

Webinar Title: Disrupting the Cycle: Caregiver Accommodation and the Maintenance of Child Anxiety Disorders and OCD
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Moderator: Hello and welcome to today's webinar, Disrupting the Cycle: Caregiver Accommodation and the Maintenance of Child Anxiety Disorders and OCD. This topical webinar is paid for by McLean Hospital, a top-ranked free-standing psychiatric hospital, a leader in psychiatric care, research, and education, and the largest psychiatric teaching hospital of Harvard Medical School. Some important points before we get started.

Drs Meredith Elkins and Maria Fraire, the presenters for today's webinar, have working relationships with McLean Hospital. As such, they have both a financial and an intellectual interest in the webinar content. The purpose of this presentation is to provide a balanced view of caregiver behaviors that maintain child anxiety and OCD and how to reduce them. APA does not endorse any products or services. The content was created by McLean Hospital and does not reflect the views of APA or its editorial staff. Email advertising@apa.org to learn more.

Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides.

During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. The Q&A is enabled for attendee interaction with submitted questions. Attendees can view all submitted questions and upvote those they find important. This helps the presenter identify questions that many attendees want answered. A link to the presentation slides will be posted in the chat box of your webinar screen. If you miss them, don't worry. We will email them to you with the recording. Now let me introduce our presenters.

Dr. Meredith Elkins. Dr. Elkins is a licensed clinical psychologist specializing in the research and treatment of anxiety and related disorders in children and families. At McLean Hospital, she is Co-Program Director of the McLean Anxiety Mastery Program and a faculty member at Harvard Medical School. Her work focuses on treating anxiety and mood disorders in children, adolescents, and families, with a special emphasis on the parent-child dynamic and emotional health across the family system.

Dr. Maria Freire. Dr. Freire is a licensed clinical psychologist and the Program Director of McLean's OCDI Jr., overseeing clinical training and research efforts for children and adolescents with OCD and related conditions. Her expertise includes developing tailored treatments for complex comorbidities and advancing clinical supervision and program development. Together, they bring deep clinical and research experience in pediatric anxiety, OCD, and family-centered care. Welcome, Drs. Elkins and Freire.

Dr. Maria Fraire: Thank you. Welcome, everyone. Thank you for joining us this afternoon. I'm going to kick off our presentation talking a bit about the education that

we like to really emphasize with caregivers when we're discussing the role of accommodation and anxiety and OCD. I'll be spending time specifically focused on talking about how we talk about anxiety with our families and caregivers, and think a little bit about how avoidance influences the role of anxiety and accommodation, and really start thinking about how we talk about accommodation with our caregivers. Then I will hand it off to my colleague, Dr. Elkins, where she will talk about the drivers of accommodation, how we reduce accommodation, as well as wrapping with some clinical considerations and resources.

Why are we all here today? Given that you've joined this webinar, we imagine that you are probably already aware that the rates of anxiety in children and youth today only continue to rise. Unfortunately, we've seen a pretty steady increase of this across the last 20 years, and especially when the global pandemic hit. Many of our kids are starting to experience these pretty significant anxiety symptoms, and families are looking for ways to provide support to their children.

We are fortunate in that there are effective treatments for youth with anxiety. However, one of the things that is standing out is even for our children who are able to access effective treatments, there's still more work to be done. When we say effective treatments, we're really focusing on cognitive behavioral therapies with an emphasis on exposure therapy, as this, in combination with medication, are the gold standard approaches that we use to treat anxiety and OCD in youth.

While there has been a really concerted effort in providing education and resources to therapists to provide really good CBT and exposure, even our kids who are getting good treatment are still not having the same symptom relief that we would hope to see when they're only engaging in individual therapy.

There has been this really emerging focus on the critical role that caregivers play, and in particular, the role that both accommodation feeds the anxiety that a child may be experiencing, but the good news being if we work on reducing that accommodation and the barriers caregivers may face in that drive to provide accommodation, we'll see even more increases in symptom relief for our youth with anxiety.

As we move through our talk today, we're going to use a case example of Layla. To get us all on the same page, Layla is a 13-year-old cisgender Latina female presenting to our clinic with feelings of high anxiety, worries about any and everything. She and her parents decided to seek treatment because they were concerned that her anxiety was impacting her performance in school, health, and relationships.

During the initial assessment, Layla shared she was really stressed and worried about a range of topics, including school, friendships, the state of the world, the future, climate change, her family's health. This may start sounding familiar to a number of you and the kids that you may see in your practices. Parents noticed an increase in irritability, reported Layla frequently complained of headaches and stomachaches. They also expressed worry that her physical symptoms were leading to irreparable physical harm. They had sought multiple medical appointments, but no medical issues had been found.

Layla's parents described how their days had gradually begun to revolve around the anxiety. They often took time off work to bring her to the doctor whenever she worried something might be wrong. At home, they tried to shield her from anything that could upset her, turning off the news when she walked into the room, avoiding any mention of distressing events, providing excessive reassurance around worries, and even hiding if someone in the family wasn't feeling well. When Layla felt overwhelmed at school, they would immediately come and pick her up. We will revisit Layla's case as we move through our talk.

When we meet with caregivers, there are certain areas that we start with where we want to make sure that there is a foundational understanding. Where we'll often start is what anxiety is and what it isn't. Anxiety is a normal human emotion. It's human to feel anxious. It was evolutionary based in the fact that anxiety was very, very important, especially in the early days, for survival.

Everyone experiences fear and anxiety when a threat is perceived, and that's normal. This is not something that people should be ashamed of. It doesn't mean they're broken. Anxiety is a very normal part of the human experience, but it does exist along a continuum. There are some who are just biologically prone to be more sensitive to the feelings of anxiety. There are times where it's more normal to feel higher rates of anxiety and times when you would feel less anxiety.

One of the challenges with anxiety is that it also can come along with these physical symptoms that we have associated with this sense of the need to fight, the need to flight, the need to freeze.

Again, this was biologically very useful. Our body would have a physical response to the emotion of anxiety that you might feel in your head or your stomach, your body tensing up. It's getting ready to do one of these things that would be a very typical response if there was an actual threat. However, given that anxiety exists on a continuum and some folks are more sensitive to it than others, sometimes the anxiety can inadvertently trigger false alarms. That's what we start seeing in kids who are experiencing anxiety disorders and OCD, is a false alarm starting to kick off this anxiety response and starts spiraling.

While anxiety as emotion can be challenging, it's actually the physical symptoms that start making it feel really badly. It feels badly to feel anxious, but the anxiety as an emotion itself cannot hurt you. The physical symptoms, though, can heighten that fear that this is something really terrible that needs to be handled or needs to be gotten rid of. What we end up finding is that the behaviors associated with the emotion of the anxiety and this physical response, those can sometimes put one at risk.

What I mean by behaviors is those things that kids start engaging in to make that feeling go away. In the more extreme side, these will be kids who feel very anxious, and they just have to get out of the situation. They're running out of school, they're trying to get out of the house, they're running through spaces, or they're engaging in behaviors that are really feeding their avoidance. They are refusing to leave the house, to get out of their bed. They are engaging in behaviors that are inadvertently making it much harder for them to engage in their everyday lives. That is where the risk of anxiety comes in.

Why am I talking about this? Why do we want to make sure our caregivers really understand the foundational thoughts around anxiety, how we think about it, and what we're going to do with it? We have found that educating caregivers about why anxiety occurs makes the experience a little less scary for everyone. If you can work through internally, "Okay, this is what my child is experiencing in front of me, yes, it looked terrible, yes, they don't feel good, and I have a better understanding that it's not a physical issue, that it's something that isn't as scary as it may present." then as a caregiver, they can start modeling, "Yes, this is hard, and it's something we can ride out."

When caregivers have a better understanding of where their child's anxiety is coming from and what that child might be experiencing internally, they'll also have a better chance about being able to empathize and validate the child's experience as they're going through the distress, helping them stay in that moment even though it's hard.

We've also found that giving this education around what anxiety actually is and what it isn't will also help caregivers calm down themselves, not over-pathologize their kid, not do their own catastrophizing around like, "What does this mean that my child's anxious?" and instead, be able to come back into this moment, "This is what my child's experiencing, and here's how I can help." Having that education and understanding about what anxiety really is, is a really great place to start.

Ultimately, caregivers can be more skillful and effective when they understand that anxiety is natural, normal, and harmless. Just because someone is uncomfortable does not mean they're unsafe. Having this understanding is a really important first step as you're starting to work with a caregiver and help them understand their own behaviors and in reducing their own accommodations.

The other area that we'll spend a fair amount of time talking about with caregivers is how important the interplay is between avoidance and anxiety. If we think about it from this layout version and looking at how intensity will increase over time, avoidance is one of the major players in this relationship. It is very normal to not want to do something that feels uncomfortable. The downside to that is that it's also very reinforcing to avoid things that feel uncomfortable. At the smaller level, it's like, "Okay, I feel better. Great. I avoided that thing. I'm no longer feeling anxious."

The challenge is that over time, you need more and more avoidance to feel that relief. You'll see that over time, these small behaviors that children or their parents are engaging in to make the anxiety go away will build. They'll end up avoiding more and more and more in their everyday life. Their anxiety will also increase over time as children start to feel that they have to avoid in order to feel better and miss out on really important learning opportunities that we emphasize as part of the treatment process, which I'll get to more in a moment.

As long as our caregivers can start having a good understanding of this relationship between the increase in anxiety and distress leading to these avoidance behaviors, which gives some sense of relief, so very understandable that kids want to avoid, the parents want to accommodate, the challenge is the anxiety is going to come back up again. Everyone will be stuck in this cycle of having to avoid to feel better. Caregivers can be more effective partners in their child's anxiety treatment when

they understand how integral this relationship is between avoidance and anxiety and OCD.

Let's move a little bit more into what you're actually here for today, which is talking more about caregiver accommodation. Why are we talking about this? Why is this so important? As I alluded to earlier, caregiver accommodation is associated with a wide range of mental health concerns, but particularly, we see it a lot in the anxiety and OCD realm. The research has emerged to show that caregiver accommodation could account to up to 50% of that association between child anxiety and the impact it has on their everyday life, going to school, having good friendships, relationships within the family, being able to plan for their future.

The reductions in caregiver accommodation during treatment has also been shown to be associated with the reduction of symptoms for children. This is especially important because, one, reducing caregiver accommodations can help augment when children are in their own individual cognitive behavioral therapy and help capture some of that. The kids who were able to not engage in the treatment as well as we had hoped, adding in the parent relationship and behaviors makes a big difference in what the kids can gain out of the treatment. The parents are such an important role in that. We have specific ways to help target that.

It's also really important to note the role that reducing caregiver accommodation can play for those kids who are not quite ready to really engage in treatment. We will feel the number of calls from parents who say, "My kids are not ready to do treatment. What can I possibly do? They have to be in therapy to get better." The good news is they don't always have to be in therapy themselves. We can start with the parents and their behaviors. That has already been shown to influence the child's own experience.

Specifically, when we're talking about accommodation, what do we actually mean? We are talking about the changes that caregivers make to their own behaviors that inadvertently help their child's anxiety. It usually helps them avoid. It's one of the questions we'll have parents asking, "Are you doing something that is driven by what anxiety wants you to do?" That is going to help them start sorting out, "Is this something that's actually helpful for my child, particularly in the long run, or is this just something that anxiety is making our whole family do?"

The accommodations can be specific to the parent's own behavior, the parent who opens the door for their child who is worried about germs, the parent who provides a lot of cleaning supplies, **[unintelligible 00:17:43]** supplies, all of the paper towels the kids demand, the parents who are doing their best because they want to help their children feel better. Again, very normal for caregivers to just want their children to feel better.

Anxiety will take control of that and put caregivers in a situation where they are accommodating so much that their children's anxiety is actually only increasing. We look out for that in individual parent behaviors, as well as parents modifying entire family routines, getting siblings to do specific things or not do certain things in the service of the child's anxiety, changing up parents' own work schedules and their school schedules to accommodate the child's anxiety. We're really looking at how are these behaviors influencing the entire family system? We'll talk to parents and

caregivers who really say, "Anxiety is keeping us hostage. How do we get out of this?"

It follows such a similar trajectory. We've already talked a little bit about this, how avoidance plays such an important role. Caregiver accommodation inadvertently ends up being a big part of how a child can avoid feeling anxious, riding out the distress, and most importantly, starting to learn that they can handle anxiety in other ways besides avoiding. When a caregiver is inadvertently accommodating all the time, the child is internalizing, "Well, the parents are the ones who make me feel better. They have to do certain things to make me feel better. I need my caregivers to do these things so that I feel better." There's less autonomy and ownership in the child in developing their own skillset.

If we go back to our case example of Layla and think about that last bottom part there, here we can really focus on, "Well, what anxiety-driven behaviors are Layla's parents engaging in?" They describe how their days gradually begin to revolve around her anxiety. They often took time off work to bring her to the doctor whenever she worried something might be wrong.

At home, they tried to shield her from anything that could upset her, turning off the news when she walked into the room, avoiding any mention of distressing events, providing excessive reassurance around worries, and even hiding if someone in the family wasn't feeling well. When Layla felt overwhelmed at school, they would immediately come to pick her up.

These are all different ways that we find Layla's parents inadvertently helping her avoid her anxiety, changing their own behaviors to feed anxiety's needs, and changing up their entire family routines, which, inadvertently, was creating even more anxiety for Layla. [silence]

Why are we talking so much about caregiver accommodation when we think about it in relationship to the cognitive behavioral therapy, the exposures that we want kids to do, the exposures that we know work to help target anxiety and OCD symptoms? Accommodation reduces opportunities for kids to face their fears and learn that they can tolerate distress. The accommodation will reinforce this relationship of anxiety and avoidance, rather than teaching children coping and mastery in the face of their anxiety. It increases this dependence on parents to manage the distress for the children.

We really are thoughtful around how the caregiver accommodation is showing up in this relationship with children, their anxiety, and their avoidance. It gives us a very specific type of target that we can do to really help empower parents to feel like they can support their children and separate out their children from the anxiety. We'll spend a fair amount of time really helping our families see that they are a team against anxiety, and they're there to support their child, even when that means that them reducing the accommodation will temporarily provide distress in their child while looking at the long-term relief that will happen over time. With that, I will hand this over to my colleague, Dr. Elkins.

Dr. Meredith Elkins: Thanks so much, Dr. Fraire. All right. I think I get control over the screen. Hopefully, I'll be effective there. As Dr. Fraire was indicating, taking the

time to educate caregivers about accommodation is really crucial to help get them on board to reduce the accommodation. Importantly, research suggests that sometimes just educating them about what accommodation is and how it can be problematic may not be enough to curb it because the caregiver is bringing their own stuff to the table here.

Accommodation is likely to continue unless we spend some time doing some digging into the caregiver-level factors that can be driving the accommodation, and then take a time to come up with individualized plans that take into consideration the caregiver's needs as well as the child's. I want to take some time talking about that.

All right. Let's always start off by validation, by avoiding blame, and by normalizing that accommodation is such a normal caregiver thing to do. I accommodate my child all the time. I do think that this is an area where a little bit of thoughtful self-disclosure can be helpful because we do want to come in and really have a partnership with the caregivers of our patients to help them understand that in a vacuum, accommodation is normal. We take steps to decrease the distress of our loved ones all the time. The problem is that anxiety and OCD hijack this well-intentioned pattern of behavior and can turn it against the family and the child and make things so much harder.

It can be helpful to start by normalizing this. There's great research on the top reasons that parents report accommodating. It's great to go through these with families. One, parents report they accommodate because it's hard to see their kids in distress. Table for two. We are biologically wired to intervene when our kids are in distress. It helped our early ancestors survive. Now, when your kid cries out in the night, you get that lurch in your stomach, and you have this biological drive to intervene. That's so normal.

Then sometimes we accommodate because it's just easier in the moment. We are tired. Accommodating saves time. It prevents conflict. It avoids that meltdown that we just don't have the bandwidth for. That's useful to name.

Another reason why parents report accommodating is because their child becomes upset, angry, or even aggressive if they don't accommodate. Of course, parents are accommodating because if they don't accommodate, anxiety gets worse in the short term. Then finally, parents will note that they accommodate because they're afraid that if they don't, their child will think, "My parents don't care about my feelings." That drives them to accommodate and to be responsive.

We find it helpful to review these reasons with families and to see what resonates with them the most, and then you can develop a plan as they're reducing accommodation to where is it going to be a weak point for you? Where is something where you feel like you're more likely to fold because you have the thought, "My child is going to think I don't care about them," or whatever might be unique to the family situation?

The reasons why caregivers accommodate, I think this covers a lot of it, but it's going to be different for every child and every family, particularly, if there are kids who are coming in with comorbidities like ADHD or autism or other common comorbid conditions. It can be so important to get a better sense of how these conditions are impacting the parents' drive to accommodate in the moment. Is the parent worried

that there will be implications with the school if they're not accommodating somehow? Are they concerned about emotion dysregulation or sensory sensitivities, and that's impacting how they're going to accommodate in the moment?

With neurodivergent kids, exposure work and accommodation reduction may be still indicated, but we may need to do it a little differently. These kids may benefit from a lot of repetition or going more gradually in some of these reduction patterns. We really want to be thoughtful about what each kid and family is working with.

Importantly, are there concerns about risk? Some families come to us and they express the fear that if they don't accommodate, their child is going to hurt themselves or somebody else. They are truly held hostage to the child's emotions. I think it's really important to note here that if the accommodation is serving as a risk prevention, anxiety and OCD is no longer the top concern. The child may benefit from a more DBT-informed treatment to ensure safety and safe-coping with big emotions before we can adequately do this work. That's a really important thing to parse out. Sorry, when I'm clicking, it's not always responding. That's probably a user error on my end, I'm sure.

In addition to just these reasons why parents endorse that they accommodate, there are some other caregiver-level factors that can be really important to explore. Taking some time, having some parent-only sessions to get into some of these factors that I want to review, can really pay off. Maria alluded to this earlier, but how caregivers think about anxiety, how they think about negative emotions really shapes how they respond to it.

When parents believe that simply experiencing anxiety is somehow harmful or dangerous, and that their child can't handle feeling that, that it's dangerous for their child to feel that way, they're more likely to accommodate, of course. These beliefs that anxiety is harmful send these unintended messages that anxiety itself is dangerous, and then that creates that pattern where then the child and the parent are both anxious about anxiety.

It's really important to dispel these myths, because even with a solid accommodation reduction plan, if a caregiver is changing their behavior and anxiety spikes, and we get that extinction burst, it is really hard to hold your ground in the moment if you're afraid you're doing something that's going to hurt your kids. It's really key to spend some time here to explore these beliefs, and then to help parents to challenge those beliefs so that they can be more effective in this work.

In addition, we've known for ages that having a caregiver with an anxiety disorder or OCD places them at higher risk for having a child with anxiety or OCD, but there are a number of mitigating factors here that drive accommodation. It's not as simple as, "I'm an anxious parent, so I'm going to accommodate my anxious kid." It's worth naming and exploring some of these factors with caregivers and see what tracks for them. That brings awareness to these factors, and then you can help caregivers, again, keep an eye out for them when they see them coming up in themselves.

We know that caregivers with anxiety and OCD themselves, they're more likely to be sensitive to threats in the environment. These parents see the playground as a death trap rather than a fun outing. We know that anxious parents are more likely to expect

that their kids will be anxious in these situations. If you are a parent who is particularly threat sensitive and you expect your kid is going to be anxious, you're going to be on the lookout for any sign that your kid might be having a hard time, and you're probably more likely to intervene and say, "Are you doing okay? We can leave. I'll just tell Aunt Becky that we're sick and we can get out of here." Sharing and normalizing this as part of the experience, but then being on the lookout for it can be really helpful. In addition, we know that caregivers with anxiety disorders or OCD, they may struggle with their own distress intolerance.

Not only are they worried about upsetting their child because their child would be upset, and they love their child, but they're worried about how that distress is going to make them feel. It's so much more reinforcing to quell your child's distress if it also means that your heart rate goes down. We want to name this distress intolerance and help build coping skills around distress tolerance. Parents who are struggling with anxiety also are more likely to have higher rates of experiential avoidance. They are eager to nip any negative emotion in the bud when it comes up.

Taken together, these tendencies really create a strong motivation to accommodate and shaping these patterns that can really reinforce anxiety in both parent and child. It's worth exploring them and naming them. Finally, we find it's increasingly helpful to take a step back and consider the [inaudible 00:31:29] may feel that allowing their child to experience distress, even in the service of growth and exposure or accommodation reduction, just feels like bad parenting.

They worry that they might be traumatizing their child or that when they reduce accommodation, it's going to harm the parent-child relationship. We find it can go a really long way to simply acknowledge to parents the waters in which we're all swimming here and how hard it is to hold a reasonable limit around anxiety and OCD when your kid is sobbing and telling you that you're the worst parent ever and you feel like the worst parent ever and your culture is telling you that you're the worst parent ever too.

Taken together, this creates this really slippery slope where well-meaning and culturally sanctioned efforts to support kids and respect their emotions can unintentionally foster accommodation and increase anxiety over time. I think this is a really important piece, and it deserves some time and discussion in sessions. This brings us to our final take-home point here, which is that encouraging caregivers to reflect on what drives their individual accommodation can position them to be more effective partners in their child's treatment. We really want to encourage folks to, even if you're working primarily individually with kids, take some time to meet with the parents and to talk about these patterns. What's showing up for them? How they view themselves when their child is distressed, how they think others might view them as well, and helping them to anchor in their own values and goals for their family life, rather than just deferring to the norms and expectations of modern parenting.

This discussion can be really empowering, and it's a great place to start before you dive into the work of reducing accommodation. This is where the rubber meets the road. This is where we partner with caregivers and integrate kids whenever possible to get their buy-in to come up with individualized plans to reduce accommodation. We want to start by identifying the accommodation targets. This can sometimes be a

little bit tricky because the same behavior could be an accommodation or not an accommodation depending on the context.

For example, say you're working with an anxious child who's refusing school. If they are willing to take that exposure step of getting into the school building if dad sits in the lobby during the school day, in that moment, dad sitting in the lobby, we're not considering that an accommodation. That is something that the child needs to take that next big exposure step. However, if the child is then only able to go to school if dad is in the lobby, that same behavior is now an accommodation, and the work of treatment is to gradually pull dad back from the lobby.

It can be really helpful to parse apart, is this accommodation or not? Eli Lebowitz, who's been a real pioneer in this field, we'll reference him a lot, suggests walking caregivers through the following prompts. For a given behavior, is this helping my child to gradually cope more, or is it actually helping my child to avoid more? Is this getting worse despite my help? Is this a step forward or backward relative to how my child has been coping recently?

These are always good markers for you to have as you're getting curious with parents about their behaviors and how that's impacting the treatment trajectory. Once we've identified the accommodation targets, we can help caregivers be successful in some other ways as well. First, we do want to set realistic expectations here around accommodation reduction. The child is not just going to be thrilled that the parent has decided to shift their behavior around the child's anxiety. This is when some good psychoeducation about an extinction burst is really key.

We want to normalize the fact that when a caregiver reduces accommodation, a child's anxiety is going to increase. The behavior may get worse before it gets better. This is a predictable part of the change process. This is not a sign of failure. We need to highlight the importance of staying consistent here because giving in when distress is really high is just going to reinforce that cycle of anxiety and avoidance even more. We want to help then prepare caregivers for how to tolerate their own distress in that moment when they've reduced the accommodation and the child gets really upset.

We want to help with cope-ahead plans for parents and set these realistic expectations. We also want to guide caregivers to start with the low-hanging fruit. Sometimes, making small changes to a family's routine that increase child independence in a developmentally appropriate way, like encouraging the child to take on some more independent chores or carving out some time for the caregiver to do some self-care away from the child. Starting with this low-hanging fruit that creates mild distress in the child and shifts the behavior pattern, that can be a really good place to start. It can help to build confidence.

Then, just as we do in exposure-based treatment with the child, we want to create a fear and avoidance hierarchy. A hierarchy of accommodation targets with the family, ranked from least interfering to most interfering, least distressing to most distressing, and use that as a roadmap to start pulling back against the accommodation patterns. If we look at Layla's case example here, it's clear that without addressing her parents' responses to anxiety, she's just got a reduced opportunity for exposure.

Reducing accommodation effectively gives her the space to do her own treatment. We could identify some of the accommodation targets here and then come up with a plan for reducing those in a gradual way that both challenges Layla to cope but gives her a lot of support. Some suggestions here would be agreeing on the conditions for which a doctor's appointment is okay. A fever of 104 and five days of symptoms without relief or something like that. Other than that, we're not going to the doctor.

We could identify a length of time that parents agree to wait before they respond to anxious texts, and then over time, increase that length of time. No longer separate the poor, sick family member. Don't make dad sleep in the basement when he's got COVID. We can leave the television on or engage in some spiky political conversations at dinner. Again, doing this will create this comfortable level of discomfort for Layla and allow her to challenge herself and to do the exposure of tolerating that anxiety.

To support her with the school, this would likely involve a lot of collaboration with the school staff to help avoid reinforcing school avoidance. If she wants to pull that escape hatch and go home, what is an alternative that helps her ride out that big emotion and stay in the school? How can they positively reinforce staying in the school? Then a lot of accommodation reduction around school refusal means examining the home environment to make sure that there aren't things in the home environment that are extra reinforcing for Layla when she comes home from school.

If she has the option to call parents, say, "I don't feel good. I want to come home," and she gets access to Netflix and TikTok and snuggle with the cat and her favorite foods, it's just going to be so much harder for her to fight back against that urge when the alternative is just so lovely. A lot of accommodation reduction around school refusal involves considering the home environment and making it less cushy. That can be really hard for parents because they want home to be the cushy place, and it is the cushy place, but that can be handicapping the efforts to stay in school. We want to be thoughtful about that as well.

Finally, I just want to address some important clinical considerations. This often goes hand in hand with reducing accommodation in kids and in families. Let's start by acknowledging that this is really hard to talk about. As clinicians, we know that the caregivers of anxious kids are trying so hard. When they get to us, they are so burnt out. It can be really hard to point out how their well-intentioned efforts at mitigating their child's distress is actually backfiring, and we don't want caregivers to feel blamed.

The challenge for us as clinicians is to figure out how to share this knowledge in a way that isn't blaming, but that's creating a partnership. This is why I spent so much time on those drivers of accommodation. Creating the space to explore this more with parents and figuring out what's coming up for them, normalizing that, and sharing in that can be really, really powerful. For families who are coming to you and you're worried, are parents going to even acknowledge that there's work that they need to do?

Taking that time can really help to thread that needle so that parents don't feel blamed. You're building this rapport with them, and you're a partner with the parent and the child against their anxiety and their OCD. We also want to address any

misalignment between caregivers. One caregiver may be way more willing to reduce accommodation than the other. I'm sure everybody here has worked with families where one person identifies as the softy and the other one identifies as more strict.

If there is a caregiver who will always accommodate, that can really undermine the efforts that we would be taking to reduce accommodation. This is where getting the caregivers together and exploring what are you afraid will happen if you don't accommodate in this moment. What's your worst-case scenario? What is your fear? What are your values and your beliefs, and your goals? How can we create a treatment structure here that aligns with that can help get caregivers more aligned?

If they're just not aligned, then the one who's willing to reduce accommodation, can we let them try first and have the one who's less willing take a knee and take a back seat? Often, we'll find that the parent who's struggling more with accommodation reduction will rise to the challenge once they've seen the success that the parent who has been willing to do it makes. That can be a way to approach misalignment, but it's certainly challenging. The other end of this is that sometimes you get parents who, once a clinician says, "It is okay for your child to experience some distress." Or, "Great, let's get at it. Let's get rid of all of the accommodation here. Let's hold a firm line."

It's really important to acknowledge that undersupporting kids can be just as bad for child anxiety as fragilizing kids. We don't want to rip the rug out from under kids before they have the skills and feel like they have the support to make these hard changes. We do really want to reduce accommodation gradually. There can also be really important practice limitations. Sometimes accommodation is deep, and you just do not have the ability to adequately address it and still treat your child patient when you have one session with them a week.

Particularly if the family only has the time or the resources for one behavioral health experience a week, and that is most families, it may be very well worth your while to advocate for parent-only sessions for the time being to really address accommodation. Again, this may not be what parents are expecting. The old model of "My child is struggling with anxiety, I'm going to plug them in with a therapist and they're going to come out fixed."

That may be what they're expecting. Again, the importance of having your own relationship and trust with the parents to help them see, actually, the best way to use your resources and your time with me is to have us do some work together to begin this accommodation reduction plan can be really impactful. Then finally, a caregiver's own mental health can significantly impact how they're able to rise to this challenge. It's a very big challenge. Being thoughtful about when you need to make a referral for the caregiver's own individual mental health treatment, so that they can help better cope with the stress of reducing accommodation.

Quick review of our take-home points here. Parents are likely to be more skillful when we emphasize to them and they understand that anxiety is natural and normal and harmless. We can educate parents about how avoidance and accommodation fuel anxiety and OCD in the long-term, even if it reduces distress in the short-term, so they understand what we're getting at with exposures and accommodation reduction, and encouraging caregivers to reflect on what drives their individual

accommodation can equip them to respond more effectively and become more active partners in their child's treatment.

We know you're going to get these slides, and we do have some resources for you. Eli Lebowitz, who really is the pioneer in the accommodation world, has a great manual for clinicians that's through ABCT, which is also a great resource. Lebowitz has created the SPACE treatment, which is Supportive Parenting for Anxious Childhood Emotions. It's a good acronym.

The training is really worthwhile. If you're looking for a continuing education opportunity, becoming trained as a SPACE trainer, this is where the therapist works exclusively with the parents, even though the child is the treatment, to really focus on accommodation reduction as the key change-maker in the child's treatment. Lebowitz also has a great book that's for caregivers. *Breaking Free of Child Anxiety and OCD* is a wonderful resource directed to caregivers and that outlines all of this.

I think it's actually great for clinicians too. I refer to it a lot. Anne-Marie Albana's *You and Your Anxious Child* is always a good resource for families who are looking to better understand anxiety and OCD. I want to pass it back to Maria to tell you all a little bit about the program that she leads at McLean.

Dr. Fraire: Sure. Thank you. I'm the program director of OCDI Junior. We are a residential and partial level of care program for youth ages 12 to 18 who experience significant OCD and anxiety. 10-bed residential, a relatively small PHP. We're located in the Boston area, and we are an insurance-based program, which can be pretty tough to find. Fortunately, that gives us the opportunity to provide support to a wide range of families.

We provide individual and group therapy for the kids that are with us. We have a really strong emphasis on CBT and exposure therapy work. Even though a number of our kids live with us, families are still a very important part of our treatment. We have required weekly family meetings and an optional parents' group. We're really a multidisciplinary team here, social work, psychology, psychiatry, a pretty big training program. Please feel free to email us for more information about our program.

Dr. Elkins: Thanks, Dr. Fraire. Similarly, I'm the co-program director of the McLean Anxiety Mastery Program, or MAMP. We are an intensive outpatient level of care. Kids come to us in the afternoons. We are designed for kids ages 6 to 19. We have a child track and an adolescent track. The program was designed to give about a year's worth of outpatient CBT with a real emphasis on exposures and a real emphasis on parent support within a matter of weeks.

We are also located within the Boston area, but many families will relocate to Massachusetts to be able to participate in our services. I frame it as taking a class for a minimum of four weeks. Average length of stay is about seven. Kids and families are really digging into anxiety and OCD, and it enables them to make pretty rapid treatment gains. We're also multidisciplinary, psychologists, psychiatrists, and doctoral student trainees.

Please feel free to reach out if you think you've got a kiddo who might benefit from more intensive services. Then we've got all our references for you. Just click through

them quickly, and delighted to answer some questions. Thank you so much for having us.

Moderator: All right. Thank you so much. We are now moving on into the live Q&A. Thank you to everyone who submitted questions during registration and to those adding them into the Q&A box today. Drs. Elkins and Fraire will do their best to answer as many as possible, though they may not get to all of them. Your questions are appreciated. Let's dive in. Our first question asks, what do you think is the greatest challenge in addressing caregiver accommodation, and how do you meet it?

Dr. Elkins: I'm happy to take a stab at it and then pass the mic back. I alluded to this, but I do find that often, as caring clinicians, accommodation feels like the elephant in the room, and it can be really hard to bring up. We don't want parents to feel blamed. I find that even though we are trained to be direct communicators, the urge to make our kids and their families feel better. It's like our own accommodation patterns.

We don't want to point out the elephant in the room because it feels bad for them, it feels bad for us. I think it can be done skillfully if it's addressed with a lot of empathy, if we're showing families the research behind this, if we're normalizing accommodation and really saying the problem isn't accommodation itself. Again, everybody accommodates everyone. I'm tempted to accommodate the dog who wants to get into this office right now, but I'm not going to do it.

Then to say that it's really the anxiety and the OCD that is hijacking this pattern where we feel that we want to minimize distress. If we can get there with parents in a gentle but firm way and tolerating our own distress in the moment, then I think that we can be off to the races. It can be tough to do. I think it can be tough, especially for junior clinicians or maybe clinicians who aren't parents themselves sometimes struggle. We talk about this with our trainees or our junior clinicians a lot with coming up with these recommendation for parents because they're afraid of this topic. Maria, I'm curious what your thoughts are.

Dr. Fraire: Such a great answer. I think that's absolutely valid that it can be hard to target this especially because we are coming at it from the angle of we don't want parents to feel blamed. That's why I think we spend so much time in the early days of building that rapport and also emphasizing how much we are a team. We'll often talk to families about how we feel like it's a combination of the parent knows the child the best, the clinician knows the research and the therapy. It's our powers combined that is going to make this difference for supporting their child.

The other thing I think about when I hear this question of what can be really challenging when talking about caregiver accommodation is caregivers own burnout and mental health and how much that is also showing up in the room. Especially by the time families get to us in our higher levels of care, they've often been in the treatment system for a while. They've been trying to support their child for a really long time. It can be a lot.

We will spend time being mindful that the child may be our identified patient, but how do we support the parents in filling their cup so that they can support their child and how important that is to skill them up so that they can tolerate the distress that will

show up when they begin to reduce these accommodations. It does take time. This isn't a one-session thing where you'll talk about accommodation and then parents will go home and just do it and then all of a sudden it is better. You're in it for the long haul.

Having that conversation with caregivers also about short-term goals versus long-term goals. Yes, this is really hard. We'll see those extinction bursts. You'll see anxiety and OCD spike as you're working through these things because it really feels like it fights back to be like, "No, you have to accommodate. You have to help me avoid. How else will I survive?" Long-term, we'll talk to parents. What are their hopes for their kids? What are their goals? It's going to take a while to get there, but only if we all work together, moving the needle forward, will we even be able to realize these things. Those are the other pieces I was thinking about.

Moderator: All right. Thank you so much. Our next question asks, how do you balance empathy, validation, and the perceived need to accommodate with intervention?

Dr. Elkins: I don't see these as mutually exclusive. I think that it's a natural human tendency to want to compartmentalize things. We have families who sometimes come in and they learn about accommodation and one of the parents is like, "See, I've been telling you we need to be tougher on them."

It really leads into black and white thinking. These things are not mutually exclusive. Validation and empathy should always come first. Lebowitz, in his book, actually, the one that's intended for caregivers, recommends a skill called a supportive statement. A supportive statement, he says, is a two-ingredient recipe. You need both the validation and the empathy and then the confidence.

Basically, if a child is struggling with anxiety, you start with validating. It makes so much sense that you're anxious about your schoolwork because you really care about how you do. Then the second part is communicating confidence. I know you can handle this homework assignment. I'm going to be downstairs and I'm going to let you work through it a bit. You're not just saying, "Good luck getting through this on your own."

You're really validating and showing empathy, but then you are setting a boundary on how much bandwidth anxiety and OCD can take in the family's life. I don't see those as mutually exclusive, but I think it's really important when we're talking about accommodation to make sure that parents understand that we are still leading with empathy and validation.

Dr. Fraire: Yes, I definitely agree. I think to build on that, that's also why we'll spend time talking with caregivers about the importance of separating anxiety from the child and being mindful of the language that they're using when talking to their child about it. Even sometimes something as simple as the difference between, "You are making us late and we have to get out the door," and shifting that to, "Your anxiety is making us late and we have to get out the door," is sometimes a really good place to start.

Then it also helps parents think about, "I can still validate, support, encourage, be empathetic with my child, but not the OCD," and helping the child also understand

that difference. "Yes, absolutely. I love you. I know you can do this. This is really hard. I see how hard you've been working, and we're still going to do X, Y, and Z," because that's a big part of our individual treatment with the child is also this idea that things can be really hard and you can still do the hard things versus anxiety has tricked you into thinking things are really hard and you can't handle it. That's why the powers combined of doing exposure therapy and helping caregivers reduce accommodation is just so critical to a child's quality of life.

Moderator: Very nice. Thank you. We have another question that asks, what strategies have you discovered to help caregivers understand how their anxiety contributes to the children's anxiety?

Dr. Elkins: I feel bad always starting first. Maria.

Dr. Fraire: That's fine. It sounds like skills. If I caught the first part of the question, it was what skills helped separate out the two. What it made me think about in listening to the question, though, is sometimes it is useful to teach the parents the skills and the service of their children, but have the parents also practicing that. If you are looking for a roundabout way to help parents maybe alleviate some of their own anxiety, especially when you have some of those parents who are maybe not quite ready to get into that or they feel like it's beyond the scope of what they want you to talk to them about, but doing a lot of family practicing of the skills you want the kids to learn has been very valuable.

Not only because you're actually practicing the skills, but because it gives a shared language. You don't always have to go straight at it if you have a parent who's maybe not quite ready to talk about their own role of the anxiety, but if they want their children to learn the skills, we know that so many children learn by what's modeled around them. Helping parents understand if you're asking your child to do these certain things and you're not willing to do them yourself, that sends a very mixed message to the child.

Dr. Elkins: Absolutely. I'll just add that I think so much of this is just dialogue. Your solid therapeutic skills of being in empathic conversation with the parents to help them and using Socratic questioning to help them. "It sounds like when your child feels this, this pulls at this for you. Am I right there? What do you think that means? What is the feared outcome here?"

Asking these questions in dialogue, just as you would with the child, to maybe help the parent to get to a better understanding of their contribution here. Then using gentle reflection of, "It sounds like when your child feels really anxious, you feel like your life is just about to fall apart and all of this weight comes in." Just again, reflecting back to them. I think a lot of this, in addition to having them practice the concrete coping skills, are the therapeutic skills that you're already doing and that you're already so skilled at in your work.

Moderator: Thank you so much for joining us, Drs. Meredith Elkins and Maria Fraire. Thank you to all our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen.

Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

[01:00:10] [END OF AUDIO]