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## Family Accommodation of Child and Adolescent Anxiety: Mechanisms, Assessment, and Treatment

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### Abstract

**TOPIC**—Anxiety disorders are the most common mental health concern for youth. Unfortunately, a substantial number of children and adolescents do not respond positively to current evidence-based interventions and/or relapse. As pediatric anxiety disorders are fundamentally a systemic phenomenon, focusing on the ways in which parents become involved in their children’s anxiety symptoms may be a promising alternative approach to treatment.

**PURPOSE**—To inform psychiatric mental health nurse practitioners (PMHNPs) about the phenomenology, associated neurobiology, and assessment of family accommodation (FA) as well as clinical interventions targeting FA. FA refers to ways that parents adapt their own behaviors to reduce their children’s anxiety-related distress.

**SOURCES USED**—A literature search was performed using Psyc-INFO and PubMed.

**CONCLUSIONS**—Current findings indicate a high prevalence of FA associated with pediatric anxiety disorders. FA has a potentially deleterious impact on course of illness and treatment response and is associated with greater caregiver burden. Potential neurobiological underpinnings of FA include dysregulation of parent cortico-limbic circuitry and the oxytocinergic system. PMHNPs are in a unique position to identify families engaged in problematic FA, educate their clientele, provide psychotherapy services with the goal of reducing FA, and consult with multidisciplinary team members.

### Search terms

Assessment; family accommodation; neurobiology; nursing; oxytocin; pediatric anxiety disorder; treatment

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Anxiety disorders are the most common mental health concern for children and adolescents, with lifetime prevalence estimates ranging upwards of 30% (Costello, Egger, & Angold, 2005; Merikangas et al., 2010). Pediatric anxiety disorders are chronic illnesses and are often associated with physical health concerns (Gandhi, Cheek, & Campo, 2012). They significantly impair the functioning of youth and burden families (Keller et al., 1992).

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Psychiatric mental health nurse practitioners (PMHNPs) are in a valuable position to be agents of positive change, working at the crossroads of medicine, mental health, youth, and their families. In the current paper, we aim to discuss the need for additional treatments for youth with anxiety disorders, introduce family accommodation (FA) and its role in pediatric anxiety, and present potential neurobiological systems involved in FA. We will conclude with the assessment of FA and its modification through parent-based interventions. Our goal is not to be comprehensive, but to provide an overview of the topic and discuss the implications for PMHNPs.

## Clinical Interventions for Pediatric Anxiety Disorders

Frontline interventions for childhood anxiety disorders include cognitive-behavioral therapy (CBT), medication management with selective serotonin reuptake inhibitors, and a combination of these two treatments (Rapee, 2011; Silverman, Pina, & Viswesvaran, 2008; Walkup et al., 2008). Despite the availability of evidence-based interventions, a substantial number of children who receive them do not respond positively and/or relapse (Barrett, Duffy, Dadds, & Rapee, 2001; James, Soler, & Weatherall, 2005; Walkup et al., 2008). Moreover, less than one fifth of children with anxiety disorders (17.8%) receive any disorder-specific mental health treatment (Merikangas et al., 2011).

Several factors have been identified as possible barriers to successful CBT with children (Rey, Marin, & Silverman, 2011). CBT requires active child collaboration for therapy to be effective, but children may be unable or unwilling to participate in therapy. They may fear treatment will not help, be too anxious to confront their fears during therapy, or lack awareness that a problem exists (Eisenberg, Hunt, Speer, & Zivin, 2011; Lebowitz, Omer, Hermes, & Scahill, 2014). Comorbid mental health concerns such as depression or oppositional defiance may also impede participation in treatment (Liber et al., 2010). Practical barriers to treatment include lack of accessibility of appropriate services, costs, time off from school or extracurricular activities, mental health literacy, and stigma associated with receiving psychotherapy (Booth et al., 2004; Meredith et al., 2009; Owens et al., 2002; Warfield & Gulley, 2006). Even when individuals are willing to participate, CBT may not be suitable if children have difficulty identifying and articulating internal experiences (Renaud, Russell, & Myhr, 2014). These limitations highlight the need for additional therapeutic approaches for youth who either do not present for treatment or do not sufficiently benefit from currently available interventions.

Research exploring family factors that impact the development and maintenance of childhood anxiety symptoms has led to the reasonable hypothesis that involving parents in the therapeutic process may enhance the efficacy of psychosocial treatment for pediatric anxiety disorders (Manassis et al., 2014; Rapee, 2012; Silverman, Kurtines, Jaccard, & Pina, 2009). This hypothesis has now been tested several times in studies that compared CBT alone to CBT with added parent work. Involvement of parents has generally emphasized training parents as lay CBT therapists who can deliver CBT-like interventions at home. Thus far, research has not yielded a reliable increase in the utility of CBT when parents are involved (Silverman et al., 2008; Thulin, Svirsky, Serlachius, Anderson, & Ost, 2014), although one meta-analysis indicated that inclusion of parents may facilitate maintenance of

therapeutic gains (Manassis et al., 2014). An alternative approach to treatment is to focus on the systemic, interpersonal nature of pediatric anxiety disorders, such as the ways in which parents become enmeshed in their children's anxiety.

## **FA: Description, Theory, and Research Findings**

FA is an interpersonal feature of pediatric anxiety. It refers to actions that parents engage in, or deliberately do not engage in, to help alleviate or avoid a child's distress related to a psychological disorder. FA of pediatric anxiety disorders can include both active participation by parents in symptom-driven behaviors and modification to family routines or schedules (Lebowitz et al., 2013). Some of the most common types of FA include providing reassurance, speaking in place of the child, allowing the child to sleep in the parents' bed, providing special meals, and facilitating avoidance of school or social engagements (Benito et al., 2015; Lebowitz et al., 2013; Thompson-Hollands, Kerns, Pincus, & Comer, 2014).

Young children, like other mammals, rely on caregivers for protection from danger and for the regulation of anxious arousal; in response, parents are motivated to protect and nurture their offspring. In youth with anxiety disorders, who experience chronic and excessive activation of the anxiety system, it is natural for parents to modify their behaviors to minimize their children's distress. However, FA of anxiety symptoms is one factor that may actually maintain, rather than alleviate, the anxiety disorder (Lebowitz et al., 2013). FA promotes ongoing avoidance by the child and provides negative reinforcement for the reliance on parents rather than independent coping (through short-term fear reduction). For example, consider parents who answer 20 phone calls a day from their child with separation anxiety disorder (SAD) while at work. Although their behavior is a natural response to the child's worry about their safety, this situation contributes to caregiver distress and hinders child opportunities for self-regulation of anxiety. FA may also contribute to lower insight on the part of the child as the parents are ostensibly validating the need to avoid the feared situations (Benito et al., 2015; Lebowitz et al., 2013).

Research on FA focused initially on obsessive-compulsive disorder (OCD) and demonstrated that FA is highly prevalent among families of youth with OCD (Calvocoressi et al., 1995, 1999). FA in OCD has been repeatedly linked to greater severity of symptoms, more functional impairment, worse clinical course, and poorer response to both psychosocial and psychopharmacological interventions (Albert et al., 2010; Cherian, Pandian, Bada Math, Kandavel, & Janardhan Reddy, 2014; Garcia et al., 2010; Lebowitz, Panza, Su, & Bloch, 2012; Merlo, Lehmkuhl, Geffken, & Storch, 2009). FA is not specific to OCD; it occurs broadly across pediatric anxiety disorders and is significantly less prevalent in nonanxious youth (Lebowitz, Scharfstein, & Jones, 2014). Almost all children with anxiety disorders, and their parents, endorse at least some FA on self-report measures or during semi-structured interviews (Benito et al., 2015; Lebowitz et al., 2013; Thompson-Hollands et al., 2014). FA in pediatric anxiety disorders is associated with functional impairment and caregiver burden (Benito et al., 2015; Lebowitz et al., 2013).

Recent studies have sought to identify factors associated with FA across childhood anxiety disorders to help identify families who may be engaging in problematic FA (Benito et al.,

2015; Lebowitz et al., 2013; Thompson-Hollands et al., 2014). Preliminary evidence suggests that greater scope, frequency, and interference of FA are related to maternal distress, including maternal anxiety and depressive symptoms (Benito et al., 2015; Flessner et al., 2011; Jones, Lebowitz, Marin, & Stark, 2015; Thompson-Hollands et al., 2014). Moreover, FA was found to mediate the relationship between maternal and child anxiety symptoms (Jones, Lebowitz, Marin, & Stark, 2015). Data regarding fathers' perceptions of FA are limited.

One study thus far has investigated children's perspectives on FA. Lebowitz, Scharfstein, and Jones (2014) found that a majority of youth with anxiety disorders understood that FA will not alleviate their anxiety in the long term, yet did not wish their parents to stop the FA. In fact, most parents report negative consequences of refusing to accommodate their children's anxiety. These consequences include a temporary increase in the child's anxiety, anger, or even abusive behavior (Lebowitz, Omer, & Leckman, 2011; Lebowitz, Vitulano, Mataix-Cols, & Leckman, 2011; Lebowitz, Vitulano, & Omer, 2011; Lebowitz et al., 2013).

Given the high frequency of FA, the potentially detrimental influences of FA on the course of the illness and response to treatment, as well as the burden on parents, it appears to be a meaningful environmental factor in the study and management of childhood anxiety. There is a need for accurate assessment of FA and the role it plays in pediatric anxiety, such as how FA progresses from the inconsequential modification of parental behavior to FA that is maladaptive. In addition, the field would likely benefit from psychosocial interventions aimed at reducing FA. This research may be informed by a better understanding of the underlying mechanisms involved in FA. Next, we briefly discuss the neurobiology of parental responses to child distress and suggest two pathophysiological processes as potentially implicated in excessive FA: dysregulated cortico-limbic circuitry and an impaired oxytocinergic system.

## Neurobiological Systems Associated With FA

Child anxiety triggers the attachment system which includes evolutionary-shaped and interrelated biological, behavioral, cognitive, and affective responses in the parents and children (Nolte, Guiney, Fonagy, Mayes, & Luyten, 2011). Parental sensitivity and protectiveness in response to threat are important parts of this process that serve to ensure the survival of offspring. The range of parental responsiveness to child distress lies on a continuum: both over-preoccupation with the child and insufficient attention may be problematic (Abramowitz, Schwartz, Moore, & Luenzmann, 2003; Barrett et al., 2012; Leckman et al., 2004).

New parents tend to be highly preoccupied with their infants' needs and exhibit a constellation of generally adaptive behaviors intended to create a safe, comfortable, and supportive environment for the child (Leckman et al., 2004). For example, parents may work to child-proof the house or try to anticipate when their children will be hungry so they can have food prepared. In addition to such behavioral changes, parental preoccupations often involve worries about the infant's well-being and one's adequacy as a parent (Leckman et al., 1999). Following the birth of an infant, there is a gradual decrease in parental vigilance,

as parents gain experience and confidence over time (Leckman et al., 1999). Learning to remain calm and effectively self-regulate one's own anxiety when a child is distressed is part of this normative developmental process. For parents, finding an appropriate balance in the amount of protection and involvement in the child's distress is a continual process.

Swain et al. (2014) proposed a model for the brain processes involved in shaping parental sensitivity and protective behavior. These processes include executive functions (e.g., attention to child cues), emotion regulation (e.g., emotion recognition and attunement), reward/motivation (e.g., attribution of salience to child signals), cognition (e.g., thoughts about one's child), and behavioral responses. The corresponding neural networks involve those associated with arousal/salience (i.e., amygdala and ventral striatum), reflexive/instrumental caring behaviors such as nursing and carrying (i.e., hypothalamus), emotion regulation (i.e., medial prefrontal cortex [PFC] and anterior cingulate cortex), and cognition (i.e., dorsolateral PFC, insula, inferior frontal and orbitofrontal gyri, and temporoparietal junction). Communication among these highly interconnected neural structures is regulated through a complex array of neurotransmitters (e.g., dopamine) and neuropeptides (e.g., oxytocin [OT]) (Nolte et al., 2011; Swain et al., 2014). Focusing on brain circuitry implicated in parental responsiveness, and on the biochemical communication network linking that circuitry generates hypotheses about the neurobiological infrastructure of FA.

## Dysregulated Cortico-limbic Neural Networks

Dysregulation of the cortico-limbic circuit may contribute to imbalances in parental responses to child distress, such as over-involvement or preoccupation with the child's well-being. Evidence from functional magnetic resonance imaging (fMRI) consistently implicates amygdala hyperactivity as essential to the experience of fear and anxiety, whereas the PFC is generally hypoactive in anxiety disorders (Martin, Ressler, Binder, & Nemeroff, 2010; Strawn et al., 2014). The PFC is involved in the integration of information and top-down regulation of emotions and behaviors (Martin et al., 2010). Preliminary research suggests that healthy parental neural activity in response to one's infant may transfer from the limbic system to the PFC with time, as parental preoccupation wanes (Swain et al., 2014).

The mirror neuron system modulates amygdala activity via the insula; this system is associated with the imitation of behavior and empathy (Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003; Ho, Konrath, Brown, & Swain, 2014; Lenzi et al., 2009). Activation of the mirror neuron system in response to infant faces was explored by Lenzi et al. (2009). The researchers conducted a fMRI study of healthy mothers imitating facial expressions of their own infants versus other babies. Mothers had greater activation in the amygdala and insula when viewing emotional versus neutral facial expressions and when interacting their own children versus other infants. Ho et al. (2014) found that mothers' personal distress (a form of empathy) in response to one's child displaying a distressed versus positive facial expression was associated with greater cortisol reactivity and neuronal activation in the amygdala and hypothalamus. Therefore, parents with hyperactivation in these regions may accommodate an anxious child out of their own personal distress (associated with amygdala activation) rather than exhibit more thoughtful, calculated responses (associated with PFC activation). This pattern likely gets reinforced over time as the parents temporarily relieve

both the children's anxiety and their own. Patterns of neuronal activation in these regions when involved in tasks relevant to FA may serve as a potential biomarker for individuals who may benefit most from parent guidance programs, such as those described below, to reduce pediatric anxiety by reducing FA.

## Impaired Oxytocinergic Functioning

OT, a neuropeptide that is primarily secreted by the hypothalamus and acts on both the central and peripheral nervous systems, is implicated in both anxiety regulation and in the modulation of close interpersonal behavior. Specifically, there is mounting evidence for the role of OT in anxiety, social affiliative behavior, and parenting (Galbally, Lewis, Ijzendoorn, & Permezel, 2011; Heinrichs, von Dawans, & Domes, 2009; MacDonald & Feifel, 2014). Much of the research regarding the role of OT in these domains has been conducted with animals using drug administration, knockout mice, and selective breeding.

In humans, several studies have found associations between OT and parental sensitivity, parental preoccupation, child protection, empathy, and attachment, all of which play a role in FA. Feldman, Weller, Zagoory-Sharon, and Levine (2007) found that levels of plasma OT among 62 healthy mothers were associated with greater parental sensitivity and preoccupation during child play tasks, as measured by systematically coded behaviors, an interview, and a self-report measure (Feldman et al., 2007). Elmadih et al. (2014) investigated the relation between maternal sensitivity and plasma OT levels over the course of a brief parent-child play task. Less sensitive mothers had higher concentrations of plasma OT, both at baseline and after the play task, compared with the more sensitive mothers (Elmadih et al., 2014).

The maternal aggression task has been used in animal research to study the role of OT in parental protective behavior (Bosch, Meddle, Beiderbeck, Douglas, & Neumann, 2005). This task involves introducing an "intruder rat" into the same cage as a mother rat with her pups and quantifying the mother's defensive aggression toward the intruder. Recently, Mah, Bakermans-Kranenburg, Van, and Smith (2015) developed an analogous paradigm in humans called the "enthusiastic stranger task." Sixteen mothers diagnosed with postnatal depression participated in a placebo-controlled within-subject study of the effects of intranasal OT on protective responses to an "ebullient socially intrusive" (p. 78) confederate's attempt to engage their infant. Maternal protectiveness was greater in the OT condition compared to the placebo condition, further supporting the role of OT in shaping maternal protective behavior.

Several studies have explored the role of OT in empathy. Intranasal administration of OT during a double-blind placebo-controlled study ( $n = 29$ ) was associated with empathy for others in pain but not for the self (Abu-Akel, Palgi, Klein, Decety, & Shamay-Tsoory, 2015). Moreover, intranasal OT administration significantly increased neuronal activation in the insula and inferior frontal gyrus among 54 female undergraduates when responding to a baby's cry labeled as coming from a sick infant and decreased activity in the same regions when the baby was labeled as bored (Riem, Voorthuis, Bakermans-Kranenburg, & van Ijzendoorn, 2014).



In summary, research points to the oxytocinergic system and dysregulated cortico-limbic circuitry as a possible neurobiological infrastructure for the kind of overly protective parental behaviors that contribute to high levels of FA. Considerably more research is needed before a true biomarker of highly accommodating parents can be identified. Currently, FA is assessed through youth- or parent-report questionnaires and clinician-administered interviews.

## Assessment

Table 1 presents the instruments developed to assess FA in pediatric anxiety disorders. The Family Accommodation Scale (FAS) was developed to study FA in OCD in 1995 (Calvocoressi et al., 1995, 1999). However, the systematic study and measurement of FA across anxiety disorders is much newer. In the past few years, three instruments have been developed to measure this construct, each by a different research team. The Family Accommodation Scale-Anxiety (FASA) is the most frequently used assessment of FA in pediatric anxiety and has been studied in multiple countries. It is quick and easy to administer, making it conducive to the fast-paced settings in which PMHNPs generally work (e.g., psychiatric inpatient units).

Psychometric investigations of each measure have only been conducted by the instrument developers. They all appear to have at least adequate internal consistency ( $\alpha \geq 0.70$ ) and good inter-rater reliability ( $ICC > 0.74$ ), as appropriate. However, reliability statistics for some of the scale versions and subscales are lacking. With regard to construct validity, the FASA total score and subscale scores have been confirmed through factor analysis; however, the FAS, Pediatric Accommodation Scale (Benito et al., 2015), and Family Accommodation Checklist and Interference Scale (FACLIS; Thompson-Hollands et al., 2014) have not. Only the FACLIS has data to support its predictive validity. Each measure has research supporting its convergent and discriminant validity. Specifically, significant correlations were found between each measure and either a self-report, parent-report, or clinician-rated measure of anxiety symptom severity. A significant correlation was also found between the FACLIS and the FASA (Thompson-Hollands et al., 2014). Discriminant validity was determined by exploring associations between each measure and questionnaires regarding symptoms of depression, externalizing disorders, aggression, or inattention. For example, a correlation between the FASA and a measure of child-rated depressive symptoms was not significant when controlling for the relationship between depression and anxiety.

It would be useful for researchers to continue exploring the psychometric characteristics of these measures. For example, the psychometric properties of each measure were established with predominantly White, middle-class individuals in specialty clinics. Therefore, the validity of the instruments could be strengthened by assessing FA in a variety of cultures and treatment settings with larger sample sizes. To date, these measures have been used in the pediatric anxiety literature for two purposes: to provide descriptive information on FA and to quantify associations between FA and various demographic and clinical attributes. These measures may also help investigate links between FA and treatment outcomes in childhood anxiety.

It is well known that perceptions of behavior vary greatly depending on the individual. The same is true for symptoms of childhood anxiety and FA. Ratings are often discrepant when comparing parent, child, teacher, and clinician report (Davis et al., 2010; Lebowitz, Scharfstein, & Jones, 2014; Thompson-Hollands et al., 2014). Research indicates that children endorse a lower frequency of FA than parents and underestimate how the frequency of FA impairs home life (Benito et al., 2015; Lebowitz, Scharfstein, & Jones, 2014). Parental distress has been shown to influence ratings of child anxiety symptoms and FA (Krain & Kendall, 2000; Lebowitz, Scharfstein, & Jones, 2015; Moreno, Silverman, Saavedra, & Phares, 2008). For example, Lebowitz, Scharfstein, and Jones (2015) found that mothers reported significantly greater amount of FA than children and that maternal anxiety moderated the association between mother and child reports of FA. Therefore, assessment of FA may be improved with multiple informants, especially if the parent(s) experience depression or anxiety themselves (Lebowitz, Scharfstein, & Jones, 2014). It is also important for research on FA to distinguish between frequency (how often FA occurs) and scope (how many behaviors or situations are changed to alleviate or avoid child anxiety) as well as the impact/interference for the child versus the parents. Assessing the severity of FA can help identify families who may benefit most from interventions targeting FA.

## Clinical Intervention

Available parent-based clinical interventions for pediatric anxiety disorders vary with regard to the emphasis placed on decreasing FA. Most parent-based CBT manuals (e.g., *From timid to tiger: A treatment manual for parenting the anxious child*, Cartwright-Hatton, Laskey, Rust, & McNally, 2010) encourage parents to reduce their facilitation of the child's avoidant behavior but do not make the systematic assessment, monitoring, and reduction of FA a central goal of treatment. We will summarize below current treatment programs targeting OCD (Comer et al., 2014; Freeman et al., 2014; Lebowitz, 2013; Thompson-Hollands, Abramovitch, Tompson, & Barlow, 2015) and other anxiety disorders (Lebowitz & Omer, 2013; Lebowitz, Omer, Hermes, & Scahill, 2014) from those that include a minimal focus on FA to those in which reducing FA is the primary target of treatment (Table 2). We included interventions for both youth and adults with OCD because there is only one empirical study exploring the effectiveness of reducing FA among the parents of youth with anxiety disorders.

Comer et al. (2014) developed a 14-week intervention for early-onset OCD (< 9 years of age) delivered via video-teleconferencing to parent and child jointly. The program involves the parents as coaches for their children and teaches them how to facilitate child motivation and exposures. It also instructs parents in modeling, scaffolding, contingency management, and differential attending. Attention to FA was minimal. Children are taught to "boss back" OCD and use the feelings thermometer to gauge anxiety. Toward the end of treatment, children and parents are taught about relapse prevention. A case series with five children indicated a partial diagnostic response in all children and full diagnostic response in 60% (3/5) of children. Improvement in symptoms of OCD and global functioning were noted from pre- to post-intervention with large effect sizes.



Freeman et al. (2003) developed a family treatment for young children with OCD that combines exposure and response prevention (E/RP) for youth with behavior management techniques for parents. The intervention includes 12 sessions conducted over 14 weeks. Parents are taught how to implement CBT with their children at home. FA is an explicit treatment component, although emphasis is limited. Several research studies have noted the efficacy of this approach in randomized controlled trials (RCTs) when compared to a family-based relaxation intervention (Freeman et al., 2008, 2014).

In 2015, Thompson-Hollands et al. studied the efficacy of a brief adjunctive intervention to reduce FA in family members of adults involved in standard E/RP. Family members (e.g., spouses/significant others) were randomized to participate or not participate in two sessions of psychoeducation and skills training. Results showed that individuals whose families were randomized to the adjunctive treatment had greater reduction in FA and OCD symptoms than those patients who did not receive the additional intervention (Thompson-Hollands et al., 2015). Moreover, among the patients who were randomized to the FA intervention, reduction in baseline reports of FA accounted for a significant amount of variance in reduction of OCD symptoms posttreatment.

The Supportive Parenting for Anxious Childhood Emotions (SPACE) Program is the first intervention to target pediatric anxiety without requiring child participation. SPACE involves 10–12 parent guidance sessions, with reduction in FA as the primary objective. Open trials of SPACE have been completed for youth with OCD (Lebowitz, 2013) and pediatric anxiety disorders (Lebowitz, Omer, Hermes, & Scahill, 2014). A RCT is currently in process. Both open trials supported the acceptability, feasibility, and effectiveness of SPACE for children aged 9–13. Treatment components include psychoeducation with an emphasis on the systemic and interpersonal nature of childhood anxiety, charting and monitoring of FA, systematic reduction of FA, and tools for coping with child reactions. For example, in the case of the child with SAD discussed above, the parents will first be instructed to chart all instances of FA throughout the week. Then, a target accommodation, such as amount of phone calls they answer per day, is chosen and monitored. After informing the child of the specific upcoming changes in their behavior, parents will begin reducing the amount of phone calls they answer each day. Both parental and child progress is monitored and discussed in session; changes or extensions to the plan are implemented as appropriate. Moreover, parents are taught to respond to their child's anxiety with "parental support," a communication style that combines an understanding and validation of the child's anxiety with a confidence that he/she can tolerate slightly more negative affect. Tools grounded in principles of nonviolent resistance are provided to help parents appropriately respond to child aggression or increased distress.

In summary, research findings provide preliminary support for targeting FA in the treatment of child and adolescent anxiety disorders. At present, several treatment options exist: family-based interventions (in person or delivered via the web), child-based treatments with adjunctive sessions for family members, and parent-delivered intervention. Research is required to (a) determine if the interventions targeting FA in patients with OCD are also effective broadly across pediatric anxiety disorders, (b) investigate what treatment works best for which patients, and (c) establish best practices for individualizing care.

## Clinical Implications and Recommendations

PMHNPs can play a pivotal role in increasing awareness of FA, as they often work in multidisciplinary teams and serve as consultants to other health professionals. They are also involved in direct patient care and provide psychoeducation to families. It is recommended that nurses include an assessment of FA in their comprehensive psychiatric evaluation of youth with anxiety disorders. A referral to a mental health provider who is practiced in interventions aimed at reducing FA may be warranted if problematic FA is endorsed by the family and/or the patient is unwilling or unable to engage in psychotherapy at that time. When introducing parent guidance interventions as a potential avenue for treatment, it may be helpful to clarify that (a) the primary aim is to reduce the child's anxiety, and (b) parents are not to blame, yet they can be an important part of the solution. As clinical intervention is another core competency of PMHNPs (National Panel for Psychiatric Mental Health NP Competencies, 2003), it may be useful for nurses to gain experience delivering this type of intervention. For enthusiastic researchers, there is much to be explored regarding the phenomenology, associated neurobiology, and assessment of FA, as well as treatment research in this area.

## Conclusions

FA is a promising interpersonal construct with the potential to inform research and clinical intervention targeting pediatric anxiety. Research investigating the role FA plays in the etiology, maintenance, and treatment of childhood anxiety is limited but growing. Current findings indicate a high prevalence of FA among families struggling with pediatric anxiety disorders, the potentially detrimental influence of FA on course of illness and treatment response, as well as its association with greater caregiver burden. Exploring the neurobiological correlates of FA may enhance our understanding of this interpersonal phenomenon and help in the personalization of childhood anxiety treatment. PMHNPs are in a valuable position to increase awareness of FA and include it in the assessment and treatment of pediatric anxiety disorders.

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**Table 1**  
Measures for Assessing Family Accommodation in OCD and Pediatric Anxiety Disorders

Instrument	Diagnostic range	Brief description	Example of assessment item	Time frame	Versions	Reliability (version/scale)
Family Accommodation Scale (Calvocoressi et al., 1999; Pinto, Van Noppen, & Calvocoressi, 2013)	OCD	IR = 12 items. R = 19 items. Includes assessment of OCD symptoms in addition to FA. Scores represent the frequency and extent of accommodation.	"Helping patient to undertake/complete rituals."	Past week	R/IR	Internal consistency: R/total scale = 0.90; IR/total score = 0.76–0.82. IR/inter-rater reliability = 0.75–0.99
Family Accommodation Scale-Anxiety (Lebowitz et al., 2013; Lebowitz, Scharfstein, & Jones, 2014)	All anxiety disorders	13 items. 9 items assess frequency of accommodation, 1 item assesses parental distress and 3 items assess child responses. First 9 items yield two subscales: participation and modification.	"Have you avoided things, going places, or being with people because of your child's anxiety?"	Past month	C/P	Internal consistency: P/total scale = 0.90–0.91
Family Accommodation Checklist and Interference Scale (Thompson-Hollands et al., 2014)	All anxiety disorders	20 items. Assesses engagement in specific types of accommodation behaviors (S) and associated interference for parents (I). Similar structure to the ADIS.	"Answered questions directed to my child."	Past 2 weeks	P	Internal consistency: S = 0.70–0.86; I = 0.78–0.82
Pediatric Accommodation Scale (Benito et al., 2015)	All anxiety disorders	IR = 14 items. P = 5 items. Yields three subscales: frequency (F), parent impact (PI), and child impact (CI).	"Reducing child responsibilities."	Past week	IR/P	Internal consistency: IR/F = 0.80; IR/PI = 0.80; IR/CI = 0.76; PF = 0.84; P/PI = 0.82; P/CI = 0.80 Inter-rater reliability: IR = 0.82–1.0

OCD, obsessive-compulsive disorder; C, child; P, parent; IR, interviewer rated; R, any relative (e.g., parent, sibling).

**Table 2**

**Interventions Targeting Family Accommodation in OCD and Anxiety Disorders**

<b>Intervention/research</b>	<b>Diagnostic range</b>	<b>Brief description</b>	<b>Duration</b>	<b>Emphasis on FA</b>	<b>Research</b>
Family-based CBT (Comer et al., 2014)	OCD	Family-based intervention delivered via Internet video-teleconferencing. Includes CBT and parent guidance.	14 sessions	Minimal	A case series with five children.
Family-based CBT (Freeman et al., 2003, 2008, 2014)	OCD	Combines E/RP for youth with behavior management techniques for parents.	12 sessions	Minimal	One open trial. Two RCTs of family-based CBT versus family-based relaxation training.
Adjunctive family intervention for adults with OCD (Thompson-Hollands et al., 2015)	OCD	Brief adjunctive treatment to E/RP. Family intervention sessions include psychoeducation and skills training to reduce FA.	2 sessions	Primary	One RCT of adjunctive treatment versus TAU.
SPACE Program (Lebowitz, 2013; Omer, Hermes, & Seahill, 2014)	OCD; pediatric anxiety disorders	Parent guidance sessions include psychoeducation and skills training to reduce FA. Children are not directly involved in treatment.	10–12 sessions	Primary	Two open trials. RCT of SPACE versus CBT in progress.

CBT, cognitive-behavioral therapy; E/RP, exposure and response prevention; FA, family accommodation; OCD, obsessive-compulsive disorder; RCT, randomized clinical trial; SPACE, Supportive Parenting for Anxious Childhood Emotions; TAU, treatment as usual.