Managing School Refusal

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Objectives

• Review school refusal in context of the anxiety spectrum

• Explore treatment approaches

• Discuss management of specific cases
Anxiety Disorders: Overview

- **FOCUS** is important
  - Is there a *specific* fear, or *global* worry?

- Specific anxieties respond best to cognitive-behavioral interventions
  - Desensitization for phobias
  - Benzos can be used for infrequent events

- Random-onset or global anxiety responds to medication and therapy
  - Combination is best
Simple Phobia

• Persistent (at least 6 months) *excessive* fear of a specific object or situation (e.g., getting a shot, spiders, heights)
  – fear of dogs in the months after a bite is *not* a phobia

• Exposure causes an immediate anxiety response (crying, fleeing, clinging, panic symptoms)

• The phobic situation is avoided or endured with marked distress

• The phobia causes impairment in function
Social Phobia

• Marked, persistent fear of unfamiliar social or ‘performance’ situations
  – Child must be able to form social relationships
  – Children may or may not recognize the fear as excessive

• Exposure to the situation predictably causes anxiety

• The situation is avoided
  – The avoidance causes functional impairment

• Duration at least 6 months
Separation Anxiety Disorder

• Developmentally inappropriate, excessive anxiety, onset before age 18, lasting at least 4 weeks

• Three of the following:
  – intense distress on separation (or anticipation)
  – worry about harm befalling parent
  – fear of being kidnapped or getting lost
  – reluctance or refusal to go to school
  – fear of being alone
  – inability to go to sleep without parent (or go on sleepovers)
  – nightmares about separation, physical complaints when separation anticipated
  – Repeated physical sx when separation occurs or is anticipated
Generalized Anxiety Disorder

- Excessive worry (what if something happened to mom/dad, natural disasters, break-ins, family finances, future employment...)
- Worry is hard to control: doesn’t respond to reassurance, distraction
- At least 3 of the following:
  - feeling restless or on edge
  - being easily fatigued
  - poor concentration
  - Irritability
  - muscle tension
  - sleep disturbance
  - (children may report stomachache, headache)
Panic Disorder

- Discrete, random episodes of intense fear or distress, abrupt onset, peaking within 10 min.
  - Palpitations, tachycardia, pounding heart
  - Sweating
  - Shaking/trembling
  - Dyspnea
  - Choking sensation
  - Chest pain
  - Nausea
  - Dizziness
  - Derealization or depersonalization
  - Fear of losing control, going crazy
  - Fear of death
  - Parasthesias
  - Chills
Age at Onset of Anxiety Disorders

• Generalized anxiety, separation anxiety, phobias, PTSD can be seen at any age

• Older children and adolescents:
  
  – OCD median age at diagnosis: 10
  
  – Panic disorder typically starts in late adolescence to third decade of life
Separation Anxiety: Prevalence

• 4% of school-aged pre-adolescents
  – Ask about adjustment to day care or kindergarten

• 1-2% of adolescents

• About 1/3 of all children with separation anxiety continue to have the disorder as adults, so those who still have it as adolescents are likely to have a fairly chronic course
Separation Anxiety

• M=F ratio

• Strong overlap with other anxiety disorders, especially GAD

• **SCHOOL REFUSAL** occurs in 75% of children with separation anxiety, or *3% of school aged children*
School Refusal: Differential Diagnosis

• GI problems, migraines
  – Pattern of occurrence is a clue

• Realistic fear for parent’s safety (DV, parent’s illness)

• Conflict with teacher, bullying, interpersonal ‘drama’

• Obsessional fear or social phobia
  – Look for OCD symptoms
  – Fear of vomiting, germs
School Refusal vs. Truancy

- **Severe emotional distress** about attending school; may include anxiety, temper tantrums, depression, or somatic symptoms.

- Parents are aware of absence; child often tries to persuade parents to allow him or her to stay home.

- **Lack of excessive anxiety or fear** about attending school.

- Child often **attempts to conceal** absence from parents.
School Refusal vs. Truancy

- Absence of significant antisocial behaviors such as juvenile delinquency.

- During school hours, child usually stays home because it is considered a safe and secure environment.

- Child expresses willingness to do schoolwork and complies with completing work at home.

- Frequent antisocial behavior, including delinquent and disruptive acts (e.g., lying, stealing), often in the company of antisocial peers.

- During school hours, child frequently does not stay home.

- Lack of interest in schoolwork and unwillingness to conform to academic and behavior expectations.
20-29 Year Outcomes: 35 Swedish Children With School Refusal

- Did not complete high school: 45%
- Adult psychiatric outpatient care: 43%
- Adult psychiatric inpatient care: 6%
- Still living with parents after 20-year follow-up: 14%
- Ever married at 20-year follow-up: 41%
- Number of children at 20-year follow-up
  - None: 59%

Psychiatric diagnoses of Parents of School Refusers in Turkey

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Özlem ÖZCAN, Birim Günay KILIÇ, Ayla AYSEV Türk Psikiyatri Dergisi 2006; 17(3)
School Refusal: Assessment

• Look for context of separation anxiety or generalized anxiety symptoms
  – If not present, consider other causes

• Symptoms may worsen after a weekend or vacation

• Agitation can be intense, with threats of suicide, aggression to caregivers
School Refusal Assessment

- Children usually present with recurring physical complaints, for months or YEARS before diagnosis
- Parents often have some separation anxiety themselves
- Ask about child’s early separations, inclination to worry, similar behavior in past years, family history of anxiety
- Determine pattern and number of missed school days
Treatment Rules of Thumb

• Normal worry gets better with reassurance or distraction- the anxiety of school refusal INCREASES with talking about it
  – Anxious parents find it difficult to set limits on children’s excessive calls
  – This contact just increases the desire to be with parent

• The least anxious adult in the house should play a leading role if possible
  – Consider possible marital stressors
Working with Parents

• Talk about importance of restoring school attendance for future life success

• Explain need for consistency
  – Risks of intermittent reinforcement
  – With each school day missed, child’s escalation will increase the next time

• Establish clear criteria for staying home from school

• **NO RETROACTIVE SCHOOL EXCUSES**
Working with Parents

• Start right away- not at the start of the next semester, or after spring break

• Explain to parent and child that school attendance is required by the law, and not a point of negotiation

• Promise the child that you will work to make it as comfortable as possible
School Cooperation

• Obtain consent to work with school
• Contact nurse and teacher to develop plan
  – Keep ‘goodbyes’ short: can staff help at the ‘dropoff zone’?
  – If child too distressed to be in classroom, try to allow for short ‘time outs’ in nurse’s office
  – If parent must be contacted, school staff should make the call- *direct phone contact between child and parent tends to exacerbate anxiety*
  – If possible, only send child home if there is objective evidence of illness (fever, injury, etc)
Sertraline and CBT Study

• 488 children ages 7 to 17
• Randomized, controlled multicenter study
• separation anxiety disorder, generalized anxiety disorder, or social phobia
• CBT (14 sessions) , sertraline (mean dose 140 mg), combination, or placebo drug alone

Scores on the Pediatric Anxiety Rating Scale

Imipramine + Cognitive-Behavioral Therapy in School Refusal

- Randomized, double-blind design
- N=63, 8 week trial
- Imipramine or placebo with CBT
- After 8 weeks, attendance rate 70.1% for imipramine group, 26.7% for placebo group
- Both groups improved on depression and anxiety scales

School Refusal: Treatment

• **Early:** less than 1 consecutive week of missed school, no academic failure due to frequent sick days

  – Parental firmness, cognitive-behavioral therapy, and school cooperation may be sufficient

  – Medication:
    • SSRI or TCA if other anxiety sx. prominent
School Refusal: Treatment

- **Active**: more than 1 consecutive week since any school attendance, academic impact
  
  - Cognitive behavioral therapy, parent education (and treatment if indicated)

  - Medications
    - SSRI or TCA
    - At first, can use HS or AM tranquilizers

  - **Sleepy at school beats awake at home**
School Refusal: Treatment

• **Chronic**: over a month of non-attendance, loss of credit for excessive absences

• Non-attendance becomes the “new normal”
  – Close case management and therapy
  – CPS referral if parent unable or unwilling to engage in treatment, or if child has been enlisted for adult duties (babysitting, housekeeping)
  – **NO** retroactive excuses
  – Use caution in recommending home schooling
School Refusal: Treatment

• Develop a very specific plan for parent(s)

• Night before:
  – Limit ‘anxiety talk’
  – Don’t bring up school
  – Try not to focus on somatic complaints

• School mornings:
  – Stay matter of fact
  – Use distraction if possible
  – Don’t get hung up: breakfast, toothbrushing
  – Keep things moving: “tell me about it while you’re putting on your shoes”
School Refusal: Treatment

• Bus stop or ‘dropoff zone’:
  – Who takes child there?
  – Distracting, light conversation
  – Avoid ‘anxiety talk’
  – Can school staff help at ‘dropoff zone’?
  – What if child is combative?

• School day:
  – No child-parent phone calls, or one brief call at lunch
  – Time-outs in nurse’s office if panicky
School Refusal: Treatment

• If child becomes physically aggressive or self-injurious, inpatient treatment may be indicated (rare)

• Tailor expectations to chronicity:
  – in early refusal, aim for full attendance to resume without delay
  – In active refusal, start with half-days for 2 or 3 days, then increase to full days
  – In chronic refusal, may need to start with a half morning for a week, then a full morning, then full days
School Refusal: Treatment

• Initial care is very labor-intensive, but once attendance resumes, time demand drops off very quickly

• Make contact with the school, share the plan

• Success rate is high if parents are on board
  – If not, explore parental anxiety, marital issues

• Try to schedule visits outside of school hours

• Short-term prn medication is OK for agitation
  – HS clonazepam or even risperidone