

The SPACE program, a parent-based treatment for childhood and adolescent OCD: The case of Jasmine

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Current evidence-based treatments for obsessive-compulsive disorder in children and adolescents include cognitive-behavioral therapy, specifically exposure and response prevention, and psychopharmacological treatments. Despite the established efficacy of these treatments, many youth do not benefit from them, and barriers, including lack of motivation and resistance to treatment, prevent many youth from even attempting them. Parent-based treatments offer an alternative approach to child-based therapy. SPACE (Supportive Parenting for Anxious Childhood Emotions) is a parent-based treatment that focuses on systematically reducing family accommodation, or the changes that parents make to their own behavior to help a child avoid or alleviate distress related to the disorder, while increasing supportive responses to the child's symptoms. This article presents the theoretical background for SPACE and illustrates its implementation through a case description. Conclusions and knowledge to be gained from the case are discussed. (Bulletin of the Menninger Clinic, 82[4], 266-287)

Keywords: OCD, family accommodation, child, adolescent, parent, therapy

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Background

Phenomenology and treatment literature

Obsessive-compulsive disorder (OCD) affects approximately 2%–3% of youth and causes significant distress and impairment (American Psychiatric Association, 2013). Front-line treatments for OCD include cognitive-behavioral therapy (CBT), specifically exposure and response prevention (ERP), and psychopharmacological treatment with selective serotonin reuptake inhibitors (SSRIs) (Geller & March, 2012; Strauss, Hale, & Stobie, 2015). Despite the established efficacy of these approaches, many children and adolescents do not respond adequately to either treatment, underscoring the need for additional interventions (Albert et al., 2017; Barrett, Farrell, Pina, Peris, & Piacentini, 2008; Lebowitz, 2013). Further highlighting this need, barriers to treatment prevent a large number of youth from even attempting ERP. Among these barriers are poor insight and low treatment motivation (Storch et al., 2010). Cognitive-behavioral therapies, including ERP, require a high level of motivation from the patient. Engaging in behavioral exposures, the key ingredient of ERP, is challenging and requires patients to confront, albeit in gradual fashion, their obsessive fears and thoughts. A child or adolescent who is not motivated to overcome his or her problem or who has poor insight into the pathological nature of his or her obsessions and/or rituals poses a major problem for the behavioral therapist. In such cases, alternative treatment approaches become highly attractive. In particular, parent-based treatments are an appealing alternative to individual child-based therapy, as parents may be significantly more motivated to engage in the therapeutic process. Research into the familial and systemic aspects of OCD has suggested novel treatment approaches. A large body of research has highlighted the importance of addressing the ways in which parents may become entangled in their children's OCD symptoms through the process of family accommodation (Calvocoressi et al., 1995; Garcia et al., 2010; Storch et al., 2007).

Theoretical model

Family accommodation refers to the ways in which parents and other family members change their own behavior to help their relative with a psychiatric illness avoid or alleviate distress related to the illness. Family accommodation in OCD was first systematically studied in the relatives of adult patients, but much research has demonstrated that parents of youth with OCD almost invariably accommodate their children's symptoms (Lebowitz, Panza, & Bloch, 2016). Accommodation by parents of youth with OCD can include active participation in symptom-driven behaviors as well as modifications to the family's routines and schedules. Examples of active participation in symptom-driven behaviors include a parent who engages in cleaning rituals or physically carries the child over "contaminated" areas, repeatedly performs checking rituals, maintains a specific order or symmetry in household objects, or provides repeated reassurance or regularly listens to the child's compulsive confessions. Examples of modifications to family routines and schedules include a parent who maintains a rigid schedule of mealtimes, drives special routes to avoid contaminated areas, avoids inviting guests into the home, or carefully chooses recreational activities that will not trigger symptoms of OCD in the youth.

Research has consistently shown that family accommodation, although helpful in reducing distress in the very short term, is actually associated with more severe symptoms and impairment over time and predicts poorer treatment outcomes for both ERP and pharmacological treatment (Albert et al., 2010; Amir, Freshman, & Foa, 2000; Caporino et al., 2012; Flessner et al., 2011; Garcia et al., 2010; Strauss et al., 2015; Vikas, Avasthi, & Sharan, 2011; Wu et al., 2016). Conceptually, family accommodation is viewed as maintaining the disorder by promoting avoidance and reinforcing pathological beliefs relating to the OCD. For example, a child who fears contamination by environmental toxins and insists on windows in the home being closed may feel relieved when parents agree to close the window, but is likely to remain anxious about the exposure and to continue to believe that an open window represents a realistic

risk. The child may also view the parent's accommodating behavior as confirmation of this belief. Given the strong emphasis of ERP on practicing exposure and reducing avoidance, it is not surprising that high levels of family accommodation are associated with poorer treatment outcomes. Figure 1 demonstrates the theoretical cycle/model by which accommodation contributes to the maintenance of symptom severity and impairment.

Family accommodation may also lower a child's motivation to engage in therapy. Parents who provide high levels of accommodations may be unwittingly "helping" a child to cope with the OCD without need for treatment. To take the same example of the child who fears environmental exposure, his or her motivation for treatment is likely to be higher if faced with the discomfort of having to contend with the open windows at home than if he or she is accommodated by parents who keep the windows closed.

Gap in treatment literature

The evidence for the high prevalence of family accommodation and the data linking family accommodation to poorer treatment outcomes for youth with OCD, as well as the theoretical conceptualization of family accommodation as encouraging avoidance and reducing treatment motivation, all indicate the importance of considering the role of family accommodation in treatment planning. Indeed, the issue of family accommodation has been increasingly addressed in interventions for OCD in youth. Whereas early protocols for ERP for childhood OCD included only relatively minor focus on the issue of family accommodation, with guidance for parents to refrain from behaviors that encourage or facilitate avoidance (Comer et al., 2014; Freeman et al., 2014), more recent protocols have devoted greater emphasis to the topic of family accommodation and presented more systematic tools for monitoring and reducing accommodation (Gomes et al., 2016; Thompson-Hollands, Abramovitch, Tompson, & Barlow, 2015). To date however, only a single intervention, the SPACE (Supportive Parenting for Anxious Child-

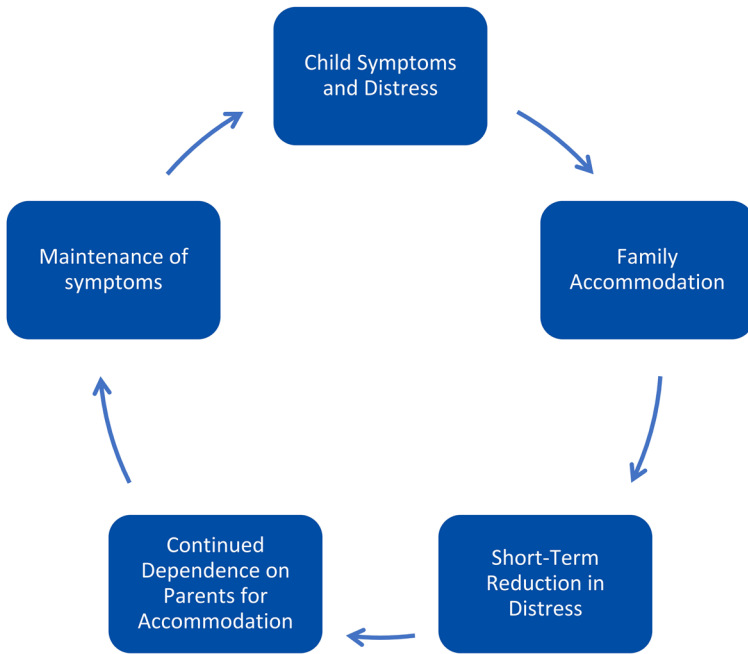


Figure 1. Theoretical model of the cycle through which family accommodation maintains symptoms of a child's disorder.

hood Emotions) Program, places accommodation reduction at the core of its theoretical foundation and treatment objectives. Additionally, SPACE includes a set of practical tools that help parents identify the various forms of provided accommodation, help parents design and implement detailed plans for reducing family accommodation, and equip parents with strategies for coping with the range of difficult responses often exhibited by children when accommodation is not provided (Lebowitz, 2013; Lebowitz, Omer, Hermes, & Scahill, 2014).

The case of Jasmine, described in this article, illustrates the need for parent-based alternatives to treating OCD in youth and exemplifies the SPACE treatment approach.

Case conceptualization and assessment

Unique manifestation of OCD symptomology and treatment barriers

Jasmine was a 13-year-old White, English-speaking girl who lived with both her mothers, Jenny and Dana, and her 9-year-old brother, William (all names are pseudonyms). Jasmine was referred for treatment by her primary care physician, who had diagnosed OCD. Jenny and Dana described Jasmine as a smart, vivacious, and sociable child, who got good grades in school, played soccer in the summer and danced ballet, and played the flute in her school band. The parents also noted a history of generalized anxiety, with chronic worries around making mistakes or not being “good enough” at academics or dance. Jasmine had received CBT 3 years prior to the current referral, with some degree of improvement in her worries.

Jasmine’s current symptoms began a few months earlier after a Black History Month lesson at school. The teacher talked with the class about the assassination of Dr. Martin Luther King, Jr., and showed a film about the assassination. Jasmine was deeply moved and disturbed after watching the film, replaying the assassination over and over in her head. In the following weeks, Jasmine had trouble falling asleep and became fearful that she would have bad dreams relating to the movie. Jasmine’s thoughts about the assassination persisted and began to take on an intrusive and obsessive quality, depicting Jasmine herself as the assassin. She began to worry that she would actually hurt other people, specifically people of color. The phrase “I am going to kill a Black person” played over and over in her mind, especially when she was out of the house and around bedtime. Jasmine’s feelings of guilt and shame led her to conceal the content of the thoughts from her parents, causing her even greater distress and a growing sense of isolation. Jasmine also began to exhibit increasingly compulsive behaviors. She avoided going alone to the park after school, for fear that if she saw a Black child playing she might behave aggressively or hurt the child.

Initially, Jasmine felt safe in the presence of other friends, believing there was a lower chance of her acting violently if she

were not alone. But soon even the company of friends did not alleviate her fear, and she stopped hanging out after school altogether. Instead, she took to going straight home after school, looking fixedly down at the sidewalk to avoid seeing a person of color.

Gradually, Jasmine's avoidance increased and broadened. She stopped watching TV shows or movies if any person of color appeared, and soon after became avoidant even of unrelated stimuli that were associated with the color black. For example, Jasmine stopped wearing any black clothing, erased the word *black* from books and notebooks, removed black things from her room to make it "safe," and would even examine groceries for any usage of the word *black* (e.g., black pepper) and would try to throw away items that triggered her fear. She also began to avoid knives and other sharp objects because of the belief she might use them to attack a person of color. A particularly painful choice for Jasmine, and one that astounded her parents, was her decision to quit ballet, which she did because of the presence of two Black girls whom she feared she would hurt.

Jasmine's fear of hurting a person of color also took on a doubting quality, with Jasmine becoming unsure of whether she had in actual fact hurt someone. She began to ask her parents to reassure her that she had not hurt or killed anyone and insisted on a rigidly ritualized version of reassurance. To calm her fears, her parents had to state, for example, "Today, the fourth of May, Jasmine did not hurt anyone of color." Jasmine even began videotaping this statement and watching it over and over before she fell asleep. And on a number of occasions Jasmine called her mother Jenny from school crying and saying that her thoughts were "too strong" and that she did not feel able to stay in school.

Jasmine's parents, Jenny and Dana, engaged in many forms of accommodation. At first, they saw her emotional reaction to the movie about MLK as merely a manifestation of her sensitive and caring but anxious nature and assumed it would fade with a little time. They soon understood, however, that the problem was growing bigger rather than smaller. Because Jasmine was too ashamed to disclose her obsessive thoughts at first, they

were initially horrified by her avoidance of Black people, which struck them as shocking and racist. After a particularly angry exchange during which they accused her of behaving unconscionably, Jasmine wrote them a note saying, "Afraid I will hurt those people." The parents' anger turned to concern for Jasmine's mental state, but they remained deeply embarrassed by her fears, which contributed to their accommodating behaviors.

Jenny and Dana accommodated by not taking Jasmine to places she feared, and they stopped inviting over guests of color, or allowing the younger brother, William, to do so as well. After leaving restaurants on two occasions because of the presence of a Black diner or employee, they stopped going out as a family altogether. The parents also agreed to lock away all the knives in the house and to cut Jasmine's food for her, so she would not have to handle a knife at mealtime. They agreed not to wear black clothing when Jasmine was home and tried to avoid even using the word *black* in any context. Both parents would participate in the nightly ritual of reassuring Jasmine that she had not hurt anyone, and, because riding the school bus was very stressful for her, they agreed to drive her to and from school each day, an accommodation that necessitated that Jenny begin working from home in the mornings. This also allowed Jenny to be available to pick up Jasmine from school on days she called to say she was feeling overwhelmed.

Need for specialized treatment due to the case

Jenny and Dana initially tried to enroll Jasmine in ERP and made several attempts to do so. Jasmine refused to participate in the treatment, however, stating that even talking about the problem just made it worse, and believing it would increase the likelihood of her actually harming someone. On one occasion the parents, frustrated by Jasmine's lack of cooperation, attempted to mislead her by saying they were going out for ice cream but actually trying to take her to see a therapist. Jasmine noticed the sign on the building they were approaching and flew into a rage at her parents for lying to her. Subsequently she refused to speak to them for over a week, apart from the nightly

reassurance ritual, and relented only when they promised to not raise the topic of therapy again.

Other factors indicating the need for specialized parent-based treatment included the high level of family accommodation being provided to Jasmine and the likelihood that the accommodation was maintaining her OCD and reducing her willingness to engage in therapy. The accommodation was also taking a heavy toll on the entire family. The younger brother had to be prohibited from inviting over guests of color and was suffering as a result of the family no longer being able to go out together, and both parents were significantly impacted by the need to accommodate. Even the family finances had been affected, as Jenny's decision to work from home in the mornings had led to a reduction in income.

Finally, while Jasmine herself was adamant about not going to therapy, both parents were eager to help her and to get help for themselves. For all of these reasons, a parent-based approach was recommended by the therapist that the parents had contacted, with the option of engaging Jasmine in treatment if her attitude changed.

Treatment

Assessment

The assessment was based only on the parents' reports, as Jasmine herself refused to attend the evaluation session. The parents were administered the Anxiety Disorders Interview Schedule (ADIS) and a number of rating scales. Based on the descriptions provided by Jenny and Dana, the primary care physician's diagnosis of OCD was confirmed. Parents also completed a parent-rated Children's Yale-Brown Obsessive-Compulsive Scale (CYBOCS) and scored 31, indicative of severe OCD. In addition, Jasmine also continued to meet criteria for a diagnosis of generalized anxiety disorder, though the OCD was clearly the primary concern at the moment.

Intervention

The treatment followed the SPACE Program protocol (Lebowitz & Omer, 2013; Lebowitz et al., 2014). SPACE was developed specifically to be implementable without direct child involvement when necessary. As such, throughout the SPACE treatment process parents are not expected to be able to directly modify their child's behavior and no guidance is provided that is contingent on a child's agreement. Instructing parents to modify their child's behavior when the child is not amenable to the change frequently leads to escalating conflict in the parent-child relationship, as parents try to impose the change on the reluctant child. For example, were a therapist to instruct Jenny and Dana to make Jasmine engage in an exposure such as watching a film with an actor of color, it is likely that the result would be a heated conflict and the possibility of therapeutic gains would be low.

Instead, SPACE focuses on the parents' own behavior, and in particular on their responses to the child's symptoms. By attempting to modify only the parents' behaviors, and not the child's, the risk of escalation is drastically reduced. A child may still be angry at the parents' behavior (e.g., refusal to accommodate), but the parents, having responded according to their own plan, have little reason to escalate the conflict or to respond with anger towards the child.

The SPACE Program follows a manualized set of steps. Treatment begins by setting the stage for the parent work by introducing the rationale for the treatment and its underlying principles and addressing any misgivings or concerns parents may have about the treatment. Following this psychoeducational step, parents are introduced to the two key concepts that are the focus of SPACE: *Support* and *Accommodation*. Supportive responses to the child's symptoms are defined in SPACE as any parental response that conveys to the child both acceptance/validation of the child's genuine distress, and confidence in the child's ability to cope with and tolerate distress. Parents practice making supportive statements in response to the child's symptoms, and the therapist aims to identify and modify responses that do not meet this definition of support. Accommodation is carefully and comprehensively mapped out, with the goal of

identifying all the ways that parents are accommodating to the child's symptoms. A target accommodation is selected based on a number of guiding principles. The target accommodation is generally one that occurs frequently, that parents have a high degree of control over, and that causes the parents some significant amount of distress or interference. Having selected a target accommodation, the therapist and parents make a detailed plan for how the parents will modify their behavior to reduce or remove the accommodation, and the plan is conveyed to the child in an open, transparent, and supportive manner. Parents then begin carrying out the accommodation reduction plan, troubleshooting with the therapist and problem-solving challenges that arise. Modules of SPACE aimed at equipping parents with tools to cope with difficult child reactions are implemented as needed. Frequently, a second target is undertaken once significant progress has been made in the first accommodation.

Jenny and Dana responded well to the introduction to SPACE, feeling that the treatment would provide them with a way to help their daughter despite her resistance and lack of motivation. Both parents had been feeling helpless in the face of her resistance to treatment and guilty both for their lack of ability to help her and for attempting to mislead her to get her into therapy.

In discussing the concepts of support and accommodation, both parents identified themselves as low on support (especially acceptance/validation) and high on accommodation. Specifically, Jenny rated herself as lower on the acceptance/validation component than Dana. Jenny spent more time with Jasmine during the day, had made more impactful changes to her work routine, and found Jasmine's OCD symptoms to be very frustrating and agitating. Consequently, she felt that she had less and less acceptance for them. Jenny and Jasmine would get into fights over Jasmine's ritual of throwing away groceries, and over Jasmine's attempts to not allow William to enter a room she was in when he was wearing black clothing. Dana, who came home later from work, was more patient with Jasmine's OCD symptoms. When she arrived home, she would take over handling Jasmine while Jenny would focus on taking care of Wil-

Table 1. Chart of family accommodation

| | Jenny | Dana |
|--------------------------|--|--|
| Morning | Avoids wearing black clothes | |
| Getting ready for school | Makes sure William is not wearing black | |
| Breakfast | | Cuts Jasmine's pancakes for her so she doesn't need to use a knife |
| Going to school | Drives Jasmine and William to school Cannot drive on Blackwell Rd. Drops Jasmine off at a specific entrance with fewer people to reduce likelihood of seeing a child of color Works from home Picks Jasmine up from school. Does not stop for errands (or if she stops, Jasmine stays in the car) Sometimes picks Jasmine up from school in the middle of the day | |
| Afternoon | Avoids going out to parks or public places with Jasmine | |
| Dinner | | Cuts Jasmine's food |
| Both parents | | |
| Family time | When Jasmine is downstairs only cartoons are allowed on TV | |
| Bedtime | Make video of reassurance Lock knives away | |
| Weekends | Don't invite friends of color to the house | |

liam. Both parents stated that they tried to convey confidence to Jasmine, saying things like “You are stronger than this,” “We are sure that you can take the bus,” or “Nothing bad will happen if you say the word *black*.” Jasmine, however, responded negatively to these statements and often yelled back with tears in her eyes, “You just don’t get it” or “You don’t understand anything.”

The therapist explained to the parents the conflicting messages that Jasmine was getting through their verbal expressions of

confidence on the one hand and their accommodating behavior on the other. Together with the therapist the parents role-played supportive statements such as “We know this is hard for you, but we’re sure you can cope” and began to practice saying them at home.

The therapist next devoted a session to mapping the parents’ accommodating behavior. Table 1 is the initial accommodation chart that was completed in the session; it was later added to as additional accommodations were identified.

Parents and therapist agreed that stopping the nighttime ritual would be an important target, and one that they could control entirely through their own behavior. However, Jenny and Dana also expressed the fear that Jasmine’s reactions to their refusal would be extremely disruptive, and they decided they preferred to wait and address this as a second target. Instead, they agreed to work first on the accommodation relating to driving Jasmine to and from school. Because Jenny was concerned that Jasmine would refuse to go to school if she was not driven, they decided as a first step to stop picking her up from school. The rationale was that Jasmine would be sufficiently motivated to come home and would find a way to overcome her fear and ride the school bus. They also considered that if she delayed coming home the disruption would be lower than if she were late getting to school.

The therapist worked with the parents on the details of their plan and on how to communicate it to Jasmine. Together they drafted a written message to Jasmine that the parents would read to her and give her in letter format. The therapist explained that a written letter would help them to stay “on message” and lower the likelihood of them being drawn into argument. It also ensured that even if Jasmine did not listen to the message when they read it to her, she would have a physical copy that she could read later when feeling calmer. The written message was:

Dear Jasmine,

We love you very much and are so proud of the kind and beautiful young woman you are becoming. We also see how much you suffer from your OCD thoughts and how much they scare you. We know you are strong and brave and see your struggle to overcome it. We

realize now, that when we agree to do what OCD says we are not helping you in your struggle, we are actually helping OCD and making it worse for you. That is why we have decided to make some changes in the way we behave that we believe will help. The first thing we are going to change is that from now on we will not pick you up from school, and you can return home on the bus like you used to. This might sound hard at first, but we are 100% sure that you can handle this. We are not trying to hurt you or punish you in any way. We are your parents and our job is to help you in any way that we can—but our help cannot be by giving in to your OCD.
Love, Mommy and Mama

The parents' plan was to not arrive at school to pick Jasmine up. They felt that she would be safe because she was a responsible child and had a cell phone. They also planned that if Jasmine did not get on the school bus Jenny would call a family friend whom they contacted in advance and who agreed to pick Jasmine up and drive her home if necessary. The parents hoped that Jasmine would not be comfortable with a person outside of the family having to drive her home and would not persist in not getting on the bus.

The therapist asked Jenny and Dana how they expected Jasmine to react to the message. They both felt she would likely be angry and distressed and that she would accuse them of not understanding her or of not caring about how she felt. The therapist then role-played these responses with the parents, coaching them to respond in supportive manner and to disengage from the interaction if it became repetitive or began to escalate. Jenny and Dana reported in their next session that, as they expected, Jasmine was upset about the plan. She started to cry and begged them not to make this change. The parents managed not to engage in argument, and Dana was able to hug Jasmine for 2 minutes. Gradually she calmed down and both parents left the room.

The following day Jasmine cried on the way to school. Dana called and spoke with her on the phone. She told her that she understands this is hard for her but that she knows she can handle it. Jenny said she was nervous all that day and could not concentrate on her work. Jasmine did not call her mothers from

school but also did not take the bus. Instead, she walked home. It took her an hour and a half, and she was exhausted when she finally arrived home. She continued to walk home for the next 3 days, until the next therapy session.

During the next session both parents expressed the thought that the plan was not working because Jasmine was still not taking the bus. The therapist reassured the parents and reminded them that the plan was not for Jasmine to take the bus, a behavior over which they do not have control, but rather for them not to accommodate by driving her. The therapist told Jenny and Dana that the plan was working because they had successfully managed not to accommodate as before and had maintained a supportive attitude, and that it could take time for Jasmine's own behavior to change. The therapist encouraged the parents to continue with the plan and introduced one of the SPACE Program modules: Recruiting Supporters. Supporters are friends and relatives who can help the SPACE process by reinforcing the importance of the parents' actions. In many cases supporters are also used to address disruptive child responses, but this was not necessary in Jasmine's case.

Jenny and Dana were hesitant to reach out to supporters for help. In particular, they were embarrassed about the content of Jasmine's obsessions, which could be misconstrued as racist (an error they themselves had made) and were worried about violating Jasmine's privacy. The therapist understood their apprehension but also emphasized how important it is to show Jasmine that they do not view her fears as "bad," and that by agreeing the thoughts must be kept secret they may also reinforce Jasmine's own sense of shame or guilt. The therapist also told the parents that most people do not respond with criticism when asked for help, but rather wish to help if they can. Dana agreed and said that if a friend shared a personal problem with her she would feel honored and would definitely want to help. In response to the fear of violating Jasmine's privacy the therapist agreed that Jasmine had a right to privacy, but also noted that this right did not override her even more basic right to her parents' commitment to help her in overcoming challenges and struggles.

Following this discussion, the parents were able to think of a number of close friends and relatives they could ask for help. These included a friend of Jenny's who is also the mother of one of Jasmine's friends from school; Jenny's own mother; Jasmine's ballet teacher of many years; and another friend of the family who incidentally is a person of color. After Jenny spoke to her friend, the friend in turn spoke with her daughter (though without sharing the details of Jasmine's fears), who then asked Jasmine to ride the bus with her at the end of the next day. Jasmine agreed and resumed riding the bus home.

After Jasmine had been riding the bus home for one week the parents and therapist decided it was time for the next step, and they informed Jasmine that they would not drive her to school either. This decision was met with less resistance, and Jasmine seemed more resigned and more confident that she could cope with the change. During that week Jasmine also received a postcard from a favorite uncle who wrote that he heard she had started taking the bus and was super proud of her! Jenny said Jasmine was trying to hide a smile as she ran to her room.

Having had success in reducing the accommodation around the school bus, the therapist and parents agreed it was time for another target. They were still apprehensive about removing the nighttime reassurance ritual but agreed it was important to do so. The therapist and parents again worked on the details of the plan and on how to communicate it to Jasmine, including another written message.

On the first night of the new plan Jasmine begged them persistently to "just say it one time at least" and grew increasingly agitated. She cried and yelled for over an hour, accusing them of not loving her, and despite efforts to not engage, Jenny ultimately lost her temper and yelled at her when Jasmine's crying woke up William. The next night they invited a friend from their list of supporters to be in the house during bedtime. Jasmine refrained from yelling but texted them multiple times from her room before eventually falling asleep. The following morning Dana told Jasmine, "We are so proud of you!" Jasmine responded, "Proud? What are you proud of?? It was awful, and I texted you like a million times!" Dana told her, "We're proud

of you because we know how hard this is for you, but we knew you could do it and, look, you fell asleep without the ritual! That's awesome!" The next few nights continued to be hard, but the time Jasmine spent begging them to reassure her decreased steadily until it seemed like more of a token request with no expectation of actually eliciting the reassurance and without Jasmine seeming actually upset.

The parents continued to refrain from the target accommodations and gradually noticed the ability to reduce other accommodations as well. They stopped putting away the knives, and Dana stopped cutting Jasmine's food without a formal announcement, simply stating, "I'm sure you can cope, and you know I don't want to help your OCD, I just want to help you!" They also resumed wearing black clothes and going to places that Jasmine preferred to avoid, though not insisting that Jasmine come with them.

Jasmine's own symptoms also appeared to be improving. She no longer left the room if the TV was on and she resumed hanging out with friends after school sometimes, even going shopping in a mall, which had been a major source of fear and avoidance. She appeared less preoccupied with OCD thoughts, and when her ballet teacher called her and asked if she would consider rejoining the class she agreed.

During this time the supporter who was a person of color wrote Jasmine an email saying that her parents had shared her OCD thoughts with him, and that he knows that she is a loving and caring person and that he is not afraid that she will ever do anything to deliberately hurt him or any other person. Jasmine did not reply to the email, but Jenny and Dana noticed that she had printed it out and kept a copy of it in her room. Shortly after, the parents were very moved when Jasmine on her own initiative apologized to her younger brother for having made him go along with her OCD and told him that if he wanted to invite friends over he should, regardless of their race.

The parents were extremely encouraged by all of Jasmine's progress and despite having previously promised not to raise the issue of therapy again, they did broach the topic and asked her whether she would consider going to treatment herself. Jasmine

did not become angry but told them she thought she had the OCD under control, and it was not really impacting her that much anymore. She agreed to tell them if she thought it was coming back and that she would consider therapy if that were to happen. Dana half jokingly said, "So you would be fine wearing a black shirt now?" Jasmine appeared thoughtful and said, "Well, I would, but I don't have any, I threw them all away!" The family decided to act on the moment and went together to buy a black shirt, which Jasmine proudly wore home.

Therapy ended with a discussion of relapse prevention. The therapist encouraged the parents to be on the lookout for a recurrence of OCD symptoms, and for either recurring or new accommodations. The therapist conveyed to the parents that relapse in OCD is common and that the focus of the symptoms is likely to change, and thus they should also be aware of symptoms not relating to people of color or to thoughts of harm. The therapist emphasized the importance of maintaining a supportive attitude toward symptoms of OCD and anxiety, and of not being afraid to "rock the boat," meaning to address the accommodation when they notice it, rather than hoping that if they accommodate a little the problem will go away. Parents reviewed what they had learned in therapy and expressed that they now viewed Jasmine as much stronger than they previously believed. They felt empowered by the ability to help her and agreed to reach out to the therapist if they sensed that symptoms were reemerging. They also scheduled a follow-up meeting for 2 months later to review how things were going subsequent to treatment.

Treatment outcomes

Treatment occurred over 12 weekly sessions. Following the last session, a post-treatment evaluation was conducted, which Jasmine agreed to participate in. Jasmine and her parents were separately administered the ADIS and respective versions of the CYBOCS. Jasmine's ADIS results indicated no clinical impairing diagnoses and subthreshold symptoms of both generalized anxiety and OCD. Her CYBOCS score was 10, corresponding to mild OCD. The parent ADIS interview still indicated the

presence of generalized anxiety, with a clinician severity rating of 4. The generalized anxiety symptoms related to academic and achievement worries. The parent ADIS also indicated the presence of some OCD symptoms, which did not meet criteria for a diagnosis. The parent CYBOCS score post-treatment was 8, indicative of some mild OCD symptoms (compared with 31 prior to treatment).

Conclusions and knowledge learned from case

Jasmine's case illustrates many of the challenges faced by parents of youth with OCD (as well as other anxiety-related disorders). Parents almost universally become entangled in their child's symptoms through the process of family accommodation and are often at a loss for how to help their child, especially when the child is refusing to receive help. The common dilemma facing parents is that the accommodation appears to be the only way to help the child be less anxious, but that through ongoing accommodation the child's symptoms are actually being maintained and exacerbated.

Parent-based treatment offers a novel and effective solution, either as an alternative or an adjunct to child-based therapy. The data indicating that high levels of family accommodation predict poor treatment outcomes for ERP and for medication suggest that even when a child is engaged in therapy directly, the therapist should consider the issue of family accommodation and coach parents in reducing accommodation in a supportive manner. When a child is not directly engaged in therapy or when the child's therapy is not proving effective, the need to address accommodation is even more critical.

Jasmine's case also underscores how important it is for parents to have systematic and practical guidance in reducing the accommodation. Merely telling parents that accommodation is unhelpful or instructing them in broad terms not to accommodate is akin to telling an anxious individual that avoidance is harmful or advising him or her not to avoid. Behavioral therapists know that reducing avoidance requires a much more systematic and detailed approach, with close counseling by a

knowledgeable therapist. Similarly, reducing family accommodation requires equally detailed and specific tools. Systematically mapping out the accommodation, formulating detailed plans for how to modify the parental behavior and replace it with supportive parental responses, and providing parents with tools for coping with difficult child reactions are crucial elements of treatment without which most parents are unlikely to succeed in reducing family accommodation.

The development of effective parent-based interventions such as SPACE has the potential for high impact on the field. Treatment for OCD and anxiety disorders was revolutionized decades ago by advance of pharmacological and behavioral interventions, specifically SSRIs and CBT. Since these innovations were introduced, however, there has been relatively little progress in treating these common disorders. SPACE has the potential to significantly impact the field through its novel approach to the disorders, framing the childhood anxiety response as a systemic phenomenon that inherently involves both child and parent, and by providing an alternative treatment for the many patients who either cannot or will not benefit from direct child-based therapy. SPACE can also be implemented alongside other treatments, both behavioral and pharmacological, with the potential to increase the number of patients who can be effectively treated. While more research on SPACE is needed, promising results from open trials and a large randomized trial (NCT02310152; manuscript not yet published) support the efficacy of SPACE and its promise for the field.

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