Title

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Journal

Cognitive and Behavioral Practice, 28(3)

ISSN

1077-7229

Authors

Raila, Hannah E
Julian, Megan
Lebowitz, Eli R
et al.

Publication Date

2021-08-01

DOI

10.1016/j.cbpra.2020.06.004

Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice 28 (2021) 422–434

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

Separating From the Mothership: A Coordinated Individual and Parent–Based Approach to Severe Agoraphobia in a Young Adult

Hannah E. Raila, *Stanford University*
Megan M. Julian, *University of Michigan*
Eli R. Lebowitz and Wendy K. Silverman, *Yale Child Study Center*

Families are invested in an older adolescent gradually separating from the family to live independently as an adult, but for many families, adolescent psychopathology makes this transition difficult. Addressing such psychopathology is critical in preventing "failure to launch," a breakdown in gaining age-appropriate independence from parents. This case study illustrates a promising approach directed at helping an 18-year-old female with agoraphobia and panic disorder who, upon intake, was at risk for long-lasting, prohibitive dependence on her parents. The clinical approach entails the convergence of two psychological treatments conducted in the same treatment center. One provider, working directly with the patient, delivered traditional cognitive-behavioral therapy (CBT) for anxiety. A second provider, working with the parents, delivered Supportive Parenting for Anxious Childhood Emotions (SPACE) a parent-based treatment focused on reducing family accommodation of the patient's anxiety. Behavioral indices and self-report scores indicated clinically significant improvement following the combined intervention. Attention is drawn to the convergence of those treatments and the utility and special considerations in taking this kind of approach. Overall, the combined treatment may have been more successful than the sum of its parts at preventing failure to launch. This case study, the first to describe the integration of CBT and SPACE, can provide useful guidance for clinicians helping families of adult children to transition to independence.

A fundamental and universal component of late adolescence is the transition from dependence on one's parents to increased independence (Arnett, 2000). When this transition goes awry, and young adults remain highly reliant on parents while unable to pursue higher education and employment, or the young adult's autonomous functioning is reversed after an aborted period of independence, it can be baffling for both parents and clinicians. The increasingly common scenario of an adult child living at home and being highly dependent on parents has been described as "failure to launch" (Lebowitz, 2016).

The young adult's difficulty in achieving an independent life is often fueled by distress and underlying psychopathology, and clinical experience suggests that anxiety is a common factor (Lebowitz, 2016). Anxiety leads to avoidance of situations that are deemed threatening, and *family accommodation* of the anxiety by parents can reinforce the avoidance—thereby perpetuating the child's reliance on them.

Family accommodation of childhood anxiety refers to participation by parents or caregivers in anxiety-driven behaviors and to modifications of the home environment that support anxious-avoidance—such as cooking only certain foods that a child with emetophobia believes he or she can tolerate or providing, to a child with illness anxiety, repeated reassurance that he or she will not get sick. Family accommodation is highly prevalent among parents of anxious children (Lebowitz et al., 2013; Thompson-Hollands et al., 2014), alongside other parent behaviors associated with child anxiety, such as parental overcontrol during interactions with the child (Wood et al., 2003). Data consistently link family accommodation to greater symptom severity and worse impairment, and high levels of family accommodation may predict poor treatment outcomes (Kagan et al., 2016; Storch et al., 2015). Theoretically, family accommodation may negatively reinforce maladaptive avoidance behaviors in anxious children, while the immediate albeit temporary reduction in child distress serves to reinforce the accommodation behaviors themselves—leading to an ongoing

Keywords: agoraphobia; exposure; cognitive-behavioral therapy; parent therapy; anxiety

cycle of the child's avoidance and the family's accommodation.

This cycle can continue through adolescence and into adulthood, hampering the natural transition to independence and autonomy—for example, an anxious child who has been allowed to miss school when anxious may struggle to attend college classes and continue to be accommodated by parents, who provide a comfortable and reassuring environment on missed days or who coordinate with college professors on the child's behalf. Family accommodation provides the child temporary relief from anxiety and distress, but reinforces his or her maladaptive avoidance, and the reduction in the child's aversive displays of anxiety reinforces the parents' accommodating behavior. Furthermore, parents' well-intentioned efforts to create a home environment that is free from anxiety-provoking stimuli (e.g., preventing visits from guests because of social anxiety) can make coping with the less accommodating out-of-home environment seem increasingly daunting. This can in turn reduce the likelihood of independent adult functioning, and it can ultimately lead to difficulties, such as failure to find employment, failed or dropped college courses, and avoidance of "adult" tasks, such as grocery shopping. Thus, family accommodation provides in-the-moment relief from anxiety, but can contribute to the persistence of anxiety in the longer term, and may impede the shift to independence in adult children. The present case study seeks to guide case conceptualization and to illustrate a useful intervention strategy for these thorny situations.

Because of the critical importance of family accommodation, one-on-one psychotherapy sessions with highly anxious young adults may be insufficient—as the ongoing accommodation at home, occurring between therapy sessions, maintains the avoidance and impairment. Further, individual treatment with a young adult may not be possible because of low motivation for treatment, high anxiety about therapy, or poor insight—and low child involvement predicts poorer treatment outcomes in response to cognitive-behavioral therapy (CBT) for anxiety (Chu & Kendall, 2004). Parents of children who have reached the age of majority do not have the legal or practical ability to initiate individual therapy without the child's consent and often feel helpless in the face of their child's refusal.

For these reasons, parent-based treatments are gaining increased attention to address the anxiety and family accommodation that underlies many failure-to-launch cases (Lebowitz et al., 2012). Such parent-based treatments turn the systemic nature of anxiety psychopathology into a strength—enabling parents to influence the system by focusing on their own accommodating behaviors, and to achieve change even when work with the patient individually is not feasible or sufficient. In particular, Supportive Parenting for Anxious Childhood Emotions (SPACE) is a parent-based treatment focused on reducing family accommodation and increasing supportive responses to childhood and adolescent anxiety. A number of open trials and case studies of SPACE demonstrated its feasibility and acceptability with parents of anxious children and adolescents (Lebowitz, 2013, 2015; Lebowitz & Majdick, 2020; Lebowitz et al., 2014), and recently, a randomized controlled trial found it to be as efficacious as individual CBT (Lebowitz, Marin, Martino, et al., 2019). Though targeted at children and adolescents, SPACE is being adapted for implementation with young adults (Lebowitz, 2016), and an open-label trial on a closely related approach with adults suggested its utility for this population (Lebowitz et al., 2012).

In anxiety disorder treatment, parent-based interventions have traditionally emphasized training parents to manage their child's behavior or be lay CBT therapists (Lyneham & Rapee, 2006; Silverman et al., 2019; Thienemann et al., 2006). A key benefit of parent-based approaches is that they can be conducted in tandem with more traditional, child-based CBT. Indeed, these two treatments may be complementary, as principles of the parent-based approach (e.g., reducing negative reinforcement through reducing parent participation in the child's anxious avoidance) align well with those of CBT (e.g., reducing fear and avoidance through exposures; Silverman et al., 2009). Further, the inclusion of a separate parent-based component that specifically targets family accommodation addresses a key aspect of family processes around anxiety that is underaddressed in individual treatment (e.g., Butler et al., 2006).

Despite this theoretical recognition, more guidance is needed for clinicians wishing to *combine* a parent-based intervention addressing family accommodation with individual CBT in a young adult. This integrated treatment approach simultaneously targets both child-level (e.g., cognitive distortions) and family-level (e.g., accommodation) factors that contribute to the maintenance of anxiety disorders and can thwart independence. Further, both the child and the parent interventions are independently robust enough to constitute a standalone treatment, but are also dynamically informed by each other as treatment progresses, and the coordination of the two results in an approach that could be greater than the sum of its parts.

The present case study illustrates the clinical details of how clinicians can combine these two approaches, as well as when one may want to do so. Indices of progress in this case suggest that such a combined approach may be very useful in ameliorating anxiety, reducing

family accommodation, and averting failure to launch. The standard recommendation for building an evidence-based intervention is to show preliminary effectiveness in case studies and then undertake controlled studies (Bruce & Sanderson, 2005). Though further research and randomized control trials are needed, the present case study supports the promise of a combined individual and parent-based approach.

Case Description

Treatment Setting and Context

All treatment was conducted at an academic hospital outpatient clinic, specializing in the treatment of children and adolescents. The parents initiated contact, seeking treatment for their daughter due to concerns about the lack of independence of their daughter, who at that point had moved home following a couple of weeks trying to live in a college dormitory a few towns away. The CBT therapist was a female graduate student while the SPACE therapist was a female predoctoral intern; treatment fees were partially covered by insurance.

Family Demographics

The family was a White, middle-class family living in a house in a New England suburb. Both parents were middle-aged working professionals. In addition to the patient and her parents, the family included a second adult sibling who lived outside the home and would visit occasionally.

Young Adult Patient

The patient was an 18-year-old female, presenting with agoraphobia and panic disorder. She reported symptom onset around age 15 and described fear of future panic attacks that greatly limited her ability to feel safe outside the home. She showed marked functional impairment; at intake, she had not driven alone for 4 months and had moved back home after a 1-month attempt to stay in her college dormitory. Even at home she was unable to stay alone without her parents. She intermittently refused to attend her college classes because she feared she "would not be able to escape" if she felt panicked, and she was more likely to attend class if her parents stayed near the classroom—something they often did. She was often self-critical (e.g., reporting feeling "stupid" or "silly") for not being able to do the activities she used to do, and she identified regaining daily functioning as her top treatment target. She expressed passive suicidal ideation, which she indicated was heightened at those times when she thought about her recent functional decline.

Her previous treatment history was limited. She had attended outpatient psychotherapy for 1 year at age 12 for obsessive-compulsive disorder (OCD) with partial success, and was treated briefly by another psychotherapist a few years later, though she had stopped treatment due to difficulty connecting with the therapist. She had been referred to a day treatment program but had never attended. She had never been prescribed medication for emotional difficulties.

She also reported a history of nonsuicidal self-injury, specifically wrist cutting and burning since age 14, as well as OCD and bulimia since middle school. These were not the focus of individual sessions and were not directly targeted in the parent-based approach. Of note, the treatment team identified that feelings of disappointment in her daily functioning and in her parental dependence were a precipitant to self-injury, and the self-injury (which was monitored throughout treatment) declined as her daily functioning improved.

Family System and Parent Accommodation

Early on in individual CBT with the patient, it became clear that certain aspects of the family system were, to a critical degree, maintaining the patient's anxiety. Her parents engaged in numerous accommodation behaviors in an effort to assuage her anxiety. Though stemming from the goal of comforting her, the accommodation provided negative reinforcement for the patient's avoidance and fear of daily tasks, including driving and sitting in her college classes.

The full extent of parent accommodation became apparent 6 weeks into treatment, when the parents presented the individual CBT therapist with a request for a Family and Medical Leave Act (FMLA) form for unpaid leave from work. At this time, they reported that the father had been missing work on a weekly basis—not only to drive the patient to her college classes every day but also (especially when the patient's anxiety was highest) to wait outside her classroom before bringing her to work with him. On days that he did not or could not wait outside the classroom, the patient would often refuse to attend class, due to fear of having no one safe to go to should she feel panicked.

Following discussion between the individual clinician and the parents, the father was granted 16 hours/week of FMLA-approved work time, on a time-limited basis for a few weeks. This spurred a deeper discussion about the level of parent accommodation in the home. In addition to relying on her parents to get her to class, and accompanying them to work, the patient accompanied her parents wherever they went.

Indeed, they had not felt it possible for both parents to leave the patient alone for several months. It is notable, though perhaps not uncommon, that the full degree of family accommodation did not become apparent until the sixth session. This highlights the importance of assessing for accommodation, through measures such as the Family Accommodation Scale—Anxiety (FASA; Lebowitz et al., 2013; Lebowitz, Marin, & Silverman, 2019) and clinical interview, both at intake as well as on an ongoing basis.

Although the family genuinely enjoyed spending time together, the degree of enmeshment spurred by the daughter's anxiety was wearing on both parents. They longed for the "empty nester" life they had imagined they would have but were left with even less time alone as a couple than they had had earlier in their parenting years. Further, both parents acknowledged that they were being held back professionally because of the time spent accommodating their daughter's anxiety. Both parents had a difficult time imagining how she would become an independent, self-sufficient adult. Without further intervention, she was at high risk of "failure to launch."

In summary, the high degree of parent accommodation in this case made it clear that for the patient to overcome her anxiety and avoid "failure to launch," intervention on the family level would be necessary, in addition to the already in-place CBT with the patient.

Intervention Procedure and Results

Overview of Treatment

Treatment ultimately consisted of an integrated approach in which individual (CBT) and parent (SPACE) sessions were implemented separately but concurrently. The individual sessions were initiated first, and parent sessions were added at Session 12 of the individual treatment. Individual and parent sessions were kept separate because, although there was a strong need to address the family system (elaborated on below), the young adult strongly preferred to maintain her own therapist with whom she could talk confidentially and whom she perceived as being "her own." Although parent and individual sessions were conducted with two different clinicians, they were coordinated in order to align topics being addressed in each.

Initial Assessment and Conceptualization

The patient and her parents were invited in for a semistructured diagnostic interview based off the Anxiety Disorders Interview Schedule (ADIS; Silverman & Albano, 1996). The patient also completed self-report measures of symptoms of depression and anxiety. Diagnoses were made based on this information (it was initially unclear whether the patient was experiencing panic-like symptoms or full panic attacks, but agoraphobia was prominent). Although the evaluation included assessment of family accommodation, both the patient and her parents were initially reluctant to reveal the full extent of the accommodation, which as noted became increasingly apparent as treatment progressed.

In terms of case conceptualization, the patient's behavior of not leaving the house alone was understood to be driven by her fears of being unable to handle situations, including an expectation of feeling acute physiological discomfort, as she was highly sensitive to anxiety-related sensations. As a result, she adopted the safety behavior of staying near caregivers, which negatively reinforced her anxiety and increased her reliance on these "safe" people. When pushed to confront her anxiety (e.g., take a subway, be left home alone), she became angry and sometimes had what were described as age-inappropriate "meltdowns." This mapped onto chronic difficulties with emotion dysregulation, a vulnerability that had been salient since early adolescence. Depression symptoms seemed elevated in part because behavioral activation (both pleasure and mastery) opportunities were severely limited by her isolation, and because she perceived a lack of control over her life, which interfered with her self-esteem. As such, an increase in leaving the house alone (the primary treatment target) was expected to decrease depressed mood.

To address these difficulties, individual graded exposure to feared scenarios was determined to be the treatment of choice, along with strategies to improve emotion regulation. Parents were initially included in treatment to the degree that they are with most older adolescents (i.e., intermittent all-family meetings and brief check-ins with only the parents), although the patient expressed discomfort about her therapist meeting with the parents alone and did not waive confidentiality. As a result, the family system remained relatively opaque for the first six to eight sessions of treatment.

Individual CBT Sessions With the Patient

Forty-one individual CBT sessions with the young adult patient, each lasting 45–60 minutes, were provided over the course of 1 year. The majority of sessions consisted of preparing for and reviewing out-of-session exposure assignments. Other key interventions included psychoeducation about avoidance and negative reinforcement, behavioral activation and activity scheduling, in-session imaginal exposure, automatic thought challenging, and tracking triggers for mal-

adaptive behaviors, such as self-injury and purging. While cognitive work was done intermittently, behavioral approaches proved to be much more successful and remained the focus throughout treatment (as described in Silverman & Kurtines, 1996); they are described below.

Treatment was initially individual only, but during the 10th session (after clinicians noted a relative lack of progress from the individual sessions alone, highlighted by the father's request for FMLA leave to accommodate the patient), the idea of adding a parent treatment was broached with both the young adult and her parents. Starting after the 12th individual session, both treatments were conducted in tandem as a combined approach.

Exposure

In individual treatment, following psychoeducation about negative reinforcement, the first fear hierarchy was created across Sessions 3 and 4 (see Table 1). The items on the fear hierarchy reflect the high degree of functional impairment experienced by the patient. Indeed, her first out-of-session exposure was simply to walk 50 feet away from her house and back unaccompanied; she had not done this in several months. The patient was fairly motivated and compliant, and she progressed steadily through most of the exposure assignments (notably, however, while in treatment she did not ever successfully complete her top hierarchy target: staying overnight in her dormitory). By the end of her third month in treatment, she was driving alone for about 10 minutes at a time. Despite her progress in therapy, her class attendance continued to deteriorate, and she reached a point where she was never attending class unless her father promised to wait outside the classroom the whole time.

After completing most of the tasks on the first fear hierarchy, a second and more challenging hierarchy was created, approximately 6 months into treatment (see Table 2). At that time, the patient was able to drive throughout her neighborhood, and top exposure goals became driving to farther away destinations, navigating crowded spaces alone, and spending time at home alone without her parents. By the end of treatment, she had completed nearly all of the planned exposure tasks from this second hierarchy, as well. She was regularly driving alone to and from school, and starting about 8 months into treatment, she was staying home alone for her parents' entire workday. This was the first time she had felt able to do so in close to 2 years.

Throughout treatment, the patient's shame about her difficulties and reluctance to disclose them were apparent. She frequently expressed frustration at being so limited in her life that she had to work on things that she "should" be able to do easily. This made assessment of her progress difficult, as she would occasionally refuse to discuss with her therapist the challenges she was facing—for example, during the first 2 months of treatment, she significantly underreported the increasing frequency with which she missed class when her parents could not stay outside the classroom. The therapist was aware of it only when her father requested the FMLA hours to cover the time he was spending with her. This aspect of the therapy—discussed further below—made the information gathered from the parent sessions even more essential.

Table 1
First of Two Fear Hierarchies Used in Individual CBT Sessions With the Patient

Task	SUDS
Sleeping overnight in my dormitory	100
Driving by myself for 5 minutes or more	100
Being at home alone for 10 minutes or more	95
Going out to a restaurant with friends	95
Being in my dormitory alone for 30 minutes	95
Being at home alone for 6 minutes	95
Walking around my neighborhood by myself for 1 hour	90
Walking around my neighborhood by myself for 5 minutes	85
Driving 1 minute away from my house and back	75
Walking around my neighborhood with my mom for 20 minutes	70
Being at home alone for 2–3 minutes	70
Driving by myself 100 feet away from my house and back	60
Going to the store with someone else	50
Walking through the school cafeteria by myself	50
Walking 100 feet away from my house and back	40
Walking 50 feet away from my house and back	20

Note. This hierarchy was constructed in the third and fourth individual sessions. CBT = cognitive-behavioral therapy; SUDS = subjective units of distress.

Behavioral Activation

As (a) an incentive to complete the exposure assignments, as well as (b) a counter to the patient's tendency toward depressed mood, enjoyable activities were scheduled—often in conjunction with exposures—for example, the patient identified that she enjoyed babysitting her younger cousin, so one assignment paired an exposure (driving to the cousin's house) with a scheduled rewarding activity (babysitting for 2 hours). Generally, the patient's mood improved more readily in response to a sense of mastery over

Table 2
Second of Two Fear Hierarchies Used in Individual CBT Sessions With the Patient

Task	SUDS
Drive to nearby grocery store and get full list of groceries	100
Drive from work to class 1 hour ahead of mom or dad	100
Drive from home to work 30 minutes after mom or dad leaves	100
Wait in coffee shop across the street all day while dad is at work	80
Drive from work to class 10 minutes ahead of mom or dad	80
Drive to work 5 minutes after mom or dad	70
Drive from work to class 5 minutes ahead of mom or dad	70
Drive to nearby pharmacy and buy five items	65
Wait at coffee shop across the street for 1 hour while dad works	60
Drive to nearby grocery store and buy five items	55
Wait in coffee shop across the street for 20 minutes while dad is at work	55
Drive into work with mom or dad following in separate car	50
Drive from work to class with mom or dad following	40

Note. This hierarchy was constructed in the nineteenth individual session. CBT = cognitive-behavioral therapy; SUDS = subjective units of distress.

her increasing independence than in response to such scheduled activities, but the described behavioral activation did often motivate completion of an exposure (e.g., leaving the house alone, driving, being in public stores) as a means to accessing the enjoyable activity (e.g., seeing friends, shopping).

End of Treatment

The end of individual treatment focused on acknowledging treatment progress and planning for relapse prevention. The patient reported a sense of mastery over her new repertoire of behaviors, and she took pride in comparing her end-of-treatment functioning to her initial fear hierarchy.

Parent Treatment Sessions

Overview of the SPACE Intervention

SPACE helps parents to decrease family accommodation of a child's anxiety, and increase supportive responses to anxiety symptoms. Supportive responses convey acceptance of the child's distress along with confidence in the child's ability to tolerate anxiety (Lebowitz & Omer, 2013). SPACE can be a freestanding parent-based treatment, or it can be delivered in conjunction with child treatment—as in this case.

Rather than training parents as lay CBT therapists or instructing parents to directly modify the child's behavior, SPACE focuses on helping parents to change their own behavior. The SPACE program begins with psychoeducation about anxiety and accommodation, with an emphasis on the systemic nature of anxiety in childhood and adolescence. Parents are then taught supportive responses and encouraged to practice delivering these in interactions with the child.

Addressing accommodation in this way is done in several steps. First, the therapist instructs parents on the nature of supportive statements (that convey both acceptance and confidence) and specific statements are formulated for the parent to use between sessions with the child. The therapist then helps parents to identify and monitor the various ways that they are accommodating their anxious child and explains that accommodation can negatively reinforce the child's anxiety (e.g., in the case of social anxiety, driving the child to school so he or she can avoid taking the bus with peers). Next, a specific target accommodation is selected for modification, and a detailed plan is constructed for how parents will reduce the accommodation (e.g., gradually decreasing the number of days driven each week). Parents then work on implementing the accommodation reduction plan, and the therapist provides supportive strategies for coping with difficult child reactions to the reduced accommodation. The way that these steps were applied in the present case are elaborated on below.

SPACE sessions with the patient's parents began after 12 individual sessions. As a young adult, the patient wanted to ensure that the content of her own treatment was kept private from her parents, which can be a consideration in many young adult cases, so a second clinician was added to the therapeutic team to conduct SPACE with the parents. The two clinicians communicated with each other frequently about the parents' progress in SPACE, and the patient's desire for privacy was respected. As such, very limited information about the individual treatment (e.g., patient attendance at her session) was communicated to the SPACE clinician or to the parents, and only with the patient's approval.

Psychoeducation

In the initial phase of SPACE, the parents were provided with psychoeducation about anxiety. Despite their daughter's long history of anxiety, they had fairly minimal understanding of anxiety and of how some parental behaviors could either make anxiety improve or worsen. Within the family, the anxiety was rarely discussed directly. Working with the SPACE therapist pro-

vided the parents with clarity about and a conceptual frame regarding their daughter's anxiety and with appropriate language for discussing it with her. Specifically, parents were taught about how anxiety manifests in behavioral, cognitive, emotional, and physiological symptoms, and the ways anxiety can blur the boundaries between parents and children and affect the family system. They were also taught about the connection between exposures and habituation to feared scenarios, and how escape and accommodation contribute to the maintenance of anxiety. Importantly, distinctions were made between parental protection (e.g., "She can't handle stress") and support (e.g., "It's hard for her, and at the same time, she can learn to manage it"), and parents were coached to shift toward the latter style—so that they would both provide both validation for their daughter's feelings as well as confidence that she was capable of managing the situation. Once such psychoeducation occurred, her anxiety became a more comfortable topic for the family to discuss. The father, in particular, found that he was better able to talk to his daughter about times when she has been anxious and relate to her in a more sensitive and accurate way once he began to use the supportive statements.

Targeting Accommodation

Next, the SPACE therapist helped the parents outline all the ways their behavior had changed as a result of the patient's anxiety. They compiled a list of accommodation behaviors that they engaged in on a regular basis. It included bringing her along to all social outings, allowing her to accompany them to work, and accompanying her to her college courses and waiting right outside until class was over. The bulk of the accommodation stemmed from the patient's difficulty being alone; as previously noted, she was with her parents almost constantly.

In identifying an appropriate first target for treatment, the therapist aimed to select an accommodation behavior that was a significant problem, that occurred regularly, and that parents were motivated to address. The most interfering accommodation, with the largest negative impact on the family, was the father driving the patient to college and waiting on campus while she was in class, and then taking her with him to his workplace after her class. The parents, however, were reluctant to change this accommodation as a first target. They felt they had "too much skin in the game"—in terms of their financial investment and determination that the patient would complete her college courses. Instead, as a first target, they agreed to focus on leaving the patient at home alone.

As in CBT exposure hierarchies, reducing accommodation in SPACE can follow a gradual progression, with step-by-step reduction of parental accommodation. Specific accommodation targets were decided upon through discussion with the parents, and were meant to be small reductions that progressed toward the goal of the patient being able to stay home alone for a full day. Initial plans called for both parents to leave the house together for about 5 minutes at a time. At first, they took short walks together, and as they were able to extend their time away to 10, 20, 30 minutes, and more, they took short drives or ran errands. They described being able to gauge their daughter's anxiety during these outings by the look on her face when they returned; they observed that she looked more sullen when she was more anxious. The parents noted, however, that the patient began to keep herself busy while they were away from her, and she would frequently clean the house during their planned time away.

When the parents' steps toward reducing accommodation were reviewed in session, frequent discussion topics included comparing the parents' expectations for it to the reality of how the step went, as well as connecting their observations of their daughter's affect and behavior to their burgeoning understanding of anxiety and habituation. Discussions also highlighted the patient's functional improvements and parents' increasing self-efficacy and confidence in supporting (rather than protecting) their daughter. Parents were motivated to engage in the proposed accommodation reductions, because the impact of their daughter's symptoms on their day-to-day life was significant, and they were forthcoming and thoughtful in their review of each week's progress. Particularly at the beginning of treatment, they had a strong preference to progress slowly due to their fear of how their daughter would respond, and they were reluctant to engage in direct conversations with her about anxiety and upcoming stressful events; these issues are addressed further below.

Once the parents gained confidence in the patient's ability to be at home alone, and she appeared to be coping better with their absence, they agreed to start working to reduce their accommodation of accompanying her to college courses. First, the father began driving separately from the patient, following in his car right behind her to her school. Gradually, he increased the distance—for example, by leaving the house several minutes ahead of her or behind her, so that they were not within sight of each other during the drive. Around this time, the father also began moving his location on campus farther away from the classroom—first to the student center next door, then to the college library, and finally to a community library several miles away.

Throughout this process, the patient and her father had regular conversations about each step. He would share the details of his plan for reducing accommoda-

tion and listen to what the patient felt ready to tolerate. Because the patient was motivated to become more independent, and because the patient's individual CBT out-of-session exposure tasks were selected to align with the parents' accommodation-reduction plans, a high degree of coordination was possible between the individual therapy and the SPACE work. As the patient became less anxious, her parents also put in place opportunities to encourage her to leave the house by herself—whether to babysit a cousin, run an errand, or meet a family member for lunch.

Parents' Conceptualization of the Patient

In addition to directly addressing accommodation behaviors, SPACE sessions also focused on shifting the parents' understanding of their daughter and helping them to reflect to her their growing belief in her competence and self-efficacy. Initially, the parents wanted to advance very slowly; they were afraid of how their daughter would respond, and anticipated that she would be "incapable of tolerating" high levels of anxiety. The therapist addressed this view and helped the parents see that in reflecting this view to the patient, they were also likely contributing to her seeing herself as weak and vulnerable. The therapist encouraged the parents to note the differences between how they predicted the patient would respond to reduced accommodation and how she coped in actuality. In nearly every case, the patient was less anxious than her parents had predicted. In discussing their plans with the patient and collaboratively agreeing on the degree of accommodation reduction, the parents realized they almost always underestimated what their daughter perceived herself to be capable of. In highlighting these instances, the therapist was able to help the parents to update their conception of what their daughter was capable of with new data. The apprehension and worry that dominated conversations earlier in treatment gradually transformed into curiosity and wonder about their daughter, who was surprising them every week.

At first, the parents continued to be anxious about whether it was helpful for them to discuss anxiety with their daughter, or whether it would be easier for everyone if the "code of silence" around anxiety was maintained. At one point, when the family was feeling a great deal of success with their progress, they took a short trip to New York City. The patient became overwhelmed with anxiety on this trip, and the family made the decision to end the trip early. The parents felt that the intensity of her anxiety left them no choice but to talk to her about it directly. This decision was reinforced by the knowledge that another upcoming family trip was planned, this one across the country, for just 1 month later.

In reviewing their New York trip in session, parents identified factors that may have contributed to their daughter's difficulty on it. They recognized that a significant contributor may have been her limited psychological preparation for it, along with the novel settings and activities. With their upcoming vacation as motivation, the parents thus engaged in several discussions with their daughter to help her prepare. They planned the itinerary together, visited the airport in advance as practice, and talked at length about how various aspects of the trip would go. In session, discussions centered on the parents' expectation versus experience in talking with their daughter about these topics, as well as on their own sense of comfort in bringing up these anxiety-focused themes at home. Similar to their experience with reducing accommodation, parents reported that they had expected their daughter to push back or respond poorly to such conversations, but that when they actually had them, the conversations felt increasingly comfortable for all and left the family feeling more prepared for their vacation. When they returned from the trip, the parents reported that although the patient had been anxious at times, they had felt confident that she could manage it and were able to discuss her anxiety in a supportive and helpful way.

End of Treatment

As the family approached the end of treatment, the parents appeared considerably more relaxed; they felt much less need to shape their plans around the patient's anxiety. They were able to provide appropriate levels of support, and told the SPACE therapist that they learned that "when you coddle your child, you're communicating to them that you don't think they are capable of handling it on their own!," an encapsulation of the message of support central to SPACE. They felt they now understood that the goal "is to be able to ride out the anxiety without letting it interfere." The parents began to actively check in with their daughter about things that might be hard for her, and to discuss ways that they could help her to prepare—often by practicing something anxiety provoking ahead of time. This was in contrast to their old pattern of avoiding discussions of anxiety, simply hoping that the patient would handle things, and then being frustrated and disappointed when she did not. Their descriptions of the patient were markedly different in both tone and content, relative to prior to the SPACE treatment. Where they had initially described her as "fragile" and driven by her high level of anxiety, they now saw her as anxious yet capable, and they were gratified to see her personality "coming through." They described her as "like the person who was always inside her, who had never come out before. She is more mature, confident, and proud of herself."

Integrating the Approaches and Special Considerations

In productively and effectively integrating these two approaches together—with one clinician working directly with the young adult patient and a second provider working with the parents—there are several notable considerations.

First, this case lent itself to conducting the CBT sessions and SPACE sessions with separate providers—however, other cases may be conducive to the same provider delivering both approaches. In this case, the patient was highly concerned about the contents of her treatment being shared with her parents. Regular meetings between her therapist and her parents would have contributed to the patient continually worrying about whether her privacy was being respected. Rapport between the patient and her therapist was adequate but not exceptional, and the treatment team was concerned that initiating parent work with the same therapist could be interpreted by the patient as a betrayal of confidence. Keeping the treatments separate allowed the CBT therapist to still be identified as "her" clinician, without concerns that the therapist would "take the side" of the parents.

At the same time, including some combined parent–patient sessions may be helpful and more efficient for other young adults comfortable with that arrangement. Combined sessions allow the accommodation to be discussed openly among the group, they may make the rationale for accommodation reduction more transparent to the young adult, and they allow the young adult to have agency in developing the plan for systemic family change. These benefits are advantageous though not essential for treatment success.

Second, and relatedly, separate clinicians allowed for a barrier of confidentiality between the two clinicians. In this way, information could pass from the SPACE therapist to the CBT therapist (to which the parents had no objection), but not vice versa—thus, for example, the CBT therapist could learn valuable information that the patient had difficulty sharing and which was useful in shaping treatment, without the SPACE therapist accessing information about the patient that she did not want disclosed (either intentionally or unintentionally) to her parents. Indeed, for patient privacy reasons (as the patient was 18 and refused to waive confidentiality), the CBT therapist *could not* share information from their sessions with the SPACE therapist. Naturally, the patient was made aware of the limits of confidentiality and the importance of acting to protect her safety when her physical integrity was at risk. Her individual therapist conducted regular risk assessments for self-harm and suicidal ideation, and fortunately they were never severe enough to warrant breaking confidentiality.

This is not to say that the individual work did not inform the parent work—for example, there were times when the CBT therapist learned of instances of the patient engaging in self-harm following parent SPACE assignments. Although the CBT therapist could not disclose the self-harm to the parents (which resulted in its not being directly targeted in the SPACE sessions), she could provide important input into planned parent assignments, in a manner that increased the patient's safety and reduced the risk of self-harm.

However, more often the parent work informed the individual work—for example, when the CBT therapist was aware that a particularly difficult SPACE assignment was planned, she could utilize individual sessions to discuss strategies that the patient could use to cope with these assignments (e.g., self-soothing activities, positive self-talk). In this way, individual treatment complemented the parent work, through providing skills the patient could use to better tolerate distress associated with reduced accommodation.

Third, the integrated approach was significantly enhanced through coordination between out-of-session CBT exposures and out-of-session SPACE plans, allowing the patient to develop coping strategies tailored to the challenges she met through the parent work. This resulted in a sense of mastery for both the patient ("I can handle what my parents ask of me") and the parents ("We are capable of pushing our daughter outside her comfort zone"). As an example, in the same week that the patient planned with the CBT therapist an exposure in which she drove to a grocery store, the SPACE clinician planned for the parents to not accompany the patient to the store when she needed things, such that she was motivated to go on her own. Similarly, in the same week that the patient planned an exposure of driving apart from her parents, the SPACE clinician encouraged the parents to inform the patient they would no longer accommodate by driving together. Coordinating between the processes—the patient's individual fear hierarchy and the parents' plans for accommodation reduction—in this way increased the sense that everyone in the family was "on the same page" and working in concert. It also helped allay the patient's fears that SPACE would require more of her than she could handle.

Overall Treatment Outcome

Young Adult Self-Report

The combined approach corresponded to a reduction in the patient's anxiety symptoms, as assessed at

both treatment termination and follow-up, and to changes in how her anxiety was addressed at home. Treatment gains appear to have been maintained through the 8-month follow-up (see Figure 1). Naturally, symptom reductions are comparisons and may also reflect non-treatment-related effects. For each self-report measure, we report the Reliable Change Index (RCI; Jacobson & Truax, 1991), a statistical approach for measuring individual change in self-report scores (standard deviation and reliability for RCI calculations were estimated based on the original scale references, unless otherwise noted); RCIs greater than 1.96 indicate reliable change, likely attributable to treatment, rather than measurement error.

Measures administered include the Multidimensional Anxiety Scale for Children (MASC; March et al., 1997), Beck Depression Inventory (BDI-II; Beck et al., 1996), Anxiety Sensitivity Index (ASI; Reiss et al., 1986), and the Family Accommodation Scale—Anxiety (FASA; Lebowitz et al., 2013). The BDI-II and the ASI were measured at intake as part of standard procedures, while the MASC and the FASA were first administered 6 months into treatment (i.e., 2 months into the addition of the parent intervention) once it became more apparent that they were relevant measures for case conceptualization. Below, scores are compared between first date of measurement (i.e., either intake or 6 months into treatment) and the 8-month follow-up.

First, the patient reported marked decreases in anxiety-related and depressive symptoms. She reported a 59.7% reduction in anxiety (MASC; from 77 or "very elevated" to 31 or "low"; RCI of 10.4). She reported a 64.3% reduction in depression (BDI-II; from 14 or "mild" to 5 or "minimal"; RCI of 3.77 with standard deviation taken from Whisman & Richardson, 2015), and a 25.0% reduction in anxiety sensitivity (ASI; from 28 to 21; RCI of 1.4 indicating that this change may be attributable to measurement error). These outcomes, overall, point to clinically significant improvement in several of the patient's symptoms that lasted several months after treatment ended. The patient-reported MASC was slightly *increased* immediately posttreatment, despite the parent-reported MASC being decreased (see below) and functional change indicating a reduction in anxiety. This may partly reflect the patient's growing understanding of anxiety symptoms, which were now part of the family conversations, as well as her fears about terminating treatment, which she expressed in her final sessions. See Figure 1 for score progression over treatment.

Second, the patient indicated a 77.8% reduction in family accommodation (FASA; from 45 to 10; RCI of 12.4) from first measurement to 8-month follow-up. This may indicate a lasting change in the family patterns aimed at reducing accommodation of the patient's anxious avoidance.

Finally, though not a primary treatment target per se, the patient also reported an increase in self-esteem, as measured by the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965), with a 280% increase (from 10 to 38 [out of 40]; RCI of 16.1 with standard deviation and reliability taken from Sinclair et al., 2010) from 6 months into treatment (the earliest date of measurement) to 8-month follow-up.

Parent Report

Parent-report questionnaires also indicated a marked reduction in the patient's anxiety severity (MASC) and in family accommodation (FASA). Scores on these measures decreased by 42.5% (from 87 or "very elevated" to 50 or "average"; RCI of 7.6) and 89.2% (from 28 to 3; RCI of 8.9), respectively, from first measurement to posttreatment. Both of these gains were sustained at 8-month follow-up (see Figure 2). This multi-informant agreement strengthens confidence in the outcomes, and suggests that all involved parties perceived changes in anxiety symptoms and how they were accommodated.

Functional Change and Qualitative Reports

In line with these self-report measures, functional changes and qualitative reports from the patient and her parents reflected improvement in anxiety symptomatology and meaningful growth in the patient's independence. By the end of the combined treatment approach, the patient was regularly driving alone many miles away from her house and had been consistently attending all classes on her own for several months. Eight months posttreatment, the patient wrote to the team on her own initiative to say that she was moving out of her parents' home and into a college dormitory, as well as returning to work, both things that she "once thought were impossible." She described her life as "incredibly different" compared to before treatment.

Discussion

This case study is the first to describe coordination between SPACE (a parent-based intervention) and CBT (an individual intervention) in the treatment of severe and impairing anxiety in a young adult. Preliminary outcomes from this case are promising and suggest that such a combined approach may be a fruitful avenue of investigation for further studies. This patient, who was experiencing significant functional impairment and was at high risk of failure to launch, appeared to have benefited from the coordinated approach that addressed both her own and her parents' roles in the maintenance of her anxiety.

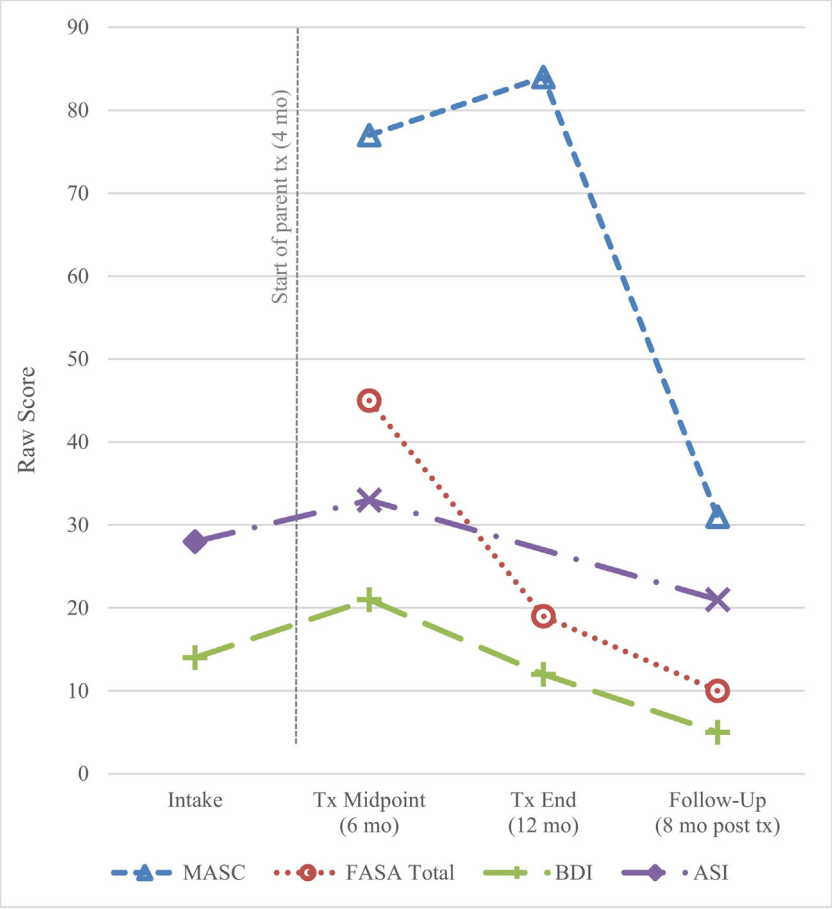

Figure 1. Outcome measures completed by the young adult patient. Measures indicate overall clinical progress that was sustained at 8-month follow-up. MASC = Multidimensional Anxiety Scale for Children; FASA = Family Accommodation Scale—Anxiety; BDI = Beck Depression Inventory; ASI = Anxiety Sensitivity Index.

Functional changes, qualitative reports, and standard self-report measures all point to clinically significant improvement following the combined approach. Importantly, while the patient was working hard in therapy and making some gains during the 4 months of CBT only, her functioning had actually deteriorated in some regards, and her rate of improvement increased once SPACE was added. Although it is possible that some additional gains would have accrued in CBT during this time period even without the parent work, the treatment team believed that the addition of SPACE resulted in more rapid improvement.

Indeed, both the family and the clinical team felt strongly that the lasting changes in the parents' behavior were largely responsible for the maintenance of clinical improvement 8 months posttreatment. The parents' deeper understanding—of the role of accommodation and of principles such as negative reinforcement and avoidance—enabled them to alter the family environment and prevent avoidance of anxiety-provoking stimuli. This in turn helped the patient to maintain subclinical levels of anxiety and a high level of function and coping, long after individual CBT exposures had stopped.

At the same time, the coordination between accommodation reduction in SPACE and the CBT work promoted in the patient a sense of mastery over her changing family world. It also allowed the reduction in negative reinforcement—fostered through both parent changes and individual exposures—to progress more rapidly than had one approach been occurring without the other.

In addition to the present application to agoraphobia and symptoms of separation anxiety, the combined approach could be used for young adults with other anxiety disorders—for example, for a patient with social anxiety, the individual could complete standard exposure-based treatment while the family reduces accommodation that has been negatively reinforcing social avoidance (e.g., enabling their child to stay home from school or college courses, speaking on behalf of their child—for instance, when ordering food or shopping), or providing reassurance to the child about social evaluation. Or in OCD, for example, a

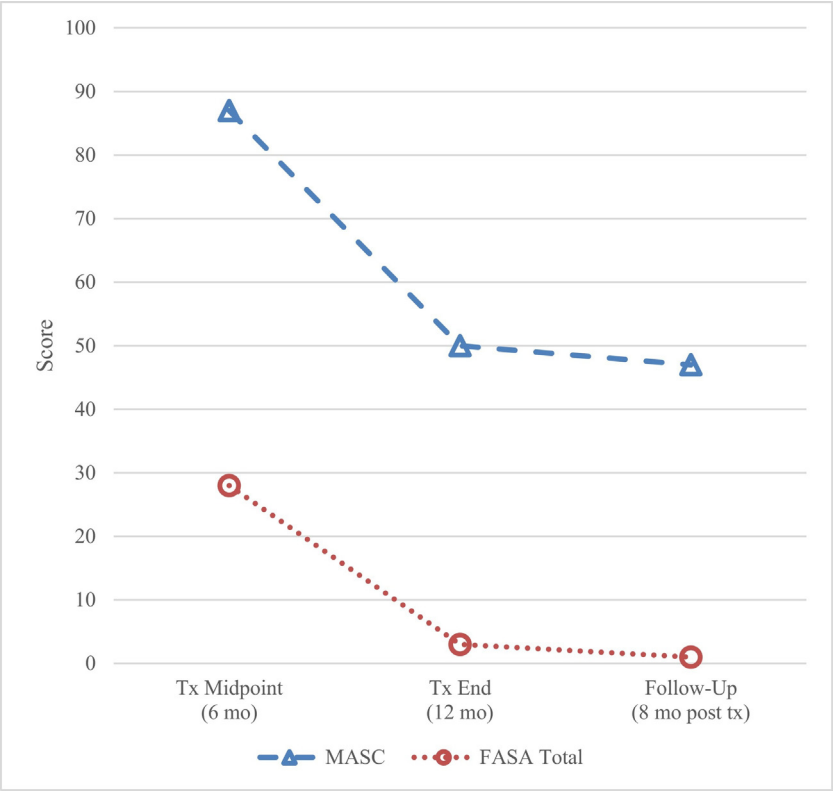

Figure 2. Outcome measures completed by the parents. All scores average together the scores separately reported by mother and father. Measures indicate overall clinical progress that was sustained at 8-month follow-up. MASC = Multidimensional Anxiety Scale for Children; FASA = Family Accommodation Scale—Anxiety.

SPACE clinician may augment individual exposure and response prevention work by reducing accommodation (e.g., stopping the practice of making the child special meals to minimize contamination fears). In all cases, a primary goal is to create a home environment that facilitates independent coping and conveys a supportive attitude toward the patient's symptoms.

In clinical settings in which time and/or personnel resources are limited, this type of dual-treatment approach could likely be applied by a single clinician, splitting time between parents and child. However, particularly with older adolescents and young adults, separating the treatment approaches among two separate clinicians enables a young adult patient to continue to have a dedicated treatment provider and to maintain privacy from parents in certain aspects of his or her treatment. In this case, given the overarching goal of separating the patient from her parents, the separate treatment providers aligned with the narrative of encouraging her independence.

In conclusion, this case study describes an integrated treatment approach that coordinates parent and individual sessions, each delivered by a separate clinician and both targeted at reducing a young adult's severe anxiety and, ultimately, preventing failure to launch. More clinical research is needed to further our understanding of the integration of these approaches for anxiety and other disorders. It remains to be determined how representative this case is for other individuals. Nonetheless, the present case describes a promising approach in which the whole could be more successful than the sum of its parts.

References

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55*, 469–480. https://doi.org/10.1037/0003-066X.55.5.469.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory–II*. Psychological Corporation.

Bruce, T. J., & Sanderson, W. C. (2005). Evidence-based psychosocial practices: Past, present, and future. In R. A. Hayes & C. E. Stout (Eds.), *The evidence-based practice: Methods, models and tools for mental health professionals* (pp. 220–243). Wiley.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17–31. https://doi.org/10.1016/j.cpr.2005.07.003.

Chu, B. C., & Kendall, P. C. (2004). Positive association of child involvement and treatment outcome within a manual-based cognitive-behavioral treatment for children with anxiety. *Journal of Consulting and Clinical Psychology, 72*, 821–829. https://doi.org/10.1037/0022-006X.72.5.821.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19. https://doi.org/10.1037/0022-006X.59.1.12.

Kagan, E. R., Peterman, J. S., Carper, M. M., & Kendall, P. C. (2016). Accommodation and treatment of anxious youth. *Depression and Anxiety, 33*, 840–847. https://doi.org/10.1002/da.22520.

Lebowitz, E. R. (2013). Parent-based treatment for childhood and adolescent OCD. *Journal of Obsessive-Compulsive and Related Disorders, 2*, 425–431. https://doi.org/10.1016/j.jocrd.2013.08.004.

Lebowitz, E. R. (2015). Treatment of extreme family accommodation in a youth with obsessive-compulsive disorder. In E. A. Storch & A. B. Lewin (Eds.), *Clinical handbook of obsessive-compulsive and related disorders: A case-based approach to treating pediatric and adult populations* (pp. 321–335). Springer. https://doi.org/10.1007/978-3-319-17139-5_22.

Lebowitz, E. R. (2016). "Failure to launch": Shaping intervention for highly dependent adult children. *Journal of the American Academy of Child and Adolescent Psychiatry, 55*, 89–90. https://doi.org/10.1016/j.jaac.2015.10.014.

Lebowitz, E. R., Dolberger, D., Nortov, E., & Omer, H. (2012). Parent training in nonviolent resistance for adult entitled dependence. *Family Process, 51*, 1–17. https://doi.org/10.1111/j.1545-5300.2012.01382.x.

Lebowitz, E. R., & Majdick, J. M. (2020). The SPACE program, a parent-based treatment for childhood and adolescent anxiety: Clinical case illustration. *Journal of Cognitive Psychotherapy, 34*(2).

Lebowitz, E. R., Marin, C., Martino, A., Shimshoni, Y., & Silverman, W. K. (2019). Parent-based treatment as efficacious as CBT for childhood anxiety: A randomized noninferiority study of SPACE. *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2019.02.014.

Lebowitz, E. R., Marin, C. E., & Silverman, W. K. (2019). Measuring family accommodation of childhood anxiety: Confirmatory factor analysis, validity, and reliability of the parent and child Family Accommodation Scale—Anxiety. *Journal of Clinical Child and Adolescent Psychology*, 1–9. https://doi.org/10.1080/15374416.2019.1614002.

Lebowitz, E. R., & Omer, H. (2013). *Treating childhood and adolescent anxiety: A guide for caregivers*. Wiley. https://doi.org/10.1002/9781118589366.

Lebowitz, E. R., Omer, H., Hermes, H., & Scahill, L. (2014). Parent training for childhood anxiety disorders: The SPACE program. *Cognitive and Behavioral Practice, 21*, 456–469. https://doi.org/10.1016/j.cbpra.2013.10.004.

Lebowitz, E. R., Woolston, J., Bar-Haim, Y., Calvocoressi, L., Dauser, C., Warnick, E., ... Leckman, J. F. (2013). Family accommodation in pediatric anxiety disorders. *Depression and Anxiety, 30*, 47–54. https://doi.org/10.1002/da.21998.

Lyneham, H. J., & Rapee, R. M. (2006). Evaluation of therapist-supported parent-implemented CBT for anxiety disorders in rural children. *Behaviour Research and Therapy, 44*, 1287–1300. https://doi.org/10.1016/j.brat.2005.09.009.

March, J. S., Parker, J. D. A., Sullivan, K., Stallings, P., & Conners, K. (1997). The Multidimensional Anxiety Scale for Children (MASC): Factor structure, reliability, and validity. *Journal of American Academy of Child and Adolescent Psychiatry, 36*, 554–565. https://doi.org/10.1097/00004583-199704000-00019.

Reiss, S., Peterson, R. A., Gursky, D. M., & McNally, R. J. (1986). Anxiety sensitivity, anxiety frequency, and the prediction of fearfulness. *Behavior Research and Therapy, 24*, 1–8. https://doi.org/10.1016/0005-7967(86)90143-9.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton University Press. https://doi.org/10.1515/9781400876136.

Silverman, W. K., & Albano, A. M. (1996). *The Anxiety Disorders Interview Schedule for DSM-IV (child and parent versions)*. Oxford University Press.

Silverman, W. K., & Kurtines, W. M. (1996). *Anxiety and phobic disorders: A pragmatic approach*. Plenum Press.

Silverman, W. K., Kurtines, W. M., Jaccard, J., & Pina, A. A. (2009). Directionality of change in youth anxiety treatment involving parents: An initial examination. *Journal of Consulting and Clinical Psychology, 77*, 474–485. https://doi.org/10.1037/a0015761.

Silverman, W. K., Marin, C. E., Rey, Y., Kurtines, W. M., Jaccard, J., & Pettit, J. W. (2019). Group- versus parent-involvement CBT for childhood anxiety disorders: Treatment specificity and long-term recovery mediation. *Clinical Psychological Science, 7*, 840–855. https://doi.org/10.1177/2167702619830404.

Sinclair, S. J., Blais, M. S., Gansler, D. A., Sandberg, E., Bistis, K., & LoCicero, A. (2010). Psychometric properties of the Rosenberg Self Esteem Scale: Overall and across demographic groups living within the United States. *Evaluation and the Health Professions, 33*, 56–80. https://doi.org/10.1177/0163278709356187.

Storch, E. A., Salloum, A., Johnco, C., Dane, B. F., Crawfod, E. A., King, M. A., ... Lewin, A. B. (2015). Phenomenology and clinical correlates of family accommodation in pediatric anxiety disorders. *Journal of Anxiety Disorders, 35*, 75–81. https://doi.org/10.1016/j.janxdis.2015.09.001.

Thienemann, M., Moore, P., & Tompkins, K. (2006). A parent-only group intervention for children with anxiety disorders: Pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 37–46. https://doi.org/10.1097/01.chi.0000186404.90217.02.

Thompson-Hollands, J., Kerns, C. E., Pincus, D. B., & Comer, J. S. (2014). Parental accommodation of child anxiety and related symptoms: Range, impact, and correlates. *Journal of Anxiety Disorders, 28*, 765–773. https://doi.org/10.1016/j.janxdis.2014.09.007.

Whisman, M. A., & Richardson, E. D. (2015). Normative data on the Beck Depression Inventory—Second Edition (BDI-II) in college students. *Journal of Clinical Psychology, 71*, 898–907. https://doi.org/10.1002/jclp.22188.

Wood, J. J., McLeod, B. D., Sigman, M., Hwang, W. C., & Chu, B. C. (2003). Parenting and childhood anxiety: Theory, empirical findings, and future directions. *Journal of Child Psychology and Psychiatry, 44*, 134–151. https://doi.org/10.1111/1469-7610.00106.

This study was supported by the NIMH K23MH103555 (Eli Lebowitz) and R61MH115113 (Wendy Silverman and Eli Lebowitz). The authors also wish to thank the family for their participation in this treatment.

Hannah Raila, Megan Julian, and Wendy Silverman have no conflicts of interest to report. Eli Lebowitz receives royalties from Wiley and Oxford.

* Address correspondence to Hannah Raila, Ph.D., Stanford University, Department of Psychiatry, 401 Quarry Road, Stanford, CT 94304 e-mail: hannah.raila@stanford.edu.

Received: May 6, 2019
Accepted: June 8, 2020
Available online 24 July 2020