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A Preliminary Examination of the Link Between Maternal Experiential Avoidance and Parental Accommodation in Anxious and Non-anxious Children

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Abstract

Studies point to parental experiential avoidance (EA) as a potential correlate of maladaptive parenting behaviors associated with child anxiety. However, research has not examined the relationship between EA and parental accommodation of child anxiety, nor the extent to which parental negative beliefs about child anxiety help explain such a relationship. In a sample of mothers (N=45) of anxious and non-anxious children, the present study investigated the potential link between maternal EA and accommodation of child anxiety and whether this link may be indirectly accounted for via maternal negative beliefs about child anxiety. EA was significantly and positively associated with accommodation of child anxiety, but when negative beliefs about child anxiety were incorporated into the model this direct effect was no longer significant. Findings highlight the contribution of parental emotions and cognitions to behaviors that may exacerbate child anxiety, and may inform treatment and prevention efforts with families of anxious youth.

Keywords

child anxiety; parenting; accommodation; experiential avoidance

Anxiety problems are among the most common mental concerns affecting children and adolescents [1]. These problems are associated with considerable impairments in family, social, and academic functioning, and are linked with pediatric sleep problems, irritability, substance misuse, and overall life interference [2–8]. Additionally, childhood anxiety often persists into adulthood when left untreated, and can increase risk for other adverse outcomes including depression, substance use disorders, educational underachievement, and reduced

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quality of life [9–13]. Given the prevalence, impairment, persistence, and negative outcomes associated with childhood anxiety, identifying underlying mechanisms of child anxiety is critical.

Children of anxious parents are at significantly elevated risk for suffering from anxiety themselves [14–17]. While this relationship is partially attributable to genetic factors [18–20], environmental factors also exert a significant influence [21]. In particular, parenting factors, such as overcontrolling and overprotective parenting styles, have been associated to some extent with the onset, maintenance, and/or exacerbation of anxiety-related problems [22–29]. Parents of anxious children have been observed to show higher levels of intrusiveness and controlling behavior during parent-child interactions, particularly in the context of child distress [24]. Controlling parenting behaviors that deny children autonomy in age-appropriate situations are particularly associated with child anxiety [27]. Although protective parenting behavior can reduce child anxiety in the short-term by facilitating children's avoidance of (or rescuing children from) anxiety-provoking situations and stimuli, such parenting can maintain child anxiety in the long-term as it denies children important opportunities to independently navigate stressful situations and develop skills and internal resources to master their own anxiety [24, 26, 30].

One specific kind of parental involvement related to child anxiety that has been at the center of a growing body of research is *parental accommodation*. Parental accommodation refers to behavior modifications that attempt to reduce child distress in specific response to child anxiety [31], and can include enabling or encouraging a child to avoid situations that increase anxiety, adjusting family routines in order to prevent child distress, or providing excessive reassurance to an anxious child [32]. While parental accommodation research initially focused on families of children with obsessive-compulsive disorder (OCD), an increasing literature now documents how prevalent parental accommodation is across child anxiety disorders [26, 32–35]. For example, both Thompson-Hollands and colleagues [32] and Lebowitz and colleagues [33] found in separate samples that as many as 97% of parents of children with anxiety disorders engage in at least some parental accommodation. Kerns and colleagues' [26] experimental investigation showed how parental accommodation may in fact mediate links between parental and child anxiety, particularly if anxious parents become emotionally dysregulated in the presence of child distress. Furthermore, greater parental accommodation is positively associated with more severe presentations of child anxiety and impairment [32–33, 35].

Parental accommodation patterns can be maintained through negative reinforcement properties—when the child is confronted with a fearful situation or stimulus, parental accommodation reduces the child's distress and the parent learns that accommodation can decrease child anxiety [36]. That said, there is heterogeneity in the extent of parental accommodation that occurs across families of anxious and non-anxious youth, and at present little is known about the circumstances that dictate when parents are most likely to accommodate.

A small body of research has begun to consider how parental anxiety is associated with increased parental accommodation [e.g., 26, 37], and how parental emotion dysregulation in

the face of child distress is associated with increased parental accommodation [26]. It has been suggested that anxious parents may have particular difficulty tolerating their child's negative affect in anxiety-provoking situations [26, 34, 37–39]. In such cases, parental accommodation may in fact be negatively reinforcing for parents as well as for their children—parents learn that accommodating their child's anxiety not only reduces their child's distress, but it also reduces their own internal distress associated with exposure to their child's displays of distress. Relatedly, in a study of children with OCD and their parents, Selles et al. [40] found that greater parental tolerance of child distress predicted stronger treatment response, further highlighting the potential role of parental distress tolerance as it relates to the clinical portrait of child anxiety.

Experiential avoidance (EA)—defined as attempts to avoid or control distressing internal experiences [41]—may be particularly relevant to understanding why some parents accommodate child anxiety more than others. EA has been linked with a range of clinical problems, including anxiety [42–43], and is associated with distress intolerance as well [44]. Additionally, parental EA may be associated with differential parental responses to child distress [38]. In a sample of families seeking treatment for child anxiety, Cheron, Ehrenreich, and Pincus [45] found that parents exhibiting high EA were more likely to avoid emotionally arousing events, including negative emotional experiences in their children's lives. In another study of mothers of preschoolers, Shea and Coyne [46] similarly found a relationship between parental EA and maladaptive parenting. Importantly, despite initial findings linking parental EA and child anxiety, and despite observed links between child distress and subsequent parental emotion dysregulation, to date research has not examined whether higher parental EA is associated with increased parental accommodation.

If parental EA is associated with the extent to which parents accommodate child anxiety, parental negative beliefs about child anxiety may play a key role in supporting this link. Preliminary findings suggest that parents who hold more negative beliefs about their child's experiences of anxiety (e.g., “If my child gets too nervous, it could be really harmful”) display more severe patterns of parental accommodation of child anxiety [34]. It is possible that parents who have more difficulty tolerating their own distressing internal experiences (i.e., those with high EA) in turn foster negative beliefs about the acceptability of their child's distress, which may then prompt them to more readily accommodate their child's anxiety.

The present study provides the first empirical examination of the extent to which parental EA is indeed associated with increased parental accommodation, and further considers whether parental negative beliefs about child anxiety help explain this relationship. In a sample of families of anxious and non-anxious youth, it was hypothesized that maternal EA, maternal negative beliefs about child anxiety, and maternal accommodation of child anxiety would all be significantly related, that higher maternal EA would be positively correlated with greater maternal accommodation, and that this link may be indirectly accounted for via maternal negative beliefs about child anxiety.

Methods

Participants

Given the relatively lower rate of parental accommodation in the general community, an anxiety-enhanced community sample was recruited. Participants ($N = 45$) were mothers of anxious and non-anxious children between the ages of 3 and 8 ($M = 4.84$, $SD = 1.71$) recruited from the community using recruitment flyers and online advertisements ($N = 24$) and from the pool of families presenting for services at the Boston University Center for Anxiety and Related Disorders ($N = 21$). Participating mothers (Mean age = 38.00 years; $SD = 5.68$) were predominantly non-Hispanic White (80.5%) and varied in total annual household income (44.4% reported < \$100,000/year, 37.8% reported \$100–200,000/year, and 17.8% reported more than \$200,000/year). All participants were English-speaking. Mothers were excluded from participation if their child had primary presenting problems of conduct or oppositionality, if their child had developmental delay, or if their child had ever received cognitive-behavioral treatment given that such treatment could have influenced natural patterns of maternal accommodation. Anxious children with secondary problems of conduct or oppositionality were not excluded.

Measures

Maternal EA—The Acceptance and Action Questionnaire-II [AAQ-II; 47] is a 7-item self-report questionnaire that assesses key aspects of adult EA and psychological inflexibility including willingness to accept negative internal events and the ability to retain cognitive and emotional control in spite of these experiences [47]. Respondents rate each item (e.g. “My painful experiences make it difficult for me to live a life I would value;” “I’m afraid of my feelings”) on a 7-point Likert-style scale indicating the extent to which each of 7 statements is true (1 = *Never true* to 7 = *Always true*). Scores from each item are summed to produce a total score. The AAQ-II has demonstrated appropriate reliability and validity and strong internal consistency [47; Cronbach $\alpha = .96$ in present sample].

Maternal accommodation—The Family Accommodation Checklist and Interference Scale [FACILIS; 32] assesses the presence of a range of common forms of parental accommodation of child anxiety symptoms as well as the extent of personal and family interference associated with the accommodation. Parents specify whether or not they have engaged in 20 specific types of accommodation in response to child fear or anxiety during the previous two weeks (e.g., “Let my child stay home from school/daycare,” “Let my child sleep in parent’s bed,” “Picked my child up early from a sleepover”). Tallying the number of total items endorsed yields an Accommodation Scope score. The FACILIS has demonstrated strong reliability and validity and adequate internal consistency [32; Cronbach $\alpha = .68$ in present sample].

Maternal beliefs about anxiety—The Parental Beliefs about Anxiety Questionnaire [PBA-Q; 48] measures the extent to which parents hold negative beliefs about their child’s anxiety experiences. Parents rate each of 17 items (e.g., “If my child gets too nervous, it could be really harmful;” “When my child is upset, it makes me very anxious”) on a 4-point Likert-style scale indicating the extent to which they agree with each statement (0 = *Strongly*

Disagree to 3 = Strongly Agree). Scores from all items are summed (with two items reversed) to produce a total score, with higher scores indicating greater levels of negative beliefs about child anxiety experiences. The PBA-Q has demonstrated good internal consistency, reliability, and validity [48; Cronbach $\alpha = .87$ in present sample].

Child anxiety—The Spence Children’s Anxiety Scale for Parents [SCAS-P; 49] measures parent-reported child anxiety symptoms in children and was used to assess child anxiety in children ages 6–8 in the present sample. Parents rate each of 39 items (e.g., “My child worries about things;” “My child is afraid when (s)he has to talk in front of the class”) on a 4-point Likert scale indicating how often each item occurs (0 = *Never* to 3 = *Always*). The Total Anxiety score was used in the present study. The SCAS-P has demonstrated good internal consistency in clinical and non-clinical samples and convergent validity with related measures [50]. The measure demonstrated strong internal consistency in the present sample (Cronbach $\alpha = .94$).

The Preschool Anxiety Scale-Revised [PAS-R; 51] measures parent-reported child anxiety symptoms in preschoolers and was used to assess child anxiety in children ages 3–5 in the present sample. Parents rate each of 34 items (e.g., “Is scared to ask an adult for help (e.g., a preschool or school teacher;” “Has difficulty stopping him/herself from worrying”) on a 5-point Likert scale indicating how well each item describes the child (0 = *Not True at All* to 4 = *Very Often True*). The Total Anxiety score was used in the present study. The PAS-R has demonstrated good construct validity and reliability and strong internal consistency [51; Cronbach $\alpha = .95$ in present sample].

We calculated a standardized anxiety variable based on the PAS-R for children ages 3–5 and the SCAS-P for children ages 6–8 in order to capture each child’s deviations from the published means of each anxiety measure (see [26] for additional details). Higher standardized anxiety scores are indicative of higher child anxiety.

Procedures and data analysis

All study procedures were approved by the Boston University Institutional Review Board. Eligible participants completed the above questionnaires as part of a series of unrelated research studies and/or as part of a baseline evaluation prior to child anxiety services. Mothers completed all measures through a secure and encrypted online survey platform. Informed consent was obtained prior to participation.

Bivariate correlations examined zero-order associations among maternal EA, maternal accommodation, and maternal negative beliefs about child anxiety. The PROCESS macro for SPSS [52] was used to assess the indirect pathway between maternal EA and maternal accommodation via maternal beliefs about anxiety. The indirect effect of maternal EA on maternal accommodation passing through maternal negative beliefs about child anxiety was computed as a_1b_1 [52–53]. Bias-corrected bootstrapping methods were used to determine 95% confidence intervals. The null hypothesis of no indirect effect was rejected when the confidence interval did not overlap with 0. We further examined whether anxiety status/recruitment source (i.e., whether family was recruited from the general community or through the child anxiety clinic) moderated observed indirect relationships by computing an

index of moderated mediation in the PROCESS macro for SPSS. The null hypothesis of no moderated indirect effect was rejected if the confidence interval for the index of moderated mediation did not overlap with 0.

Results

Mean child anxiety scores in families recruited from the general community were .69 standard deviations below normative means. Mean child anxiety scores in families recruited from the child anxiety clinic were 2.11 standard deviations above normative means.

Table 1 presents the means and standard deviations of study variables, as well as the bivariate correlations among measures. All study variables showed significant associations with one another. The zero-order associations between maternal EA and maternal negative beliefs about child anxiety, and between maternal accommodation of child anxiety and maternal negative beliefs about child anxiety, were large in magnitude. The zero-order association between maternal EA and maternal accommodation of child anxiety was medium in magnitude.

Figure 1 includes the a_j path and the b_j path estimates of the model examining the indirect effect of maternal negative beliefs on the association between maternal EA and maternal accommodation of child anxiety. When the indirect effect of maternal negative beliefs about child anxiety was entered, the direct effect between maternal EA and maternal accommodation was no longer significant ($t = .76$, $p = .45$, index of mediation = .05, 95% CI: $-.08$, $.18$), and the indirect effect was positive and significant (index of mediation = .08, 95% CI: $.02$, $.16$). The total effect of the model was also significant ($t = 2.25$, $p = .03$, index of mediation = $.13$, 95% CI: $.01$, $.24$). The significant indirect effect of maternal negative beliefs about child anxiety was not moderated by child anxiety status (mental health clinic versus community recruitment) (index of moderated mediation = $.0001$; 95% CI: $-.21$, $.17$).

Discussion

The present analysis offers the first empirical examination of the link between EA and parental accommodation in anxious and non-anxious youth, and the extent to which parental negative beliefs about child anxiety may explain this relationship. As hypothesized, findings indicated that higher EA in mothers is significantly and positively associated with greater parental accommodation of child anxiety symptoms. Such findings are consistent with recent studies indicating that maternal traits, such as maternal anxiety, are correlated with more severe patterns of accommodation [32, 34, 37] and extend earlier work suggesting that parents with higher EA are more likely to avoid negative emotional experiences in their children's lives [45]. The present study provides initial indication that mothers with a strong inclination to avoid internal experiences of negative emotion are more likely to attempt to reduce and control their child's fear and anxiety, and further clarifies that the specific relationship between maternal EA and maternal negative beliefs about child anxiety may indirectly explain this link. Previous research has demonstrated that negative beliefs about child anxiety can result in punitive parenting and exacerbation of child anxiety [34, 54];

however, this is the first study to identify how important parental negative beliefs about child anxiety may be in linking EA and parental accommodation behaviors.

The present findings may have important implications for treatment and prevention. Parents can be critical agents of change in the treatment of child anxiety and related problems [55–58], but research has been unreliable in demonstrating a consistent advantage of parent involvement in child anxiety treatment over child-only treatment [59–60]. Inconsistent findings may, to some extent, reflect how varied the clinical targets are across child anxiety treatments with parental involvement, and it remains unclear which aspects of parent involvement are the most beneficial in treatment. Some programs explicitly focus squarely on parents' own anxiety and some focus on parental accommodation and overcontrol, whereas others simply have parents attend sessions while the clinical focus is entirely on the child's symptoms. The present findings suggest child anxiety treatments involving parents may be best positioned to yield improvements when such treatments focus on aiding parents to better cope with their own negative emotions and to re-examine their negative beliefs about child anxiety. Incorporating such treatment elements may help reduce patterns of parental accommodation in families with a parent with high EA, which may, in turn, help eliminate patterns of child anxiety and avoidance. Preliminary work in the context of pediatric OCD treatment indicates that improving parental distress tolerance is indeed associated with improved treatment success [40]; however, more work is needed to determine whether interventions specifically targeting distress tolerance and associated negative beliefs about child anxiety can enhance symptom improvement in the context of treatment for child anxiety more generally. The present findings may also have important implications for early identification of families at greatest risk for maladaptive patterns of parental accommodation, particularly if the present findings are further supported by longitudinal examinations of the relationships between parental EA, parental negative beliefs about child anxiety, and parental accommodation.

Several limitations should be taken into consideration when interpreting the results of the present study. First, because these data were collected at a single time-point, matters of causality and the directionality of effects cannot be inferred. To consider alternative directions of effects, we re-ran our models in reversed orders and the indirect effect was no longer significant, providing further support for our conceptual model. However, longitudinal research is necessary to consider temporal relationships between EA, maternal beliefs about child anxiety, and maternal accommodation. Second, this preliminary study was conducted in a relatively small sample of anxious and non-anxious children. While a strength of the study is that the observed indirect pathway was uniform across families of anxious and non-anxious children, it is nonetheless possible that anxiety status may have significantly moderated the associations in the context of a larger sample. Third, this study only assessed self-reported maternal accommodation, and mothers may not always be aware of their accommodating behaviors. Future research should consider utilizing observations of parent-child interactions in a laboratory setting in order to more comprehensively assess patterns of parental accommodation. Fourth, the FACLIS may perform differentially across age groups due to the nature of the specific items. For example, some FACLIS accommodation domains (e.g., sleepovers) might be less relevant at younger ages. Indeed, although overall internal consistency across the sample was adequate (Cronbach $\alpha \sim .7$),

reliability was lower among parents of younger children (i.e. below the mean age; Cronbach $\alpha = .64$) than among parents of older children (i.e. above the mean age; Cronbach $\alpha = .73$). That said, when we re-ran our analyses entering child age as a covariate, the indirect effect of maternal EA on maternal accommodation via maternal beliefs retained significance (index of mediation = .08, 95% CI: .02, .16). Finally, this study only examined maternal accommodation, and did not consider patterns of paternal behavior. Less is known about the links between paternal accommodation and child anxiety, and accordingly similar work is needed to consider whether the presently observed relationships are robust across parents or whether they are specific to mothers.

Summary

Despite limitations, the present study provides preliminary support for a link between EA and parental accommodation, with parental beliefs about child anxiety acting as one explanation for this link. With continued support, the present findings can inform the improved identification of families at risk for accommodation and child anxiety, and can inform improved treatment and prevention efforts for child anxiety that involve families. Although the clinical targets included across treatments for child anxiety that involve parents are quite heterogeneous, the present findings suggest that specifically targeting parental difficulties with negative emotions, as well as maladaptive parental cognitions about child anxiety, may be particularly important. Simply educating parents about the role that parental accommodation can play in reinforcing child anxiety may do little to curb such parental accommodation if parents are not taught skills to improve their tolerance of internal experiences of negative emotion or to re-examine their negative beliefs about child anxiety.

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Figure 1. Indirect link between maternal experiential avoidance and maternal accommodation, via maternal beliefs about anxiety

* $p < .05$ (two-tailed), ** $p < .01$ (two-tailed)

Table 1

Means, standard deviations, and bivariate correlations among study measures concerning mothers

	M	SD	1	2
1. Experiential avoidance ^a	15.91	7.17	--	--
2. Family accommodation ^b	3.40	2.61	.34 [*]	--
3. Negative beliefs about child anxiety ^c	38.98	7.70	.53 ^{**}	.47 ^{**}

^a Measured via maternal self-report on the Acceptance and Action Questionnaire-II (AAQ-II).^b Measured via maternal self-report on the Family Accommodation Checklist and Interference Scale (FACIS).^c Measured via maternal self-report on the Parental Beliefs About Anxiety Questionnaire (PBA-Q).^{*} $p < .05$ (two-tailed),^{**} $p < .01$ (two-tailed)