AUCD – 4/23/21 Learning to Face Fears from Home: Unexpected Benefits and Discoveries

MAUREEN JOHNSON: Hello and welcome to the learning to face your fears from home, unexpected benefits and discoveries webinar. My name is Maureen Johnson, program specialist at AUCD. I would like to thank you all for joining us today. Before we begin, I would like to address a few logistical details before -- because of the number of participants, you will be muted throughout the call. You can submit questions at any point via the chat box. There will be a time for questions at the end. All questions will be read aloud to accommodate all attendees. We have CART captioning available, and if you would like to access it, please click the CC button to view subtitles. This webinar is being recorded, and will be available as an archive following this event, as well as a written transcript. So, please join me in welcoming the autism special interest group co-chair Brian Be. As a reminder, this webinar is part of the autism acceptance month series, hosted by the autism special interest fair. Again, welcome, Brian Be.

BRIAN BE: Thank you, Maureen, and thank you AUCD folks supporting autism acceptance month webinar series. Again, as Maureen mentioned, I am on the autism spectrum, and I have the privilege to serve as the co-chair for the special interest group. Maureen, would you please show the flier? What is the special interest group? Hi! If I just came on your camera. What is the AUCD's special interest group? That is a great question that we are going to answer next week on Thursday the 29th at 12:00 mountain time where I'm at, and at 2:00 p.m. Eastern Time. We're going to do an open house for AUCD's autism special interest group.

Coming up shortly will be the link where you can register for that open house, as you can see there on the screen. At the end of this webinar, I will share this again, and we will show you a flier where you can copy a QR code. Now it is my privilege to introduce one of my colleagues Dr. Jude Reaven, Dr. Reaven, if I'm dealing with autism spectrum disorder in a young person and also having in anxiety, do you have in resources for me?

JUDY REAVEN: You've come to the right place. Thanks so much, Brian and Maureen. We're all really thrilled to be here and excited to present on the telehealth issues we've come across with regard to the "facing your fears" program. You can see I'm not in this alone. There are four of us that will be presenting today. I'm going to get things started, then I'll turn it over to two of my colleagues, to Lisa and Caitlin who are going to talk some about getting in the weeds with the telehealth program, and we'll wrap up with Robert Murphy, a parent and recent participant with his son in the facing your Facing Your Fears program. I do need to disclose I receive royalties from the clinical base program. Here is what we're going to cover today, three things. One, we'll review from the core components of Facing Your Fears are. Rear going to talk about how we've adapted it for the telehealth delivery, and then as many of you who are probably in the weeds with telehealth as well, you know there are some things that are going well and some things that are challenging. We'll share those things for us as well.

Let's talk about why we want to work with our youth with ASD and anxiety. There's several main reasons for this. One, it's very common. I'm pretty sure everyone on this call has a good understanding about that. There's really high rates of prevalence with teens and children with autism. You may know that when anxiety is part of the picture, it can be really interfering. That means it can affect us if we go to school, in our school day, at home, at work, in the community. So, it can be really problematic.

The most encouraging piece about all of this is the strong potential to treat. We know this through various studies where CBT interventions have been really effective. We know in the work on modifying CBT for our population, it's been successful. We need to go after it.

So, what is the real-world impact of anxiety? Well, I can probably talk about this for a long time, but some of the main things I want to say are here are the common fears that many of our kids might experience. Problems using public restrooms for all reasons. Not just about germs or other noises. Could be the automatic hand driers and toilet splashing can be anxiety-provoking for some folks. Fears of being late, late to school, late to appointments. Problems with the dark or other kinds of specific fears or phobias. Social fears and anxieties, could be talking to new people, asking for help, talking to your teacher, starting a conversation with a peer. We've got many of those.

Problems just with separation. If parents leaving to go to errands, sometimes it's even just leaving to go from one floor of the house to another floor of the house or one room to the other room without their parents. Problems with making mistakes or fear of failure, school failure. Accepting criticism and feedback. This is really just a sampling, but it's to give you a general idea about the kinds of challenges that our folks come to us with and where we might want to start.

You know, I thought a little bit about does this look any different in the virtual world? You can see there's similarities. There's still social challenges. It might look a little different, having to write in a chat or having to unmute and speaking out loud. But we've also come across kids who have trouble and fears that they're going to lose internet.

I have that fear too (laughs), but the way that I've seen it come up has been where kids log onto their school, they're afraid they're going to lose the internet, and when they log back on, they maybe missed something important. Some kids have challenges keeping their video on and being in front of the camera when they're doing Zoom work.

Again, the social fears as I said, and the generalized worry about making mistakes and failure. There's kids of course who have more concerns about getting sick and getting COVID.

So, all of that to say what do we know about the best practice interventions? Psychoeducation intervention for people who have interfering anxiety. We know it can be CBT. I'm not going to spend a lot of time about what is CBT. You can see I've laid out what we mean by cognitive behavioral therapy for the treatment of anxiety, just in anyone, not necessarily specific to ASD. We know the components are based on psychoeducation, which means talking a little bit about what anxiety symptoms might look like, and then working on coping strategies, somatic management, managing your body's reaction, what people are telling themselves. We want people to face fears a little at a time, and that is the exposure piece. We spend time talking with folks about now that you've learned all of your good coping skills and strategies, how are you going to put them into use, even six weeks from now, three months from now, and so on.

The Facing Your Fears program -- gosh, we've been working on this for a long time. I think we published our first paper in the early 2000s. You can see it's modeled very much on CBT. It is a CBT program. It's 14 weeks. This is the clinic-based program I'm talking about now. An hour and a half each time. We've kids come with their parents and they're there for the duration. Again, this is the clinic-based program.

Sometimes we meet with kids alone and parents alone and groups occurring at the same time. Sometimes parents and kids work together in dyads and large group activities. You can see the Facing Facing Your Fears program is like other programs, two chunks. First chunk is psychoeducation, where again, we talk about what I was just referring to earlier, which is defining what anxiety might look like, helping kids understand coping strategies and introducing the idea of facing fears. We also help kids work on some emotional regulation so when they experience intensity of emotion they have strategies for how to bring themselves back down. The last seven weeks is all about facing fears actively in group.

So, when we first developed the program, it was important to us to have a good research and data behind it. This is a sampling of our early work in trying to establish the initial efficacy and ultimately effectiveness of the intervention. I'm happy to provide more references if people are interested.

One of the things we learned about doing a clinic-based program, there's so many access issues. Families and communities that live in rural parts of our state, families on long waitlists who maybe can't get to a clinic for whatever reason related to travel, related to childcare, related to time off. And we felt we were really only able to allow access for a very small group of the population who needed this kind of work.

So, prior to COVID, this program, we raised the idea of could we do a telehealth intervention or telehealth version of Facing Your Fears? Probably eight years ago, something like that, some of our initial conversations. The solution was really trying to address the limitations that I just referenced. Maybe you don't need as many people to run a group. Maybe you can reach people from rural parts of our state. Maybe families don't have to worry about transportation, time away from work, things we're all reaping the benefits of, that maybe didn't occur to us as much prior to the pandemic. It was raised.

So, as we think about the telehealth, we have to understand well, if you're going to adapt an evidence-based intervention, you want to make sure that you're balancing the treatment fidelity with adaptation. You want to make sure you're keeping the core components of the intervention. That's important to us. We also recognize with any evidence-based intervention, you know you're going to have to adapt. We want to adapt so our programs and interventions can be sustainable across context and time.

We were introducing this idea of adaptation prior to the pandemic, and our friend Susan Hepburn led the effort. Can we do a telehealth version? This was published five years ago. We learned a lot of things. We didn't have reliable internet and a good platform like Zoom. We used some other platforms that I think had their own sets of challenges. Nonetheless, we saw good fidelity to the intervention, good completion and satisfaction with the program, and reductions in anxiety symptoms. For us, it felt like okay, maybe we're onto something here.

Parents felt good about it. You know, we're excited. Unfortunately, after the first version, it kind of sat on the shelf. We picked it up again because in the last year or so we've all been experiencing the effect of a pandemic. We needed to resist that telehealth version, see what other additional adaptations we needed to make to be ready for 2020 and 2021.

So, this is where I think I pass it over to Lisa.

LISA HAYUTIN: Yup. Thanks, Judy! So, as our clinic team thought about transitioning from in-person to telehealth, we really wanted to be thoughtful about the changes that we made. We knew we'd have to make some changes to the program. We wanted to be thoughtful about it. The CDC fortunately offers this really nice way to think about making changes to an evidence-based program by sorting those changes into three categories. Green light adaptations are safe and encouraged. Go ahead and do them. Those are the tweaks you need to make in order for a program to fit a different age group or culture or setting.

Yellow light adaptations are ones that you want to be really thoughtful and cautious about because they may impact the outcomes. So, things like changing the session order. It may be okay, but perhaps there is something really meaningful or valuable about delivering information in a particular order, so you really want to be thoughtful and cautious about that.
Red light adaptations. We want to try to avoid because there is a higher likelihood that it's going to impact the outcome, so this is things like reduced dosage of a treatment, or eliminating activities altogether.
I'll take the next one, Judy. Thanks. I'm not going to walk you through every little change we made because we don't have time to and it may not be that interesting, but I want to give you a sample of the changes we made.
A couple of examples. In the Facing Your Fears original in-person group, the session is designed to be 90 minutes long. In the telehealth version, it's 75 minutes and we consider that a green light adaptation. If you were paying attention a slide ago, you would say wait Lisa, that looks like a decreased dose of a treatment. Isn't that a red light? We paused and thought about that too, but really, when we're in-person, we spend several minutes walking from the place where families check in to the group work, and then when parents transition to the group, that's another few minutes walking down the hall. When kids come in, they get snacks and we don't get going. That loss of 15 minutes is really a lot of the transition time that happens when we're treating in-person.
Another example of a change that we thought was a green light change is how we deliver rewards. In-person, we provide stickers and prizes to the participants in session each week. That was just sort of in practical to do by telehealth, but we use the chat for that purpose. While one of us is leading the discussion or leading, teaching about a particular skill, the other group leader is in the chat differentially reinforcing our participants who are sitting quietly or waiting their turn or saying something brave. There is this public celebration for those positives. You'll see there's a session format change that doesn't have a dot next to it. We'll bookmark that and come back to it.
These are all the delivery and format changes, or many of them that we made. Let's shift to talking about content.
Just as Judy said, the program is divided in our minds into the first half, which is psychoeducation, and the second half, which is exposure and fear facing. We're going to talk about it in those two chunks. Here's the changes to psychoeducation, which we largely estimated to be green light changes. Again, we're talking about how we identify anxiety, how we externalize anxiety as being something that isn't who we are but something that occurs in our minds alongside who we are.

Managing our feelings. Physiological reactions to anxiety and managing those thoughts. So, in the in-person group, these skills are taught through a series of activities and discussions and worksheets. In the telehealth model, really most of that is preserved. We send workbooks to families so they can use them. They bring them to the group and reference them and use them during the group. Our activities are largely the same.

I'm going to give you an example of a green light activity change we did and a yellow light activity change. An example of a green light, in the parent group, when we're in-person -- in the beginning, we talk about rewards, and the importance of rewarding your child for doing these hard things. As part of thinking about that, in the parent workbook, there's a sheet where parents fill out ideas for specific things their child might find rewarding. Favorite foods they have or privileges or activities or tangible things they might buy that parents fill out in detail. When it comes time to help their child move forward and their child needses a reward, we have something easy to reference. In the parent group, when we meet in-person, we discuss this and parents pull out their workbooks and they fill it out in the group. We felt doing that by telehealth was a waste of this time together, so we know families -- people have a harder time sitting through a session or group or meeting by telehealth than in-person. Why don't why assign that for homework instead? We still do the setup, talking with rewards, and we say fill this out in the coming week, and in the following week we will talk about it. We will felt that was just a tweak that had very little, if anything, really nothing lost in terms of what families might get out of the activity.

In contrast, there is another activity that we do with kids called worry bug, helper bug. It's part of teaching kids about externalizing anxiety. Anxiety is not who you are. It's happening alongside of you. We give them play dough and have them create their worry bug, the thing that tells you the worried thoughts, and create a helper bug, the character that might coach you to think more adaptive manageable thoughts.

When we do this in-person, it's always like one of our favorite sessions for the kids too. It's fun, dynamic, the kids laugh, they have fun showing one another their worry bugs.

We also knew it would be really hard to do that in session because we can't keep the kid's attention for a very long time by telehealth. If we spent 20 minutes working on this activity, it would be really hard to address the other content we needed to address in that session.

So, similar to the parent activity, we set it up at the front end, talk about the concept, tell them how to do the activity, and then we send them to do that activity in the week that follows. At the next session, they bring their worry bug and helper bug and show it to us.

Because this is a dynamic and interactive activity, we thought it was a yellow light change. Maybe there's magic lost in terms of transitioning this to a homework assignment. I can report there's been variability. There's been groups where this has been just as dynamic as it felt in group, where the kids come the following week and they clearly put a lot of time and effort into their worry bug and helper bugs and they're excited about theirs and one another's, and it feels very similar to as it did in-person.

There have been groups where kids drew something on a piece of paper and it felt more maybe half-hearted than what would have perhaps happened if we were all in the same room together. So, we tagged that one as a yellow light adaptation.

Let's move on. I want you guys to -- you had time to look at those. If you have questions about particular changes we made, we can talk about that during the Q&A, but I don't want us to run out of time, and I know those of us who maybe doing therapies for anxiety probably want to talk about exposure because it's the thing we felt more apprehensive about, and I assume there's others who feel the same. This is the Facing Your Fears a little bit at a time.

I have to say, the fear-facing has gone better than I would have anticipated before doing it. But there have been changes we've had to make that fall into the red light category. When we do this group in-person, there is a portion of each group about 20 to 30 minutes where a therapist, child, and parent meet in a smaller group and face their fears in individual session. In the telehealth version, we have done this in variable ways, depending on the kids we have, how many kids we have, how many group leaders we have, and the dynamic and the fears that the kids have chosen.

In the group we're doing right now, what it looks like actually is very similar to what it looked like in-person. We have enough group leaders that we can assign one to each participant, and we do breakout rooms. When it's time to face fears, a group leader goes into a breakout room with the family and they come up with the things they're going to practice that day. Also, one of the benefits is they're practicing in their real-life home. If a child is afraid of the dark and they're working on facing that fear in their home, there can be really benefits to that in terms of generalizing to the areas in which it really impacts your life negatively.

In other groups, we have not had enough group leaders or, again, the group dynamics did not allow it. We ended up doing a model we call kid of the week, which is where one or two kids choose to be the ones -- not choose. Would be assigned to be the ones to practice their fear-facing in session in front of the rest of the group. We didn't break into breakout rooms. The benefit of this is that the children who are not fear-facing that day get to really focus on coaching in a more concentrated way, which was really valuable, I thought, because they get to hear themselves saying the things we want them to be saying to themselves. So, that was at any pretty powerful. Kid of the week, each kid gets a lower dose of the in-person practice, and parents get a lower dose of the therapist coaching in session, which is one of those things I just said was a red light change, a change in dose.

It's something for us to be thoughtful about and to consider in terms of how we would think about outcomes.

The other red light change we made really has to do with that structure that I said I'd come back to before. In the in-person group, we meet as a large group, and then we break into individual families, and then parents and kids meet separately. During that time in the kid group, the kids are working on creating a movie for Facing Your Fears, where they have a script and roles they play. We record them and they put together this video where they face a fear of their choosing. Could be fear of making mistakes, spiders, whatever. They show those steps when facing fears. We really do think this serves to reinforce those principles. It has a component of repetition, a component of fun associated with practicing these things that we think is valuable, and we really just don't have the opportunity to do it by telehealth, in part because we know the kids we're working with, really any kids, have a hard time sitting through a really long session via telehealth. We really try to limit their participation to the first 30 to 40 minutes so they're losing some content and getting a smaller dose. So, we would consider that a red light change.

Before I hand off to Caitlin, I wanted to share a little bit. We really have been able to do many of the same fears in terms of the goals we're bringing in that we were able to do in-person. So, we've done fear of bugs and spiders, fear of the dark, contamination and germ fears, fear of making mistakes, fear of talking to new people or starting conversations. Again, at the front end, we were more apprehensive being more selective about the things we could do by telehealth, and we are thoughtful in the screening process about that, but we've been able to cover a similar range of fears by telehealth as we could in-person.

So, now thinking about getting started. We first need to -- there's some logistic things we want to think about. We need to confirm that the video platform works and is appropriate for telehealth. Make sure we do a test run so everything is working. We need to think about where and when the group will occur. Privacy issues, plans for children, other children in the home to not be disruptive. It can be really tempting as a participating parent, I think, to need to multitask somewhat. We want to be thoughtful about coaching parents to really put those parameters on the session.

We need to make sure we get their workbooks and other materials to them. During Facing Your Fears, there are these videos we show to help model what fear-facing looks like. We need to make sure those are working properly.

We need to plan for what kids will do when you're meeting with the parents alone. Finally, to create a clear visual structure, schedule, systems. We do a lot of share screening. Sometimes we put up a worksheet and we'll mock up that worksheet together to ensure it isn't just us talking at families, and it feels interactive.

I think with that, I'll pass to Dr. Middleton.

CAITLIN MIDDLETON: We're going to talk about the screening process and other additional considerations for doing the telehealth program now that we have a few cycles of the group under our belts. I'll say a thing or two about the screening process first.

Actually, Lisa, would you mind jumping back in here? Judy, could you go to the next slide?

Would you mind doing this slide Lisa, on the screen?

LISA HAYUTIN: Not at all. When thinking about who is appropriate for Facing Your Fears via telehealth, we have put more thought into that screening process because the screening criteria are similar to some degree, the age range of the kids is the same, the types of anxiety that we want to address are similar.

But we are more thoughtful about -- and probably conservative -- about screening for safety and crisis risks. If there is a child who has had previous hospitalizations or who has expressed when they get really upset they make comments that they'll hurt themselves or something like that, those are things that typically in-person we would ask more questions about. If things seemed they weren't in crisis in the moment, we'd say come on in. If something comes up, parents have a seamless ability to pull us aside and talk to us about those things. We pull them into another room. By telehealth, all of that sort of moving around can be a lot harder.

We are more conservative about bringing in those concerns because we want to feel confident we can manage effectively if they come up.

Having questions about kids who would do well in a video format. There are some kids who just don't, for some of the reasons Judy mentioned, in terms of having specific anxieties around that, as well as kids who may have some more behavioral challenges. When we're in-person,

we can often assign a group leader to snuggle up with that participant who is having a harder time managing their behavior and work very diligently and uniquely with that child to reinforce the behavior we want to see in group.

In the telehealth group, it's really up to parents to do that management, and that can be harder both because kids can be their hardest self for their parents and sometimes we're not able to offer the structure.

Finally, considering a virtual format, regarding types of worries and graded exposures. Maybe specific, my child is really worried about inserting themselves with their familiar peers at school. So, even if we could create some social exposures in our group format, we're not their peers at school. If their social fear is not more generalized and more narrower in scope, it's harder to address effectively. We do a more robust screening at the front end.

CAITLIN MIDDLETON: Judy, if you wouldn't mind going back a slide. I want to say a thing about generalization here. We talked about screening process and generalization is also an issue when doing telehealth. You know, when we have our in-person programs, we are in the context of a big hospital, so we have the luxury of being able to take kids to do exposures and face fears in the cafeteria, we can walk around and go to different rooms in the hospital.

So, we can more easily try to generalize some of the skills they're learning into different context. When kids are at home, we may not have that luxury of generalization, although we can think about generalization in other ways because kids are at home and in the real world and more real-world context. But I think we have to work a little bit harder when kids are at home and facing fears in order to have them generalize to different environments and context.

Behavior management. I mean, that's one of the biggest things that -- or the big of biggest challenges we have running group in-person or over telehealth. We will talk in a moment about some of the most common behavior management challenges or the most challenges in general with telehealth and solutions about that.

We don't really have the same tools at our fingertips that we do when we're in-person to manage some of those harder behaviors, and we are having to rely more heavily on parents to manage some of the harder behaviors.

Reading the room. It's something, as clinicians, that we do really naturally when we're in-person. It's much harder to do in a telehealth format. There's more interruptions, reading social cues, knowing when somebody is going to jump in is harder. That's a tricky thing. You try to keep that in the back of your mind as you're doing telehealth programming to really try to check in and see how kids and families are engaging, how they're understanding the material, if they need more support in different ways. We'll talk about some of the ways we've navigated that.

Then building relationships with families and kids and at other levels too, if we have trainees running through our group. It's very different in a virtual format. We have to work a little bit harder and create more intentional moments to be able to connect with families and kids during telehealth group.

So, this is not meant to be an exhaustive list of all the challenges we come across, but some of the ones that we have encountered over and over again.

The first one being kids who refuse to be on screen. This is really common and tends -- we tend to see it, or we have seen it in every group we've done. You can go to the next.
We'll bring it up one at a time. You may think of other solutions to try. Some things we have worked on is being able to go really slow. Almost like doing an exposure and facing fears a little bit at a time, where we reward small efforts for kids to be on screen for longer and longer periods of time, and we work with parents to encourage their kids to be on screen for longer periods of time, not to reinforce the off-screen behavior, but to get them to be more on screen.

Kids who are dysregulated in group, that happens in in-person groups and in telehealth. Again, it's harder, I think, to manage in a telehealth format. Kids who may be having meltdowns or shut down, not cooperative. Some of the solutions we found that work for this particular challenge is we've really tried to use those breakout rooms if we notice that kids are having a hard time. We ask parents privately in a private chat or something like that if they would like to go into a breakout room, and we can then support them and put an individual therapist in their with them to work through that meltdown or whatever it is that's going on.
We can work to set up a reward plan or system for participation, and setting those clear expectations using lots of visual supports so kids know exactly what to expect.
Another common challenge, parents and kids are at home, they're comfortable, they're in their home routines, so maybe there's other things going on. Parents might be making dinner or kids might be watching TV, might be pets running around in the background that are distracting. So, some solutions that we've worked on for this challenge, we try to set those clear expectations right at the beginning of the group, even during the screening process we'll ask questions like, will you have other distractions like other kids or other family members that are around?
If it continues to be a challenge, again, we use some of those private chat features to send parents a message to say you know, hey, can you put that aside? Can we help support if your kid is distracted? Helping to set up a contingency or reward program for kids using a first-then, strategy first. You can do your worksheet, Pokemon, put your dog, whatever is distracting.
Finally, technology problems, probably the most frustrating and something we've all dealt with during this time. We try to determine are these technology problems ongoing? Is it happening every week, or is it a one-off situation we can troubleshoot? Do we need to get more tech support involved through our hospital system or something like that? Really working with parents to troubleshoot. Some of this is also done during the screening process, trying to understand parent's access to technology.

What we have really found, we've talked about challenges, and there are challenges just like there are with doing any evidence-based treatment in-person, but what we've really found is there's so many silver linings. the biggest one, families are being given access to evidence-based practices during a very stressful time, during a pandemic, during a time that has been hard on all of us.
Families that live far away -- I know Judy mentioned the more rural families in our state that may not have access to this treatment. For families where there are multiple children, there's work schedules that are hard, parents working late and they can't drive across town or sit in traffic for an hour to get to a clinic-based program.

I know I talked about challenges with generalization, but it also is a benefit that kids are getting to practice these fears and these skills in a real-world setting at home and when they go to the playground or in the community. They have more opportunity to do that.

I feel like the telehealth program offers more flexibility not just with the childcare piece and travel piece, but also in getting more creative in how we do some of the things we do in the group. We use other forms of communication that we would not necessarily use in an in-person group. We use emoji reactions, we use chat features and polls to really get kids and parents engaged.

I'm just going to wrap up here, and then we are going to hear from our parent who is participating today. Just to send you home with these take-home messages, we know that anxiety is really common in kids with autism, and that Facing Your Fears is an evidence-based effective approach in treating anxiety in kids with ASD.

This program started as a clinic-based program, but we have identified access issues and difficulties with families accessing care, and telehealth delivery is really one approach that can address those access issues.

When we're thinking about adapting a treatment like Facing Your Fears through telehealth format, we have to be thoughtful and careful about what we adapt and what we change. We really need to maintain those core components so that the benefits continue long-term.

With that, I'm going to turn it over to Dr. Reaven and Robert.

For our parent perspective.

JUDY REAVEN: Thank you Caitlin and Lisa both. So, that's the content of the program. Now we really want to hear from Robert. So, as I mentioned earlier, Robert has had personal experience with the program, and really can provide some good insights into benefits and continued challenges around telehealth. Before we get any further though Robert, if you could do a brief introduction of who you are and you're son.

ROBERT MURPHY: Yes. I'm Robert Murphy and my son Sam who is on the spectrum is now 14 in middle school, going into senior high school -- just baffling to me. He has just undertone of anxiety, and that's what really brought us into something we wanted to get a resource for him that was not going to limit his ability to live the life that he's going to have to live or get to live, or privileged to live.

JUDY REAVEN: Right, right. Great. So, talk to us. What did you like about telehealth?

ROBERT MURPHY: Yeah. I had the best of both worlds, Judy, where we had at least half the program was in-person, and then half the program turned into telehealth. I was really surprised in how fast and how adaptive the team was. I was expecting it to be much more cumbersome. What I liked about the telehealth, my son's reward was he really liked the social, bringing people into his story line kind of thing. He was able to do that more readily when we were in our house.

He has backyard chickens. The therapist expressed they were interested in the chickens. He would showcase the chickens and do teaching during a show and tell. That signified to me he was more engaged during that time. I liked I didn't have to commute. My commute across town was at rush hour. A commute that took 15 minutes took 45. I had to plan that. It was right around dinnertime as well, so it was just -- it was pretty much a three-hour commitment because of the commute. Sorry about that.

JUDY REAVEN: It's okay. So, talk to us. I hear some of the benefits, and we have certainly heard families talk to us about similar things. We want to hear what's hard about it. We have our own view of what we think is hard, but I'll I'd love to hear what you think is hard about the telehealth modality.

ROBERT MURPHY: I think what was hard in particular with my son, because he has always seen video entertainment. He did a lot of recording of himself making various sounds on the iPad (laughs) which we have years years of that. It was cute to look at, but annoying. He usually uses a screen for entertainment, and to be honest with you, we give him a screen when we need a break. I was concerned about that.

One of the other benefits, I could mute him. My son is an interrupter often with his thread of story line and not really engaged there. That was another benefit.

It's interesting how the shorter time -- I did not realize until I saw Lisa's presentation that it was a shorter time because I felt it was a fulfilled time. So, that's something that was intriguing as well.

JUDY REAVEN: If you had -- I love that you had the experience of both. You had the in-person, you had telehealth, but you know, in the future, as you think about -- because you know, lots of us are talking about telehealth is here to stay, we'll think about it whether it's Facing Your Fears or other interventions or programs.

Do you have strong feelings? It doesn't even have to be about Facing Your Fears. In-person versus telehealth?

ROBERT MURPHY: It was interesting. Thinking about this, if it was internal medicine with my doctor, I'd have no problem meeting in telehealth because I think it's psychology and all of that kind of stuff. I have traditionally had exposure, and I think we all have, through the suggestions, through being one-on-one. So, I question whether or not, especially in a room dynamic, I think there's a lot of intuitiveness that comes through being in-person and being able to I guess allow the heart exposure and vulnerability at that time, which could be easily turned on and off in I think a telehealth session.

I may just cover it with a sneeze (laughs) or something like that. So, I think if I was to do it, I would want to have an established relationship with a therapist first, then I'd be okay with planned sessions going telehealth. So, if I was in a rural setting and I wanted access to this and I just accepted that I don't have the resource within the community or my style, it would change. That would totally change it.

I think another thing, I would think in the city too, if it was in-person versus telehealth, and they were an apples to apples as far as the financial commitment, I would probably say well, the in-person, I'm going to get bigger bang for the buck. It has a perceived higher value, whether or not it's true, but that's my perception. It's like, if I was to go into telehealth, I would probably be able to buy into that more if there was a perception value difference. --

; JUDY REAVEN: I appreciate those differences. You may have already addressed this. I have one last question and we'll take questions from the group. Is there a time you just say no telehealth? That you just say you know, this is not going to work for me or for my family?

; ROBERT MURPHY: I would say that it would be when working with psychologists, especially a one-on-one psychologist, if there was not an established rapport, and if there wasn't an opportunity to be in-person at times. Then I would probably not go there.

It would be very hard. There's a lot of the dance that happens between a client and the psychologist, mostly by the client's design. There has to be an openness to vulnerability. I think that the practitioner would have to get really creative about how you can facilitate creating vulnerable opportunities through a distance, I guess, even though it feels intimate. We're face-to-face. There is a distance, but we're both aware.

JUDY REAVEN: Yeah. I really appreciate that. You're really speaking to the importance of the relationship, not just about content, content in intervention. So, that's really super helpful. With that, we have a few minutes.

I'm going to invite the other presenters to turn their videos back on. I have not looked at the chat yet, so I don't know if other folks have looked at it. Maybe -- I don't know if while we're looking at it, Maureen, if there's some questions that you have marked that you'd like to pose to us as we look at the chat?

MAUREEN JOHNSON: Sure, Judy! Please feel free to put questions in the chat box. If you would like to ask your question via video, you can raise your hand using the feature on your webinar console. Should be at the bottom of the screen.

Brian Be has raised his hand. I'll spotlight him and get his question.

BRIAN BE: This question would be more Dr. Middleton or for others on the team. Thank you all for presenting here today. D r. Middleton, you mentioned intentionally creating some spaces that maybe were natural otherwise. There's been a lot of emphasis on relationship and rapport just in the conversation now. What's one or two examples of intentional spaces for that?

CAITLIN MIDDLETON: Yes. Oh my gosh, Brian. Such a good question. I think pets have been a really nice example. We haven't necessarily been able to control when our dogs are on the screen or maybe a kid walks in the room or another family member is yelling for us or something. There's humanistic moments of saying yeah, I'm at home too, and calling out when we see other kids in the group, if they have their cats or their chickens or their dogs. Being able to make those connections.

I know my dog often comes into the room, and I'll call out and say you know, hey guys, do you want to meet my dog really quickly? He came into say hi to you all. To create some of that positive interaction and relationship, as we can, as those moments allow.

BRIAN BE: Thank you. I think I heard you say welcomed spontaneity.

CAITLIN MIDDLETON: That's a great way to put it. We have to be flexible. We have to be spontaneous and just roll with the punches.

BRIAN BE: Anyone else listening out there, spontaneous! (laughs).

CAITLIN MIDDLETON: (laughs).

ROBERT MURPHY: It's a Disney ref reference (laughs).

LISA HAYUTIN: The use of show and tell. Show and tell is a routine part of Facing Your Fears and by design in part because it's fun and it's a way for kids to find the program engaging, but also because it really highlights the sense of you being this whole person! Not being something

or someone who is consumed by anxiety or identified by anxiety, but that anxiety is this thing that happens alongside, who you are as a human.

In the in-person group, we introduce show and tell in session 3. From session 4 until the end, every week there's an opportunity for show and tell, and it's always a hoot, even with our 13-year-olds who at first think they're too cool for show and tell.

In this group, in the telehealth group, we knew that building relationships was going to be something that we had to be more deliberate about. We introduced show and tell at session 1 and tell them from the get go. Starting next week, you'll have a chance to bring us your favorite stuff! Pets, whatever it is to talk about and show about. It's an opportunity to build some of those connections earlier on. I will remember for the rest of my life, one of our groups where a kid mentioned his -- he had an interest in airplanes. All four boys in the group were like ahhh! I love airplanes! Got into this whole conversation about all of the very specific aspects of aviation they know more about than I do. It was such a wonderful opportunity for that group to happen. That's another example of something that we do to build community.

BRIAN BE: Thank you.

JUDY REAVEN: I like that example, Lisa, especially for the older kids because I know when I consult with other kids doing this program with the young teens, they say that's so young! Show and tell? I say we'll call it show off time. Everyone wants to show off. I think what you just described was showing off, in the best way. So, I really enjoy that.

I was going to answer the question, someone had a question about is there a central place to find current listing face your fears in a particular area. We've thought about that over the years (laughs). We've done a tremendous amount of trainings in the U.S. and Canada, and we have not kept that list. What I suggest, if you're looking for folks, is shoot me an email, and I'll give you some ideas about places that we train.

If there are folks not specifically trained in Facing Your Fears, you want to find someone who has good training in CBT and CBT in ASD particular, but it could be a good mental health provider who knows CBT would work well. Shoot me an email and I'll see if I can be helpful. I don't know if there's any other questions. I want to leave a few minutes for Brian. Did I miss anything? It looks like we're probably pretty good in terms of our questions.

MAUREEN JOHNSON: We do have time for a couple more. Please feel free to put your questions in the chat. You can also raise your hand and I can spotlight you so you can tell your question over video. I've also put the email contacts of Dr. Reaven, Dr. Hayutin, and Dr. Middleton in the chat as well for those that want to connect with them after the presentation.

BRIAN BE: Well, we're in the final few minutes. I'm a -- yes, Jolene just put in the chat. Thank you all. Please, if you have your reactions, you can use your clap emoji. We talked about telehealth and interacting. Please join me in thanking our presenters again for being here today. This presentation today was brought to you by -- yeah, look at all those claps going on there! Brought to you by AUCD's autism special interest group.

What is the autism SIG? Find out at the open house, which is next week, Thursday at 2:00 p.m. Eastern Time. The link to register for that is in the chat. We're going to talk about the two main

things we do throughout the year in the autism special interest group. We did an in-person conference, which is now an online conference, in November. Then we do autism acceptance month, April webinars, which is what this is a part of.

Come join us, especially stakeholders. People like parents, teachers that might be joining today, listening, Robert who joined and folks like myself, if you live on the autism spectrum or similar. I'm Brian Be, and this has been one of the autism acceptance April webinars.

Come again.

MAUREEN JOHNSON: Thank you so much, Brian. Again, I really want to thank all of our presenters, Judy, Caitlin, Lisa, and Robert for this wonderful presentation. Again, this presentation was for the autism acceptance month series by the autism special interest group at AUCD. This webinar has been recorded, and the recording as well as a written transcript will be available shortly after today.

So, I please ask if you can provide feedback on this webinar, the link is in the survey. This helps with the technical assistance for the AUCD network.

So, again, I would like to thank you all again for coming, and have a wonderful weekend!