

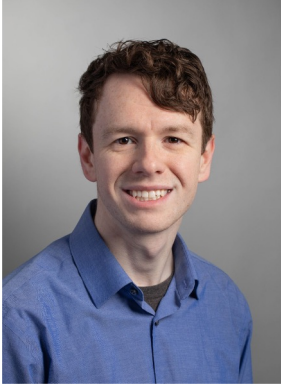
EFFECTIVE
COLLABORATION
STRATEGIES TO
IMPROVE ERP
OUTCOMES: TIPS TO
ENGAGE PARENTS AND
SCHOOLS

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ABOUT US...



Brian, Zoboski, Ph.D., NCSP is an Assistant Professor at Yale University and Director of the Intensive Anxiety and OCD Program at Bridgeport Hospital, CT. Dr. Zoboski consults with school-based mental health providers on anxiety and obsessive-compulsive related disorders and the provision of exposure-based services in school settings.



Marni L. Jacob, Ph.D., ABPP is Clinical Director of the Jacob Center for Evidence-Based Treatment in Boca Raton, FL, where she provides intensive and weekly treatment to children, adolescents, and adults with OCD, Anxiety, & related disorders. She is a faculty member of the IOCDF Pediatric BTTI, and President of OCD Central & South Florida.



Scott Cypers, PhD, is the Director of Stress and Anxiety programs at the Helen and Arthur E. Johnson Depression Center and an Associate Professor in the Department of Psychiatry at CU Anschutz. Dr. Cypers has built an anxiety program that is being implemented in schools throughout Colorado.



Philosophy & Overall Approach Regarding Collaboration

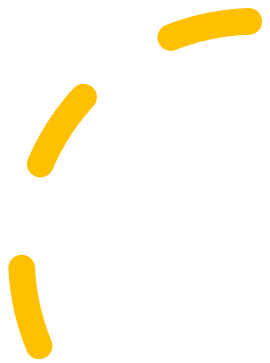




Cypers Philosophy

Age Related Approach

Age	Amount of Parent Involvement	Amount of School Involvement
0 to 5	<ul style="list-style-type: none">• Parent Part of All Aspects of Work• Sometimes Only Parent Work	<ul style="list-style-type: none">• Varies Depends on if in school
5 to 12	<ul style="list-style-type: none">• Parent Included In Aspects of Work But Will Separate at Times Depending on Observed Dynamics and Child Request• Sometimes Only Parent Work	<ul style="list-style-type: none">• Discussion of whether want school involvement, options and to what degree• Release obtained and typically biweekly emails amongst key personnel
13 to 18	<ul style="list-style-type: none">• Parent separate but kept in loop about all aspects related to OCD busting and how to support• Teen offered to have parents be part of aspects of experience• Either parent attendance at end or beginning of sessions, or emails with everyone included on emails biweekly	<ul style="list-style-type: none">• Discussion of whether want involvement, suggested that be part of process• Release obtained and typically biweekly emails amongst key personnel
18 plus	<ul style="list-style-type: none">• Parent Separate yet included as collateral support at times	<ul style="list-style-type: none">• University supports and options discussed



Parent Approach & Ideas



Working with Parents

- Including parents is highly recommended across all settings (Reid et al., 2021)
- Parents strongly influence anxiety symptom severity and response to treatment (Brendel & Maynard, 2014; Compton et al., 2014).
- Parents frequently model anxious behaviors (Caporino et al., 2012).
 - Parent anxiety indirectly influenced accommodation through internalizing symptoms
 - Family accommodation mediated the association between child obsessive-compulsive symptom severity and parent-rated functional impairment
 - Symptom severity influences accommodation, accommodation influences impairment
 - Reassurance-seeking frequently accommodated in children experiencing OC severity across multiple symptom types



Discussing Accommodation

- The goal: Explain to parents that although accommodative behaviors may reduce anxiety, they can stall the recovery process and worsen the effects of anxiety in the long-term.
- Avoid blame.
- Discuss accommodation as arising from good intentions.
 - “No parents want to see their kids suffer, but sometimes our best efforts to reduce anxiety in the short term can worsen it in the long term.”
- Parents often want to reduce anxiety when exposures are difficult by allowing avoidance or by providing reassurance (Storch et al, 2007).
 - Try a physical therapy analogy: “If an athlete did physical therapy, that would be difficult, frustrating, and painful at times. But doing it to regain their functioning and take control of their life is worth the short-term pain and discomfort. Exposures are like that.”



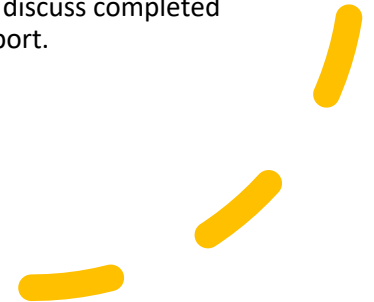
Intake

- During the intake, we recommend a comprehensive cognitive-behavioral assessment of a child/adolescents thoughts, feelings, and behaviors to facilitate the use of CBT with exposure (Sattler & Hoge, 2006)
- Parents are an excellent source of data in a multimethod, multisource, multisetting approach (Whitcomb, 2013)
 - Examines data from multiple settings
 - Compare divergent/convergent information between parents and children
 - Understand cognitive-behavioral contingencies (e.g., occasions for accommodation, parental methods for managing reassurance-seeking, antecedents for compulsions)

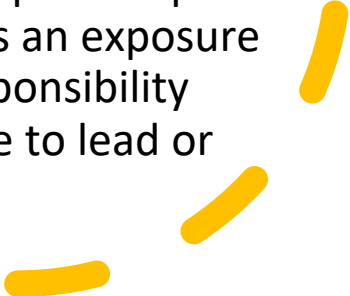


Parents As Coaches

- Some randomized clinical trials show that parent-coached ERP sessions, where they observe, assist, and lead sessions, increase treatment outcomes (Whiteside et al., 2015)
- Several evidence-based protocols
 - Parent-Led Exposure Therapy (PLET)
 - Parents and families work individually with therapists twice a week for about 10 sessions
 - By session 6 parents lead treatment activities
 - Therapists still involved to direct the session as needed
 - Parent-coached exposure therapy
 - 5 sessions
 - Session 1: Psychoed/hierarchy
 - Session 2: Planning exposures, tracking anxiety, learning from exposures
 - Sessions 3-8: Parent-coached exposures. Parents discuss completed exposures, plan and execute exposures with support.
 - Throughout, the clinician models activities



Tips for Involving Parents


- Provide psychoeducation to parents and children on avoidance, the maintenance of anxiety, how exposure works, and how this can be applied to the patient's symptoms
 - Create a strong hierarchy
 - Obtain a child's consent to have a parent involved
 - Parents require training
 - Modeling how to manage OCD and exposure assignments can be quite helpful
 - Slowly introduce the parent as an exposure coach who assumes more responsibility
 - Ideally a parent should be able to lead or co-lead exposures
- 

Intervention Termination

- There are no guidelines for terminating therapy
- An overarching principle is provided in Section 10 of the APA Ethical Guidelines (APA, 2017, section 10.09):
 - (a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.
 - (b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.
 - (c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.
- We suggest considering :
 - Whether qualitative goals were met.
 - Progress monitoring indicates stable change
 - Evidence of functional impairment is decreased



Including Parents

- Provide advance notice to clients and parents
 - Review and Discuss Maintenance strategies
 - Offer resources (e.g., IOCDF)
 - Celebrate achievements
 - Following termination, summarize clinical notes and ensure there is a means to share progress with the next school-based mental health worker.
- 


Maintenance Strategies

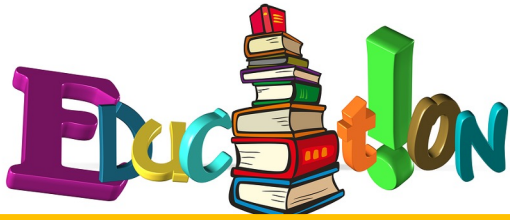
Maintenance works well when parents are trained as exposure coaches!

Provide a copy of the hierarchy to children/parents

Depending on the developmental level, the goal should be to create new exposures outside of session without the school-based mental health worker's help.

Consistent with inhibitory retrieval (formerly inhibitory learning; Craske et al, 2014; Craske et al, 2022):

1. Practice exposures in multiple settings
 2. Vary exposure difficulty
 3. Combine exposures
 4. Use of retrieval cues
 5. Explain situations in which fear may return
- 



- Nature of OCD
- Accommodation and Reassurance Impact on OCD
- OCD Blind-spots
- Treatment for OCD
- Reducing OCD behaviors in long-term
- Finding the Right Motivation
- Role of Parents in ERP



- Role of Parents in Team (Support, Wing People, Push, Self-Care)
- Role of Parents in Progress Monitoring
- Skill practice / scheduling time
- Blindspot awareness and support



- Family OCD/Anxiety Outings
- Every 3 challenges kids do they get to coach parent through 1
- How to make OCD work more fun



Best Tips / Clinical Wisdom With Parents

Clinical Wisdom: Working with Parents

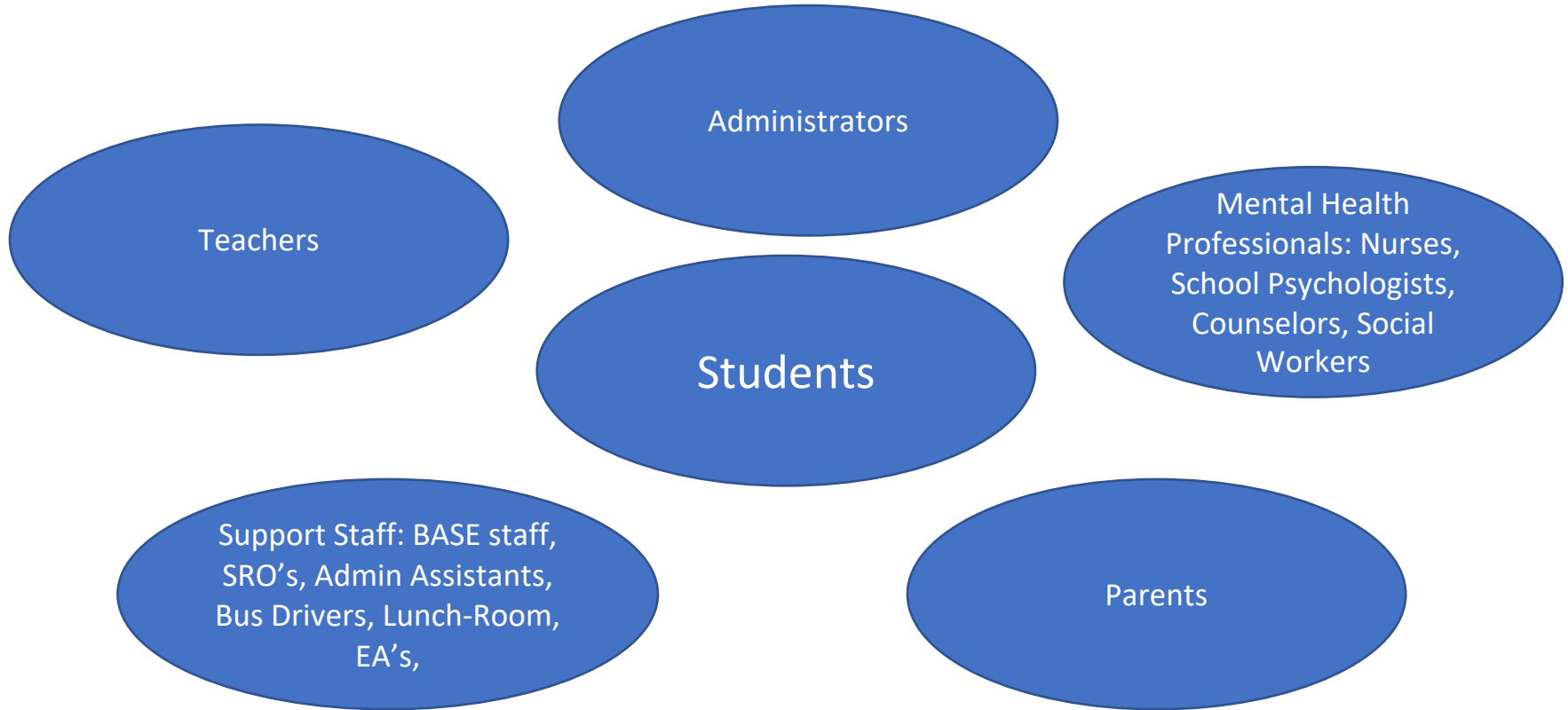
- Consider parent-child dynamic
 - Child may/may not be receptive to parent's suggestions for exposures
- Manage parental expectations
 - Early exposures should have high likelihood of success
- Establish specific guidelines for parent's role
 - What to do/what not to do (e.g., interrupting child's rituals)
- Don't let parents go *rogue* on their child!
 - Establish goals jointly, during therapy sessions



School Approach and Ideas



School Ecosystem



Teachers

- 90 Minute Overview / Training
- Web Based Videos / Interactions for deeper dives / Support Students
- Monthly Drop In Consultations

Parents

Mental Health Professionals

- 1 to 2 Day Deep Dive Training
- Workbook
- Consultation Hours Per Request
- 6 Week Group Outline
- 6 Week Individual Outline
- Train District Experts

Students

- 6 Week Individual Session
- 6 Week Group Session
- Parent letters and videos to support work

Administrators

- 90 Minute Overview / Training

Support Staff

- 90 Minute Overview / Training
- 180 Minute Deeper Dive

*Design Trainings that Meet Professionals at the Developmental Level of their Student (Elementary/Middle/High School)

*Design Trainings for Immediate Application

*Design Trainings to Help People Stay In Their Lanes

Skill Mindset

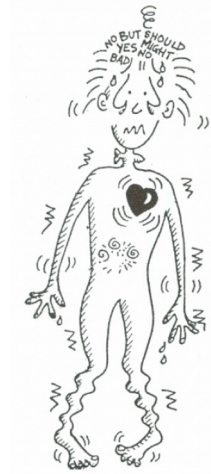
Spot Anxiety / OCD Issue

What to Do?

- If has skills to counteract OCD/ anxiety response
- If does not have skills to counteract anxiety response



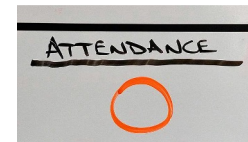
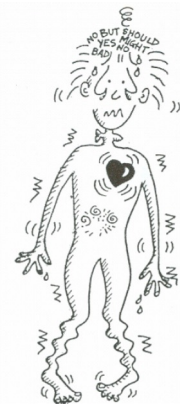
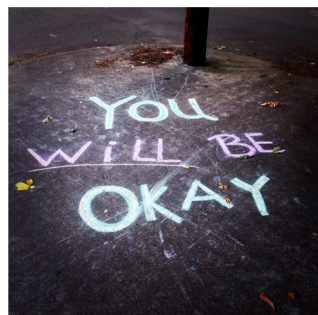
- Skill Practicing / Skill Mastery Phase
- Skill Teaching / Skill Building Phase



How To Spot Anxiety / OCD



BEHAVIOR



Presentations of OCD in School Settings

- School avoidance/refusal
- Frequent trips to the bathroom or nurse
- Excessive re-writing/erasing
- Not turning in homework
- Excessive time spent on tests
- Perfectionism
- Excessive questioning and/or reassurance-seeking
- Inattentive/distracted/preoccupied
- Disruptive behavior/acting out
- Avoidance of activities (e.g., PE, lunch)



IEP / 504

Things to Think Through:

Ultimate goal: no anxiety accommodations

Remember: Accommodate students, *not* anxiety!

- If a student does not have skills yet = implement accommodations while getting anxiety skills
- Once skills are acquired = scaffold accommodations




Section 504 Plans

- Section 504 plans originated with the Rehabilitation Act of 1973 and provide protection for individuals with disabilities (Joyce-Beaulieu & Zaboski, 2021).
- The broad legislation is a civil rights law that applies to individuals across all age groups across settings ranging from school to work
- The Americans with Disability Act (1990) and the Americans with Disabilities Act Amendment Act of 2008 (ADAAA, 2008) updated the law for educational settings
- Core Principle: Equal opportunity for individuals with disabilities to access programs, activities, and advancement
 - Quality instruction
 - Learning
 - Extra-curricular activities
- Eligibility:
 1. A physical or mental impairment that interferes with daily life activities,
 2. A record of such impairment, or
 3. The student is regarded as having the impairment.

Does not require a formal assessment battery!

Written with school and parent input.

Case Example: Working with Schools & Accommodation S

- 13-year-old, white male with OCD & comorbid depression
 - Competitive prep school
 - Perfectionism with schoolwork, related to a “need to know”
 - Checking, reassurance-seeking, mental reviewing
 - Traditional accommodations wouldn’t be a good fit
 - Extended time on tests
 - Deadlines to turn on work
 - Nurse visits/calls home
 - > exacerbate rituals
 - Collaborated with school to identify creative, short-term accommodations
- 

IEPs

- Provisions include 14 areas for special education services (Joyce-Beaulieu & Zaboski, 2021).
- 7.1 millions students (14% of all students) receive special education services (National Center for Education Statistics, 2020).
- Requires eligibility assessment and development of an IEP for supportive accommodations and modifications tailored to a student's needs
- Goals are written into the plan and progress is monitored, often by the school
- One major difference vs a 504 Plan: formalized, annual reviews are required (more often on parent request), and reevaluation is needed every 3 years
- If goals are met, special education designation can be withdrawn
- Services in an IEP may include counseling
- Students in any IDEA category can have counseling
- IDEA categories amenable to counseling include ED (emotional disturbance) and OHI (other health impaired)

Emotional Disturbance

A condition with one or more of the following that affects functioning over a long period of time:

1. Inability to learn that can't be explained by intellectual, sensory, or health factors
2. Inability to build or maintain satisfactory interpersonal relationships
3. Inappropriate behavior/feelings under normal circumstances
4. Pervasive mood of unhappiness or depression
5. Tendency to develop physical symptoms or fears associated with school problems

Needs formal assessment.

DSM diagnosis not enough.

Other Health Impaired

- Often used for chronic illness
- Heart conditions, epilepsy, diabetes, hemophilia, leukemia
- Includes limited strength, vitality, or alertness with respect to the educational environment due to chronic health problems that affect educational performance
- Medical assessment required

Postsecondary Accommodations

- Students may receive (a) academic accommodations at campus disability resource centers, (b) direct treatment of anxiety at campus counseling centers, or (c) referrals to outside providers
- Accommodations can include quiet locations, extended time, alternative coursework, allowance for missed work, technology assistance, or online class notes (Bailey, 2012).
- In a survey of college students, accommodations helped, especially extended testing time, a separate testing room, and extra breaks (Lewandowski et al., 2014).
- The responsibility of receiving accommodations typically falls on the student (Hong et al., 2007).
- Accommodations require more advocacy at the postsecondary level than K-12, so usage is lower (Bolt et al., 2011).
- Accommodations are individualized and plans vary based on student need.

Assessing for Accommodations

- In postsecondary school, students may need accommodations that they are not yet getting (Hong et al., 2007).
- Well-intentioned accommodations can strengthen anxiety and hinder progress (Zaboski & Romaker, 2021).
 - For example, a junior in high school who receives extra time for tests may find that the extra time reinforces their maladaptive cognitions.
 - “I’m just a bad test taker”
 - “My anxiety is too high for tests”
 - This is because the extra time has never allowed the student to learn that taking the test does not need to lead to some kind of feared outcome.

Some General Questions for Assessment

What accommodations do you currently have?	What classrooms are your accommodations used for?
How long have you had your accommodations?	What purpose do your accommodations serve?
Do you hope to receive accommodations/more accommodations?	Have your accommodations improved your academic performance?
Did you have accommodations before attending university?	What accommodations did you have prior to college?

Some Questions for Assessing Cognitions

What are your thoughts before using an accommodation?	Do you think you could be successful without your accommodations?
Do you have any worries about using accommodations?	Do you think accommodations help/could help you be the best student you can be?
What are your thoughts after using your accommodations?	Do you think students who need/use accommodations are inferior to those who do not?
Do you worry about how others might perceive you if you use/obtain accommodations?	Have professionals previously suggested your need for accommodations but you declined due to perceived stigma around them?

Some Questions for Assessing Behaviors














Do you use your accommodations?	Do you use accommodations to reduce feelings of anxiety?
How do you think your functioning would be impacted with/without the accommodations?	Does using accommodations reduce anxiety in settings outside of the classroom?
Do you ever avoid using accommodations?	What are some barriers for not requesting accommodations?
Do you use your accommodations?	Do you use accommodations to reduce feelings of anxiety?
Are you more likely to utilize certain accommodations more than others? If so, why?	

Some Questions for Assessing Affect

How do you feel after using an accommodation?	Do the accommodations ever worsen your anxiety?
Do your accommodations help alleviate your anxiety?	How do the accommodations impact your confidence/self-esteem?
Do you experience anxiety about using an accommodation?	Is it anxiety-provoking to try to initiate the process of receiving accommodations?
Do you have any guilt/shame about needing accommodations?	Do you ever feel jealous/upset about students who do not request accommodations?
How do you feel after using an accommodation?	Do the accommodations ever worsen your anxiety?

Element #3: Taking Skills To Mastery : Step 1: Find Your Community Metaphor



Junior belt colours (16 and under)	Adult belt colors (16 and over)	Black belt grades (19 and over)
White 	White 	Black 0-6 
Grey 	Blue 	Black/Red 7 
Yellow 	Purple 	White/Red 8 
Orange 	Brown 	Red 9-10 
Green 		

Mountain	Number	Anxiety Exposures / Challenges	OCD Exposures / Challenges
Extreme	10+	Taking a high stakes test with less time with everybody watching and having to post score on social media	Engaging with multiple very difficult triggering stimuli inside of class and practicing resisting compulsions for entire class period
	10	Taking a high stakes practice test with little time to prepare and having to post scores on social media	Engaging with multiple difficult triggering stimuli throughout a class period and practicing resisting compulsions for entire class period
Double Black	9	Taking a high stakes exam that matters with little preparation	Engaging with multiple difficult triggering stimuli inside of class and practicing resisting compulsions for entire class period
	8	Taking a high stakes exam score that counts for a grade	Engaging with multiple triggering stimuli inside of class and practicing resisting compulsions for entire class period
Black	7	Sharing embarrassing test scores with people regardless of how actually did	Engaging with triggering stimuli inside of class and practicing resisting compulsions for entire class period and a half
	6	Taking a medium stakes exam that counts for a grade	Engaging with triggering stimuli inside of class and practicing resisting compulsions for entire class period
Blue	5	Taking a timed test with everyone else for a grade that has same impact on grade	Engaging with triggering stimuli inside of class and practicing resisting compulsions for small amounts of time
	4	Taking a timed test with everyone else for a grade that has little impact on overall grade	Engaging with triggering stimuli inside of class and practicing resisting compulsions outside of class time
Green	3	Taking untimed test in the class with peers taking test too for no grade	Engaging with triggering stimuli outside of class and practicing resisting compulsions for a given class period
	2	Taking time tests with no real grade attached	Engaging with triggering stimuli outside of class and practice resisting compulsions for longer and longer periods of time
Bunny	1	Taking tests untimed with no real grade attached	Watch videos of triggering stimuli outside of class and practice resisting compulsions for longer periods of time
	0	Watching test fails with no participation	Watch videos of triggering stimuli outside of class and can engage in compulsions if need to




Best Tips / Clinical Wisdom With Schools



Support, push, wing people, self-care

Clinical Wisdom: Working with Schools

- Emphasize mutual goals of student adjustment and learning
 - Educate staff about symptoms, but less is more (only share relevant info)
 - More frequent check-ins as you progress through hierarchy & reduce accommodations
 - Make sure recommendations gets to those on front lines
 - Manage any peer-related concerns
 - Make things easy on teachers
 - Monitoring/feedback
 - Recognize efforts of all involved!
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CASE EXAMPLE #1

Would we want to include a case example and talk about how we might approach this with school and parent from our different perspectives or just open up to q and a?

Case

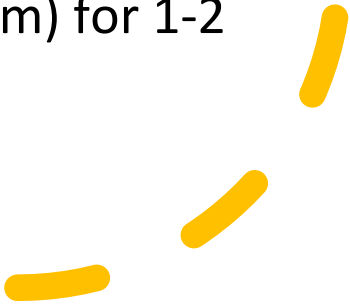
Example:

OCD-Related
School
Refusal

Procedures

- Get school permission
- Have plan to maintain confidentiality

Exposure hierarchy (examples)

- Pictures of school
 - Driving by school
 - Sitting in school parking lot
 - Walking throughout school after-hours
 - Interact with school staff/teachers
 - Sitting in school (non-classroom) for 1-2 hours during school day
 - Attending 1+ classes, etc.
- 

Case Example #2

Transitioning from Partial Hospitalization to
School-based and Outpatient-based Care

- 14 y.o. F
- Primary diagnoses: OCD, MDD, PTSD, Emetophobia, Anorexia, Social Anxiety
- Twice-exceptional: Tested into gifted program in school
- Multiple hospitalizations due to suicidal ideation, one attempt
- Attended a partial hospitalization program for OCD and anxiety disorders for 6 months

Demographic Summary



Primary Domains

- Significant fears of contamination and harming others
- Emetophobia and anorexia caused notable disordered eating

Primary Exposure Types

- Contamination exposures
- Knife and harm-related exposures
- Social exposures (e.g., presentations)

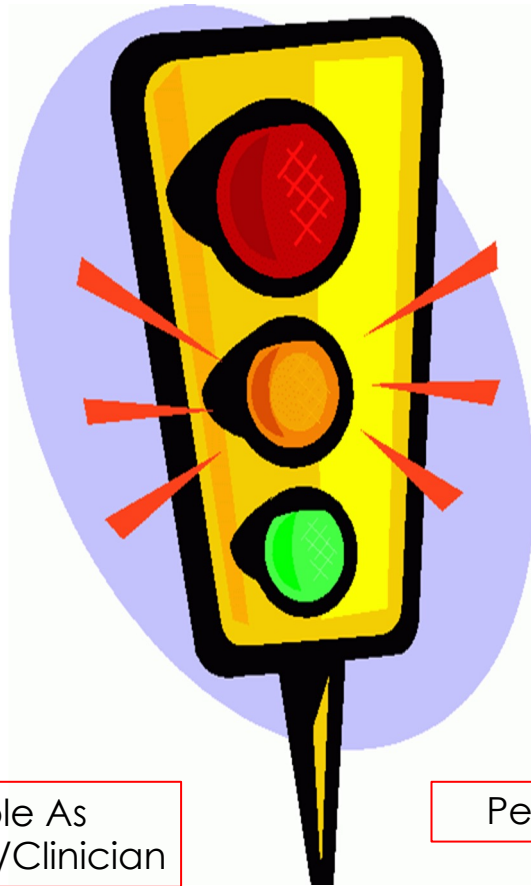
OCD Presentation

A series of several parallel white lines of varying lengths and orientations, located in the bottom right corner of the slide, creating a dynamic, abstract graphic element.

- At the student and parents' request, I had frequent calls with the school counselor to discuss the case
- Spoke to the patient's teacher
 - Provided considerable psychoeducation on OCD and how it is treated through exposure
 - Answered many questions about how the counselor and teacher can assist with classroom-based exposures
 - Discussed the pt's school accommodations

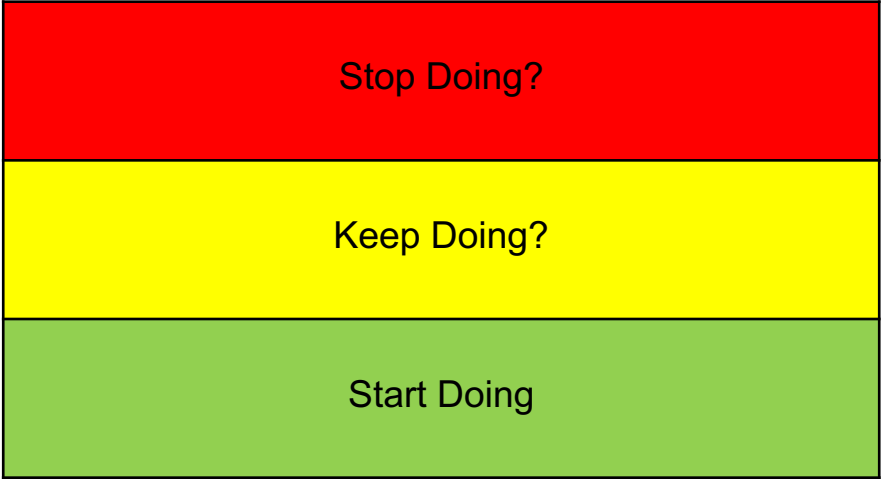
School Consultation





Role As
Parent/Clinician

Personally



Q & A

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