mild – moderate anxiety, medical contraindications for others, adjunct support

Reasons to avoid: not the strongest of our medications but some patients do respond really nicely

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Most commonly used fast acting medications:

- SARIs = trazodone
  - TTE: 2 hr, DOA: 8 hours

Reasons to consider: hypnotic effects welcome, responded well in past

Indications: very active form of distress

Reasons to avoid: Dose limitations with other serotonergics, many patients get sedation without anxiolysis

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How we use fast acting medications:

- Walk up the dose range
- Pre-test for side effects outside trigger situation
- Administer far enough in advance that already effective before the FIRST sign of anxiety/fear
- OK to combo medications of different classes – can get synergistic effects
- Bridger, until daily kicks in round the clock or PRN; PRN thereafter

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Daily Medications

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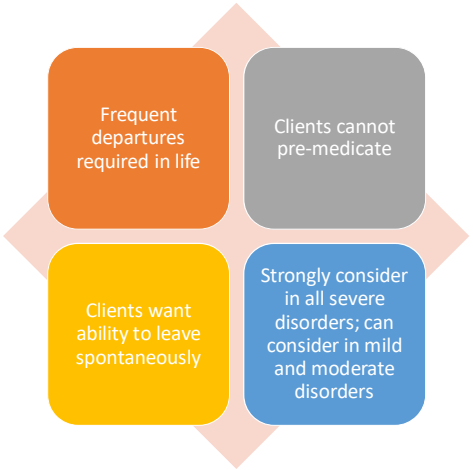
When to use:



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On-label option: Reconcile

- Veterinary branded version of fluoxetine
- SSRI
- Once daily medication
- Long half life so don't have to worry about weaning, missed doses – self-weans readily
- Can be a little harder on the GI tract than other options
- Been using for decades, good body of evidence

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On-label option: Clomicalm

- Veterinary branded version of clomipramine
- TCA
- STARTING DOSE 2 mg/kg PO BID
- Good behavioral calming effect
- "Broader hitter" but also may be more likely to have side effects
- Some anticholinergic effects
- Good body of evidence

Other SSRIs:
sertraline
paroxetine
citalopram
escitalopram

- Two encourage to start utilizing:
- **Sertraline** – helpful for patients that we need to increase joy, very shut down patients, but can increase attention seeking behaviors so may not be first choice in stifling hyperattachment cases; well tolerated typically
- **Paroxetine** – think of "Clomicalm-light"

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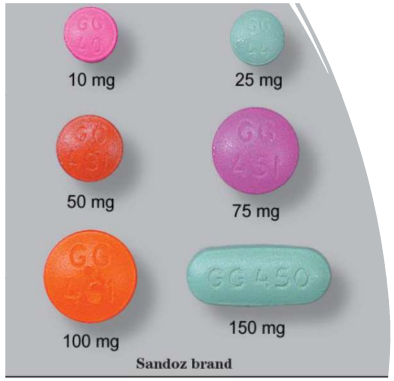
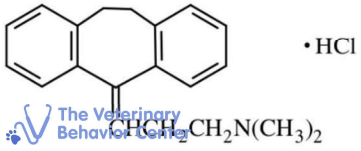


Other TCAs

- Amitriptyline most common known -
  - Don't typically recommend because lots of sedation without nearly as much anti-anxiety



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How we use daily medications:

- Generally start half dose for one week, then onto full dose if no side effects
- Side effects may self-resolve after 1-2 weeks, can wait out the mild ones, we generally don't for severe ones, depends on individual situation
- Takes 4-6 weeks to kick in
- Subsequent dose increases once at efficacious dose only take 2-3 weeks to evaluate
- If hit 50% through dose range and aren't seeing anything, abort drug, probably won't do anything
- OK to suddenly d/c if within first 2 months, after that wean depends on dosing, duration, individual case

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Using Psychopharmacology

- All medications could theoretically increase anxiety, agitation, anxiety, aggression in a small number of patients
- Often a trial and error process, just because one fails, doesn't mean another will
- Check in frequently with clients

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Natural Supplements and Pheromones

- For mild cases
- OR
- As adjunct support
- NOT first line for moderate/severe cases

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The ones with some research:

- All palatable
- None robust evidence for SRD
- All need about 4 weeks to assess efficacy
- Expect mild effects

Anxiety diets

- Contain same active ingredients (alpha cazosepine primarily) as some supplements so can do one or the other
- Weight limits on utility
- A place for certain patients, don't reach for them frequently

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Take Aways

- You can't treat effectively without knowing the diagnosis
- You can't know the diagnosis without taking a good history
- Confirm with video
- Monitor progress with video
- Does the patient need a bridger/PRN med while we are working on therapies?
- Does the patient need a daily medication?
- How can I make sure they are getting the behavioral therapy support they need?

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How We Can Help

www.vetbehaviorcenter.com

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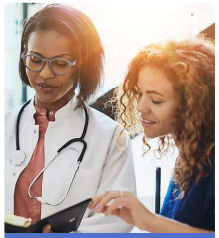
alternative track #1:



Hybrid Program

Veterinary behavioral support through your vet and behavioral therapies directly with us

our most popular service:

Comprehensive Care

Our flagship services for comprehensive support - doctor designed, team execution

alternative track #2:

Behavioral Coaching

Behavior modification for any problem behavior with a team you can trust