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Parent-based treatment for childhood and adolescent OCD

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ABSTRACT

Despite the efficacy of E/RP and pharmacotherapy for OCD, many children do not respond adequately to therapy. Furthermore, many children exhibit low motivation or ability to actively participate in therapy, a requirement of E/RP. Research has underscored the importance of family accommodation for the clinical course and treatment outcomes of childhood OCD. Recent studies highlighted the potential of family involvement in treatment to enhance outcomes for challenging cases. These interventions however still require child participation. The goal of this clinical report is to describe an exclusively parent-based intervention and present preliminary indications of its acceptability, feasibility and potential efficacy. The Supportive Parenting for Anxious Childhood Emotions (SPACE) Program is a manualized treatment focused on reducing accommodation and coping supportively with the child's responses to the process. The theoretical foundation of the intervention is presented and its practical implementation is illustrated, with excerpts from the treatment manual and a clinical vignette. Preliminary results from the parents of 6 children, who refused individual therapy, are presented. Parents participated in 10 weekly sessions and reported high satisfaction and reduced child symptoms. Research is required to investigate the potential of SPACE as a complement or alternative to other evidence based interventions for childhood OCD.

1. The need for better outcomes in childhood OCD

Despite significant evidence for the effectiveness of exposure and response prevention (E/RP) as a treatment for pediatric OCD, many children and adolescents[1] do not adequately respond to treatment (Barrett, Farrell, Pina, Peris, & Piacentini, 2008; Ginsburg, Kingery, Newman, Kelly, & Grados, 2008; Krebs and Heyman, 2010). As many as half of all patients continue to report having OCD symptoms after treatment and many still meet diagnostic criteria for the disorder. Pharmacotherapy, particularly with SRIs, has also been shown to be effective in treating childhood OCD (Geller and March, 2012). However, combining E/RP with psychopharmacological treatment improves outcomes only modestly and many youth remain non-or-partial responders (Abramowitz, Whiteside, & Deacon, 2005; Pediatric OCD Treatment Study Team, 2004). Furthermore, even after successful treatment, rates of relapse in pediatric OCD are considerable (Leonard et al., 1989).

2. Family accommodation and treatment response

Several clinical features have been associated with poor treatment outcomes for childhood OCD including severity of symptoms, comorbid conditions, and poor insight (Storch et al., 2008). Family factors have also been found to influence treatment outcome (Merlo, Lehmkuhl, Geffken, & Storch, 2009; Peris and Piacentini, 2013; Piacentini et al., 2011). Family accommodation, in particular, has been associated with poor response to treatment and refractory OCD (Garcia et al., 2010; Lebowitz, Panza, Su, & Bloch, 2012). Family accommodation is common across the childhood anxiety disorders (Lebowitz et al., 2013) and particularly prevalent in childhood OCD. Accommodation to OCD (Calvocoressi et al., 1995) includes active participation in symptom-driven behaviors (e.g., parents wash their hands because of a child's contamination fear) as well as modifications to parent and family routines (e.g., refraining from inviting guests into the home or driving special routes). Although family accommodation is usually intended to reduce the child's discomfort and to help them escape the distress caused by the disorder, higher levels of accommodation have consistently been found to predict greater symptom severity and impairment as well as poorer response to treatment (Lebowitz et al., 2012; Storch et al., 2007). E/RP encourages independent coping and confrontation of avoided triggers. Accommodation is contrary to these goals by enabling avoidance and providing reassurance. It is also plausible that parental participation in symptoms of OCD could be interpreted by the child as confirmation of the obsessive beliefs, potentially reducing insight (Adelman and Lebowitz, 2012). In most cases children actively attempt to engage their parents in accommodation, often exhibiting high levels of aggression and distress when parents are not compliant (Lebowitz, Omer, & Leckman, 2011; Lebowitz, Vitulano, Mataix-Cols, & Leckman, 2011; Stewart, 2012).

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[1] Throughout this paper we will use the term 'child' inclusively, to refer to children and adolescents for the sake of brevity.

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3. Child participation and collaboration in treatment

E/RP relies on active participation by the patient in the psychotherapeutic process, and places high demands and expectations on the patient, relative to many forms of psychotherapy. Like in other therapies the patient is expected to arrive for sessions and speak with the therapist. However, in E/RP the child is also expected to engage in active tasks and exercises, both during sessions and between them. And these tasks, by definition, involve exposure to stimuli and to situations that evoke anxiety and trigger distress. Not surprisingly, children exhibit different degrees of motivation and capacity to engage in this challenging process. A child who is ashamed of the content of the obsessive thoughts may be reluctant to disclose them, a child with poor insight can be particularly fearful of engaging in exposures and a child who has come to rely heavily on family accommodation might not wish to engage in a process that could lead to diminished accommodation.

In addition to impacting treatment outcomes, these factors may also prevent some children from ever beginning treatment in the first place. Unfortunately, estimating the number of children who are not willing to engage in treatment and therefore do not participate in clinical research is very difficult. Among adults, it has been estimated that approximately 25% of patients with OCD refuse to participate in E/RP (Franklin and Foa, 2002). There is very little data on treatment refusal in children with OCD, however clinical experience points to the existence of many children who similarly refuse to engage in treatment or do not fully participate in the therapy despite physically attending sessions (Abramowitz, Franklin, Zoellner, & DiBernardo, 2002).

4. Family involvement in individual child therapy for OCD

The evidence for parental influences on maintenance of childhood OCD and on treatment outcomes has led several research groups to explore the benefit of family-based treatment. These efforts have focused on enhancing the effects of individual E/RP by adding or incorporating family therapy into the therapeutic process (Barrett, Healy-Farrell, & March, 2004; Piacentini et al., 2011; Storch et al., 2007). Results of these studies generally supported the efficacy of the interventions, but have not demonstrated clear superiority over individual E/RP without the family components. In the case of very early onset OCD, family based behavioral therapy was shown to be a potentially effective alternative to individual therapy, which may be untenable because of developmental considerations (Freeman et al., 2007, 2008).

In a more recent study, Peris and Piacentini (2013) randomly assigned complex pediatric OCD patients at elevated risk of failing treatment, to either individual treatment or to individual treatment enhanced with family treatment sessions. They found that patients in the augmented condition were significantly more likely to respond to treatment than patient who received individual child treatment only. This encouraging result, along with similar advances in adult treatment (Abramowitz et al., 2013), bolsters the hope that increasingly focusing on the intra-family dynamics such as family accommodation may enhance outcomes for childhood OCD. However, important questions remain. Firstly, family-augmented interventions still require active child participation and do not provide a viable solution for children who decline to participate in treatment. Secondly, it is unclear which family element led to the change in child symptoms. Studies have typically attempted to modify multiple family dynamics including family accommodation, cohesion, conflict and communication. The current clinical report describes an exclusively parent based intervention that focuses on supportively reducing family accommodation in parents of children with OCD.

5. Parent based treatment—the SPACE Program

We developed and manualized a parent-only intervention aimed at reducing family accommodation, and in turn bringing about reduction in child symptoms, named the Supportive Parenting for Anxious Childhood Emotions (SPACE) Program (Lebowitz and Omer, 2013) which has shown potential for improving anxiety symptoms in children with anxiety disorders. Parents participate in 10 weekly hour-long sessions. SPACE first educates parents on the difference between protective behavior, which focuses on short-term prevention or alleviation of the child's distress, and supportive behavior, which focuses on promoting the child's ability to tolerate anxiety and self-regulate negative effect. Over the course of SPACE, family accommodation is systematically charted and monitored and parents are guided in reducing the accommodating behavior. Because some children respond initially to parents' reduced accommodation with elevated distress or aggression, the treatment includes a set of tools for problem-solving these situations supportively.

SPACE is not the only treatment program for pediatric OCD to involve parents or to address the issue of family accommodation (March, 1998; Pediatric OCD Treatment Study Team, 2004). However, SPACE is unique in (a) making the reduction of family accommodation the main objective of treatment as a means of improving child functioning and potentially increasing motivation for individual treatment; (b) working exclusively with parents on family accommodating thus allowing for treatment of children who do not themselves participate in therapy; and (c) providing a cohesive set of tools for the systematic monitoring and reduction of family accommodation and for dealing with the ensuing difficult child responses.

One conceptual framework uniquely suited to coping with children's dysregulated reactions without ‘fanning the fire’ and escalating the conflict is that of non-violent resistance (NVR). NVR is best known in the political and broader societal context, having been pioneered as an instrument for achieving social change by Gandhi and Kumarappa (1951), Martin Luther King Jr. (King Jr., 2003) and others. The underlying principle of NVR is the individual's choice to accept the limits of their ability to make another person change, and instead to focus on changing one's own behavior so that it is better aligned with their beliefs and values. This acceptance of the other and emphasis on self-change is appropriate for a parent-based intervention as it focuses attention on changes parents can make to their own behavior rather than on attempts to directly change the child. When a child responds negatively to the parental steps, parents can simply persist, neither abandoning their goals nor engaging in argument. Translations of NVR have already been applied to other family problems such as parent training for aggressive and explosive behavior(Weinblatt and Omer, 2008; Omer, Steinmetz, Carthy, & von Schlippe, 2013), as well as parent training for highly dependent young adults (Lebowitz, Dolberger, Nortov, & Omer, 2012). The NVR approach provides parents in these situations with practical alternatives to becoming drawn into the patterns of coercion and interaction that can create an unhelpful quagmire (Patterson and Reid, 1970). Like other approaches that emphasize diverting attention from negative behavior (Peed, Roberts, & Forehand, 1977), NVR emphasized modifying parental toward more adaptive patterns. NVR also adds to these approaches a toolbox of positive parental behaviors that better reflect their aims and goals. SPACE draws on NVR principle to help parents cope with disruptive or distressing child reactions to reduced accommodation. The NVR approach suits the treatment children with OCD whose behavior, though disruptive, is driven by anxiety and distress. NVR does not cast the child in the role of ‘misbehaver’ but emphasizes the need to modify parental responses. Additional components of the treatment focus on increasing the ability of both parents to work collaboratively and on engaging the help of other supporters from the broader family

and social community to aid and facilitate the process. We next present the treatment process with sample excerpts from the treatment manual, illustrate it with a clinical vignette and then present preliminary results from parents of 6 children with severe OCD who had refused individual E/RP.

6. SPACE treatment process and illustrative excerpts from the treatment manual

The SPACE manual is both structured and flexible. In order to allow for a consistent treatment process and to maintain the integrity of the intervention, treatment proceeds along a series of steps that are consistent across patients. In order to allow treatment to be tailored to individual patient characteristics and needs and to enable the therapist to respond to particular difficulties and challenges, SPACE also includes 'treatment modules' which are implemented as needed over the course of therapy.

6.1. Introduction and education

The first step in treatment introduces parents to the intervention and to the systemic, family based, view of the anxiety caused by the child's disorder.

Many parents approach parent treatment with wariness and apprehension about being blamed for the child's illness, criticized for their parenting or finding themselves reluctantly 'on the analyst's couch'. These issues are addressed explicitly and the therapist explains to the parents that the child is the patient, that parents of children with OCD are almost invariably drawn into their child's symptoms and that by limiting the child's ability to rely on them for accommodation they can increase the child's ability to overcome OCD.

> *I know you came to see me because of your child's OCD and I want to clarify that that is exactly what we will be treating here. We are going to try to help your child get much better at handling OCD so that they will feel more comfortable in those situations that make them fearful or that they have been avoiding until now. By helping your child learn that they can handle OCD you will give them much more than you could by only teaching them they don't need to fear any one particular thing. So that is our goal—to help your child learn to cope much better with OCD and feelings of fear or discomfort.*

An important emphasis of SPACE is the focus on parent change rather than direct child change. The therapist conveys this to the parents throughout treatment and introduces the principle early in treatment. As parents learn more about accommodation it is natural to view changes to parental behavior as a means to promoting more adaptive behavior in the child:

> *Although we will be treating your child's OCD we know that just saying to someone with OCD "Don't be afraid anymore", or "Stop doing that ritual and you will feel better" usually doesn't really work. As parents, you probably wish you could just flip some switch in your child's brain to make them think, act or feel differently—but the truth is you can't. In fact, trying to make someone feel differently than they do often makes them even more defensive. You may have already experienced this with your child? That's why in this treatment we focus on something you CAN control. What is it? It's your own behavior. We know that if you can change your own behavior in some important ways that can help your child to cope much better.*

When parents equate parent treatment with blame the therapist discusses the difference between parental responsibility to help a child and blame for the difficulties the child faces:

> *Imagine that your child had a fever and was feeling sick. Imagine she is too sick to go to school and needs your help in getting to the doctor, taking medicine, or perhaps she just needs some comforting hugs to help her feel a little better. Would you feel like it was part of your job as a parent to help her? Of course you would. Might you need to act differently than on other days, for example, not insisting she go to school or perhaps even staying home yourself or checking in on her more often? You certainly might. Would it be your fault that she has the flu? Of course not! Blame is entirely irrelevant to parents' responsibility toward helping children overcome challenges and difficulties. It is part of what being a parent is all about. If your child is suffering from OCD than you as a parent probably want to do what you can to help her get better—that has nothing to do with blame! Sometimes, helping your child means taking her to therapy and other times it means getting advice yourself. But either way, it is only about you being a mom or a dad.*

The therapist also introduces the idea that parents sometimes have to make decisions that reflect their love or concern for the child, even though they may not please the child. The therapist explains that for some children fighting against OCD seems too hard and they need their parents to lead some of the fight for them. The potential for child resistance to the process is discussed

> *Some children may feel compelled to resist the changes you make, because of their OCD. This is normal and to be expected. If children were able to take the long view all the time and always act in their own long-term best interests than they wouldn't be children at all! They would be quite remarkable adults. However, you need to remember that you are acting in your children's best interests and that the steps you take will not harm them. As we plan these steps, we will also talk about how to respond in a productive and supportive way to your child's reactions to the process.*

6.2. Monitoring and reducing accommodation

The next part of treatment involves methodically charting the various forms of accommodation that parents engage in, including participation in symptoms as well as modification to family routines and schedules. Written charts are used between sessions to keep track of the accommodation over the week. Systematic self-monitoring can effectively track behavior and facilitates intervention (Broden, Hall, & Mitts, 1971; Kim and Sugai, 1995; Shapiro and Cole, 1999).Then the therapist and parents choose a 'target accommodation' that they will work to reduce or stop and formulate a detailed plan for how the parents' behavior will change. The child is kept informed of the parents' decision to address the issue, and of the plan they formulate. When the relationship is strained or when disruptive behaviors are typical, written communication with the child can be used to reduce the likelihood of argument or escalation. Below is an example of a plan to reduce parent participation in bedtime rituals and a written text used to introduce the plan to the child.

6.2.1. Plan

- *One parent will say good night to child in bed—the other will say good night in the living room.*
- *Parent will leave the room immediately after saying good night.*
- *Parent will return to room after 20 min if child is awake or in distress but will not perform ritual. Parent will say "I know you are feeling uncomfortable right now, but I'm sure you can cope".*
- *Child will not be punished for staying up or acting out unless there is physical aggression.*
- *In the morning both parents will say, "I'm proud of you—you got to sleep without the rituals".*

- *If child becomes overly distressed for more than 1 h then the following night parents will arrange for aunt to stay in the home and will leave the house after saying good night once.*
- *Child will be informed of the plan—apart from the possibility of parents leaving the home.*

6.2.2. Written text used to introduce the plan to the child

Kyler[2], Mom and Dad love you so much! We know how bad you feel when you worry at bedtime and how scared you are of not doing your rituals. But we also know that by doing the bedtime rituals we are not helping you to get better and to beat OCD. We love you and our job is to help you. From now on, only one of us will come to your room to say good night. We will say it one time and then we will go out of the room. We will check on you after twenty minutes but we won't do the ritual. We know this may be very hard but we are not trying to punish you or hurt you. We are 100% confident that you will be OK! Love, Mom and Dad.

Over the following weeks the parents continue to monitor the accommodation and the therapist helps to problem-solve difficulties in implementing the plan. After reduction is achieved in the target accommodating behavior, another target is selected and the process is repeated. This time more emphasis is placed on the parents taking initiative in choosing the target and formulating the plan.

6.3. Troubleshooting the SPACE Program—treatment modules

SPACE includes a number of modules that are implemented as necessary to help overcome common difficulties in reducing family accommodation.

6.3.1. Improving cooperation between parents

A common difficulty in parent training, in our experience, is the lack of collaboration and cooperation between the two parents. This can range from minor disagreements to complete lack of cooperation or only one parent agreeing to engage in the process at all. Among the many factors that could hamper good cooperation are the different times that parents spend with child, differing parenting styles such as more authoritative or permissive parents, attributions of blame, and different degrees of identification with the child's experience. The SPACE module focuses on increasing cooperation by integrating both parents' standpoint (e.g., integrating acceptance of the child's experience with confidence in the child's ability to cope) and includes behavioral exercises such as asking parents to 'switch roles' for a predetermined time such that the more accommodating parent is placed in charge of getting a child to cope while a more demanding parents is charged with helping the child to feel better. Planning specific times for review and communication during the week also helps to improve communication.

6.3.2. Social support

This SPACE module helps parents to recruit and engage the help of friends, family and others in the broader social context who can support the treatment process. Supporters can sustain the parents' efforts, reinforce the message to the child that the OCD must be overcome, mediate between child and parent to reduce conflict, and encourage the child. The module also addresses some common reasons that we have found make parents reluctant to accept help, such as embarrassment or fear of being criticized.

6.3.3. Dealing with disruptive child reactions

This module is used when there is a likelihood that a child will react with aggression toward parents or toward themselves, or when this has occurred during treatment. Using the principles of NVR, parents are encouraged to persist in their efforts without becoming drawn into argument or escalation. The use of supporters can be helpful in attenuating child explosive behavior. For example, when a child has acted violently after parents refused to accommodate the parents can ask several supporters to call the child, inform them that they are aware of the behavior and that although they understand the child's distress violent behavior is forbidden. They can also express support for the process the parents are implementing. The therapist stresses to the supporters that the aim of the calls are not to shame the child or to accuse them. Rather, the supporters express their acknowledgment of the difficult process the child is experiencing and recognize any progress that has been made. However, they also state that acting in a disruptive or aggressive manner is an unacceptable way of dealing with the difficulty and they can offer to help if the child feels the same way again.

6.3.4. Coping with threats toward the self

When a child expresses threats or aggression toward themselves the therapist will advise the parents on practical steps to ensure the child's safety (e.g., a visit to the ED or close supervision at home) and help them to protect the child without agreeing to stop the therapeutic process.

6.4. Case example

May, a 13 year old girl, had symptoms of OCD since she was approximately eight years old. At first, her symptoms centered on the fear of germ contamination and she avoided contact with many things she considered dangerous or dirty. She was treated at age nine with E/RP and had a partial response. Her symptoms improved to the point that her functioning returned to normal but she continued to be overly concerned with contamination. For the past year however, her fear of contamination had changed. She was now afraid of exposure to harmful chemicals, radiation, asbestos and other environmental hazards. May refused to walk outside the house and would only go outside if one of her parents drove her from door to door (she would dash from the house to the car covering her mouth and nose with a surgical mask); she forbade anyone in the family to open windows in the house and would explode with rage at any violation of this rule, she asked her both her parents at least 15 or 20 questions each day relating to her fear and would question them both about any exposure they may have experienced while outside of the home; and she refused to allow them to clean any part of the house with anything but plain water, forbidding the use of detergents and cleaning agents. At school May would go directly into class from the car and refused to leave the class during recess or to sit near a window. Over the two months prior to evaluation she had missed 13 days of school because she refused to leave the house in the morning. Although May had previously been a social and well-liked girl, her relationships with friends had deteriorated as she withdrew into herself and avoided most social situations. May's siblings (7; 9) complained bitterly about the rules their older sister imposed, particularly when she embarrassed them in front of friends. They retaliated by teasing her, telling her they had opened her window or had purposely brought contaminants into the house. May refused to return to the therapist who had treated her a few years earlier stating categorically that she did not have OCD and that the therapist (whom she had actually liked very much) had been mean to her 'all the time'. She agreed to participate in an

[2] Kyler, and all names in the paper are pseudonyms. No personal information is disclosed in this manuscript.

evaluation only when her parents promised her a large prize if she came and threatened to hospitalize her if she did not.

During the evaluation, to which she came dressed in old clothes she meant to throw away immediately after returning home, she was antagonistic and only partially responsive to questions. She admitted her worries may be inflated but stated that if this were the case it was because her parents and siblings were 'grossly irresponsible' and therefore she needed to be extra careful. Her score on a measure of OCD symptoms Children's Yale–Brown Obsessive-Compulsive Scale (CYBOCS) (Scahill et al., 1997) was in the moderate range (17) but parent report on the same measure was in the severe range (31). When asked about treatment she flatly declined and then refused to answer any more questions. May's parents felt very helpless. They witnessed her symptoms growing in severity and her deteriorating functioning but were unable to help her as she refused to accept treatment. The parents participated in SPACE in the hope of alleviating her symptoms and increasing her willingness for individual treatment.

After introducing the intervention and discussing the rationale for parent treatment and the importance of family accommodation the therapist helped the parents draft a letter to May and asked them to present it to her together when they were feeling calm and composed. The therapist role-played with the parents reading the letter out loud, handing it to May and leaving the room without engaging in argument. The letter said:

> *Dear May, We love you so much and we think you are a kind and beautiful girl. We know how scared you are of getting sick. We do understand this but we know that OCD makes you feel that way and it is our job as your parents to help you get better. We are going to be working really hard from now on to help you overcome this fear. We will get as much help as we can from whoever can help us. Together we will beat OCD. Love, Mom and Dad.*

The parents reported that May listened to the letter without comment. When they handed it to her she crumpled it in her hands, threw it back and them and glared at them. Then she began to cry. Her parents stayed in the room a few minutes longer without speaking and left.

The next session included a detailed review of all the ways in which the parents' and siblings' behavior was modified to accommodate May's OCD. As a first target for change they focused on being able to open windows in the house, an issue that caused significant discomfort to the whole family. They wrote May another letter informing her that they would begin opening windows each day and that they were confident she would be able to overcome her fear. They stressed that they were not doing this to punish her but out of concern for her wellbeing. With the therapist the parents prepared a list of friends and relatives whom they thought would be able to help them and contacted each of them in turn, explaining May's difficulties and the process they had undertaken. The parents were amazed at the level of support they received. The supporters were encouraging and some of them shared similar personal experiences.

For the first time they opened a window they asked two supporters, an uncle of May's and her grandmother, to be in the house. Both parents reminded May of their decision and got up to open the window. May yelled: 'don't you dare', but the parents proceeded to open it. The grandmother spoke calmly to May and reminded her that she was a strong and capable girl. May was clearly distraught and closed herself in her room. Half an hour later her uncle went up to her room and spoke with her. A few minutes later they came downstairs together and May was able to sit in the living room with the others. The parents continued to open a window each day and May's distress was reduced after two or three days.

As a second target accommodation the parents chose to focus on May's repeated reassurance seeking questions. These had become very disruptive to them, partly because she would call them repeatedly on the phone at work when an obsessive worry preoccupied her. Together with the therapist they decided that each of them would answer no more than two OCD questions per day. If May tried to call them on the phone after they had answer two questions they would not answer. In case of emergency May was to send them a text message specifying the nature of the emergency. May's mother was concerned that if left with her doubt and not able to ask for reassurance, May's obsession would grow and grow until she 'completely lost it'. The therapist agreed that May would be very uncomfortable but assured the parents that the discomfort would pass without lasting damage. The parents wrote to May again and expressed their pride in the progress she had made at being able to tolerate open windows. They acknowledged that she asked them questions because she was truly anxious but expressed the belief that their answers were only contributing to making her OCD worse, and their determination to help her overcome the problem.

On the first day of the new plan May asked each of her parents two questions immediately after arriving home from school She then tried to ask her mother again. When the mother did not answer May became very agitated. She trailed after her mother from room to room asking her to 'promise' that she was not going to get sick. She stood very close to her and yelled her question in her ear. Then she tried to call her father for a third time. When he did not answer the phone she sent him a text message with the words 'you'll be sorry!' May began taking things out of drawers in her parents room and throwing them on the floor. She stamped on their clothes and caused the lamp near their bed to break. Her mother called the therapist who advised her not to immediately intervene and scheduled an appointment for the next morning. In the meantime the parents were to leave everything exactly as May had left it.

Both parents arrived to the next day's session very upset. They felt they had 'gone too far' and pushed May beyond her capability. The therapist acknowledged their feelings but pointed out that while May had indeed behaved very badly, she had also been able to eventually withstand not getting the answers she sought. The therapist asked the parents to contact the supporters and invite them to come to the house. The parents would not straighten up their room but rather would allow the supporters to observe what had occurred and would ask them to express to May that such behavior was unacceptable. Seven supporters agreed to come and one who could not come to the house was sent photographs of the parents' room. The supporters told May that they understood had awful she must have been feeling to act like that but stressed that her behavior was not acceptable. One supporter said: 'This is vandalism May, that's never OK. Next time why don't you call me when you are so angry? Maybe I can help.' May was very quiet and teary that evening. Before going to bed she handed her parents a note. She wrote "I am sorry. I know I should not have done that. Thank you for helping me fight OCD". Her parents were shocked as it was the first time she had acknowledged to them that her questions were symptoms of OCD. The next day, May again tried to ask more than her 'quota' of questions but did not resist when her parents refused.

Over the following weeks May's parents were able to address additional accommodations and the process became gradually easier. May learned to recognize their written announcements as signs that they would follow through with determination and became less resistant. The parents also reported seeing gradual improvement in symptoms they had not targeted. She stopped

covering her face when walking to the car and her teacher reported that she had left the classroom during recess. As a final step in treatment the parents began to wash the floors of the house with detergent, and after a few days this was expanded to include May's room. At the end of treatment May and her parents CYBOCS was both scored 10 and she expressed a willingness to begin individual treatment for her remaining symptoms. The addition of individual treatment alongside parent work allowed May to focus on symptoms her parents were less engaged with and to take an active part in her own recovery.

7. Preliminary report on six cases

Parents of six children who met DSM-IV criteria for primary diagnosis of OCD, and who declined cognitive behavioral therapy participated in the SPACE treatment program. Children were between the ages of 10–13 (M age = 11.3) and four were boys. Three children had at least one additional anxiety disorder diagnosis and two also had attention deficit hyperactivity disorder (ADHD). Five families were intact two-parent homes and one child lived with his divorced mother. Mothers participated in treatment in all cases and fathers participated in four cases. All parents completed ten treatment sessions. The most frequently implemented treatment module was accessing social support (5 cases); followed by coping with disruptive behavior (4 cases); improving collaboration between parents and coping with threats toward the self (2 cases).

Severity of OCD symptoms as measured by parent report CYBOCS ranged from 25 to 36 ($M = 29.16$). Family accommodation, as measured by the 9 accommodation items from the pilot study of family accommodation (Calvocoressi et al., 1995) ranged from 19 to 30 of a possible 36 ($M = 24.16$) and coercive-disruptive OCD behaviors as measured by the Coercive Disruptive Behavior Scale for Pediatric OCD (CD-POC) (Lebowitz et al., 2011) ranged from 27 to 65 of a possible 72 ($M = 41.5$). Overall child anxiety as measured by the Pediatric Anxiety Rating Scale (PARS) (RUPP Anxiety Study Group, 2002) ranged from 15 to 26 of a maximum possible score of 30 ($M = 21$). Three of the six children were on stable doses of medication without changes for six months (3 SRI; 1 also on atypical antipsychotic), the other 3 had refused medication as well as E/RP. None of the children had undergone E/RP in the past. No parents currently had OCD but 2 had been diagnosed with OCD in the past and 1 had current significant subclinical OCD symptoms. Parents consented to participation in the treatment study, which was approved by the Institutional Review Board (IRB). Preliminary findings are presented here as indication for the feasibility, acceptability and potential of SPACE, not as evidence of the program's efficacy.

All parents completed treatment. Client satisfaction as measured with the eight-item Client Satisfaction Questionnaire (Attkisson and Zwick, 1982) was high ($M = 30.1$ of a possible 32). Therapist post-session forms showed high adherence to the session outlines.

Average parent-report CYBOCS score after SPACE treatment was 11.5, a significant improvement of 17.6 points compared to before SPACE (paired sample t-test = 14.7, $p < 0.01$). Family accommodation as measured by FAS was reduced by an average of 13.1 and coercive disruptive behavior as measured by CD-POC was reduced by an average 24.9 (paired $t = 7.4$, $p < 0.01$ and 4.59, $p < 0.01$ respectively).

8. Discussion and conclusion

Parents of children with OCD are usually drawn into their child's disorder through complex patterns of enmeshment and entanglement involving participation in symptom driven behaviors and modification of personal and family routines (Lebowitz et al., 2012; Storch et al., 2007). These accommodations have negative impact on clinical course of the child's disorder and predict poorer response to treatment (Garcia et al., 2010). As noted earlier, it seems plausible that parent accommodation could reduce a child's insight by seemingly confirming the need for rituals. This possibility would be in line with some reports of a relation between family accommodation and poorer insight in children, though more research is needed before a causal link can be established. Accommodation could potentially also lower motivation for treatment by providing the child with a viable alternative to facing the distress caused by the disorder. Although it is unclear how many children with OCD are not being treated because they decline to attend even an initial evaluation clinical experience would indicate there are many such children. Even when ostensibly in therapy, not all children comply with the active elements of treatment such as exposures that are integral to E/RP.

Other studies in both children and adults have been investigating the benefit of involving family members in treatment, including a strong emphasis on modifying these patterns of enmeshment by targeting family accommodation. These programs however generally augment individual treatment and therefore still require that the patient consent to treatment and cooperate with it. SPACE is a novel intervention that is exclusively parent based and casts the interpersonal nature of the disorder as both potential handicap and potential benefit. It is the nature of systems that change to one part of the system will generally lead to change in the other parts. By focusing on modifying parental behavior, without the need for active child collaboration, parents work to bring about reduction in childhood symptoms of OCD. Parents are empowered to actively help their child, moving away from the frustrating feeling of helplessness that generally comes with having a child who is ill and will not accept treatment.

The small sample described in this report is typical of youth with OCD in the frequent co-occurring psychiatric diagnoses. Comorbid anxiety disorders (de Mathis et al., 2008; Kessler et al., 2009), ADHD (Lebowitz et al., 2012), as well as dysregulation (McGuire et al., in press) and rage attacks (Stewart, 2012; Storch et al., 2012) are common complications. SPACE may be particularly well suited to addressing these complications. The focus on parent change means that children who are not good candidates for CBT can still benefit, and the NVR approach is geared toward avoiding being drawn into unhelpful escalation triggered by the child's anger or rage. Parents learn to delay their response to the child's outbursts, lowering the risk of impulsively attacking back or retreating from the changes they have planned. The emphasis on social support can sustain parents and in our experience the presence of concerned supporters can inhibit explosive behavior in many children.

Preliminary indications support the potential of the program to improve child symptoms and to increase the likelihood of successful individual child treatment. Thus, though SPACE is a parent only intervention it may set the stage for child treatment to follow. An important question for future research will be the identification of psychosocial and clinical factors that moderate the effect of SPACE. It seems likely that children with highly accommodating parents are more likely to benefit than children with less accommodation but research is needed to empirically investigate this and other potential moderators. Other investigators (Peris and Piacentini, 2013) have highlighted the importance of family treatment for families with high-conflict and poor cohesion. In our experience SPACE too can be difficult to implement in some very high intra-marital conflict situations. In a current larger study we hope to be able to investigate such moderators in more systematic fashion.

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