connect

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Connecting People in Need with Care

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School Avoidance in Children and Youth

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PRESENTER DISCLOSURE

- **Presenter:** Olivia MacLeod
- **Relationships with commercial interests:** *None*
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LEARNING OBJECTIVES

1) Perform a comprehensive assessment of school avoidance behavior

2) Suggest various approaches to manage school avoidance behavior

3) Discuss the body of evidence that exists for school avoidance behavior

Please feel free to ask questions!

School Refusal Behaviour

- Definition:
  - "Difficulty attending school associated with emotional distress, especially anxiety and depression"

(King and Bernstein, 2001)

  - "Child-motivated refusal to attend school or difficulties remaining in school for an entire day"

(Kearny and Silverman, 1996)

  - Truancy vs. emotional distress

Why is Assessment and Treatment Important?

- Significant adverse consequences:
  - Short-term: (Last and Strauss, 1990; Naylor et al., 1994; Berg and Nursten, 1996)
    - Poor academic performance
    - Family difficulties
    - Peer relationship problems
    - Interferes with social and educational development
  - Long-term: (McCune and Hynes, 2005, Kearney and Albano, 2000)
    - Fewer opportunities to attend higher education
    - Employment problems
    - Social difficulties
    - Increased risk for later psychiatric illness
  - School attendance is mandated by law

School Avoidance: Prevalence

- Difficult to quantify, because includes:
  - Complete absence
  - Initially attend, then leave during school day
  - Attend after having morning tantrums or somatic complaints
  - Youth who display marked distress on school days and plead to be allowed to stay home
  - May be demonstrated as partial absences, lateness, or poor school engagement
- Estimated at **5% of all school-age children,** all SES, M=F (King and Bernstein, 2001)
- Incidence peaks at ages 5-7, 11 and 14 years (Heyne et al, 2001)

Epidemiology - Diagnosis

- Diagnostic evaluation study (Berg et al., 1993)
  - N=80, age 13-15, Absent <40% of school term,
    - 50% had psychiatric disorder
    - 33% had disruptive behaviour disorder
    - 20% had mood or anxiety disorder
  - Control group
    - 10% had psychiatric disorder

Epidemiology - Diagnosis

- Anxiety-based school refusal study (Last and Strauss, 1990)
  - School-refusers referred to anxiety clinic, age 7-17, n=63
    - 38% Separation Anxiety Disorder (mean age onset = 9)
    - 30% Social Anxiety Disorder (mean age onset = 12)
    - 22% Specific Phobia (mean age onset = 13)
    - Less frequent: PTSD, panic disorder
    - GAD was common co-morbid diagnosis
  - Study comparing co-morbid depression and anxiety with just anxiety
    - Co-morbid group had greater symptom severity

Somatization and Physical Conditions

- Infectious diseases or surgical procedures
  - May precipitate chronic school absenteeism in anxious youth
- Asthma is a leading cause of absenteeism worldwide
  - Youths with asthma miss 1.5 – 3.0 times more school days that youth without
- Somatic symptoms (no medical cause found)
  - Physical manifestation of anxiety and/or attempts to solicit caregiver permission to stay home
  - Very common: half of all-cause school refusers (Stickney et al, 1998)
  - Most common were autonomic and GI symptoms (Bernstein et al, 1997)

Family Functioning

- Families of youth with school refusal:
  - Higher than controls on measures of: (Kearney and Silverman, 1995)
    - Enmeshment
    - Conflict
    - Isolation
  - Families of school refusers with comorbid anxiety and depression: (Bernstein et al, 1999)
    - 50% of youth, 38% of fathers and 24% of mothers rated family as “extreme” on scales of unbalanced functioning
  - Significantly fewer family functioning difficulties in youth with just anxiety vs. comorbid depression and anxiety, or disruptive behaviour disorders

Assessment

- Clinical interview
- Clinical rating scales
  - Severity of anxiety and depression symptoms
  - Specific school refusal questionnaires
- Assessment of family functioning
- Psychoeducational and language assessment
- Review of school attendance

School Refusal Scales

- School Refusal Assessment Scale - Revised (SRAS-R) (Kearney, 2002)
  - Evaluation of contingency factors maintaining behaviour (i.e. due to negative vs. positive reinforcement)
  - Completed by child, parent, teachers
  - Four primary "maintaining variables":
    1) Avoidance of stimuli that provoke negative affectivity (e.g. fear, anxiety, depression)
    2) Escape from aversive social or evaluative situations (e.g. class presentations, groups of peers)
    3) Attention-getting behaviour or traditional separation anxiety (e.g. tantrums to obtain parental attention)
    4) Reinforcers outside of school (e.g. video games at home)

Treatment

- Multimodal treatment plan
  - Psychoeducation and consultation to school
  - Behavioural or cognitive-behavioural strategies
  - Family interventions
  - Pharmacological interventions (if warranted by severity of symptoms)

- Home tutoring is generally contraindicated

Psychosocial Interventions

- Study on ungraded exposure treatment (flooding) for school refusal (Blagg and Yule, 1984)
  - N=66, high school age, matched to 3 groups:
    - Flooding (careful preparation, then forced return to school with escort for as long as necessary)
    - Inpatient treatment
    - Home tutoring and psychotherapy
  - Year following treatment, flooding 93% success, inpatient 38%, home tutoring 10%
  - Flooding was most rapid (2 ½ weeks) and cheapest
  - Note: Flooding group was significantly younger, with shorter period of absence, therefore may only be relevant to this population

Psychosocial Interventions

- Review of interventions for school refusal behaviour (Pina, et al, 2009)
  - 7 group-design studies
    - Most included combination of behavioural strategies (e.g. exposure, relaxation training, contingent reinforcement) and cognitive strategies (cognitive restructuring, coping plans)
    - All studies showed improvements in attendance and symptom measures (anxiety, depression, externalizing problems, self-efficacy)
    - Long-term gains maintained (only 2 studies extended to 24 months)

CBT Strategies

- Manualized CBT or self-directed workbooks developed for each 4 functional conditions (Kearney 2007)
  1) **Avoidance of negative affectivity**
     - Psychoeducation about anxiety, somatic calming techniques, gradual re-exposure using hierarchy, self-reinforcement of gains
  2) **Aversive social or evaluative situations**
     - Psychoeducation about anxiety, somatic calming techniques and practice in real life, cognitive restructuring, gradual re-exposure using hierarchy, self-reinforcement of gains
  3) **Seeking parent attention**
     - Modify parent communication toward brevity and clarity, set morning and other daily routines, rewards and punishments, forced school attendance in specific cases
  4) **Tangible rewards with staying home**
     - Increasing incentives for attendance and disincentives for nonattendance, problem solving, communication skills, school escort as necessary, increase attendance monitoring, peer refusal skills training (saying “no” to peers who want to skip)

Is Prescriptive CBT More Effective than Non-prescriptive?

- Compared non-specific CBT (relaxation and cognitive therapy without exposure) to targeted behavioural treatments developed for each 4 functional conditions (Kearney and Silverman, 1999)
  - Advantage of prescriptive over non-prescriptive approach was "large" (*d*=4.64)
  - Treatment effects varied between domains (greater for anxiety symptoms, less for depressive symptoms)
  - Those in non-prescriptive group later offered prescriptive treatments, and then showed improvement

Is CBT More Effective Than Supportive Therapy?

- Comparison of individual CBT and "educational support" (Last, et al. 1998)
- Educational support = psychoeducation, supportive counseling with no attempts to confront fears or restructure thoughts and daily journaling)
- N=56, anxiety disorder + 10% absenteeism from class over past month
- Both groups showed improvements in attendance, anxiety, depression and global improvement ratings; 50 – 65% no longer met criteria for anxiety disorder
- **No differences between groups**
- 35% of CBT completers did not achieve remission
- 60% of CBT completers had difficulty following school year

Is CBT More Effective When Parents and Teachers are Involved?

- Comparison of individual CBT, Parent and Teacher Training (PTT) or combination (Heyne et al., 2002)
  - PTT = training in child behaviour management (problem solving, positive reinforcement) and helping parents manage own anxiety and understand their influence on child's behaviour
  - All 3 groups showed significant improvement
  - PTT > combo > ICBT (not statistically significant)
  - May suggest PTT enhances efficacy of standard CBT

Pharmacotherapy

- Fluoxetine for School Refusal (Melvin, et al, 2016)
  - N=62, anxiety disorder, age 11 – 16.5yrs
  - Randomized to CBT, CBT+fluoxetine (10-60mg, m=23mg) or CBT+placebo
  - All 3 groups: improved attendance and decreased symptoms, no significant difference
  - Overall, attendance increased from 15% to 52% (maintained at 6, 12 months)
  - FLX group increased to 72% attendance at 12 months
  - Decreased SI/NSSI in CBT+FLX group
  - Increased patient satisfaction in CBT+FLX group
  - Rate of anxiety disorder diagnosis decreased at follow up (100%, 73%, 55%, 29%), as well as depression (58%, 24%)
  - Only 34% reached 80% attendance

School Liaison

- Encourage a meeting with school guidance department or principal
- Written or telephone correspondence with teachers and guidance counselors
  - Psychoeducation on the student's mental health conditions
  - Suggested classroom accommodations; Individualized Educational Plan (IEP) and/or Individual Placement and Review Committee (IPRC)
  - Consider reduced course load or half days
  - Consider completing work in resource room
  - Educate about the importance of exposure above academic progress
  - If above measures fail, consider alternate programs

Alternate Programs

- **Primary Grades:**
  - Behavioural Classroom
  - E.A. Support
- **Secondary Grades:**
  - Resource room access
  - Spare period or half days
  - In-home tutoring (SAL Program)
  - Alternative Jr. High / High schools
  - Technical High schools

Section 23 Classrooms

- In Ontario, Section 23 Classrooms are a partnership between a mental health agency (community or hospital) and school board
- Education for students whose mental health needs are such that they are unable to attend a regular school setting
- Purpose is for students to be able to continue their educational experience while obtaining necessary treatment

Back on Track

Summary

- School avoidance is a multi-factorial problem with serious short and long term consequences
- All youths with school avoidance behaviour should be assessed for anxiety and depression
- Assessment should also evaluate family functioning and environmental reinforcers that are maintaining the problem
- Optimal treatment includes psychotherapy (CBT, with focus on prescriptive behavioural exposure), psychopharmacology (when indicated) and family interventions
- It is essential for the primary care/mental health clinician to liaise with school-based personnel to provide psychoeducation, suggest accommodations and discuss alternate educational options if necessary

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Questions or Comments?

Cases to discuss?

Ideas on how to enhance collaborative care in school avoidance?