Journal of Anxiety Disorders 35 (2015) 75–81

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

Phenomenology and clinical correlates of family accommodation in pediatric anxiety disorders☆

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ARTICLE INFO

Article history:
Received 27 January 2015
Received in revised form 9 August 2015
Accepted 5 September 2015
Available online 10 September 2015

Keywords:
Child
Family
Parents
Treatment
Risk factors
Anxiety disorders

ABSTRACT

Despite evidence documenting high prevalence of family accommodation in pediatric obsessive–compulsive disorder, examination in other pediatric anxiety disorders is limited. Preliminary evidence suggests that family accommodation is common amongst children with anxiety disorders; however, the impact on clinical presentation and functional impairment has not been addressed. This study assessed the nature and clinical correlates of family accommodation in pediatric anxiety, as well as validating a mechanistic model. Participants included 112 anxious youth and their parents who were administered a diagnostic clinical interview and measure of anxiety severity, as well as questionnaires assessing internalizing and externalizing symptoms, family accommodation and functional impairment. Some form of accommodation was present in all families. Family accommodation was associated with increased anxiety severity and externalizing behaviors, having a diagnosis of separation anxiety, and increased functional impairment. Family accommodation partially mediated the relationship between anxiety severity and functional impairment, as well as externalizing behaviors and functional impairment. Family accommodation is common in pediatric anxiety disorders, and is associated with more severe clinical presentations and functional impairment. These findings highlight the importance of parental involvement in treatment and the need to specifically target accommodation practices during interventions to mitigate negative outcomes in anxious youth. Further studies utilizing longitudinal data are needed to validate mechanistic models.

1. Introduction

Family accommodation, defined as efforts by family members to accommodate an individual's psychiatric symptoms and reduce the level of distress/impairment that the patient experiences if triggered (Lebowitz, Panza, Su, & Bloch, 2012), has been of clinical and academic interest in adults and youth with obsessive-compulsive disorder (OCD), and more recently, among anxious youth. Family accommodation can include behaviors such as providing excessive reassurance about the child's fears, allowing children to avoid stimuli that make them anxious, altering the family functioning (e.g., outings, responsibilities) to facilitate safety behaviors or avoidance, and actively engaging in or facilitating safety behaviors at the request of the child. Family accommodation negatively reinforces avoidance and other safety behaviors in both the patient and family vis-à-vis anxiety reduction in the child. Similar to the putative mechanism maintaining rituals/avoidance (e.g., in OCD), accommodation denies patients the opportunity for corrective learning experiences as their feared triggers are never directly endured.

☆ This work was supported by a grant to the first author from the Agency for Healthcare Research and Quality (1R18HS018665-01A1). The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Agency for Healthcare Research and Quality.

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http://dx.doi.org/10.1016/j.janxdis.2015.09.001
0887-6185/

Table 1
Sample demographics ($N = 112$).

Female	*N*	(%)
	50	44.6
Race		
Caucasian	94	83.9
African–American	12	10.7
Asian	3	2.7
Other	3	2.7
Ethnicity		
Hispanic or latino	15	13.4
Not hispanic or latino	97	86.6
Any psychiatric comorbidity	94	83.9
Comorbid diagnosis[a]		
Separation	21	18.8
Generalized anxiety	35	31.3
Social phobia	24	21.4
Specific phobia	28	25.0
Obsessive compulsive disorder	9	8.0
Agoraphobia	2	1.8
Posttraumatic stress disorder	3	2.7
ADHD	48	42.9
Opposition defiant disorder	14	12.5
Conduct disorder	1	.9
Major depressive disorder	7	6.3
Dysthymia	4	3.6
Enuresis	7	6.3
Selective mutism	6	5.4

[a] All comorbid diagnoses were included.

Historically, family accommodation has been mostly studied in adult and pediatric OCD. Some level of family accommodation occurs in the families of virtually all youth with OCD (Caporino et al., 2012; Flessner et al., 2011; Peris et al., 2008; Storch et al., 2007) and up to 97% of adults with OCD (Amir, Freshman, & Foa, 2000; Calvocoressi et al., 1995, 1999; Geffken et al., 2006; Stewart et al., 2008). Common forms of accommodation included providing reassurance, participating in behaviors related to the child's compulsions, assisting the child with avoiding anxious triggers, and modifying leisure activities due to OCD (Storch et al., 2007). Family accommodation has been directly linked to obsessive-compulsive symptom severity, functional impairment, child externalizing behaviors (Caporino et al., 2012; Storch et al., 2007; Storch et al., 2012a), and family discord (Peris et al., 2008). Baseline family accommodation was associated with attenuated cognitive-behavioral and pharmacological outcomes (Garcia et al., 2010), and reductions in family accommodation predicted improved cognitive-behavioral therapy outcome (Merlo, Lehmkuhl, Geffken, & Storch, 2009; Rudy, Lewin, Geffken, Murphy, & Storch, 2014).

There are considerably fewer data examining family accommodation in non-OCD pediatric anxiety. Existing studies suggest that accommodation occurs in approximately 95–97% of families with an anxious child (Benito et al., 2015; Lebowitz et al., 2013; Thompson-Hollands, Kerns, Pincus, & Comer, 2014), similar to rates in youth with OCD (Lebowitz, Scharfstein, & Jones, 2014). Common forms of accommodation that have been identified in families of children with anxiety disorders include providing reassurance, participating in behaviors related to the child's anxiety, assisting the child with avoiding anxious triggers, and providing items to alleviate anxiety (Benito et al., 2015; Lebowitz et al., 2013). Family accommodation has been linked to increased anxiety symptom severity and functional impairment (Benito et al., 2015; Lebowitz et al., 2013; Thompson-Hollands et al., 2014), separation anxiety and generalized anxiety disorder caseness (Thompson-Hollands et al., 2014) and younger age (Thompson-Hollands et al., 2014).

Externalizing behaviors are also common in anxious children, with approximately 10% of anxious youth meeting diagnostic criteria for oppositional defiant disorder and many more exhibiting subclinical levels of externalizing symptoms (Johnco, Salloum, Lewin, McBride, & Storch, 2015; Kendall et al., 2010; Verduin & Kendall, 2003). While anxiety and disruptive behavior disorder diagnoses may co-occur, often, externalizing behaviors are driven by a reluctance to confront fear-evoking stimuli, despite the child exhibiting mostly acceptable behavior when not confronted by anxiogenic triggers. Youth with concurrent disruptive behavior and anxiety exhibit a more severe clinical presentation (Franco, Saavedra, & Silverman, 2007; Johnco et al., 2015) and worse illness trajectory (Storch, Lewin, Geffken, Morgan, & Murphy, 2010a,b; Stringaris, Cohen, Pine, & Leibenluft, 2009) by virtue of compounded impairment due to multiple comorbidities as well as increasing reliance on maladaptive coping strategies in response to anxious triggers. Although rage outbursts have been associated with family accommodation in pediatric OCD (Storch, Jones, Lewin, Mutch, & Murphy, 2011; Storch et al., 2012a), less extreme externalizing behaviors may also impact family accommodation practices either as a result of parents complying with the child's request after repeated refusals, or through family members preemptively facilitating anxious behaviors to avoid confrontation. Family accommodation often obscures the severity and impact of the child's symptoms, as parental and family behaviors may become more elaborate over time in an effort to avoid triggering distress in the child. However, this dynamic is usually unsustainable in the longer term, and ultimately maintains or perpetuates symptoms.

Among pediatric OCD patients, two models examining the relationship between family accommodation and clinical presentation and/or impairment have been examined; one describing family accommodation as mediating the relationship between symptom severity and functional impairment, while the other hypothesizes that externalizing behaviors increase family accommodation, which in turn increases symptom severity and functional impairment (Storch et al., 2007; Storch et al., 2012a,b). In the former model, we conceptualize higher anxiety severity as driving family accommodation vis-à-vis the need to mitigate the child's distress. Paradoxically, this accommodation negatively reinforces the child's anxiety, and impairment is exacerbated. In the latter model, we conceptualize that the child engages in externalizing behaviors to drive family accommodation, and parents continue to accommodate to reduce or avoid triggering the child's disruptive behavior. Again, accommodating behaviors reduce distress thereby negatively reinforcing the child and further contributing to increased anxiety symptom severity and impairment. Although initial studies of family accommodation in non-OCD anxiety have elucidated clinical correlates, these models have not been tested among youth with non-OCD anxiety. Accordingly, this study extends these findings from pediatric OCD, and builds on initial work in anxious youth (Benito et al., 2015; Lebowitz et al., 2013; Thompson-Hollands et al., 2014) by examining family accommodation among anxious children, as well as examining the role of externalizing behaviors in family accommodation and functional impairment.

There were four specific aims of this study. First, we sought to examine the nature and incidence of family accommodation among treatment seeking anxious youth seen in community mental health centers. Based on past findings in youth with OCD and anxiety (Benito et al., 2015; Lebowitz et al., 2012, 2013), we expected that family accommodation would occur with high frequency. Second, we aimed to examine the relationships among family accommodation and demographic characteristics, anxiety severity, functional impairment, and child internalizing and externalizing behavior problems. Previous studies vary in whether they find gender differences in family accommodation, with some finding greater family accommodation amongst parents of girls than boys (Lebowitz et al., 2013) and others finding no difference (Flessner et al., 2011; Peris