School avoidance and refusal: What clinicians need to know

David M. Jacobi, PhD, and Andrea Hartman, PsyD

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ROGERS Behavioral Health

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Disclosures

David M. Jacobi, PhD, and Andrea Hartman, PsyD, have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe the four functions of school refusal behavior
2. Identify four problematic and four appropriate accommodations for a child who refuses school
3. List four ways in which parents and school personnel can assist with return to school

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What we'll cover in this webinar

- Diversity factors related to school avoidance and refusal
- School refusal behaviors, functions, and consequences
- Cognitive behavioral treatment for school refusal motivated by anxiety disorders
- Special considerations for accommodations related to school refusal and anxiety
- Including caregivers and school personnel to support with school success
- Case discussion
- Moderated Q&A

Please use the Q&A feature to send your questions to the moderator.

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Diversity factors related to school avoidance and refusal

Please use the Q&A feature to send your questions to the moderator.

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Diversity-related factors leading to absenteeism

- **Child factors** – trauma, history of absenteeism
- **Parent factors** – low expectations for school performance/attendance, language/ cultural differences between parents and school personnel
- **Family factors** – poor access to educational aids, poverty
- **Peer factors** – gang activity, pressure to leave school, bullies
- **School factors** – dangerous location, inadequate response to diversity
- **Community factors** – unsafe neighborhoods, gang activity, lack of support/educational services

(Kearney, 2018)

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Diversity and treatment

Barriers to treatment
May include cost, transportation, stigma, fear of therapy, lack of awareness of anxiety symptoms and proven treatments for anxiety, lack of providers trained to treat anxiety, cultural beliefs barring involvement in mental health treatment

Symptom dimensions
Misdiagnosis of anxiety and related disorders and may not receive appropriate care

Comorbidity
Majority of those with anxiety and related disorders have co-occurring disorders (mood, substance use) which can complicate diagnosis and treatment

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School refusal behaviors, functions, and consequences

Please use the Q&A feature to send your questions to the moderator.

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What is school refusal?

Refers to children and adolescents who refuse to attend school **– *or* –** aren't able to stay in school the full day due to anxiety.

- As many as 28-35% of children demonstrate school refusal behavior
- Problem occurs equally among boys and girls
- Most are between the ages of 10 and 13 years old, but may also occur at times of new school changes (5-6 and 14-15) or any life transition

(Kearney, 2018)

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Definitions

School refusal – Missing school due to anxiety-based issues

School refusal behavior – child refusing to attend school and/or difficulty staying in class for the entire day

Acute school refusal behavior – refusing school for two weeks to one year, more days than not

Chronic school refusal behavior – refusing school for more than one calendar year; usually affects at least two academic years

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Problematic school refusal behavior

- Has missed a minimum of 25% of total school time over the past two weeks
- Experiences severe difficulty attending school over the past two weeks that is associated with significant disruption in child or family function
- Is absent* from school for 10 days or more during any 15-week period

* *Absence defined as missing at least a quarter of the school day*

(Kearney & Albano, 2018)

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What does school refusal behavior look like?

Internalizing	Externalizing
Social anxiety	Tantrums
Withdrawal	Verbal/physical aggression
Depression	Reassurance seeking
Fatigue	Clinging
Stomachache	Refusal to move
Headache	Noncompliance
	Running away from home

(Kearney & Albano, 2018)

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Functions of school refusal behavior

Negative reinforcement

- To avoid stimuli that trigger experiences of anxiety, depression, somatic issues
- To escape social or other evaluative situations

Positive reinforcement

- To receive attention outside of the school setting
- To obtain rewards

(Kearney & Albano, 2018)

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Consequences of school refusal behavior

- Associated with lower academic performance and achievement
  - Lower reading and mathematics scores, literary skills and grade retention
  - Increased risk of dropout
- Increased involvement with the juvenile justice system
- Increased likelihood for psychiatric, occupational and marital problems in adulthood

(Kearney, 2016)

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Cognitive behavioral treatment for school refusal motivated by anxiety disorders

Q&A Please use the Q&A feature to send your questions to the moderator.

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What are the anxiety disorders?

Per *DSM-5*:

- Generalized anxiety disorder (GAD)
- Separation anxiety disorder
- Social anxiety disorder
- Selective mutism
- Panic disorder

OCD moved out from under the Anxiety Disorder section, into a new diagnostic category: Obsessive Compulsive and Related Disorders Obsessive-compulsive disorder (e.g., BDD, Hair pulling disorder, Hoarding disorder)

PTSD also moved out and was placed in a new category: Trauma and Stressor-related Disorders (e.g., RAD, Disinhibited social engagement disorder, adjustment disorders)

(APA, 2022)

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Examples of anxiety in school

- Test anxiety
- Checking for mistakes
- Incomplete assignments due to perfectionism
- Reassurance seeking from teachers
- Being called on in class
- Worries about stuttering when talking in class
- Being away from caregivers
- Eating in the lunchroom
- Contaminated school items (e.g., desk, bathroom, chair)
- Talking with other peers
- Participating in physical education (gym class)

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Clinical assessment

- Frequency of school refusal due to:
  - ***Distress about something at school***
  - ***Avoidance of unpleasant social or performance situations at school***
  - Being able to get attention from a caregiver or significant other
  - Being able to get tangible rewards from some source outside of school
- School/classroom observation

(Kearney & Albano, 2018)

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Clinical Assessment

Measure	Description	Interpretation
School Refusal Assessment Scale-Revised	A 24-item self-report inventory used to evaluate school refusal symptoms in children and identify their reasons for school avoidance and refusal.	Each item is scored on a 0-6 scale and contributes to a different function which may be contributing to a child's school refusal behaviors. The function with the highest mean score is considered to be the primary cause of school refusal. Four functions: 1) Avoidance of stimuli provoking negative affectivity 2) Escape from aversive social and/or evaluative situations 3) Attention seeking 4) Tangible rewards
Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)	Used to assess both current and past symptoms in child and adolescent patients with obsessive compulsive disorder (OCD).	Scores range from 0-40. Patients scoring in the mild or higher rage are likely experiencing a significant negative impact on their quality of life. Severity Range: 0-7 = Subclinical 8-15 = Mild 16-23 = Moderate 24-31 = Severe 32-40 = Extreme
Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA)	24-item measure designed for children older than age 7. The LSAS-CA assesses both fear and avoidance associated with activities in school and social settings that a patient has experienced in the past week. Each item is given both a fear score and an avoidance score rated from 0 (no anxiety/never avoid) to 3 (severe anxiety/usually avoid).	Total scores range from 0-144. Higher scores indicate greater social anxiety. Severity Range: 55-64 = Moderate Social Anxiety 65-79 = Marked Social Anxiety 80-94 = Severe Social Anxiety 95-144 = Very Severe Social Anxiety

(Kearney & Albano, 2018)

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Setting up treatment for success

- Monitoring of behaviors and mood
- Coordinating with school and other medical or mental health providers
- Clear goals for the end of treatment and alignment from caregivers involved in supporting the patient
- Clear expectations for school attendance based upon the patient's current ability to attend school
  - Morning, afternoon, lunch, favorite time of day, attendance in non-classroom setting, combination

(Kearney & Albano, 2018)

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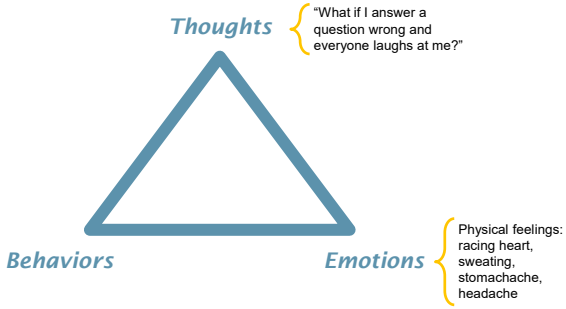
Cognitive-behavioral treatment



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Core treatment components

- Creating a list of situations that the patient finds anxiety-provoking and avoids
- Facilitating exposure to anxiety-provoking situations via an exposure hierarchy
- Supporting patients in practicing the skills in real-life social situations
- Increasing patient's ability to praise themselves for coping with negative emotions

(Kearney & Albano, 2018)

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Core treatment components

- Developing skills to increase physical relaxation
- Identifying what the patient tells themselves in anxiety-provoking situations
- Changing negative thoughts to more effective coping statements

(Kearney & Albano, 2018)

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Exposure treatment

- Placing an individual in feared situation
  - Needs to be *prolonged enough* to lead to habituation during an exposure to the feared situation
  - Needs to be *repetitive enough* to lead to habituation in between exposures
  - Needs to be *graduated*
- Blocking the typical response (e.g., compulsion, avoidance, safety behavior) *before, during, and after exposure* so habituation can take place

Overall, leads to more accurate beliefs about feared stimuli, reduced anxiety, and increased ability to cope/tolerate distress

(Abramowitz, Deacon, & Whiteside, 2019)

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Exposure treatment

- Imaginal exposure (e.g., worry script)
- *In vivo* exposure
- Interoceptive exposures
- Eliminating safety behaviors

(Robichaud, Buhr, & Antony, 2018; Khanna & Ledley, 2018))

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Examples of safety behaviors

- Repeated questioning
- Rewriting and erasing
- Carrying certain objects to “feel better” (e.g., water bottle)
- Wearing earplugs
- Clinging to caregivers
- Having someone else make decisions on their behalf

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Anxiety and avoidance hierarchy development

- Based on information gathered from clinical assessment and conversation with patient and family
- Create a list of objects and situations that will be targeted throughout treatment
  - Rank situations from easiest to hardest
  - Be creative
  - Include accommodation
  - Include avoidance

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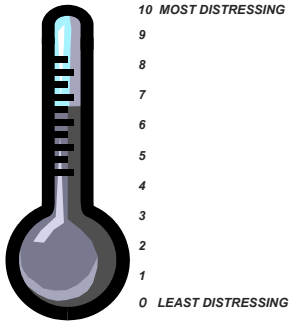
Measuring fluctuations in anxiety

- Use a consistent scale (e.g., 0-7, 0-10, 0-100)
- Discuss how fears can be ranked and may differ
- Rating of anxiety and avoidance of the objects and situations at each session
- Assists with development of anxiety and avoidance hierarchy



(Kearney & Albano, 2018)

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Example hierarchy

Situation, Object, or Place	Anxiety Rating	Avoidance Rating
Staying in school all day without contacting parents	7	7
Raising hand in school and answering a question wrong	6	7
Volunteer to read out loud or write on the board	6	6
Raising hand in school and answering a question	6	6
Staying in school all morning without contacting parents or going to the nurse	5	5
Waiting for caregiver to pick up from school with caregiver being late	5	5
Getting clothes ready the night before school	4	4
Call a peer from school and ask bout school homework	4	4
Having tutoring at school without a caregiver present	4	4
Asking the tutor an obvious question	3	3
Going to school to pick up homework and visit the teacher	3	2
Going to lunch at school	3	3
Meeting with tutor at home while caregiver is not present	3	2
Starting a conversation with someone I know	2	2

(Kearney & Albano, 2018)

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Somatic skills

Additional support when experiencing a full-blown anxiety reaction

- Progressive muscle relaxation
- Breathing retraining
- Paired muscle relaxation

(Kearney & Albano, 2018)

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Younger Children

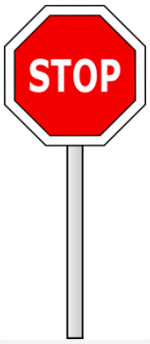
Identifying and challenging negative thoughts

S = Are you feeling scared?

T = What are you thinking?

O = Other helpful thoughts

P = Praise yourself for using these steps and plan for the next time



(Kearney & Albano, 2018)

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Older Children

Identifying and challenging negative thoughts

1. Identification of automatic thoughts (e.g., all-or-nothing thinking, catastrophizing, mind reading)
2. Teaching the patient to recognize cues or triggers for anxiety
3. Conducting the exposure
4. Processing after the exposure to examine the thoughts and behaviors that occurred during the exposure
5. Challenging the negative thoughts with evidence from the exposure
6. Praising yourself for using these steps and plan for the next time

(Kearney & Albano, 2018)

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Healthy, realistic thinking vs. positive thinking

Healthy thinking

- Realistically examining the situation and the resources available to manage the situation
- Focused on problem solving and task management, and adaptive thoughts

Positive thinking

- Can interfere with focusing on and accomplishing a task
- Doesn't provide real information or coping solutions for the child to rely on and use
- Can perpetuate child's physical tension, negative thoughts, and poor performance

(Kearney & Albano, 2018)

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Key strategies throughout treatment

- Provide praise and encouragement for any degree of participation or effort, particularly at the beginning
- Reduce accommodation (e.g., reassurance) alongside exposure work
- Incorporate and maximize the use of homework
- Process exposures briefly with patient in order to provide feedback about what happened to the patient's anxiety during the exposure

(Kearney & Albano, 2018)

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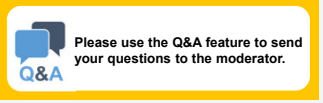
Special considerations for accommodations related to school refusal and anxiety



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Reasons to miss school

Temp of 100º or higher
Recurrent vomiting
Bleeding
Lice
Severe diarrhea
Severe flu or asthmatic symptoms
Severe medical condition – pain/contagious disease

Not good reasons:

- Headache (migraines)
- Tummy ache
- Oversleeping/trouble getting out of bed
- Tired
- Body aches
- medication side effects
- Conflicting appts.

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Accommodations

Problematic accommodations

- Being allowed to leave the classroom at any time
- No limits on amount of time spent taking breaks
- Being allowed to use cell phone against school policy
- Greatly reduced workload
- Parent/Guardian completing schoolwork for child
- Calling child in sick when they do not meet American Medical Association guidelines
- Making frequent changes in classroom assignment and/or school setting
- Rearranging parent/guardian schedules
- Not providing consequences

(Calvocoressi et al., 1995; Lebowitz et al., 2013)

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Accommodations

Appropriate accommodations

- Child can leave the classroom to take a break when anxiety is a 7/10 or higher
- Break is taken in a quiet and supervised place – typically the guidance office
- Break is time-limited, and child is expected to return to class – typically no more than 15-20 minutes
- Child is expected to use a relaxation skill and/or thought challenging during the break
- Breaks should be mostly independent and processing with school personnel limited

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Consequences for school refusal

Once the expectation is set for attending all or part of the school day, consequences for not attending should also be made clear, including:

- Limited verbal and physical attention
- Reducing access to isolation
- Removal of access to electronics
- Removal of access to other enjoyable activities
- Options for time period they are expected to be at school:
  - Schoolwork
  - Chores
  - Treatment work
  - Sitting quietly alone

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504 plan

Rehabilitation Act of 1973

- Federal statute that requires the needs of people with disabilities to be met as adequately as the needs of those without disabilities
  - Disability is defined as a “mental or physical impairment that substantially limits one or more major life activities.”
  - Examples: asthma, allergy, injury, anxiety disorder, depression
- Any school or institution receiving federal funding must comply
- Any student between the ages of 3 and 22 can qualify
- No formal testing is required, and anyone can refer the child for evaluation

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Individualized Education Plan (IEP)

Individuals with Disabilities Education Improvement Act (IDEA) of 1990

Federal statute that funds special education programs

- Any school or institution receiving federal funding for special education services must comply
- Any student between the ages of 3 and 21 whose disability adversely affects the child's educational performance or ability to benefit from general education
- Multifactor evaluation and legal documentation is required for approval
  - Parents can request outside assessment if they disagree with the school's evaluation

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Other options if child behind on schoolwork

- Credit recovery – School may offer opportunities for child to work independently or with the help of tutors to complete some or all of missing work
- Ask for a reduction in homework / alternate way to demonstrate knowledge
- Summer school
- GED
- Virtual school

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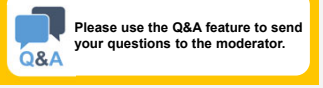
Including caregivers and school personnel to support with school success



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Caregiver involvement in treatment

- Provide psychoeducation on diagnosis, symptoms, and impact on school functioning, and treatment
- Obtain alignment from caregivers on treatment goals and expectations
- Discuss parental involvement with school coordination

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Caregiver strategies for school success

- Supporting and engaging with treatment homework (e.g., exposures, reducing/eliminating accommodation related to anxiety)
- Clear expression of beliefs that your child can be successful at school
- Problem solving and intervening when appropriate (e.g., bullying)
- Establishing consistent bedtime and morning routines
- Establishing consistent family routines (e.g., who packs lunches)

(Kearney, 2018)

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Caregiver strategies for school success

- Differential attention
- Establishing formal rewards and consequences for school attendance and schoolwork completion
- Creating a dedicated time and space for schoolwork
- Maintenance of “school schedule” during breaks
- Not reinforcing negative beliefs or distress by rescuing child

(Kearney, 2018)

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Caregiver strategies for school success

- Creating “cope ahead” plans
  - To tolerate caregiver distress
  - To make a plan for when the child will ask to come home from / not go to school
- Avoidance of homeschool, online school, and frequent changes in education environment if possible

(Kearney, 2018; Linehan, 2015)

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School involvement in treatment

- Providing psychoeducation on diagnosis, symptoms and impact on school attendance
- Coordinating on the plan for reintroduction into the school setting (e.g., attending part of the school day, full school day, etc.)
- Discussing and implementing appropriate accommodations and removing inappropriate accommodations
- Identifying specific school personnel that will be supports
- Creating a plan for continuing schoolwork

(Kearney, 2018)

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School involvement in treatment

Frequent school coordination throughout treatment:

- Attendance log
- Behavior log
- Daily report card
- IEP meetings

(Kearney, 2018)

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Key takeaway for caregiver and school support

Everyone involved needs to consistently be following the school plan!

Treatment team, caregivers, school personnel, coaches, etc.

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Case discussion

Please use the Q&A feature to send your questions to the moderator.

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Case example:

A: 13-year-old
D: Obsessive Compulsive Disorder, Social Anxiety Disorder, Major Depressive Disorder
D: Dyslexia and epilepsy
R: None reported
E: Puerto Rican and White
S: Bisexual
S: Upper-middle class
I: Puerto Rican
N: United States born
G: Female

Additional information:

- History of school refusal
- Missed majority of school in start of school year (fall 2022). As a result, school changed to half days however still did not attend.
- Attended a private school specifically for students with learning difficulties
- Some history of CBT treatment
- History of suicidal thoughts, intent, and plan
- History of current non-suicidal self injury (NSSI)
- High risk while in treatment

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Primary targets for monitoring

- Avoidance
- Rumination
- Isolation
- Suicidal ideation / attempt
- NSSI

Additional areas of focus:

- School reintegration
- Parental accommodation

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A sample of exposures and ratings

- Attend a half day of school (7)
- Answer a question wrong on purpose (7)
- Interrupt staff when they are with another patient (6)
- Ask staff an obvious question (6)
- Volunteer to speak first in group (6)
- Initiate conversation with a peer (5)
- Give staff constructive criticism (5)
- Write a summary on a topic with no reviewing/checking (4)
- Wear a mismatched outfit (4)

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Caregiver and school involvement

- Bedtime and morning routine
- Consistent rewards and consequences
- Cope ahead plans
- Coordination with school

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Assessments

Measure	Admission	Discharge
School Refusal Assessment Scale-Revised (SRAS-R)	**Rankings of function:** 1) escape from aversive social and/or evaluative situations 2) avoidance of stimuli provoking negative affectivity 3) attention seeking 4) tangible rewards	
Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)	25 (Severe)	10 (Mild)
Quick Inventory of Depressive Symptomatology Self-Report (QIDS)	16 (Severe)	9 (Mild)
Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA)	99 (Very Severe Social Anxiety)	53 (Mild Social Anxiety)

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Time for questions and answers…

- Please use the Q&A button – not the chat – to submit your question
- If we don't get to your question, please feel free to send an email to **webinars@rogersbh.org** and we will follow-up with you

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Where to get additional information…

School Avoidance Alliance – schoolavoidance.org
Anxiety Canada – www.anxietycanada.com
Anxiety and Depression Association of America – adaa.org
International OCD Foundation –iocdf.org

Assessment measures:
SRAS-R Parent https://schoolavoidance.org/wp-content/uploads/2021/11/SRAS-interactive-pdf-004.pdf
SRAS-R Child https://schoolavoidance.org/wp-content/uploads/2021/11/sras-child-version.pdf
LSAS https://nationalsocialanxietycenter.com/liebowitz-sa-scale/
CY-BOCS https://capp.ucsf.edu/sites/g/files/tkssra6871/f/CYBOCS.pdf

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About the presenters….

David M. Jacobi, PhD

Dr. Jacobi is the clinical director at Rogers Behavioral Health's Sheboygan, WI, location

Andrea Hartman, PsyD

Dr. Hartman is the clinical director at Rogers Behavioral Health in Seattle

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