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Highlights...

Drs. Jelalian and Long discuss the epidemic of pediatric obesity, the impact this has on child mental health, and various treatment approaches.



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- Being bullied during childhood and later self-harm

What's New in Research... See pages 3-4

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- Risk of autism may be lowered by use of folic acid

Guest Commentary

- Time to ratify the United Nations Convention on the Rights of the Child
— By Margaret Paccione-Dyszlewski, Ph.D.
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Free Parent Handout...
**Obesity and Mental
Health: Information
for Parents**

CABL

Obesity

Pediatric obesity and mental health: Assessment and treatment

By Elissa Jelalian, PhD., and Kristin Long, Ph.D.

The Epidemic

The prevalence of pediatric obesity has increased significantly over the past thirty years, with obesity now identified as a leading cause of preventable deaths. One third of U.S. children 2-19 years old are overweight or obese, defined as having a body mass index (BMI) >85th or >95th percentile, respectively, for their age and gender. Pediatric obesity has widespread effects on bodily systems and confers increased risk for obesity in adulthood.

Children and adolescents who are overweight or obese report impaired health-related quality of life, negative self-concept, more depressive symptoms, decreased physical self-worth, and higher body dis-

satisfaction than normal weight peers. They also report more problematic peer relationships. This includes experiencing more overt (i.e., physical) and relational (i.e., damage to friendships) victimization and being both victims and perpetrators of verbal bullying with peers (see Jelalian & Hart, 2009, for an overview).

Challenges across emotional, social, and behavioral functioning that co-occur with obesity fall within the realm of mental health. Likewise, some psychiatric disorders may result in increased risk for weight concerns. Therefore, practitioners are likely to encounter questions of whether, how, and when to address weight concerns in
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Anxiety

Family accommodation in pediatric anxiety: Research update

By Kristen Grabill Benito, Ph.D.

Anxiety disorders represent the most common group of psychiatric disorders in children, with prevalence rates of 12% to 20%. Anxiety disorders in childhood cause impairment across multiple domains, including academic and interpersonal functioning, and are associated with lower levels of social supports, academic underachievement, and high comorbidity with other disorders. Additionally, untreated pediatric anxiety disorders often continue into adulthood.

Efficacious treatments for childhood anxiety disorders include cognitive behavioral therapy (CBT) and selective serotonin

reuptake inhibitors (SSRIs), yet there remain children who do not respond optimally to these treatments. Therefore, clinicians and researchers have increasingly become interested in identifying barriers to successful treatment so that those barriers may be targeted for optimal treatment outcome.

Family accommodation

Family accommodation has been clinically reported as a barrier to pediatric anxiety treatment by virtue of being counter to the principles of CBT (these principles include,
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scoring method in a non-clinical population. *Eat Weight Dis* 2006; 11:201–210.

Correll CU, et al.: Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents *JAMA* 2009; 302:1765–1773. doi:10.1001/jama.2009.1549.

Jelalian E, Hart CN: Pediatric obesity. In M.C. Roberts & R.G. Steele (Eds.) *Handbook of Pediatric Psychology Fourth Edition*. Guilford Press: New York, NY; 2009.

Luce KH, Crowther JH: The reliability of the eating disorder examination – Self-report questionnaire version (EDE-Q). *Int J Eat Dis* 1999; 25:349–351.

Meyer AL, Gullotta TP (Eds.): *Physical activity across the lifespan*. Springer: New York, NY; 2012.

Tanofsky-Kraff M, et al.: A multisite investigation of binge eating behaviors in children and adolescents. *J Consult Clin Psychol* 2007; 75:901–913.

[Author's note: It is beyond the scope of the current article to address the unique challenges of weight gain associated with psychotropic medications such as anti-psychotics and mood regulators. The reader is referred to Correll and colleagues (2009) for a recent consideration.]

Anxiety

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among others, encouraging children to confront feared objects or situations). Family accommodation refers to ways in which family members accommodate patient symptoms, such as providing reassurance, allowing kids to avoid feared stimuli, taking over a child's duties, participation in rituals, and modifying family routines.

Theoretically, family accommodations reinforce a patient's symptoms, thereby increasing symptom severity and adversely affecting treatment outcome. For example, giving reassurance is negatively reinforcing because it temporarily reduces anxiety. Similarly, allowing the patient to avoid feared situations is negatively reinforcing.

Family accommodation in OCD

In children with obsessive compulsive disorder (OCD), which is characterized by intrusive thoughts and maladaptive rituals, up to 90% of families report at least minimal accommodation of symptoms. In children with OCD, high levels of family accommodation are related to increased symptom severity, greater functional impairment, and presence of more comorbid internalizing and externalizing behavior problems. Additionally, accommodation is associated with high levels of parent psychopathology, parent distress, and use of avoidant/escape coping strategies.

Some studies have shown that baseline family accommodation is related to symptom severity after treatment with CBT, suggesting that family accommodation hinders progress in treatment (Amir et al., 2000). This seems to indicate that family accommodation should be addressed as part of treatment with CBT for OCD. Similarly, another study reported that patients who did not respond to CBT treatment demonstrated the highest levels of family accommodation of all patients in the study (Ferrao et al., 2006).

In one study of CBT for pediatric OCD that included components designed to address family accommodation, researchers reported that family accommodation was reduced following treatment (Storch et al., 2007). However, researchers in that study did not directly investigate whether response to treatment was a result of reduced family accommodation. Finally, recent studies of family accommodation across treatment show that decreases in accommodation during the course of treatment predict better treatment outcome (Merlo et al., 2009).

Other anxiety disorders

Similar to the manner in which family accommodation is theorized to interfere with treatment of OCD by reinforcing symptoms, families of children with other anxiety disorders may also be reinforcing symptoms through accommodation. In generalized anxiety disorder (GAD), for example, parents may provide reassurance about many different worries, or allow their chil-

dren to avoid situations which might elicit anxiety (e.g., watching the news).

In Social Phobia (SP), parents may allow their children to avoid feared social situations, or rearrange family routines to accompany the child to social situations that the child might otherwise fear.

By nature of the disorder, parents of children with separation anxiety disorder (SAD) are involved in symptoms. Parents of children with SAD likely spend extra time upon separating trying to reassure the patient, or rearrange family schedules to allow children to avoid separation. Accommodating behaviors such as these have the potential to interfere with treatment, as they may undermine techniques that are central to completion of CBT.

Despite the theoretical rationale for studying family accommodation in children with GAD, SP, and SAD, as well as clinical reports regarding its interference during CBT, studies have not investigated family accommodation in this group of children. The primary reason for lack of research in this area is related to the need for a reliable

Percent of Parents Endorsing Accommodation Behaviors (Clinical Interview)

Accommodation Item	Example	Percent Endorsing
Providing reassurance	Answering questions about fears	97.1
Facilitating avoidance of feared situations	Not taking child to feared places	71.8
Change in parent leisure activities	Staying home instead of leaving child with a sitter	33.0
Change in family routine	Getting up early to provide extra help before school	66.0
Change in parent work schedule	Going to work late when child resists going to school	26.5
Reducing child responsibilities	Not finishing homework because homework is anxiety-provoking	36.9
Changing child school schedule	Allowing child to stay home when anxious	26.7
Changing child social activities	Dropping out of sports or clubs due to anxiety	38.8
Change in child sleep routine	Sleeping in bed with parents	50.5
Parent/family distress	Parent becomes upset when providing accommodation	76.7
Child response to non-accommodation	Child becomes angry/sad/more anxious when accommodation not provided	62.7

Percent of Parents Endorsing Accommodation Behavior (Parent-Report)

Accommodation Item	Example	Percent Endorsing
Providing reassurance	Answering questions about fears	95.9
Facilitating avoidance of feared situations	Not taking child to feared places	76.5
Change in family routine	Getting up early to provide extra help before school	68.0
Parent/family distress	Parent becomes upset when providing accommodation	74.0
Child response to non-accommodation	Child becomes angry/sad/more anxious when accommodation not provided	72.9

and valid measure to assess family accommodation in this population.

Pediatric Accommodation Scale

New data collected by the Pediatric Anxiety Research Clinic (PARC) and partners at Temple University in Philadelphia provide evidence supporting the use of a new scale, the Pediatric Accommodation Scale (PAS), in children with anxiety disorders. The PAS is an 11-item clinician-administered measure of family accommodation that assesses both frequency and severity of different accommodation behaviors (see table, page 6). It is important to measure both frequency and severity because some forms of accommodation, such as providing reassurance, may happen very frequently but have less impact on child functioning.

Alternatively, some accommodation behaviors, such as missing school, may happen infrequently but have a serious impact on child functioning. It is important to note that the PAS is designed to be administered by a clinician who has experience with child anxiety because accommodation behaviors may be underreported by less experienced clinicians and/or parents when completing a questionnaire. However, a clinician-administered measure is not feasible for use in some settings (e.g., busy clinical practice). Therefore, we also developed a short (5-item) parent-report version of the PAS for situations in which brevity is of high value (see table, this page).

Validating PAS

We administered the PAS (clinician and parent versions) to 105 children (69 from PARC and 36 from Temple) with a primary diagnosis of GAD, SP, or SAD. The PAS was administered as part of a larger battery of measures given to families during a clinic intake appointment. Results show that the PAS correlates strongly with other measures

of anxiety and has a weaker relationship with measures of different constructs (e.g., externalizing disorders). This evidence supports the construct validity of this measure.

Additionally, the PAS demonstrates good internal consistency and inter-rater reliability. These results also showed that the majority of families report at least minimal accommodation of child symptoms (over 95%) and that most parents report feeling distress when accommodating their child's symptoms (over 75%).

Overall, these percentages suggest that a large number of parents accommodate anxiety symptoms in this population of patients. In addition to the frequency of accommodation, our results suggest that facilitation of avoidance is the accommodation behavior associated with the greatest anxiety symptom severity. Providing reassurance is the accommodation behavior associated with the lowest anxiety symptom severity ratings.

In addition to the high number of parents reporting accommodation, results show that higher levels of family accommodation are related to higher levels of impairment due to anxiety and to higher overall anxiety severity. This replicates findings in the OCD literature and is consistent with the CBT treatment model for children with anxiety disorders.

Interestingly, family accommodation was strongly related to both parent symptoms of depression and anxiety. These results suggest that parents with higher levels of their own symptoms engage in more accommodation of child symptoms. Families in which parents are experiencing symptoms of anxiety and depression may benefit from targeted intervention to facilitate reduced accommodation.

Comparison of the clinician-administered and parent-report versions shows a strong correlation between the measures. The parent-report version also shows stronger relationships with similar constructs

(i.e. symptom severity/impairment, anxiety symptoms) than with dissimilar constructs (i.e. depression symptoms and externalizing symptoms). This provides evidence of construct validity for the Parent-Report PAS. Additionally, items were endorsed on this version similarly when compared to the clinician-administered version.

This suggests that the Parent-Report PAS is an accurate measure for use when brevity is of high value (e.g., in a busy clinical practice). The Clinician-Administered Pediatric Accommodation Scale may be preferred when detail about accommodation behaviors is of high value (e.g., research settings, for treatment planning).

Conclusions

Overall, family accommodation appears to be an important construct that is related to impairment, symptom severity, and treatment outcome in children with OCD. Recent research from our laboratory in collaboration with Temple University suggests that it may play a similar role in children with GAD, SP, and SAD. However, more research is needed to determine the cause-effect relationship (i.e., whether increased symptoms lead to increased accommodation or vice-versa) and to directly investigate the role of family accommodation in treatment for pediatric anxiety.

Many clinicians and researchers include reduction of family accommodation as an important part of treatment; however, its contribution to treatment outcome has yet to be investigated.



Kristen Grabill Benito, Ph.D., is Assistant Professor (Research) at the Alpert Medical School of Brown University and a Staff Psychologist at Rhode Island Hospital.

References

- Amir N, et al.: Family distress and involvement in relatives of obsessive-compulsive disorder patients. *J Anxiety Dis* 2000; 14:209–217.
- Ferrao YA, et al.: Clinical features associated to refractory obsessive-compulsive disorder. *J Affect Dis* 2006; 94:199–209.
- Merlo LJ, et al.: Decreased family accommodation associated with improved therapy outcome in pediatric obsessive-compulsive disorder. *J Consult Clin Psychol* 2009; 77:355–360.
- Storch EA, et al.: Family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: Comparison of intensive and weekly approaches. *J Am Acad Child Psychiatry* 2007; 46:469–478.

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