ESCAPING THE ACCOMMODATION PARADOX THROUGH OPERATIONALISING GRADUAL EXPOSURE IN SCHOOL-BASED WELLBEING SYSTEMS

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Abstract

Despite a rapid expansion of universal whole-school wellbeing initiatives across Western educational settings, student anxiety remains increasingly prevalent. This paper examines the accommodation paradox within secondary school settings, where static, individualised and generalised adjustments such as assessment exemptions or isolated examination environments provide immediate academic access but inadvertently reinforce avoidant safety behaviours. We argue that pressures for immediate customer satisfaction reward these permanent environmental modifications, creating a systemic role ambiguity that forces pedagogical staff into unsustainable clinical spaces. To address this concern, the authors propose a conceptual framework to implement Provisional Exposure Tracks (PETs). By transitioning from static accommodations to a dynamic, psychologist-led fading system, PETs preserve crucial academic equity while systematically operationalising gradual exposure principles. Schools may be able to resist the medicalisation of normative distress by repositioning school psychologists as central clinical consultants and equipping educators with anxiety-aware pedagogy. This may ultimately cultivate authentic long-term resilience and self-efficacy among secondary students.

Keywords: student anxiety, school-based wellbeing, avoidance, special provisions, Provisional Exposure Tracks (PETs).

INTRODUCTION

Secondary school adolescents are most often reported to be suffering from anxiety disorders based on clinical criteria (Islam *et al*., 2025). According to the United Nations (UN), adolescents aged 10–19 experience an explicit vulnerability to anxiety disorders due to their transition from childhood to adulthood driven by emotional, physical, and psychosocial transformations (World Health Organisation [WHO], 2024; Liu *et al*., 2024). These clinical conditions often lead to severe

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functional impairments, including chronic school absenteeism and significant disruption to academic learning (Lawrence *et al*., 2015). More importantly, contemporary schools bear the responsibility of addressing a much broader spectrum of student distress, ranging from these formal clinical disorders to normative, everyday academic stress (Leslie *et al*., 2025). Over the past decade, educational institutions have rapidly expanded school-based wellbeing initiatives (Love *et al*., 2019). In practice, this has translated into a wide range of universal, whole-school interventions designed to foster collective resilience, social-emotional learning, and mental health literacy across the entire student body (Berger *et al*., 2022). Concurrently, schools have also experienced a dramatic rise in the utilisation of individualised, targeted adjustments. For instance, separate examination environments or altered assessment tasks are designed to protect specific students experiencing acute distress (Dally *et al*., 2019). This dual responsibility has sparked a critical debate regarding how student distress is conceptualised within secondary education, raising concerns that framing ordinary emotional or academic friction as pathological can inadvertently contribute to the medicalisation of normative stress (Leslie *et al*., 2025). While universal well-being programs aim to build broad psychological resources, the systemic implementation of individual, protective accommodations can inadvertently conflict with established psychological principles by facilitating avoidance behaviour. This tension does not stem from a deficiency in pedagogical care; rather, it reflects a systemic role ambiguity where educational staff are increasingly caught between the necessity of providing immediate academic access and the long-term clinical objective of fostering psychological resilience.

The tension between academic access and clinical avoidance represents an international educational phenomenon. Across secondary educational settings in North America, the United Kingdom, and Europe, administrative frameworks, such as Section 504 Accommodation Plans in the United States or Education, Health and Care Plans (EHCPs) in the United Kingdom, frequently utilise comparable environmental modifications to support anxious youth (Conroy *et al*., 2022; Weist *et al*., 2023). While these accommodations are legally underpinned by fundamental commitments to disability equity and educational access, their unmonitored application to internalising distress can unintentionally mirror the dynamics of family accommodation observed in clinical child psychology (Lebowitz *et al*., 2020). When school systems adopt open-ended environmental modifications without planned clinical fading, schools risk inadvertently operating as institutional safety nets that reduce immediate functional demands at the expense of developing long-term psychological coping repertoires.

Importantly, a nuanced distinction must be maintained between accommodations that facilitate essential access and those that inadvertently maintain anxious avoidance. For students presenting with sensory impairments, physical disabilities, neurodevelopmental conditions such as Attention-Deficit/Hyperactivity Disorder (ADHD) or Autism Spectrum Conditions, or

primary cognitive processing deficits, structural accommodations (*e.g.*, screen readers, ergonomic seating, sensory regulation breaks, or task chunking) serve as indispensable equity tools that level the pedagogical playing field (Lovett, 2021). The conceptual challenge addressed in this paper specifically concerns the subset of environmental modifications deployed to manage internalising emotional distress, where the primary function of the adjustment is the removal of the conditioned feared stimulus (*e.g.*, complete exemption from public presentations, isolation during standard academic collaboration, or unprompted classroom departure). In such scenarios, the accommodation ceases to act merely as an access bridge and instead assumes the functional architecture of a clinical safety behaviour.

Ongoing systemic issues highlight significant challenges in how pastoral and wellbeing supports are implemented in practice, including limited specialised training for staff, substantial variability between schools, and a lack of clarity in translating abstract policy into consistent educational action. More broadly, there are clear limits to what schools alone can achieve, particularly when students' mental health is shaped by complex factors beyond the classroom, such as family circumstances, socioeconomic pressures, and access to external clinical supports (de Jong & Kerr-Roubicek, 2007). Within contemporary school-based mental health frameworks, a critical tension arises between immediate educational accommodation and long-term psychological recovery. Specifically, targeted Tier 3 student adjustments such as individual accommodation and modification strategies can unintentionally reinforce avoidant safety behaviours in students experiencing elevated anxiety. While these adjustments are designed by educational professionals as well-intentioned measures to ensure immediate academic access and protective care, they can run counter to the mechanisms of evidence-based psychological treatments like Cognitive Behavioural Therapy (CBT). Because clinical recovery relies on gradual exposure and the development of active coping skills, static educational accommodations may, in some instances, inadvertently contribute to the maintenance and persistence of anxiety or worsened outcomes rather than its functional resolution. This conflict becomes particularly pronounced when distinguishing between normative student stress and diagnosable clinical pathology. The DSM-5-TR defines the diagnostic criteria for Generalized Anxiety Disorder as excessive, uncontrollable anxiety and worry regarding a range of everyday activities and events (American Psychiatric Association [(APA), 2022]. The clinical presentation highlights that the intensity, duration, or frequency of this worry is significantly disproportionate to the actual likelihood or impact of the anticipated event, severely interfering with attention, learning, and daily functioning (APA, 2022).

Conversely, secondary school students routinely navigate normative, developmental stress related to academic demands, peer social expectations, and future trajectories (Wuthrich *et al*., 2020). A significant challenge in modern education is that current school structures often struggle to differentiate between these two domains, leading to a system where standard academic friction is pathologized.

This structural vulnerability is prominently visible within Elite Grammar schools, which frequently operate within a marketized framework predicated on consumer satisfaction. Within these institutions, institutional well-being is sometimes commodified and positioned as a primary marketing asset to enhance institutional reputation and secure competitive advantages within the educational marketplace (Stentiford *et al*., 2025; Thabrew *et al*., 2023; Weist *et al*., 2023). This commercial pressure can create institutional incentives to prioritise immediate, visible consumer relief. Consequently, rather than facilitating long-term, psychologist-led clinical work that fosters resilience through gradual exposure, schools may face systemic pressure to rely on permanent, un-faded environmental modifications that remove the immediate stressor, inadvertently entrenching the accommodation paradox. To resolve this, this paper urges for caution against such accommodation strategies, outlines the limitations of static methodologies and proposes a novel framework using Exposure and Response Prevention (ERP) principles involving Provisional Exposure Tracks (PETs) as a scalable, researchable alternative that balances necessary academic equity with evidence-based psychological exposure.

CONCEPTUAL FRAMEWORK AND METHODOLOGY

To examine educational accommodation policy, psychological exposure paradigms, and educator professional identity, this paper employs a critical conceptual review and synthesis methodology (Baumeister & Leary, 1997). Rather than conducting an exhaustive systematic review or meta-analysis of empirical effect sizes, this analysis was designed to evaluate theoretical conflicts across distinct disciplines. This paper focuses specifically on educational policy, clinical child and adolescent psychology, school-based mental health, and teacher professional identity theory, with the intention of formulating an actionable conceptual framework.

LITERATURE IDENTIFICATION AND SELECTION SCOPE

The literature informing this synthesis was identified through multi-database scoping searches conducted across PsycINFO, ERIC (Education Resources Information Centre), PubMed/MEDLINE, and Google Scholar between January 2000 and January 2026. The conceptual inquiry prioritised contemporary theoretical developments and empirical studies published between 2015 and 2026, supplemented by foundational theoretical works in exposure paradigms and family accommodation. Search strings coupled terms across three primary domains:

1. School Mental Health & Accommodation: (“educational accommodations” OR “academic modifications” OR “school-based accommodations” OR “special provisions”) AND (“school anxiety” OR “adolescent anxiety” OR “test anxiety”);

2. Psychological Mechanisms: (“inhibitory learning” OR “gradual exposure” OR “fear extinction” OR “safety behaviours” OR “negative reinforcement” OR “accommodation avoidance trap”);
3. Interdisciplinary Systems: (“school psychologist” AND “teacher role ambiguity” OR “multidisciplinary mental health” OR “pastoral care” OR “pedagogical boundaries”).

INCLUSION AND SYNTHESIS CRITERIA

Sources were evaluated for their conceptual contribution to help clarify certain distinctions. First, we looked at the behavioural and cognitive mechanisms linking academic environmental adjustments to the maintenance or reduction of student anxiety. Secondly, we examined systemic, institutional, and legal boundaries governing school accommodations. Lastly, we assessed collaborative models between educational staff and embedded clinical mental health practitioners. Educational jurisdictions were utilised as illustrative real-world policy case examples imposed by curriculum authorities in the United States, the United Kingdom and Australia and compared against international peer-reviewed research from the US, the UK, and Europe. The resulting conceptual framework, termed Provisional Exposure Tracks (PETs), was inductively derived through iterative synthesis by mapping evidence-based clinical exposure principles onto the administrative realities of secondary school assessment environments.

HABITUATING AVOIDANT BEHAVIOURS

The Mechanics of Accommodation Strategies

To understand the institutional maintenance of student anxiety, it is critical to evaluate the psychological mechanisms underpinning individual student accommodations. Accommodation in an educational context describes how school pastoral and well-being teams modify institutional demands or environmental expectations with the primary intention of alleviating acute, immediate distress caused by anxiety disorders in specific, targeted students. Although these individualised practices are designed as essential protective measures to maintain basic academic access, their clinical trajectory remains complex. While these adjustments successfully reduce a student's distress in the short term, they operate with negative reinforcement. By allowing the student to evade the immediate stressor, these accommodations can inadvertently enable structural avoidance, paradoxically increasing the probability of heightened distress during subsequent re-encounters with the situation and leading to the long-term maintenance of the clinical disorder (Calvocoressi *et al*., 1995). In practice, these individualized strategies frequently involve the temporary or permanent removal of specific

anxiety-provoking academic stimuli. Typical administrative examples include allowing a highly anxious student to receive assessment results in a private setting rather than a standard classroom environment or providing an open-ended pass to leave the classroom when distress peaks.

From a pedagogical standpoint, such adjustments are introduced with compassionate intent to safeguard a student's immediate academic engagement and preserve their self-concept from perceived peer scrutiny. Clinically, however, the immediate physiological relief generated by escaping the stimulus functions as a negative reinforcement, consolidating the avoidance response and reducing future coping attempts (Phillips *et al*., 2022). Historically, clinical exposure models framed the therapeutic reduction of anxiety primarily around emotional processing theory and habituation, positing that repeated, sustained exposure to a feared academic scenario leads to a within-session and between-session decline in subjective physiological distress (Foa & Kozak, 1986). Under this classical extinction interpretation, static school accommodations can be counterproductive when they interrupt the duration required for the student's autonomic nervous system to habituate to the classroom stressor (Håland & Bertelsen, 2025).

However, contemporary clinical science increasingly conceptualises exposure through the lens of Inhibitory Learning Theory (Craske *et al*., 2014, 2018). Under an inhibitory learning framework, fear memories and negative associations are not erased or overwritten by habituation; rather, exposure fosters the formation of new, non-threat safety associations that compete with and conditionally inhibit the original fear conditioning. The primary therapeutic mechanism is therefore expectancy violation. This refers to the degree to which a student's catastrophic predictions such as "If I enter the examination hall, I will lose complete control and collapse", are directly tested, disconfirmed, and superseded by new non-threat interpretations in the presence of the feared stimulus (Craske *et al*., 2014). When school-based accommodations eliminate the stressor entirely, they prevent expectancy violation from occurring. This deprives the students from learning that catastrophic outcomes do not occur, or that they possess the distress tolerance and psychological self-efficacy required to navigate physiological discomfort (Jordan & Lovett, 2025; Ginsburg *et al*., 2023). This reinforcement risks validating a cognitive distortion that the school environment is inherently dangerous and that they lack the personal self-efficacy to survive the distress. Thus, while implemented by educational professionals purely as a duty of care, static accommodations that lack an active coping component fail to foster the emotional regulation skills required to navigate anxiety triggers long-term (Lovett & Harrison, 2021).

Consequently, the therapeutic objective of school-based interventions must transition from eliminating subjective distress to maximising inhibitory learning through structured, variable, and ecologically grounded exposure. When schools rely on extreme, permanent escape options such as complete exemptions from public speaking, frequent unmanaged retreats to the school nurse, or utilizing

homeschooling as damage control for severe social phobia, they risk reinforcing severe functional impairments (Jones *et al*., 2019). Without a structured, clinical triage framework to step these provisions down, these safety behaviours can accelerate school refusal. This highlights the urgent need for a researchable alternative built on the gold standard of ERP principles involving Provisional Exposure Tracks (PETs), which transition these vital student supports from static escape routes into active, fading exposure tools.

Modification Strategies

Beyond physical accommodations, schools frequently rely on modification strategies to manage student distress. In this context, modification refers to targeted Tier 3 adjustments made to a student's educational environment, lesson delivery, or assessment methods such as administering shortened assessments or, in some systemic frameworks, altering grading expectations. This is done to compensate for perceived functional impairments (Cannon *et al*., 2013). Pedagogically, these strategies are highly documented measures designed to enhance academic equity, protect student motivation, and ensure vulnerable individuals can access higher education despite facing severe emotional challenges. However, when these modifications become permanent fixtures rather than dynamic interventions, they present complex psychological trade-offs. Securing eligibility for formal special provisions typically requires students to be assigned a clinical diagnostic label (Brown & Carr, 2019). While these diagnoses are intended to unlock vital institutional support, an over-reliance on individual pathology can inadvertently contribute to the medicalisation of student distress. If typical emotional reactions to systemic academic stress are pathologised exclusively as internal psychiatric defects, it can inadvertently divert institutional attention away from modifying the environmental stressors that are driving the distress in the first place.

When formal adjustments approved by curriculum authorities such as State Education Agencies in the United States (Lovett, 2021), the Joint Council for Qualifications in the United Kingdom (Woods *et al*., 2018), and State and Territory Curriculum Authorities across Australia (Dally *et al*., 2019) are delivered statically, they risk passing an unintended psychological signal to the student. By permanently removing or reducing the academic stressor based on a diagnostic label, the system can inadvertently reinforce cognitive distortions, convincing the student that standard assessment environments are inherently dangerous and that they lack the personal self-efficacy to survive the experience (Jordan & Lovett, 2025). Rather than acting as a neutral educational bridge, an over-reliance on protective adjustments can lead to iatrogenic harm, encouraging vulnerable youth to internalise their symptoms and construct a self-identity anchored in their diagnosis (Foulkes & Stringaris, 2023). This risk is highly acute in high-pressure independent grammar school environments, where providing adjustments like separate rooms or extra time can inadvertently function as an administrative substitute for long-term,

evidence-based psychological treatment (Lovett, 2021). While these measures ensure immediate institutional compliance and customer satisfaction, they leave students highly vulnerable post-graduation if they transition into higher education or occupational settings where standard institutional modifications are less readily available or absent.

The counterproductive mechanics of these adjustments are clearly illustrated in standard exam provisions. For instance, granting extra working time is a common equity measure (Zuriff, 2000). Yet, for a student experiencing severe evaluation anxiety, additional time can paradoxically extend the duration of the threatening stimulus, increasing the window spent engaged in anxious performance rumination rather than task execution. Similarly, permanent placement in separate rooms or the unmanaged use of rest breaks can function psychologically as safety behaviours that entirely remove the physical and social cues of the exam hall (Conroy *et al*., 2022). Because clinical anxiety reduction requires gradual, systematic exposure to learn that the feared scenario is survivable, un-faded provisions act as a complete bypass to distress. This structural limitation highlights why schools must move away from static modifications and instead implement a researchable, step-down framework like Provisional Exposure Tracks (PETs), which preserve necessary academic access while systematically fostering adaptive distress tolerance and long-term psychological coping.

SYSTEMIC ROLE AMBIGUITY

PEDAGOGICAL CARE VS CLINICAL EXPECTATIONS

To resolve the accommodation paradox, schools must confront the systemic role ambiguity imposed upon secondary educators. Under contemporary frameworks of professional identity theory, teachers face intense societal and institutional expectations to serve as frontline pastoral care providers alongside delivering academic instruction (Laws & Fiedler, 2012; O'Connor, 2008; Reinke *et al*., 2011). It is critical to recognize that educators implement individual adjustments as education professionals, utilizing pedagogical care to preserve immediate student engagement and academic motivation. However, a significant institutional challenge arises because current educational policies frequently lack clear clinical triage guidelines. In the absence of structured collaboration protocols, teaching and pastoral staff can inadvertently drift into an ambiguous professional territory where they feel structurally pressured to provide a form of "counselling light" to manage acute student distress (Flint, 2017). This structural bind does not stem from a deficiency in teacher intentionality, but rather from a systemic design flaw where educators are asked to manage complex mental health presentations without clear administrative boundaries.

This lack of institutional clarity can severely impact the well-being of school staff. Unlike registered psychologists or credentialed clinical professionals, teaching and pastoral staff do not receive formal clinical supervision to safely process the

vicarious emotional distress they encounter (Flint, 2017). Without this professional reflective space, educators can become emotional containers for student anxiety, increasing the risk of workplace burnout and emotional exhaustion, which ultimately compromises the long-term sustainability of school care networks. Furthermore, a critical operational mismatch exists between pastoral care frameworks and clinical therapy. While effective psychological intervention relies on strict clinical confidentiality, school pastoral staff operate within a complex educational hierarchy where their welfare duties are bound by institutional policy, disciplinary roles, and legal mandatory reporting requirements (Cardoso *et al*., 2012). This structural reality can conflict with the therapeutic alliance, inadvertently deterring highly anxious students from seeking appropriate support due to fears of surveillance or role confusion.

To bridge this operational divide, the education system requires a scalable structural intervention that clearly defines where educational modification ends and clinical guidance begins. Rather than attempting to retrain teachers as proxy mental health providers that is structurally unfeasible and outside their professional scope, schools need a mechanism that standardises collaboration between educators and clinical experts. We propose that this operational gap can be directly addressed through the prospective implementation of Provisional Exposure Tracks (PETs). Based on the foundational principles of ERP, by shifting from permanent, static accommodations to a dynamic, psychologist-led fading system, the PET framework establishes precise clinical boundaries. The school psychologist retains sole responsibility for designing and monitoring the student's systematic exposure steps, while the classroom teacher is returned to a clear, unambiguous pedagogical role that involves simply executing the specific environmental or assessment arrangements dictated by the current phase of the student’s track. This clear division of labour protects teacher identity, alleviates emotional burnout, and ensures that student care remains systematically aligned with evidence-based clinical principles.

THE PROVISIONAL EXPOSURE TRACKS (PETS) FRAMEWORK

Moving beyond the binary choice of either maintaining static, avoidant accommodations or completely withdrawing student support, the secondary education sector requires a structured, actionable alternative. Rather than attempting to integrate intensive, clinical Cognitive Behavioural Therapy (CBT) directly into universal whole-school initiatives that are typically intended for broad whole-school well-being rather than clinical disorders, schools should implement PETs as a targeted administrative and psychological protocol. A PET operationalises the clinical gold-standard of gradual exposure by transforming standard assessment provisions and accommodations (such as those approved by state or national curriculum authorities) from permanent safety nets into dynamic, fading exposure hierarchies managed within the school environment. While preliminary pilot initiatives like the Psychology School Mental Health Initiative (CMHI) have

demonstrated the feasibility of embedding mental health coordinators in primary school environments (Johnson *et al*., 2025), a structured PET framework provides an explicit blueprint tailored for high-pressure secondary school settings.

To accurately contextualise the scientific contribution of the PET model, its precise scope must be delineated. The originality of the PET framework does not lie in the conceptual discovery of gradual exposure hierarchies, safety behaviour fading, or Cognitive Behavioural Therapy (CBT) techniques, all of which represent established clinical paradigms (Craske *et al*., 2014; Phillips *et al*., 2022). Nor does it seek to replicate Tier 1 universal school-wide resilience curricula or intensive multi-tiered systems of school psychological support. Rather, the novel contribution of PETs resides in its operational synthesis focused on bridging the clinical mechanics of gradual exposure directly into the rigid, administrative tools of school special provisions and accommodations. Whereas conventional school accommodation frameworks treat adjustments as static entitlements that persist indefinitely until an external medical review intervenes, a PET integrates clinical fading schedules directly into the school's administrative authorisation workflow, transforming passive exemptions into active, time-delimited exposure steps.

Furthermore, PETs operationalise a distinct division of labour that protects both pedagogical and clinical integrity within the school ecosystem. Unlike existing collaborative school mental health initiatives that inadvertently burden classroom teachers with executing informal psychological triage (Flint, 2017; Reinke *et al*., 2011), the PET model establishes the registered school psychologist as the clinical case architect and exposure supervisor, while classroom educators operate strictly within their pedagogical domain as environmental administrators. Educators are not expected to evaluate cognitive schemas, monitor safety behaviours, or process clinical affect. Instead, they are simply informed of the environmental parameters authorised for the students' structured phases at different stages. By embedding this protocol within standard school management information systems, PETs provide an institutional bridge between parallel clinical treatments and the everyday realities of the secondary school classroom.

Under this model, an individualized adjustment, such as separate room testing, is approved conditionally alongside a mandatory fading schedule. For example, a student may transition from a private room to a micro-group setting, then to a standard classroom with a designated exit pass, and finally to the main examination hall. This ensures that the immediate academic distress is managed without habituating the long-term avoidant safety behaviours that diminish a student's self-efficacy and could potentially inflate anxiety levels into a need for medicalisation. Crucially, implementing a PET framework addresses the systemic underutilisation of school psychologists by reframing their institutional role. Frequently, these highly trained mental health professionals are restricted to administrative gatekeepers who merely test for special education eligibility, while pedagogical staff are left to navigate complex clinical distress outside their core

professional scope (Millar *et al*., 2013). A PET structure resolves this imbalance by establishing a clear consultative partnership between educators and clinical experts. The school psychologist operates as the central clinical consultant, solely responsible for designing, monitoring, and adapting the student's systematic exposure steps based on clinical criteria. The classroom teacher is then returned to a clear, unambiguous educational role of executing the specific environmental or assessment arrangements dictated by the current phase of the student's track, without being expected to deliver clinical therapy or act as a proxy welfare provider.

OPERATIONALISING THE PET LIFECYCLE

To transition the PET concept from a theoretical proposition into an operationalised protocol, schools require a structured, transparent procedural pathway. Table 1 outlines the six-stage clinical and administrative lifecycle of a Provisional Exposure Track, delineating explicit milestones, gatekeeping roles, and decision points.

Table 1

Multidisciplinary Implementation Protocol for Provisional Exposure Tracks (PETs)

Core Objective	Key Actions	Responsible Actors	Safeguard and Criteria
Phase 1: Triage & Assessment			
Differential screening and eligibility determination	– Conduct clinical interview and functional behavioural assessment – Review diagnostic reports and educational history – Administer validated anxiety rating scales (*e.g.*, RCADS)	School Psychologist in consultation with Student Wellbeing Team	Exclusion Criteria Applied: Primary intellectual disability, active psychosis, unmanaged trauma, severe acute depression/self-harm, or neurodevelopmental accommodations required strictly for accessibility
Phase 2: Collaborative Formulation and Approval			
Shared threat-expectancy mapping and goal setting	– Formulate student-specific catastrophic expectations – Construct a tailored, graduated exposure hierarchy (SUDs 0–100) – Formalise informed parental consent and student approval	School Psychologist, Student, and Parents/Guardians	Transparent discussion establishing that accommodations are provisional, time-limited, and intrinsically linked to gradual reintegration goals

Phase 3: Provisional Implementation			
Baseline temporary accommodation authorised	– Authorise Step 1 temporary adjustment (*e.g.*, isolated testing space with designated return interval) – Register PET protocol on school management system – Transmit clear, non-clinical environmental instructions to teaching staff	School Psychologist (authorisation); Classroom Teacher (execution); Academic Registrar	Adjustments are designated as "Provisional" with an explicit mandatory review date (*e.g.*, 4 to 6 weeks); static, indefinite accommodation status is prevented
Phase 4: Step Progression and Expectancy Testing			
Systematic fading of adjustments to promote inhibitory learning.	– Facilitate planned exposure trials matching the current hierarchy tier (*e.g.*, moving from private room to a micro-group of 3–5 peers) – School psychologist conducts brief post-trial expectancy violation checks – Progress to next fading tier upon demonstrated toleration	School Psychologist (monitoring); Classroom Teachers (environmental compliance)	Advancement Rule: Progression to next exposure tier occurs only when the student successfully completes 2 consecutive exposure trials with disconfirmed catastrophic expectancies and stable emotional regulation.
Phase 5: Multidisciplinary Monitoring and Pause Protocol			
Ongoing safety monitoring, review, and dynamic adjustment.	– Fortnightly check-ins between psychologist and student – Brief behavioural checklists completed by classroom teachers – Quantitative re-administration of anxiety rating scales	School Psychologist, Classroom Teachers, Wellbeing Leader	Relapse or Pause Protocol: If acute panic or functional decompensation occurs, fading is paused immediately. Support reverts to the preceding stable tier for 2 weeks; accommodations are never abruptly withdrawn
Phase 6: Integration & Post-Track Maintenance			
Reintegration into standard conditions and consolidation	– Student transitions into full environmental conditions (*e.g.*, main	School Psychologist, Academic Leadership, Student	Maintenance review at 3- and 6-month intervals post-

	exam hall with standard accommodations) – Consolidate newly formed safety associations and self-efficacy beliefs – Post-intervention evaluation of academic participation and psychological outcomes	completion to assess stability and prevent the emergence of secondary avoidant safety behaviours.

Note: RCADS = Revised Children's Anxiety and Depression Scale; SUDs = Subjective Units of Distress Scale; PET = Provisional Exposure Track.

ELIGIBILITY, APPROVAL, AND SAFEGUARDING PROTOCOLS

Crucially, we propose that eligibility for a PET is restricted to secondary students whose academic impairment is primarily driven by internalising anxiety and avoidant safety behaviours. School psychologists, in direct consultation with external healthcare providers, conduct the initial clinical formulation to ensure that students presenting with neurodevelopmental conditions (*e.g.*, ADHD, Autism Spectrum Conditions), cognitive disabilities, or primary sensory/mobility impairments maintain access to the permanent, static accessibility accommodations to which they are ethically and legally entitled under educational equity legislation (Lovett, 2021). Furthermore, PETs are not applied coercively and instead rely on indispensable clinical pre-requisites via informed parental consent and student assent. Prior to implementing a track, the school psychologist should engage the student in an educational rationale highlighting how gradual exposure will build genuine distress tolerance and restore self-efficacy, transforming the student from a passive recipient of environmental protection into an active agent of their own recovery.

MANAGING SYMPTOM EXACERBATION

A central safeguarding concern in applying exposure paradigms within school systems is the management of acute symptom exacerbation or unexpected functional decompensation. To mitigate the risk of therapeutic distress turning into traumatic overwhelm, we propose that the PET framework should incorporate an explicit, non-punitive pause and reversal protocol. Should a student experience severe panic, marked behavioural decompensation, or escalating school avoidance during a fading transition, the school psychologist should be empowered to immediately pause exposure progression. Rather than viewing temporary setbacks as programmatic failure, the student's accommodations would temporarily return to the preceding successfully consolidated hierarchy step for a consolidation window of two to four weeks. During

this stabilization phase, the clinical formulation is re-evaluated, catastrophic expectancies are reassessed, and smaller intermediate micro-steps are inserted into the hierarchy before gradual fading resumes. Under no circumstances are educational accommodations unilaterally revoked or withheld as an administrative sanction.

The efficacy of such teacher-psychologist collaborative delivery models is well-supported internationally. For instance, evaluations of the Cognitive Behavioural Group Counselling (CBGC) program demonstrate that when educators facilitate school initiatives under the direct training and clinical supervision of licensed psychologists, student resilience and academic emotional regulation improve significantly (Liu *et al*., 2025). Finally, achieving this systemic shift requires a targeted evolution in teacher professional preparation. Rather than a radical paradigm shift that mistakenly trains educators to actively guide clinical exposure, which remains highly unrealistic given existing secondary workloads and professional boundaries, higher education and professional development must focus on anxiety-aware pedagogy. Teacher training should equip educators with a foundational literacy in core CBT principles, specifically focusing on how immediate, unfaded accommodations can inadvertently reinforce avoidance and pathologise normative stress.

This localised training ensures that teachers possess the pedagogical framework needed to support a psychologist-led exposure track within the classroom environment. While teacher-led resilience programs such as the FRIENDS for Life protocol in Ireland (Ruttledge *et al*., 2016) and the My FRIENDS program in Slovenia (Kozina, 2020) have historically demonstrated success in improving generalised coping skills and school connectedness, a PET framework bridges the operational gap for students experiencing severe, targeted anxiety disorders. By systematically de-implementing static adjustments and replacing them with fading exposure tracks, schools can maintain academic equity while providing a rigorous, researchable path toward genuine long-term psychological recovery.

IMPLICATIONS FOR FUTURE RESEARCH

PETs represent an innovative conceptual proposition that has not yet been subjected to controlled clinical trials. Therefore, we propose this as a priority for empirical validation for school mental health research. Future investigations should employ a mixed-methods, quasi-experimental waitlist-control design or a series of single-case experimental designs. This could include, but is not limited to, non-concurrent multiple-baseline across-individuals designs. These methodologies historically are recognised as well-suited for evaluating school-based psychological interventions without denying vulnerable students necessary baseline care (Horner *et al*., 2005; Kratochwill *et al*., 2013). To rigorously evaluate the efficacy, safety, and institutional acceptability of the PET framework, empirical pilot studies should capture a multidimensional matrix of primary and secondary outcome measures across a minimum 12-month longitudinal window.

Clinical anxiety and symptom severity should focus on standardised psychometric assessment of internalising distress, generalised worry, and somatic anxiety utilising validated instruments such as the Revised Children's Anxiety and Depression Scale (RCADS-25/47; Chorpita *et al*., 2005) or the Multidimensional Anxiety Scale for Children (MASC-2; March, 2013), administered at baseline, post-track completion, and at 3- and 6-month follow-up intervals. Functional School Attendance and Refusal should focus on objective administrative tracking of authorised and unauthorised absences, partial-day absences, time spent in student wellbeing offices, and scores on the School Refusal Assessment Scale-Revised (SRAS-R; Kearney, 2002). Academic Self-Efficacy and Engagement should rely on Longitudinal measurement of academic self-efficacy using the Self-Efficacy Questionnaire for Children (SEQ-C; Muris, 2001), coupled with coursework completion rates and standardised examination performance. Accommodation Fading Rate should centre around frequency, intensity, and duration of formal special provisions and informal classroom modifications utilized across academic semesters, quantifying the progression of accommodation de-implementation. Lastly, implementation fidelity and stakeholder burden should involve standardised surveys evaluating educator self-efficacy and perceived workload burden (*e.g.*, the Teacher Efficacy for Inclusive Practices scale), school psychologist caseload sustainability, and qualitative student/parent acceptability metrics gathered via post-intervention semi-structured interviews.

CONCLUSION

Utilising generalised accommodations and special provisions within secondary schools positions the strategy at a critical juncture. Across international jurisdictions, educational accommodations provide indispensable legal equity and academic access for vulnerable adolescents (Lovett & Harrison, 2021; Weist *et al*., 2023). However, when administrative systems implement static, unfaded environmental modifications without clinical oversight, they risk functioning as institutional safety behaviours that inadvertently reinforce avoidant coping mechanisms and consolidate anxiety (Conroy *et al*., 2022; Håland & Bertelsen, 2025). This operational challenge is compounded when secondary educators face role ambiguity, pressured into providing "counselling light" to manage acute student distress without formal clinical supervision or structured triage pathways (Flint, 2017).

To transcend this accommodation paradox, secondary school systems must bridge the divide between pedagogical administration and clinical science. Supporting student wellbeing requires reconciling compassionate academic accessibility with evidence-based psychological treatment. Rather than treating accommodations and exposure therapy as incompatible paradigms, this paper has proposed the Provisional Exposure Tracks (PETs) framework as a scalable conceptual blueprint. Grounded

in contemporary inhibitory learning principles (Craske *et al*., 2014, 2018; Phillips *et al*., 2022), PETs re-engineer temporary accommodations into dynamic, psychologist-led exposure hierarchies executed within clear pedagogical boundaries. By replacing static escape routes with structured, fading exposure pathways, schools can protect academic equity while cultivating authentic long-term resilience, distress tolerance, and self-efficacy among secondary students.

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