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Parental accommodation of child anxiety and related symptoms: Range, impact, and correlates

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Abstract

Parental accommodation—i.e., changes in parents' behavior in attempts to prevent or reduce child distress—has been most studied in relation to OCD. Although recent work suggests parents of children with non-OCD anxiety diagnoses also engage in accommodation, little is known about the specific forms, correlates, and associated interference of such accommodation. The present study examined the range and associated interference of parental accommodation behaviors using the newly developed Family Accommodation Checklist and Interference Scale (FACLIS) in a sample of the parents of 71 clinic-referred children with anxiety disorders ($N_{\text{Mothers}} = 68$; $N_{\text{Fathers}} = 51$). The FACLIS demonstrated good reliability and validity. Ninety-seven percent of mothers and 88% of fathers reported engaging in at least one type of accommodation in the previous two weeks, with parents reporting an average of roughly 4 interfering parental accommodation behaviors. Greater parental accommodation and associated interference were associated with higher maternal distress. Among the anxiety disorders, accommodation was most strongly associated with generalized and separation anxiety disorder, as well as specific phobias. Findings (a) offer psychometric support for the FACLIS as a reliable and valid tool for the assessment of accommodation range and impact, and (b) help clarify the considerable scope and interference associated with parental accommodation of childhood anxiety.

Keywords

Accommodation; anxiety; parents; transdiagnostic

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1. Introduction

1.1 Accommodation

In the study of childhood anxiety and related disorders, parental accommodation refers to parental behavior modifications that attempt to prevent or reduce child distress associated with participation in age-appropriate activities and/or exposure to feared or avoided stimuli (Flessner, Freeman, et al., 2011; Lebowitz et al., 2013). Clinical portraits suggest that parental accommodation can include facilitating children's anxiety-related avoidance, adhering to rigid child-assigned rules related to anxiety-provoking stimuli, modifying family routines, and providing excessive reassurance (e.g., Lebowitz, Panza, Su, & Bloch, 2012). Parents of anxious youth might engage in accommodation in response to a child's direct request, or because it is an effective way to reduce child distress in the short term; however, in the longer term these behaviors maintain anxiety and facilitate further avoidance through negative reinforcement processes (Ginsburg, Siqueland, Masia-Warner, & Hedtke, 2004).

Accommodation refers to parental behaviors that are functionally related to parental overprotection, a parenting *style* that has been extensively evaluated in the context of anxious children. Parents of anxious children, with mothers being the most frequently studied, are more likely than parents of non-anxious children to use an overprotective style which emphasizes parental “control” behaviors, such as intrusive involvement and low autonomy-granting during children's age-appropriate activities (Hudson & Rapee, 2001; McLeod, Wood, & Weisz, 2007; Rapee, 2001). Just as parental accommodation of child anxiety tends to maintain anxious avoidance over time through negative reinforcement, a parental overprotection style is thought to reduce a child's distress in the short-term, but reinforce anxiety over the long term. Given this relationship, it follows that accommodation may be conceptualized as behavior that is part of an overprotective parenting style often found among parents of anxious children.

Accommodation has been most studied in relation to obsessive-compulsive disorder (OCD) (Calvocoressi et al., 1995, 1999), where greater levels of accommodation are associated with increased symptomatology and impairment, and poorer treatment response (Caporino et al., 2012; Flessner, Freeman, et al., 2011; Garcia et al., 2010; Merlo, Lehmkuhl, Geffken, & Storch, 2009; Storch et al., 2007). Importantly, accommodation is largely contrary to the functional goals of exposure-based therapy (i.e., reducing avoidance and tolerating discomfort), and successful OCD treatment is associated with decreased family accommodation behaviors (Merlo et al., 2009; Storch et al., 2010). It is, thus, not surprising that family-based treatments for OCD that target family accommodation of symptoms yield greater improvements in patient functioning than family-based treatments that do not (Thompson-Hollands, Edson, Tompson, & Comer, 2014).

In the study and treatment of OCD, accommodation has been most commonly measured using the Family Accommodation Scale (FAS; Calvocoressi et al., 1999), a clinician-administered 12-item questionnaire that systematically measures the extent of accommodating behavior related to OCD. The FAS has demonstrated good internal consistency ($\alpha = 0.82$), strong reliability across raters (ICC between 0.75-0.99), and good convergent and discriminant validity (Calvocoressi et al., 1999). A parent-report

modification of the FAS has been developed as well (FAS-PR; Flessner, Sapyta, et al., 2011), with items rated by parents rather than by clinician. Both the FAS and FAS-PR assess the *frequency* of accommodation (e.g., once per week, 2-3 times per week, every day) as well as the *severity* of accommodation (e.g., mild, moderate, extreme).

1.2 Accommodation in other disorders

Although accommodation was initially studied in the context of OCD, increasing evidence suggests that accommodation is not a disorder-specific phenomenon. Family-level factors are intimately involved in the development, maintenance, and amelioration of disorders across the anxiety spectrum (Bögels & Brechman-Toussaint, 2006; Cooper-Vince, Pincus, & Comer, 2014; Hudson, Comer, & Kendall, 2008). The dynamic and transactional interplay between parent and child factors around anxiety-provoking stimuli has been well-articulated, with key interactions supported between parenting and child temperament, attachment history, and maladaptive parent behaviors (Ginsburg et al., 2004). Among parenting behaviors, overprotective and/or overinvolved parenting that restricts children's autonomy and therefore denies children key opportunities to practice and independently master their experiences of distress has been most strongly linked with child anxiety (McLeod, Wood, & Weisz, 2007). Given such associations, there is increasing acknowledgement that parental accommodation of child symptoms may play a key role in the broad development and/or maintenance of child anxiety.

Lebowitz and colleagues (2013) recently adapted the FAS for use with parents of children with *any* anxiety disorder diagnosis. The Family Accommodation Scale – Anxiety (FASA; Lebowitz et al., 2013) is a parent-report questionnaire assessing accommodation over the past month. FASA items are directly based on the accommodation items from the original FAS developed for OCD (Calvocoressi et al., 1995), but whereas the original scale included 3 items related to the extent of accommodation (clinician-rated from “No” to “Extreme”), FASA items were modified to allow parents to indicate the frequency of different types of accommodation. Analyses using the FASA indicate that accommodation is highly common across the full spectrum of pediatric anxiety disorders, with over 97% of a sample of parents of anxious youth reporting at least some level of accommodation (Lebowitz et al., 2013). Reported levels of accommodation in this sample of family members of anxious children are consistent with, and in fact a bit higher than, accommodation reported among family members of patients with OCD (Renshaw, Steketee, & Chambless, 2005).

Such findings provide critical data supporting the role of accommodation as a transdiagnostic phenomenon across anxiety disorders. However, there are important limitations to characterizing parental accommodation solely via the FASA. The FASA assesses the *frequency* of accommodation (e.g., “How often did you reassure your child?”), but frequency alone is not sufficient to adequately capture the scope and interference associated with accommodation. Some forms of accommodation behaviors may come up frequently but have a negligible impact on family functioning (e.g., letting the child sleep with a light on every night), whereas others may be comparatively rare but extremely disruptive (e.g., having to pick the child up from school in the middle of the day).

1.3 The Family Accommodation Checklist and Interference Scale (FACLIS)

In the present study, we developed a complementary assessment of parental accommodation for use with parents of children presenting with a range of child anxiety disorders that focuses specifically on the *interference* associated with parental accommodation. Moreover, in our experience we have found many families struggle to self-identify accommodating behaviors when using existing parent-reports of family accommodation. Available parent accommodation measures assess broad domains of accommodation without providing specific examples to guide the informant. Such measures require parents to self-identify whether their specific family patterns reflect broad categories assessed. For example, a parent who routinely prepares a different meal for their child than the rest of the family because of the child's anxious rigidity might respond “no” to the FASA item “Have you modified your family routine because of your child's symptoms?” but when asked specifically “Did you let your child have a different meal from the rest of your family so as to avoid distressing your child?” the parent might respond “yes.” Accordingly, for the present purposes, we developed the Family Accommodation Checklist and Interference Scale (FACLIS), which presents a list of 20 specific and common examples of family accommodation developed in consultation with a panel of experts in pediatric anxiety disorders and asks parents to rate the extent of personal and family interference associated with each endorsed item.

This report presents psychometric properties of the FACLIS in a sample of treatment-seeking anxious youth, as well as clinical correlates associated with the scope and interference associated with accommodation in families of anxious youth. We hypothesized that the scope of accommodation would be broad-based across families of anxious youth and that the FACLIS would exhibit strong psychometric properties as evidenced by strong internal consistency and good convergent, predictive, and divergent validity (i.e., significant associations between FACLIS subscales and established measures of family accommodation frequency and anxiety, and non-significant associations between FACLIS subscales and measures of child externalizing problems). We further hypothesized that scope of accommodation would be significantly associated with interference associated with accommodation, and that both scope and interference associated with accommodation would be significantly associated with parental stress, anxiety, and depression. Finally, we hypothesized that accommodation scope and interference would be uniquely associated with each of the child anxiety disorders.

2. Methods

2.1 Participants

Participants included children ($N = 71$, $M_{\text{Age}} = 11.04$ years, $SD = 3.83$, range 4-18; 52% female), and their parents ($N = 119$; $N_{\text{Mothers}} = 68$; $N_{\text{Fathers}} = 51$), presenting for assessment and/or treatment services at a university-affiliated outpatient anxiety disorders clinic in New England. Forty-eight of the children in the sample had both parents complete the FACLIS and other measures. Children were predominantly non-Hispanic white (78.9%), with 11.3% black or other minorities and 9.8% missing or not reporting race. Thirty-five percent of families reported an annual family income of over \$100,000. Children were assigned an

average of 1.9 diagnoses (range = 1-5) following the intake. Principal anxiety and related diagnoses of children in the sample were as follows (including co-principal diagnoses): generalized anxiety disorder (N = 32); selective mutism (N = 14); social anxiety disorder (N = 13); panic disorder with or without agoraphobia (N = 8); specific phobia (N = 7); separation anxiety disorder (N = 7); obsessive-compulsive disorder (N = 3); and post-traumatic stress disorder (N = 2).

2.2 Measures

All measures were administered at clinic intake, prior to the delivery of any treatment services.

Child Diagnostic Profile—The Anxiety Disorders Interview Schedule for Children and Parents for DSM-IV (ADIS-IV-C/P; Silverman & Albano, 1997) was administered to all parents, and to all children ages 7 and older, to determine child diagnostic status. The ADIS-IV-C/P collects parent and child reports of symptoms using separate interviews, and information obtained in these interviews is used to form a composite diagnostic profile in accordance with DSM-IV using the “or” rule, in which a diagnosis is considered present if either the child or the parent(s) endorse the symptom. A clinical severity rating (CSR) is designated for each diagnosis assigned, ranging from 0 (no symptoms) to 8 (very severe symptoms), with CSRs of 4 or above meeting full diagnostic criteria and CSRs below 4 indicating the presence of symptoms that do not meet the threshold for a clinical diagnosis. The ADIS-IV-C/P is the most widely used semi-structured diagnostic interview for the assessment of anxiety disorders in youth (Silverman & Ollendick, 2005) and demonstrates good psychometric properties, particularly for the anxiety disorders. The ADIS-C/P has shown strong concurrent validity and reliability (Silverman & Ollendick, 2005; Silverman, Saavedra, & Pina, 2001; Wood, Piacentini, Bergman, McCracken, & Barrios, 2002).

Child Psychopathology Symptoms—The *Child Behavior Checklist* (CBCL; Achenbach & Rescorla, 2001) is a 120-item parent-report questionnaire that assesses emotional and behavioral problems in children. In addition to a Total Problems score, the CBCL yields an overall Internalizing score and an overall Externalizing score, as well as several subscales (e.g., *DSM-oriented anxiety*, withdrawn/depression, somatic complaints, attention problems, social problems, thought problems, rule-breaking behavior, and aggression). Parents rate each item regarding their child (e.g., “Acts too young for his/her age”) on a scale from 0 (not true) to 2 (very true or often true). T-scores are generated to characterize a child's score within the context of age and gender-matched norms. The CBCL has demonstrated excellent criterion validity, internal consistency, and test-retest reliability (Achenbach & Rescorla, 2001). The following subscales were included in the present analyses: Internalizing and *DSM-Oriented Anxiety* (for predictive validity analyses), and Externalizing, Aggression, Attention (for divergent validity analyses).

Family Accommodation—The *Family Accommodation Scale – Anxiety* (FASA; Lebowitz et al., 2013) is a 9-item parent-report questionnaire assessing frequency of parental accommodation over the past month. FASA items are based on the 9 accommodation items from the original FAS developed for OCD (Calvocoressi et al., 1995), but whereas the

original scale included 3 items related to the extent of accommodation (clinician-rated from “No” to “Extreme”), FASA items ask parents to indicate the frequency of different types of accommodation. The FASA has demonstrated good internal consistency, and convergent and divergent validity (Lebowitz et al., 2013). The FASA was administered to a subset of parents in the present sample ($N = 61$).

Parents also completed the Family Accommodation Checklist and Interference Scale (FACLIS), developed for the present purposes to assess the specific forms of parental accommodation exhibited in families with anxious youth, as well as associated interference. The FACLIS presents a list of 20 specific and common examples of family accommodation and asks parents to rate the extent of personal and family interference associated with each endorsed item. Items were generated in collaboration with a panel of experts who completed advanced postdoctoral training in pediatric anxiety disorders. Parents are asked to place a check mark next to all items they have engaged in during the previous two weeks in response to their child's fear or anxiety. For each endorsed item, parents rate the extent to which engaging in each type of accommodation interfered with the parents' and family life on a scale from 0 (“no interference”) to 8 (“extreme interference”). A 0-8 interference scale for each item was selected for consistency with the 0-8 interference ratings collected throughout the ADIS-C/P. The sum of all accommodation items endorsed on the FACLIS yields a measure of the number of areas in which accommodation is occurring (FACLIS Accommodation Scope score). Interference ratings for all endorsed items are averaged to yield a measure of mean burden associated with accommodation (FACLIS Mean Accommodation Interference score). Interference ratings for all endorsed items are also tallied to yield a measure of total burden associated with accommodation (FACLIS Total Accommodation Interference score).

For analyses examining demographic and clinical correlates of family parental accommodation and associated impairment, we generated composite FACLIS subscale scores using the “or rule” to integrate mother- and father-reports of Accommodation Scope (in which each accommodation item was considered present if either the mother *or* the father endorsed it), and by averaging interference scores across mother- and father-reports at the item level to generate composite Total Accommodation Interference and Mean Accommodation Interference.

Parental Distress—The *Depression Anxiety Stress Scales* (DASS; Lovibond & Lovibond, 1995) was administered to all parents. The DASS is a 42-item questionnaire consisting of three subscales to measure the negative emotional states of depression, anxiety, and stress in adults. The DASS is widely used in both research and clinical settings, and has demonstrated strong internal consistency and concurrent validity in both clinical and nonclinical populations (Antony, Bieling, Cox, Enns, & Swinson, 1998).

3. Results

3.1 Preliminary findings

The Accommodation Scope scores of mothers ranged from 0 to 13 ($M=3.82$, $SD = 2.86$) and the Accommodation Scope scores for fathers ranged from 0 to 17 ($M =3.67$, $SD = 3.61$),

$t(117) = .264, ns$. Mean Accommodation Interference scores according to mother-report ($M = 3.30, SD = 1.91$) and father-report ($M = 2.94, SD = 2.20$) were also comparable, $t(107) = 0.92, ns$. Total Accommodation Interference scores according to mother-report ranged from 0 to 77 ($M = 14.53, SD = 16.87$) and according to father-report ranged from 0 to 50 ($M = 11.53, SD = 11.95$), $t(107) = 1.02, ns$. Analyses found medium associations between mother and father reports of Accommodation Scope ($r = .27, p = .06$) and Total Accommodation Interference ($r = .38, p = .01$), and a small association between mother- and father-reports of Mean Accommodation Interference ($r = .18, ns$).

3.2 Reliability and validity of the FACLIS

FACLIS subscales showed good internal consistency according to mother-report ($\alpha_{\text{Scope}} = .70$; $\alpha_{\text{TotalInterference}} = .82$) and father-report ($\alpha_{\text{Scope}} = .86$; $\alpha_{\text{TotalInterference}} = .78$). Further analyses were conducted to evaluate the impact of single-item removal on total subscale alphas for each item; results indicated that no item's removal substantially enhanced the consistency of any subscale (i.e., α 's continue to be $> .80$ and no α 's reach $.90$ after removal of any individual item). Convergent validity was supported by significant correlations between mother-reported FASA scores and FACLIS Accommodation Scope scores, and between father-reported FASA scores and FACLIS Mean Accommodation Interference scores (see Table 1). Father-reported Accommodation Scope and Total Accommodation Interference were significantly correlated with CBCL Internalizing scores but fathers' FACLIS scores were not associated with CBCL *DSM*-Oriented Anxiety scores; mother-report FACLIS subscales showed the reverse pattern of associations, with Total Accommodation Interference significantly associated with CBCL Anxiety but none of the FACLIS subscores related to Internalizing. Divergent validity was supported by non-significant associations between mother-reported FACLIS Accommodation Scope scores and CBCL Aggression, Attention, and Externalizing scores, as well as by non-significant associations between father-reported FACLIS Accommodation Scope scores and CBCL Aggression, Attention, and Externalizing scores. Predictive validity of the FACLIS was supported by significant associations between father-reported FACLIS Total Accommodation Interference scores and principal diagnosis CSR, although the association between mother-reported FACLIS Total Interference scores and principal diagnosis CSR was not significant. Overall, study hypotheses regarding the relationships among FACLIS scores and measures of psychopathology were broadly supported, with minor exceptions.

3.3 Scope and associated interference of accommodation among parents of anxious youth as assessed by the FACLIS

Every item on the FACLIS was endorsed by at least one parent across the sample, with 66 (97%) mothers and 45 (88%) fathers endorsing at least one item. Frequencies and average level of associated interference for each item are presented in Table 2. Not surprisingly, both mother-reported and father-reported FACLIS Accommodation Scope scores were highly associated with Total Accommodation Interference ($r_{\text{Mother}} = .92, p < .0001$; $r_{\text{Father}} = .81, p < .0001$). Mothers' Accommodation Scope scores were also related to their Mean Accommodation Interference ratings ($r = .24, p = .05$), although fathers' Accommodation Scope scores were not related to their Mean Accommodation Interference scores ($r = -.08, ns$).

Across items, the most frequent forms of parental accommodation were letting the child have a different meal than the rest of the family (endorsed by roughly three-fourths of informants), answering questions directed at the child (endorsed by roughly two-fifths of informants), and letting the child sleep with the lights on or in the parent's bed (endorsed by roughly one-third of informants) (see Table 2). In contrast, the most interfering forms of accommodation were letting the child take a “mental health day” (mean interference = 4.68), letting the child sleep in the parent's bed (mean interference = 4.52), and answering frequent texts/phone messages from the child (mean interference = 4.51). The least frequently endorsed forms of parental accommodation were getting the child out of a performance, picking the child up early from a sleepover, and letting the child go to work with a parent, and the least interfering forms of parental accommodations were letting the child sleep with a light on (mean interference = 1.41), ordering for the child at a restaurant (mean interference = 1.68), and picking the child up early from a sleepover (mean interference = 2.10).

3.4 Demographic correlates of parental accommodation

Accommodation Scope scores were significantly greater for younger children (ages 4-11; $M = 5.90$, $SD = 4.11$) than for older children (ages 12+; $M = 3.97$, $SD = 3.17$), $t(65.89) = 2.19$, $p = .032$); Total Accommodation Interference was comparable across the two age groups ($M_{\text{Older}} = 9.44$, $SD = 9.87$; $M_{\text{Younger}} = 15.79$, $SD = 14.59$; $t(64) = 1.94$, $p = .06$), as was Mean Accommodation Interference ($M_{\text{Older}} = 2.77$, $SD = 1.77$; $M_{\text{Younger}} = 3.32$, $SD = 1.60$; $t(64) = 1.32$, ns). FACLIS items with the highest mean age for endorsement were: “Got my child out of a school assignment by telling teacher about the child's symptoms” ($M = 12.07$, $SD = 2.46$), “Let my child stay home from school” ($M = 11.99$, $SD = 3.19$); and “Parent stayed home from work” ($M = 11.92$, $SD = 2.98$); FACLIS items with the lowest mean age for endorsement were “Let my child sleep with the lights on” ($M = 9.19$, $SD = 2.84$), “Let my child sleep in parent's bed” ($M = 9.22$, $SD = 2.77$), and “Slept in my child's bed with him/her” ($M = 9.33$, $SD = 2.80$).

There were no gender differences with regard to Accommodation Scope ($M_{\text{Males}} = 5.06$, $SD = 3.95$; $M_{\text{Females}} = 4.91$, $SD = 3.67$; $t(64) = .16$, ns), Total Accommodation Interference ($M_{\text{Males}} = 14.38$, $SD = 13.52$; $M_{\text{Females}} = 12.42$, $SD = 13.20$; $t(62) = .58$, ns), or Mean Accommodation Interference ($M_{\text{Males}} = 3.45$, $SD = 1.52$; $M_{\text{Females}} = 2.77$, $SD = 1.75$; $t(65) = 1.69$, ns).

3.5 Diagnostic correlates of parental accommodation

Rates of endorsement for each FACLIS item by diagnostic group are presented in Table 3. Associations between the presence of specific diagnoses with FACLIS subscales scores are presented in Table 4. The presence of generalized anxiety disorder (GAD) and separation anxiety disorder (SepAD) were each significantly related to Accommodation Scope and Total Accommodation Interference. The presence of GAD and specific phobia (SP) were each significantly related to Mean Accommodation Interference. No other diagnoses were significantly related to the FACLIS subscales.

Given high rates of comorbidity among the anxiety disorders (Verduin & Kendall, 2003), we tested the unique predictive contributions of specific anxiety disorder diagnoses by regressing each of the FACLIS subscales onto dummy variables representing the diagnoses that were significantly correlated with that subscale in the previous analyses. For the regression simultaneously predicting Accommodation Scope from GAD presence and SepAD presence, the overall model was significant, $F(2, 66) = 4.18, p = .02$, but only GAD was a significant predictor (GAD: $\beta = .24, p = .04$; SepAD: $\beta = .22, p = .06$). In the regression simultaneously predicting Total Accommodation Interference from both GAD presence and SepAD presence the model was significant, $F(2, 64) = 6.04, p = .004$, and both diagnoses were significant predictors (GAD: $\beta = .25, p = .03$; SepAD: $\beta = .30, p = .01$). In the final regression simultaneously predicting Mean Accommodation Interference scores from both GAD and SP, the model was again significant, $F(2, 64) = 3.64, p = .03$. SP was a nearly significant predictor ($\beta = -.24, p = .06$) and GAD was not a significant predictor ($\beta = .16, ns$).

3.6 Parental distress correlates of parental accommodation

Mother-reported Accommodation Scope was correlated with their own personal levels of stress ($r = .36, p = .006$) and anxiety ($r = .46, p = .000$), but not their own levels of depression ($r = .26, ns$). Mother-reported Total Accommodation Interference was significantly correlated with depression, anxiety, and stress levels ($r_{\text{Depression}} = .33, p = .02$; $r_{\text{Anxiety}} = .53, p = .00$; $r_{\text{Stress}} = .47, p = .00$). Neither father-reported Accommodation Scope nor father-reported Total Accommodation Interference was correlated with any of the DASS ratings (Scope with depression, anxiety, and stress r s = .04, .20, and .14, respectively; Total Accommodation Interference with depression, anxiety, and stress r s = -.05, -.06, and .00, respectively).

4. Discussion

4.1 Prevalence of accommodation and psychometric support of the FACLIS

The present findings add to a growing body of empirical literature (e.g., Lebowitz et al., 2013) documenting the considerable presence of parental accommodation in the families of children with the common anxiety disorders, clarifying patterns, correlates, and interference associated with parental accommodation in affected families. Every form of accommodation assessed was endorsed by at least one parent across the sample, with parents of anxious youth reporting an average of roughly 4 interfering parental accommodation behaviors in the previous two weeks. Moreover, the present study provides psychometric support for the FACLIS as a reliable and valid parent-report measure of the scope and impact of family accommodation, adding a unique perspective to a growing portfolio of supported measures (e.g., Flessner, Sapyta, et al., 2011; Lebowitz et al., 2013) that can be used to assess various aspects of parental accommodation in the families of anxious youth.

The vast majority of participating parents reported engaging in at least one accommodation behavior over the previous two weeks. Interference ratings associated with these accommodation behaviors were, on average, moderate, although there was considerable variability in interference ratings across the sample with many parents reporting substantial

interference associated with accommodation behaviors. The most frequent but least interfering forms of accommodation tended to be simple modifications to daily routines, such as allowing the child to sleep with a light on or providing a different meal for the child than the rest of the family, whereas relatively larger changes to the family's schedule, such as letting the child go to work with a parent, were among the least frequent but most interfering. Interestingly, parents reported that allowing the child to sleep in the parent's bed was both one of the most common types of accommodation and also one of the most interfering. Future work is needed to identify why parents would continue to engage in accommodation behaviors when they are highly interfering. In the case of parents letting anxious children sleep in their beds with them, it is possible that such parents perceive it would be even *more* interfering if they were to *not* let their anxious child co-sleep with them (e.g., child might be crying all night instead of falling back to sleep in his or her own bed, keeping everyone in the house up). It is likely that short-term relief experienced when an anxious child is able to fall back asleep when in the parent's bed is powerfully reinforcing for all family members and sets the stage for entrenched patterns of continued co-sleeping and interfering accommodation.

4.2 Maternal anxiety, stress, and accommodation

Mothers' symptoms of anxiety and stress were related to the scope of accommodation, and their levels of anxiety, stress, and depression were all significantly related to the total interference associated with their accommodation. Such findings add to previous work suggesting that parental anxiety has an important relationship with accommodation (Caporino et al., 2012; Peris et al., 2008; Storch et al., 2007), by newly highlighting key relationships between accommodation and maternal stress and depression. The present finding that maternal anxiety and stress are associated with accommodation is also consistent with previous research exploring relationships between maternal anxiety, child anxiety, and parenting behaviors. In particular, Rapee (2001) discusses the tendency for mothers with elevated anxiety to display an "overprotective" style of parenting with their anxious children. Observational studies of mothers and anxious children show that anxious mothers tend to grant their children less autonomy than non-anxious mothers (Whaley, Pinto, & Sigman, 1999). Given that accommodation, as a parenting behavior, may be functionally consistent with an overprotective style of parenting by reducing a child's autonomy, it is not surprising that mothers' own anxiety was found to be related to more pervasive and interfering accommodation behaviors. Importantly, in the context of the present cross-sectional design, it remains unclear whether maternal distress leads to parental accommodation, whether parental accommodation leads to maternal distress, or whether there is a complex transactional relationship between maternal distress and parental accommodation in which each exacerbate the other. Future longitudinal work is needed to identify the directionality of observed relationships across time.

Notably, previous research examining relationships between family accommodation and parental anxiety (e.g., Caporino et al., 2012; Peris et al., 2008; Storch et al., 2007) had not examined differential relationships of maternal versus paternal anxiety with accommodation, but their parent samples were heavily female (e.g., 85-88%). The present study found fathers' depression, anxiety, and stress were all unrelated to accommodation scope and

interference. Future work is needed to clarify whether such differential associations across mothers and fathers are due to true differences or simply reporting biases.

4.3 Accommodation across age groups

We observed significant differences in accommodation between parents of children of different ages, with parents of younger children endorsing a significantly greater scope of accommodation. It may be that parents of younger children struggle to a greater extent to balance developmentally appropriate assistance to their children with resisting maladaptive accommodation related to anxiety. On the other hand, it is possible that FACLIS items are less useful in the identification of developmentally inappropriate parental accommodation in younger anxious child populations, given the high prevalence of such parental behaviors in the families of younger children who are not anxious. The FACLIS items associated with the lowest mean age of endorsement all involved sleep-related accommodations (e.g., sleeping with lights on or sleeping in the parents' bed). While sleep-related anxiety is extremely common in young children, it is notable that the mean age of the children whose parents endorsed these items was approximately 9 years old.

The FACLIS items with the highest mean age of endorsement tended to center around school attendance and assignments, perhaps reflecting the increase in school-related expectations as children get older. Greater emphasis on grades and more challenging assignments may make anxious children wish to avoid school entirely, and parents may struggle to balance empathy with appropriate firmness.

4.4 Diagnostic associations with accommodation

GAD and SepAD showed the strongest associations with accommodation scope and total interference. The particular relationship between SepAD and family accommodation supports Lebowitz and colleagues' (2013) findings, and makes sense given that the core diagnostic feature of this disorder is so intertwined with parent-child interpersonal processes—i.e., excessive fear of being separated from one's parents. A child who is afraid to physically separate from his/her parents is likely to have a particularly strong pull for parental accommodation behaviors (e.g., co-sleeping, frequent check-ins, refusing to separate from parents to attend school or social activities). Additionally, the types of accommodation children with SepAD often elicit from parents may be associated with particularly increased interference due to frequent disruptions to parent and family schedules or routines (e.g. lateness to work or school, parent needing to stay home/with their child rather than go to work or spend time with their spouse/other adults).

Findings regarding the association between family accommodation and GAD are notable, given the noted diagnostic and phenomenological similarities between GAD and OCD, relative to other anxiety disorders (Comer, Kendall, Franklin, Hudson, & Pimentel, 2004). Examples of these similarities include high levels of intolerance of uncertainty and self-doubt in children with GAD and OCD, both of which might lead to higher frequency of reassurance-seeking from parents, and in turn, higher rates of parental accommodation by way of providing reassurance. Furthermore, because children with GAD often express worries and fears spanning several broad domains in their lives (e.g. school, social/

interpersonal, health/safety of oneself and loved ones), the scope of parental accommodation of these children's fears is likely to parallel these domains in its breadth.

4.5 Efforts to reduce family accommodation

Previous studies of accommodation have found that most family members report they do not think their accommodation is helpful to the patient in the long term (Calvocoressi et al., 1999), and that they would like guidance around how best to respond to patients' symptoms (Shafran, Ralph, & Tallis, 1995). Thompson-Hollands and colleagues (under review) recently tested a two-session adjunctive intervention that successfully reduced accommodation in the family members of adult patients with OCD.. Similarly, in recent years several family-based approaches to the treatment of child anxiety disorders have placed an increasing emphasis directly on the problems of parental accommodation (e.g., Comer et al., 2012; Lebowitz, Omer, Hermes, & Scahill, in press) and are showing strong initial success.

4.6 Study limitations

While this study adds to our understanding of the role, range, and impact of parental accommodation across pediatric anxiety disorders, several limitations warrant comment. First, the cross-sectional nature of the data cannot speak to matters of temporal precedence in (a) associations between accommodation and child anxiety symptoms, (b) associations between accommodation and parental distress, nor (c) changes in the forms or associated impairment of accommodation across time. Future studies using the FACLIS would do well to incorporate prospective longitudinal designs with repeated assessments. Second, the present data were collected in an outpatient specialty clinic for the treatment of anxiety disorders, and as such results may not generalize to the general child population, to other treatment settings where children receive mental health care, or to outpatient specialty settings of different sociodemographic make-up. Furthermore, we did not examine associations between parental accommodation and child anxiety in a non-anxious sample. Future work would do well to incorporate comparison data in non-anxious youth. Third, some of the analyses examining associations between accommodation and the presence of different anxiety disorders may have been underpowered due to relatively lower base rates of some disorders versus others. Such concerns however are tempered somewhat by the significant findings observed with regard to SepAD, which was one of the least common disorders in the present sample. Fourth, the internal consistency of the FACLIS was evaluated using coefficient alpha, although other methods of computing internal consistency have been suggested (e.g., coefficient omega; see Dunn, Baguley, & Brunnsden, 2014). Further, the study sample was not sufficiently powered to afford a factor analysis of the FACLIS; future work drawing from larger samples is needed to evaluate how well FACLIS items hang together. Finally, as with previous research examining parental accommodation, we relied exclusively upon parent self-report. Future work may do well to incorporate multimethod assessment approaches that include structured behavioral observations.

5. Conclusions

The present analyses offer key data to broaden our understanding of the range and impact of parental accommodation with regard to pediatric anxiety, and clarifies the considerable scope and interference associated with accommodation of childhood anxiety—particularly among youth with GAD, SepAD, and/or SP. Moreover, the newly developed FACLIS offers a reliable and valid tool for the assessment of accommodation range and impact, and may have the potential to meaningfully inform clinical decision-making. Although family-based treatments appear to show no superiority, on average, over individual child-based treatments for child anxiety disorders (see Barmish & Kendall, 2005), for families showing particular family patterns associated with child anxiety, family-based approaches are indeed indicated (e.g., Cobham, Dadds, & Spence, 1998). In the context of increased recognition of the need for tailored and patient-centered mental health care, the FACLIS can provide critical information to help inform decisions about whether parents should be involved in an anxious child's treatment, and if so, to what extent parental accommodation overall and which specific forms of parental accommodation should be clinical targets.

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- Accommodation is a transdiagnostic process, but existing measures are limited.
- We developed a checklist to assess the scope and impact of parental accommodation.
- The measure performed well psychometrically.
- Accommodation was widespread and associated with considerable interference.
- Certain anxiety disorder diagnoses were particularly associated with accommodation.

Table 1

Correlations among FACLIS subscales and other measures of parental accommodation and psychopathology.

	FACLIS mother-report			FACLIS-father-report		
	Scope	Total Interference	Mean Interference	Scope	Total Interference	Mean Interference
FASA Total	.58 ***	.52 **	.23	.34	.46	.48 *
CBCL Aggression	.07	-.05	-.08	.25	.32	.15
CBCL Attention	.07	.10	.16	.14	.24	.01
CBCL Externalizing	-.04	-.15	-.08	.21	.26	.13
CBCL Internalizing	.17	.12	.06	.34 *	.36 *	.02
CBCL Anxiety	.29	.33 *	.26	.23	.16	-.07
Principal diagnosis CSR	.01	.08	.12	.10	.31 *	.23

Note: FACLIS = Family Accommodation Checklist and Impairment Scale; FASA = Family Accommodation Scale – Anxiety; CBCL = Child Behavior Checklist; CSR = Clinician Severity Rating from the Anxiety Disorders Interview Schedule for Children and Parents (ADIS-C/P-IV)

*
p<.05

**
p<.01

p<.001

Table 2

Endorsement rates and interference associated with FACLIS items

In the past two weeks did you engage in any of the following behaviors in response to your child's fear or anxiety?	Mother-report		Father-report	
	Percent endorsing	Mean interference ¹	Percent endorsing	Mean interference ¹
Let my child have a different meal from the rest of the family at dinner	44.12	3.79	41.12	3.50
Answered questions directed to my child	42.65	3.22	31.37	3.25
Let my child sleep with the lights on	27.94	1.72	31.37	1.00
Let my child sleep in parent's bed	27.94	5.00	31.37	3.87
Let my child stay home from school	26.47	4.00	19.61	3.33
Let my child avoid social engagements	25.00	4.50	31.37	1.69
Slept in my child's bed with him/her	22.06	4.47	27.45	2.77
Drove/picked my child up from school to avoid the bus	20.59	2.86	19.61	2.20
Ordered for my child at a restaurant	20.59	1.50	23.53	1.92
Picked my child up from school early	19.12	3.85	19.61	3.80
Let my child have a "mental health day"	19.12	4.33	15.69	5.14
Got my child out of a school assignment by telling teacher about the child's symptoms	17.65	4.42	7.84	3.50
Responded to text messages/calls from my child checking to see if I was okay	16.18	4.90	9.80	4.00
Avoided fireworks, loud movies, etc.	13.24	3.44	11.76	1.00
Parent stayed home from work	11.76	5.14	13.73	4.29
Came home early from an outing	10.29	5.00	13.73	2.71
Let my child not attend a birthday party he/she was invited to	7.35	3.80	7.84	0.75
Got my child out of a performance (play, spelling bee, etc.)	4.41	4.00	3.92	4.00
Picked my child up early from a sleepover	4.41	3.67	1.96	0.00
Let my child go to work with me or his other parent	1.47	4.00	3.92	2.00

Note: FACLIS = Family Accommodation Checklist and Impairment Scale

¹ Average interference was calculated for those respondents who endorsed the item

Table 3

Endorsement rates of FACLIS items by clinical-level diagnosis

Item ¹	Total sample % (n = 71)	GAD % (n = 38)	SocAD % (n = 23)	SP % (n = 15)	SM % (n = 14)	PDA % (n = 10)	SepAD % (n = 10)
Let my child have a different meal from rest of our family at dinner	47.9	52.6	56.5	46.7	50.0	0.0	60.0
Answered questions directed to my child	49.3	47.4	73.9	46.7	85.7	30.0	70.0
Let my child sleep with the lights on	36.6	44.7	34.8	33.3	35.7	0.0	50.0
Let my child sleep in parent's bed	33.8	42.1	34.8	26.7	35.7	20.0	60.0
Let my child stay home from school	31.0	34.2	43.5	26.7	28.6	40.0	30.0
Let my child avoid social engagements	39.4	39.5	39.1	40.0	42.9	60.0	60.0
Slept in my child's bed with him/her	29.6	42.1	8.7	6.7	7.1	30.0	50.0
Drove/picked my child up from school to avoid the bus	26.8	39.5	34.8	33.3	21.4	20.0	20.0
Ordered for my child at a restaurant	28.2	31.6	39.1	20.0	42.9	0.0	50.0
Picked my child up from school early	26.8	26.3	30.4	33.3	28.6	30.0	20.0
Let my child have a "mental health day"	25.4	36.8	34.8	20.0	21.4	20.0	40.0
Got my child out of a school assignment by telling teacher about the child's symptoms	21.1	28.9	17.4	13.3	7.1	30.0	10.0
Responded to text messages/calls from my child checking to see if I was okay	19.7	31.6	21.7	20.0	7.1	10.0	30.0
Avoided fireworks, loud movies, etc.	18.3	15.8	21.7	33.3	14.3	20.0	50.0
Parent stayed home from work	18.3	23.7	21.7	20.0	0.0	30.0	40.0
Came home early from an outing	16.9	15.8	17.4	20.0	7.1	40.0	30.0
Let my child not attend a birthday party he/she was invited to	11.3	10.5	21.7	20.0	7.1	0.0	20.0
Got my child out of a performance (play, spelling bee, etc.)	7.0	13.2	8.7	0.0	0.0	0.0	10.0
Picked my child up early from a sleepover	5.6	5.3	8.7	13.3	7.1	0.0	20.0
Let my child go to work with me or his other parent	4.2	7.9	0.0	0.0	0.0	0.0	0.0

Note: FACLIS = Family Accommodation Checklist and Interference Scale; GAD = generalized anxiety disorder; SocAD = social anxiety disorder; SP = specific phobia; SM = selective mutism; PDA = panic disorder with or without agoraphobia; SepAD = separation anxiety disorder

¹ For these analyses, items were considered endorsed if either the mother or the father endorsed that item

Table 4

Correlations among FACLIS subscales and the presence of specific anxiety disorder diagnoses

FACLIS subscale	GAD	SocAD	SP	SM	PDA	SepAD
Scope	.25	.14	-.02	-.05	-.12	.24
Total interference	.28*	.09	-.05	-.15	-.07	.32**
Mean interference	.25*	.11	-.26*	-.06	-.23	.13

FACLIS = Family Accommodation Checklist and Interference Scale; GAD = generalized anxiety disorder; SocAD = social anxiety disorder; SP = specific phobia; SM = selective mutism; PDA = panic disorder with or without agoraphobia; SepAD = separation anxiety disorder