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FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Difficult Cases: School Refusal

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School Refusal

- Why is school refusal difficult to manage?

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Epidemiology

- Prevalence: 1-5%
- Boys = Girls
- Most common ages:
  - ages 5, 6
  - ages 10, 11
  - But can occur any age!
- No socioeconomic differences

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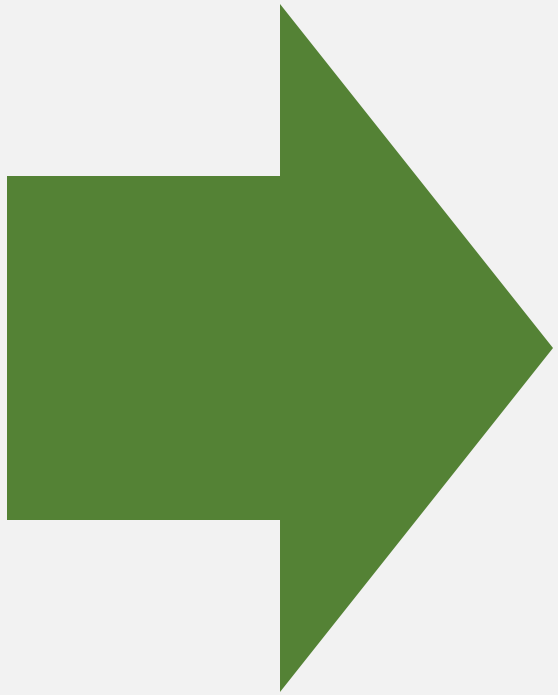
Urgent Situation?



THE LONGER THE CHILD IS OUT OF SCHOOL, THE MORE DIFFICULT IT IS TO RETURN

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Short-term Consequences

- Poor academic performance
- Family difficulties
- Problems with peer relationships

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Long-term Consequences

- Academic underachievement
- Employment difficulties
- Increased risk for psychiatric illness

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What does this mean to you (us)?

- It means intervention/treatment steps to facilitate return to school must start immediately and often before all diagnostic questions are answered!
  - Requires comfort with uncertainty
    - for providers, as well as parents and ultimately the child

Clinical Features

- Gradual and sneaky or sudden onset
- Symptoms may begin after a holiday, vacation, or illness
- Weekends, vacations exacerbate symptoms
- Stressful events – home, school, peers may trigger refusal
- Some have difficulties as they get closer to school
- Some children make no effort to leave home
- Fear, panic symptoms, crying episodes, temper tantrums, threats of self-harm, somatic symptoms

Causes

- Heterogeneous and multi-casual
- Serves different functions depending on the child
- Avoidance of specific fears provoked by the school environment
  - Test-taking situations
  - Bathrooms
  - Cafeterias
- Escape from aversive social situations
  - Children (Bullying)
  - Teachers
- Separation Anxiety
  - Parent, family member

A Variety of Dysfunctional Family Interaction Patterns

- Over-dependency
- Detachment with little interaction among family members
- Isolation with little interaction outside the family unit
- High degree of conflict

Associated Psychiatric Disorders

- School refusal is not a psychiatric diagnosis
- Related emotional distress is significant
- Anxiety and depression most common
- Children: anxiety symptoms
- Adolescents: anxiety and mood disorders

Psychiatric Disorders in Children with School Refusal

(Bernstein et al 1991)

Diagnosis			Percentage
Anxiety Disorders			54%
	Separation Anxiety		20%
	Anxiety Disorder, NOS		12%
	Generalized Anxiety Disorder		8%
	Social Phobia		6%
	Panic Disorder		4.5%
	Panic Disorder with Agoraphobia		3%
	Agoraphobia		.5%
Mood Disorders			52%
	Major Depression		30%
	Dysthymia		22%

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Psychiatric Disorders in Children with School Refusal

(Bernstein et al.1991)

Diagnosis			Percentage
Disruptive Behavior Disorders			38%
	Oppositional Defiant Disorder		24%
	Conduct Disorder		3%
	ADHD		6.5%
	Disruptive Behavior Disorder, NOS		5%
Other Disorders			27%
	Adjustment Disorder (with mood and/or anxiety)		26%
	Learning Disorder		5.5%
	Substance Abuse		2.5%
	Other		1.2%

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Final Piece of the Assessment

Collaboration with school staff regarding efforts so far to work with the child and family

- History of attendance of this child and siblings
- Review of attendance records, report cards, and any available psycho-educational evaluations

Intervention

- Primary goal – early return to school
- Avoid written excuses for Home Instruction unless a medical condition makes it necessary
- Treatment should focus on underlying psychiatric conditions, family dysfunction, and other contributing factors

Intervention

Because anxious children often present with physical symptoms, the Primary Care Provider may need to take a stand and explain that the problem is a very real physical manifestation of psychological distress and anxiety rather than a sign of a physical illness.

Treatment

MULITMODAL, COLLABORATIVE, TEAM APPROACH !!!

- Primary Care Provider
- Child
- Parents
- School Staff
- Mental Health Professional

Treatment – General Principles

- Parent involvement is critical
- Exposure to school is critical

Must take into account:

- Severity of symptoms
- Co-morbid diagnosis
- Family dysfunction
- Parental psychopathology

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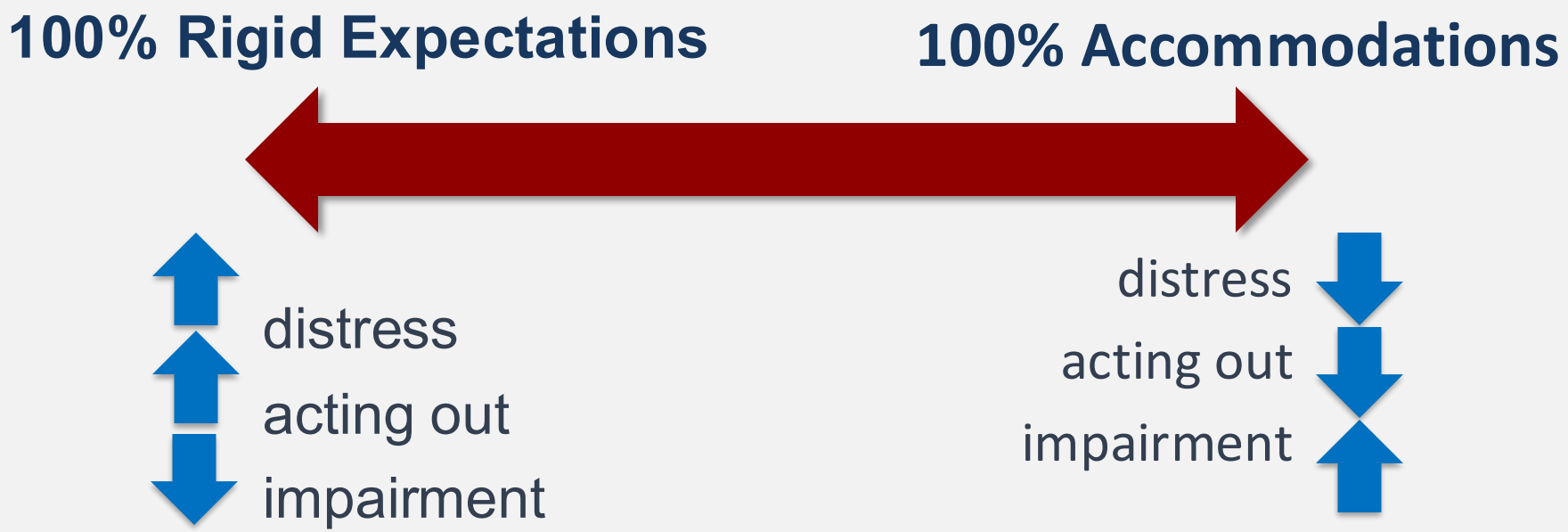
Where are the child, parents, pediatrician, and therapist on this spectrum? (Teamwork vs. Polarization)



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Treatment

- For younger kids and milder symptoms, working directly with parents and school personnel WITHOUT direct intervention with child can be effective
- With teen and more severe situations, you must work with child, parents, and school staff, especially if difficulties include prolonged school absence, severe co-morbid psychiatric diagnosis, and deficits in social skills.

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Behavior Interventions

- Primarily exposure-based treatments
- Focus on child's behaviors rather than intra-psychic conflict
- Emphasize treatment in the context of family and school

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Behavior Interventions

- Systematic desensitization
  (graded exposure to the school environment)
- Relaxation training
- Emotive imagery
- Contingency management (positive reinforcement)
- Social skills training

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Cognitive Behavior Interventions

- Cognitive behavioral therapy (CBT)
  - Specific instructions for children to help gradually increase their exposure to the school environment
  - Children are encouraged to confront their fears and are taught how to modify negative thoughts

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Medication Interventions

- Any anxiety disorder (or other disorder) associated with school refusal should be considered severe and treated accordingly.
- Medication strategies should ensure adequate trials at adequate doses.
  - Don’t wait for medication effect to initiate behavioral interventions
  - Given the urgency, consider quick titrations to target dose

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Parent - Teacher Interventions

Consultation with school personnel

- Specific recommendations to school staff to prepare for the child's return
- Make use of the strongest school-based relationships
- Use of positive reinforcement
- Academic, social, and emotional accommodations that taper (Atypical but possible 504 Plan)