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Pills from literature

Psychological and social problems in children with severe allergies

Evidence on the effectiveness of motivational interviewing and brief cognitive-behavioral therapy

Enrico Vito Buono[1], Monica De Simone[2], Giovanni Cavagni[3]

[1] Clinica Pediatrica, University of Parma, Parma, Italy; [2] University of Palermo and President of ARI-AAA3 ODV, Association for Research on Allergy,Asthma and the Environment, Palermo, Italy; [3] Centro Diagnostico Europeo Dalla Rosa Prati, Parma, Italy

INTRODUCTION

Allergic diseases in childhood impose a substantial psychosocial burden beyond their clinical manifestations. Their management requires close collaboration between families, pediatricians, specialists, social services, and healthcare systems. Allergic children should have guaranteed access to integrated health and social support, prioritizing those worsened by inadequate caregiving [1]. Moreover, the available literature on psychological and social problems in allergic children is limited, despite evidence of higher psychological disorder rates in these patients compared with the general population. For example, anxiety and depression symptoms occur in pediatric allergic patients, with some studies – particularly on food allergy – suggesting approximately a prevalence of 20-25%, varying by study design, populations, assessment methods and specific conditions. These difficulties are associated with reduced health-related quality of life (HRQoL) and social/school functioning impairments, with stronger associations in food allergy [2-6]. We read with interest the article by Verdi et al., published in August in The Journal of Allergy and Clinical Immunology: In Practice, which reported a collaborative study entitled "*Addressing anxiety and depression in the allergy clinic through motivational interviewing, brief cognitive behavioral therapy, and curious questions*" [7]. It describes a structured and clinically applicable approach to addressing anxiety and depression in the allergy clinic through motivational interviewing, brief cognitive behavioral therapy (b-CBT), and patient-centered communication strategies. In this context, the present article aims to highlight key clinical messages of this contribution and to contextualize their relevance within selected psychosocial challenges commonly encountered in the management of allergic children.

HOW TO ADDRESS PSYCHOLOGICAL AND SOCIAL PROBLEMS IN CHILDREN AND ADOLESCENTS WITH ALLERGIES

Building on the framework proposed by Verdi et al. [7], psychological distress in pediatric allergy is often driven by maladaptive risk perception, limited health literacy, and misconceptions. Within this perspective, allergy specialists should provide clear information, promote bidirectional communication, and identify patients requiring psychological support. Motivational interviewing enhances engagement, whereas CBT targets maladaptive beliefs and anxiety-driven avoidance, improving adherence and daily functioning [3-5]. In food allergy – where

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CORRESPONDENCE

Giovanni Cavagni
giovanni.cavagni@gmail.com

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psychosocial burden significantly affects HRQoL [1,6] – b-CBT and integrated clinic models may improve risk appraisal and self-management, whereas selected patients require multidisciplinary care. Although settings and specific aspects may vary, a patient-centered approach allows clinicians to address the interplay between emotions, beliefs, and behaviors, supporting more realistic disease management [7]. These principles can be translated into routine clinical practice through brief, structured interventions. This article moves beyond a purely biomedical perspective by emphasizing the importance of relational and psychological dimensions in the interaction between pediatricians and families. The integration of an evidence-based approach derived from CBT, adapted into a flexible brief format, may be feasibly incorporated into routine allergy visits, including both standard and follow-up consultations. Within this framework, the physician assumes the role of a facilitator, supporting families in developing a more rational and confident approach to disease management [7]. In clinical practice, b-CBT provides practical tools to address maladaptive risk perception and anxiety-driven behaviors. Through brief interventions, clinicians can help families identify catastrophic thoughts and reframe them into more realistic appraisals, thereby reducing excessive fear and avoidance [8]. For example, a pediatrician may ask a parent: "What do you think would happen if your child were exposed to a small trace of the allergen?" to elicit and subsequently reframe catastrophic expectations. The use of "curious questions" helps explore concerns and promote adaptive coping while strengthening the therapeutic alliance. These strategies are consistent with key principles of motivational interviewing, particularly in fostering a collaborative dialogue and supporting patient and family autonomy in decision-making. These techniques can be delivered within routine consultations through short, structured interactions (2–5 minutes), including focused questioning, cognitive reframing, and shared goal setting [7]. This approach is particularly relevant for patients with elevated anxiety, maladaptive risk perception, or poor disease management. These include children with food allergy and high parental anxiety, families with disproportionate avoidance behaviors, adolescents with poor adherence or risk minimization, and patients with recurrent emergency visits despite low objective risk [9]. A stepped-care model appears feasible, with initial support provided by the pediatrician during routine visits, reinforcement at follow-up and referral to multidisciplinary care in more complex cases. This model requires targeted training in communication and basic cognitive-behavioral principles and represents a scalable, sustainable strategy for integrating psychological care into pediatric allergy practice [10].

THE ALLERGIC CHILD IN SOCIAL CONTEXTS

The principles outlined by Verdi et al. [7] are particularly relevant in real-life settings such as the school environment and other social contexts, where risk perception and anxiety can impair daily functioning and social participation. Parental anxiety often leads to overprotection that restricts a child's autonomy and social development. Management should prioritize practical measures aligned with clinical guidelines and local policies to enable safe participation in age-appropriate activities. This approach may reduce the risk of severe reactions such as anaphylaxis or asthma exacerbations [4]. Schools are key for early socialization, and effective collaboration among families, healthcare professionals, and school staff ensures inclusive, safe environments in accordance with national regulations [5]. Practical steps include shared allergen-reduction guidelines, especially for food allergies, as well as parental medical documentation and safety protocols for meals, extracurricular and physical activities, supported by appropriate disease control and access to rescue medications. Extracurricular activities are associated with a higher risk of accidental exposure, particularly among children with food allergies [1,11]. A core challenge remains administration of emergency treatment (e.g. adrenaline auto-injectors for anaphylaxis or bronchodilators for severe asthma), which is limited in countries like Italy by the lack of legislation defining trained and authorized personnel [12,13]. Individualized action plans, prepared by pediatricians/allergists, shared with schools, and detailing staff roles, bridge this gap, despite regional heterogeneity. Social events (e.g., parties) and catering venues require similar inclusive strategies. European Union mandatory allergen labeling enhances safety, yet challenges persist with variable dish label clarity, staff training and supplier controls. In these settings, healthcare guidance, incorporating Verdi et al.'s communication tools [7], and family cooperation may minimize anaphylaxis risks while fostering peer inclusion rather than exclusion. Finally, adolescence represents a critical phase for self-management in asthma or food allergy: adolescents may underestimate their condition, reduce adherence, or avoid carrying emergency medication in order to fit in with peers. Continuous support from pediatricians and healthcare professionals, via Verdi et al.'s structured strategies [7], is therefore crucial to promote autonomy and safe disease management [13].

CONCLUSIONS

The study by Verdi et al. [7] highlights that effective risk communication and the integration of structured psychological strategies are essential components of high-quality allergy care. Such conversations are complex and may be hampered by limited patient understanding of risk and health literacy, making the establishment of open bidirectional communication essential. Within this framework, CBT may support patients and families in appropriately contextualizing risk [7]. Although specific allergic diseases, particularly food allergy, may contribute to anxiety in some patients, pediatricians should be aware that, in certain cases, anxiety may extend beyond the allergic condition into other domains of a child's life. The review by Verdi et al. highlights, with scientific evidence, that b-CBT is more than a simple technique and may represent a valuable tool to reduce anxiety and promote the overall mental well-being of both the family and the allergic child, even if not serious. Parents of allergic children deserve support from pediatricians in collaboration with specialists, while stronger social

and policy commitment is needed to ensure that children with severe allergy enjoy the same rights as peers with other chronic conditions, such as diabetes or celiac disease.

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Authors' contributions
GC, EVB and MDS conducted the literature search, analyzed the included articles, and drafted the main text. GC, EVB and MDS reviewed and revised the manuscript.

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