ABCs of School Avoidance: Fallout from the Pandemic

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Disclosures

We have no relevant financial relationship with a commercial interest to disclose:

Goals

- Who refuses to attend school?
- What psychiatric disorders and other factors underlie school refusal?
- Are there Interventions built on collaboration and communication between families, schools, Primary Care providers, Mental Health providers, wraparound and crisis services?

School Refusal
Pre-COVID Epidemiology

- Prevalence: 1-5%
- Boys = Girls
- Most common age: transitions
  - 5, 6
  - 10, 11
  - 16-18
- No socioeconomic differences

Post-COVID Epidemiology

- Prevalence: 1-5% unknown
- Boys = Girls unknown
- Most common ages: unknown
- Socioeconomic differences unknown

- All children and teens with anxious/slow to warm up temperament are at risk = 20%

How It Starts

- School avoidance starts after an absence:
  - a holiday, illness, weekend, summer or pandemic (cold swimming pool)
- There are often physical symptoms (headache, stomach ache) that improve if child is allowed to stay home
- Sometimes there is an external trigger, sometimes not!!

Bullying: Chicken or Egg

- Bullying triggers anxiety
- Anxious children are targeted for bullying due to their reactive affect and social isolation
- Anxious children "over-perceive" negative affect in others
- **Bullying should be solved without students missing any school**

Absenteeism's Short-term Consequences

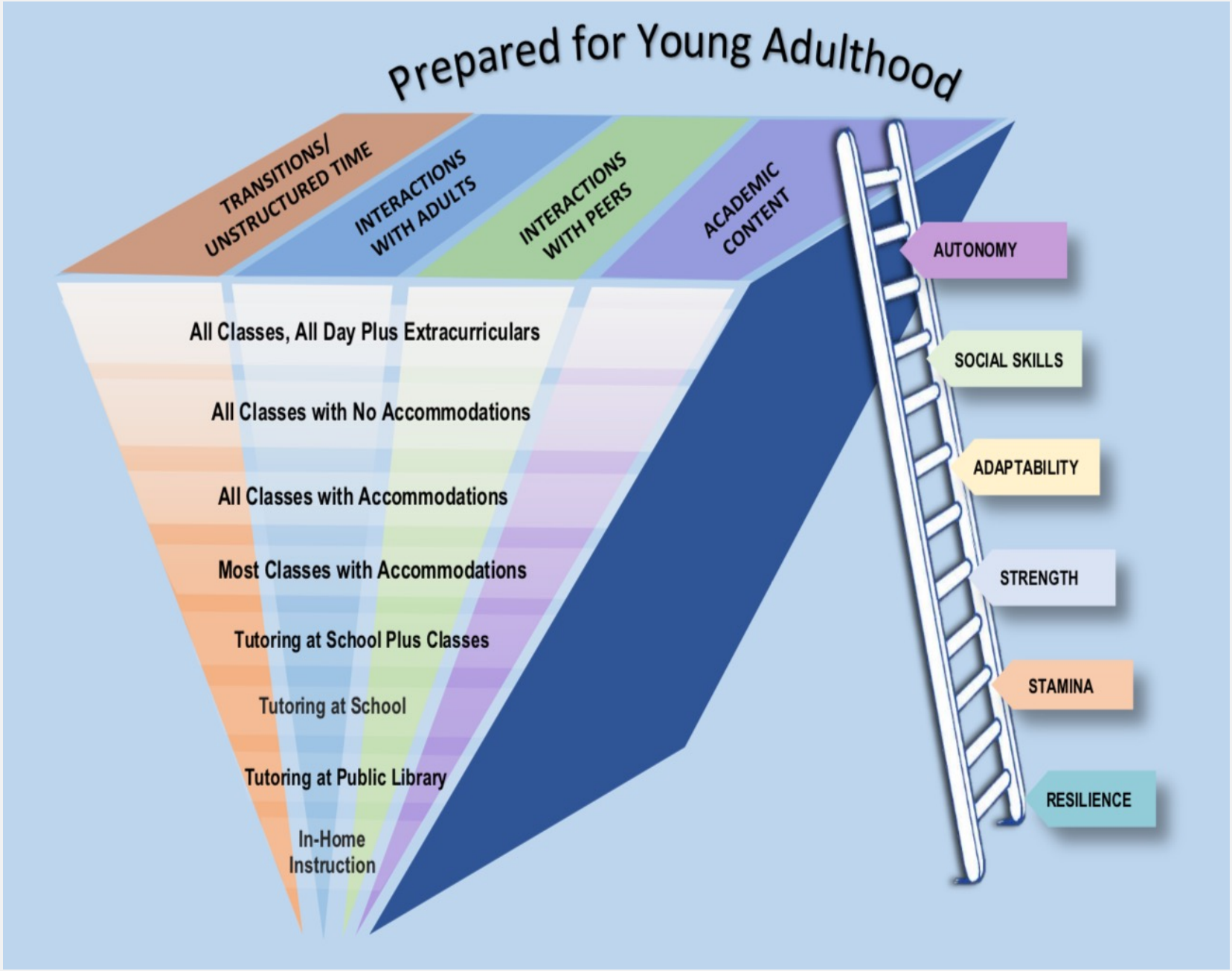
- Falling academic performance and gaps in learning
- Family stress due to practical issues, transportation, appointments, etc.
- Peer relationships suffer by falling "out of the loop"

Long-term Consequences

- Academic underachievement becomes a new norm
- Predicts future employment difficulties
- At increased risk for psychiatric illness as adult – often anxiety, depression and substance abuse

Failure to Launch

Long-Term Outcome of School Refusing Children (Flakierska-Praquin et al. 1997)		
Outcome		**Prevalence (%)**
Still living with parents after 20-year follow-up (failed to launch)		14%
Did not complete high school		45%
Adult psychiatric outpatient care		43%
Adult psychiatric inpatient care		6%
Single and childless at 20-year follow-up		59%



Associated Psychiatric Disorders

- School refusal is a symptom, not a diagnosis
- Anxiety and depression are the most common associated diagnoses
- Children: mostly anxiety
- Adolescents: 50/50 anxiety and mood disorders
- Oppositional Defiant Behavior is often present 25%
- The COVID pandemic has doubled anxiety and depression in children and teens, therefor…

Students Explain School Refusal

(Kearney & Spear, 2014):

- Avoiding emotions provoked by the school setting
- Avoiding social complexity or judgment
- Seeking adult/parental attention
- Seeking tangible reinforcements outside of the school setting (video gaming and social media)

Sleep Hygiene and School Avoidance

- Sleep problems and school refusing behaviors are associated with each other but not causative
- Non-attendance allows sleep cycle shift
- Re-establishing sleep hygiene is very challenging
  - get up early, no naps, no eating during the night, no electronics an hour before sleep or during the night

Parents of School Refusing Children

- increased rate of panic disorder, agoraphobia and depression
- have trouble tolerating child's distress
- have trouble being brief, calm and firm

- Therefore, high incidence of generational transmission of anxiety and avoidance

Useful Adult Interventions: Calm and Firm

- Normalize anxiety
- Challenge catastrophic negative beliefs
- Don’t overly protect child
- Actively problem solve
- Be scientific and objective

- Parents can model:
  - coping and relaxation
  - role playing
  - rehearsal
  - graduated challenges

Limit the Medical Assessment

- Pursue only likely medical causes and determine when "enough is enough"
- The longer the child is out of school, the more difficult it is to return
- Beware the "Home Instruction Letter" request (remember the two facts about anxiety)

Assessment of School Refusal

- Gather information from many vantage points (home, school, daycare, etc.)
- Allot sufficient time and more than one appointment to build trust and empathy
- Clinical Interviews include may include:
  - Family together
  - Child alone or with sibling
  - Caretakers without child

Critical team building

- Collaborate with all team members and providers, especially the "weakest links"
- Get information directly and be wary of biased reporting

Screening and Assessment Tools

- Provide additional information – not diagnostic
- SCARED to assess anxiety
- GAD 7 to assess anxiety
- PHQ 9 to assess depression
- www.projectteachny.org

"A" Getting to Work: Preparing for School Exposure

- Have child/teen get up and dressed
- Take them to busy places, on errands to stores, cousins, camps, sports – to get used to crowds and noise
- Work at the 4 cornerstones of health and mental health
- - healthy eating
- - improved sleep hygiene
- - regular exercise
- - maximum safe social exposure

“B” Help Families Work with the School

- Find their “trusted person”
- Go to walk-through orientations for building transitions or re-entry
- Plan for day 1 (support options at counseling office, school nurse or main office)
- Initial plan might be stepping stones

"C" Exposure by Imagination (in vitro)

- Talk about school (the S word)
- Enthusiastic back-to-school shopping
- Tell reassuring stories about school
- Talk about upcoming routine, sleep needs, etc.
- Ask child what they remember, what their thoughts are and manage distortions

"D" Gradual Live Exposure (in vivo)

- Drive past the school, into the school parking lot, bus loop, front door
- Take full advantage of orientations and tours
- Take full advantage of walk through opportunities, meeting teachers, modeling curiosity and managing anxieties
- Try to meet teacher and "trusted person" before school starts
- "Prepay" anxiety in August to decrease anxiety on day 1

"E" CBT Psychotherapy Treatment

- CBT - Exposure-based Cognitive Behavioral Therapy has the most empirical support for the treatment of anxiety disorders in youth
  - Psycho-education
  - Somatic management skills training (relaxation, diaphragmatic breathing, self-monitoring)
  - Cognitive restructuring (challenging negative expectations and modifying negative self-talk)
  - Exposure methods
  - Relapse prevention plans (booster sessions and coordination with parents and school)
  - Coping Cat (Kendall, 1990)

The CAMS Study Findings

- Exposure-based Cognitive Behavioral Therapy

  50-60% efficacy

- SSRI antidepressants (sertraline)

  50-60% efficacy

- Combination

  80% efficacy

- Placebo

  24% efficacy

"F" Medication Treatment

SSRI antidepressants should be considered for the treatment of youth with anxiety and/or depression with:

- Severe symptoms
- Impairment that makes psychotherapy difficult
- Partial response to good therapy

Medication Treatment Studies: Evidence for Efficacy

- Fluvoxamine (Rupp 2001)
- Fluoxetine (Birmaher 2003)
- Sertraline (Brawman-Mintzer 2006)
- Sertraline (Walkup 2008 CAMS)
- Duloxetine (Wright 2009)

Summary of Management of School Avoidance

- Gradual exposure to build mental muscles
- Helping parents find calm and firm "parent power"
- Building a collaborative team

In more severe cases:

- CBT Therapy with exposure for kids and families
- Medicine when necessary for more serious anxiety and depression

Websites

- Understood.org
  "What to do if Your Child Refuses to go to School"
- www.childanxiety.org
- www.aacap.org
- www.mentalhealth.samhsa.gov
- www.projectteachny.org

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Q & A

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