

Development of Child- and Parent-Report Measures of Behavioral Avoidance Related to Childhood Anxiety Disorders

Stephen P.H. Whiteside

Michelle Gryczkowski

Chelsea M. Ale

Mayo Clinic

Amy M. Brown-Jacobsen

University of Missouri–Kansas City

Denis M. McCarthy

University of Missouri

The current report describes 3 studies conducted to develop 8-item child- and parent-report measures to further the understanding of the role of behavioral avoidance in the development, maintenance, and treatment of childhood anxiety disorders. Participants included both clinical ($N = 463$; ages 8 to 12) and community ($N = 421$; ages 7 to 18) samples of children and their parents from primarily Caucasian intact families. Follow-up data were collected from 104 families in the community sample. Overall, the measures were internally consistent and related to anxiety, distress, and alternative measures of avoidance in both samples. Parent report of children's behavioral avoidance evidenced the strongest psychometric properties, differentiated among clinical and community populations, and most importantly, predicted children's anxiety at least 8 months later over and above initial anxiety ratings. Moreover, decreases in avoidance were associated with successful exposure therapy. These results are consistent with the role of behavioral avoidance in the development of anxiety and

provide an efficient tool for assessing the role of avoidance in clinical and research settings.

Keywords: child; anxiety disorders; avoidance; assessment; self-report

IN CHILDHOOD, FEARS AND ANXIETY are normative (Ollendick, Matson, & Helsel, 1985), but at elevated levels cause significant distress and interference in activities and development due to avoidance and escape from anxiety-provoking stimuli (Vasey & Ollendick, 2000). Because anxiety disorders impact functioning across many domains (e.g., social, occupational, medical, academic) and often persist into adulthood, research improving the understanding, identification, prevention, and treatment of childhood anxiety disorders is of great importance (Mendlowicz & Stein, 2000; Merikangas & Avenevoli, 2002; Quilty, Van Ameringen, Mancini, Oakman, & Farvolden, 2003). In service of these goals, it is imperative to assess all aspects of anxiety that may impact suffering and indicate the need for intervention from both the child's and the parents' perspectives.

Behavioral avoidance may be a particularly fruitful area of assessment given its prominence in theories of anxiety; the centrality of techniques to

Address correspondence to Stephen Whiteside, Ph.D., Department of Psychiatry and Psychology, Mayo Clinic, West 11, 200 First St., SW, Rochester, MN, 55905; e-mail: Whiteside.Stephen@mayo.edu.

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address avoidance in the treatment of anxiety disorders (i.e., exposure); and the fact that it may be a particularly observable, measureable, and accessible target for assessment and intervention (Barlow, 2002; Beidel, Turner, & Morris, 2000; D.M. Clark, 1999; Davis & Ollendick, 2005; Foa & Kozak, 1986; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Kendall, et al., 2005; Marks, 1969; Mowrer, 1960; Rapee, 2002; Salcioglu, Basoglu, & Livanou, 2007). Specifically, one of the earliest and most persistent models of anxiety indicates the role of avoidance in negatively reinforcing anxious arousal and cognition, thus maintaining anxiety disorders (Mowrer). Even in children with generalized anxiety disorder (GAD), arguably the most cognitive of the anxiety disorders, avoidance in the form of worry is thought to play a central role in maintaining anxiety (for review see Mineka & Zinbarg, 2006). Additionally, there is evidence that avoidance in children may be further complicated by the involvement of parents. Parental reinforcement of avoidance (e.g., promoting avoidant coping strategies or consoling in times of anxious avoidance) may contribute to the development of anxiety disorders (Dadds, Barrett, Rapee, & Ryan, 1996). For example, when parents help children to avoid or escape from feared situations, often referred to as *parental accommodation*, anxiety symptoms worsen and children frequently become more impaired (Benito & Freeman, 2011; Storch, et al., 2007; Storch, et al., 2010). Thus, it is particularly important to assess avoidance from both the child's and the parents' perspective.

Despite the centrality of avoidance in models of childhood anxiety disorders, the amount of direct evidence supporting the role of behavioral avoidance in the development, maintenance, and treatment of childhood anxiety disorders is limited by the lack of convenient measures to assess this construct in children. Inspection of the three primary measures of childhood anxiety disorders (per Muris, Merckelbach, Ollendick, King, & Bogie, 2002)—the Spence Children's Anxiety Scale (SCAS; Spence, 1998), the Multidimensional Anxiety Scale for Children (MASC; March, 1997), and the Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997)—reveals few items assessing avoidance. The majority of the items cover somatic/emotional symptoms (66%, SCAS; 51%, MASC; 54%, SCARED), such as "I feel scared when I have to take a test," or cognitive/worry symptoms (21%, SCAS; 10%, MASC; 23%, SCARED), such as "I worry about things." Each measure, particularly the MASC, includes behavioral items (13%, SCAS; 38%, MASC; 15%, SCARED) covering a wide variety of actions, such as compulsive rituals,

rule following, and vigilance. However, only the MASC contains items directly referring to avoidance (i.e., "avoid" or "stay away") and these three items are spread across two scales and intermingled with other items. McCathie and Spence (1991) adapted the Revised Fear Survey Schedule for Children (Ollendick, 1983) to create the Fear Frequency and Avoidance Survey Schedule for Children, which assesses the impact of specific fears, including avoidance. However, this measure is lengthy and did not successfully disentangle avoidance from the affective components of anxiety.

In terms of domain-specific scales, there is at least one measure designed to independently assess anxious cognitions [the Children's Automatic Thoughts Scale (Schniering & Rapee, 2002) and somatic symptom (the State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973)]. However, existing measures that include avoidance subscales tend to be specific to a single disorder [e.g., Social Anxiety Scale for Children-Revised (SASC-R; La Greca, 1999), Mobility Inventory for Agoraphobia (Chambless, Caputo, Jasin, Gracely, & Williams, 1985)]. As such, a measure specifically capturing behavioral avoidance broadly applicable to anxiety disorders would be a strong complement to the existing measures of somatic and cognitive symptoms.

The most common method of measuring avoidance in children is through behavioral approach tests (BATs), which are laboratory tasks that involve creating an environment in which to present the individual's fear and measuring the individual's approach toward that feared item. These tasks, most commonly used for children and adults with specific phobias, involve asking an individual to approach an object (e.g., a spider) and measuring the physical distance they accomplish toward it (e.g., Field, Lawson, & Banerjee, 2008; Klein, Becker, & Rinck, 2011). Variations of BATs have been used with social phobia (e.g., Beidel, et al., 2000) and obsessive-compulsive disorder (e.g., Najmi, Tobin, & Amir, 2012). Although BATs are sensitive to change and can be useful for guiding treatment (Barlow, 2002; Barrett, Healy, & March, 2003; Craske, Rapee, & Barlow, 1988; McGlynn, 1988), they are limited by the range of situations that can feasibly be assessed, are often impractical for clinical use, and are typically unstandardized (Barrett et al., 2003). Specifically, a clinician would need to have a wide variety of stimuli (e.g., different animals, social interactions, sources of contamination, public places) immediately available, as well as a standardized method for measuring the degree of avoidance that indicated psychopathology.

Other widely used measures of anxiety symptoms, such as structured interviews or questionnaires (e.g., Silverman & Albano, 1996; Spence,

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