School Refusal or School Anxiety:
Differentiation, Cognitive Behavioral Treatment and School-Based Interventions
Patrick B. McGrath, Ph.D.
Licensed Psychologist
Clinical Director, Alexian Brothers Center for Anxiety and Obsessive Compulsive Disorders Program
Co-Director, Alexian Brothers School Anxiety / School Refusal Program
Katie Torres, L.C.S.W.
Clinical Coordinator, Alexian Brothers Center for Anxiety and Obsessive Compulsive Disorders Program
AMITA Health: Alexian Brothers Behavioral Health Hospital

Illinois School Code
Compulsory Attendance (105 ILCS 5/2601)
Sec. 26-1. Compulsory school age – Exemptions. Whoever has custody or control of any child between the ages of 7 and 16 years shall cause such child to attend some public school in the district wherein the child resides the entire time it is in session during the regular school term.

Identifying a Student at Risk
• Absences from school
• Increase in somatic symptoms
• Changes in grades or academic achievements
• Marked change in attitudes or behaviors
School Refusal or School Anxiety: Differentiation

- Functional Model – Kearney and Silverman
  - Negative Reinforcement Function
    - Avoidance of Stimuli that provoke a Sense of Negative Affectivity
      » Avoid Unpleasant Feelings
      » Unable to Identify Specific Fear-Related Stimuli
    - Escape from Aversive Social or Evaluative Situations
      » Avoid Identified People and/or Activities in the Educational Setting

- Positive Reinforcement Function
  - Attention-Seeking Behavior
    » Increased Gains by Staying Home
  - Pursuit of Tangible Reinforcement Outside of School
    » School Refusal – Video Games, etc.

- Initial Function of Behavior May Not Be Function That Sustains the Behavior
  - Fluid
  - Overlap
School Refusal or School Anxiety: Differentiation

- School Anxiety
  - Diagnoses
  - Incidence
    - Onset
    - Duration
  - Causes
    - Genetic
    - Environmental

School Refusal or School Anxiety: Differentiation

- School Anxiety
  - Symptoms/Behaviors
    - Physical Symptoms
    - Educational Impact of Physical Symptoms
    - Avoidance Mechanisms
    - Secondary Gains
    - Situational Aspect of Symptoms
    - Frequency and Intensity of Symptoms

History and Context of Behavior

- Chaotic/Dysfunctional family system
- Past academic and behavioral problems
- Lack of motivation and self-confidence
- Family and/or peer group does not value education
- Poor perception of school success and confidence related to school achievement
- Lack of strong connections to school
- Poor coping skills to manage stress
Identification

Anxiety Disorders are:
• Highly prevalent (most common class of mental disorder)
• Real & potentially disabling
• Found in all groups of people
• Under-recognized & under-treated
• Variable in presentation
• Treatable

What is Anxiety?

• Normal, natural, built in through evolutionary processes
• Response to the perception of future threat or danger
• We need this to prepare for future potential difficulties
• Some anxiety is actually good for performance (Yerkees-Dobson)
What is Panic?

- Normal, natural, built in through evolution
- Response to the perception of immediate threat or danger
- We need this to protect ourselves from danger

Panic continued

- Panic is our “Fight-Flight-Freeze” response
- Natural selection selected out those that did not have this response system
- It is an alarm reaction
- Good in short bursts, problem if returns when there is no external cue for danger

Anxiety Disorders

- Our Fight, Flight, or Freeze system gets activated when it does not need to
- The fear is perceived but, by most standards, is far less than it is judged to be
- Everyday occurrences become overwhelming
- Behaviors interfere with daily functioning
Cognitive Behavioral Therapy (CBT)

- Active, problem-focused.
- Focused on Emotions/Feelings.
- Focused on Thoughts.
- Focused on Behaviors.
- Client-centered, collaborative.
- Present-centered.
- The basis of all therapy ever done.
  - All work is based on Stimulus-Response model.

Cognitive Behavior Therapy for Anxiety Disorders

- Correct misinformation and faulty threat appraisals
- Teach adaptive (nonavoidant) coping skills
- Contain maladaptive (avoidant) coping
- Facilitate exposure and readjustment to feared situations
- Teach relapse prevention
Advantages of CBT

- Favorable long-term outcome
- Inexpensive in the long run
- Minimal side effects
- Nondrug approach

PET Scans

HIGH ENERGY USE IN THE BRAIN OF A TYPICAL PERSON WITH OCD

PET Scans

Pre and post CBT and ERP for an OCD patient
Disadvantages of CBT

• Inaccessible in many areas
• Takes effort and time commitment
• Some patients prefer medications
• More expensive than medication in the short run

Basic Assumptions of CBT

• Attends to overt behaviors and cognitions.
• Behavior is learned – it can be relearned.
• Integrating cognitive and behavioral approaches is key.
• To change current behavior, it is best to focus on the present.
• The student's presenting problems are the focus of treatment.

Basic Assumptions…

• Effective therapy requires specific goals.
• The counselor is active, directive, and prescriptive.
• The counselor/student relationship is important, but not all that is needed for change.
• Based on research and empirical data.
How It Works

- What is actually going on in a person’s life isn’t as important as their thoughts about it.
  - Social Support research supports this.
    - Perceived versus received (McGrath et al., 2000)
- Other theories place a lack of control on the person we are working with, while CBT removes control totally – control is an illusion.

How It Works

- The focus is on how one thinks about a situation and how that thinking helps or hinders the progress in their lives.
- Then, CBT designs behavior programs to assist the person in challenging those thoughts and developing new ones.
- Behaviors are designed to assist a person in challenging the thoughts and the emotions.

How It Works

- Cognitive Dissonance is really at play here. If you think one way, then you will act that way to keep things in line. But, if you change behavior, then the thoughts have to change in order to preserve a balance, or cognitive dissonance will occur, and that is not comfortable.
  - Example: $1 versus $20
What May Underlie Difficulties

- Cognitive distortions and ways of behaving can get all mixed up into one. These are seen as typical “core fear” themes. The core fear is hypothesized as the motivator for the behavior. It is testable.

Four Basic Fears

Threats to the integrity of:

- Physical Status
- Mental Status
- Social Status
- Spiritual Status

Common Distortions

- **Severity**
  - It will be the worst thing in the world and I will die
- **Probability**
  - It will definitely happen, no question
- **Efficacy**
  - I will not be able to handle it
Safety Seeking

• Based on misappraisal of threat
• Intention is to avoid fear stimulus or the danger it signals
• Precludes adequate exposure to fear stimulus
• Does not allow a disconfirmation of the threat misappraisal

Cognitive Behavioral Model for the Treatment of Anxiety Disorders: Maintenance

Safety Seeking Continued

• People go for short term relief, at a long term cost
• Therapeutic anxiety prevention relies on short term discomfort with a person waiting that pain out until it goes away on its own
• They realize that there are not long term negative effects of suffering through the exposure
Case Conceptualization

- Important part of CBT.
- Begin with list of problems described in concrete behavioral terms.
- Use automatic thoughts to get at schema.
- Reformulate conceptualization early, as needed.
- Share conceptualization with the client.

Thoughts “make me”…..

- Nothing makes you do anything, other than you (example of a comedian).
- Thoughts are not good or bad, they are just thoughts. If a student comes in and says that they have bad thoughts and you agree, you are confirming that their thoughts really are bad. They may be disturbing to the student, but they are really just thoughts.

The Anxiety Disorders?

- Panic Disorder
- Agoraphobia
- Obsessive-Compulsive Disorder
- Social Phobia
- Specific Phobia
- Post-Traumatic Stress Disorder
- Acute Stress Disorder
- Generalized Anxiety Disorder
General Notes

• To be diagnosed with an Anxiety Disorder, there must be significant interference in a person’s social, occupational, or other type of functioning
• I will list some tips about seeking professional help after each diagnosis
• For Diagnosis, we use the “Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text-Revised (DSM-IV-TR)”

Separation Anxiety Disorder

• Developmentally inappropriate and excessive anxiety concerning separation from home or those to whom the individual is attached, evidenced by three or more of the following:
  – Recurrent distress when separation from home or attachment figures occurs or is anticipated

Separation Anxiety continued…

  – Persistent worry about losing or harm befalling major attachment figures
  – Worry that a feared event will lead to extended separation (as in being kidnapped)
  – Refusal to go to school or elsewhere due to fear of separation
  – Refusal to be alone or without major attachment figures
Separation Anxiety continued…

- Fear of going to sleep without being near attachment figures or to sleep away from home
- Nightmares with themes of separation
- Complaints of physical symptoms when separation occurs or is anticipated

- Lasts at least 4 weeks
- Onset before age 18
- Clinically significant impairment

Separation Anxiety

Fear Stimulus

Misinterpretation of threat

Anxiety

Avoidant Coping

Absence of Corrective Experience

- Leaving parent
- Some thing horrible will happen and I will never see them again
- Increased anxiety
- Fights going to school, plays sick
- Does not experience handling being separated; maintains faulty beliefs

School Anxiety: Signs for Getting Some Help

- Withdrawal in behavior Sunday evening, in anticipation of school the next day.
- Reassurance seeking that the caregiver will be safe and there to pick them up.
- Stomachaches in the mornings.
- Wanting to call home throughout the day.
Panic Attack

- A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed and reached a peak within 10 minutes...
  - Palpitations, Sweating, Trembling, Shortness of breath, Choking, Chest pain, Nausea, Dizziness, Derealization or depersonalization, Fears of losing control, Fears of dying, Numbness, Chills or hot flashes

Panic Disorder

- Recurrent unexpected Panic Attacks
- One of the attacks is followed by one month or more and one or more of the following:
  - Concern about having future attacks
  - Worry about the implications of an attack
  - Change in behaviors related to the attacks

Agoraphobia

- Literally “fear of the marketplace”
- A strategy for coping with panic attacks by avoiding situations in which escape might be difficult or help may not be available
- Often includes avoidance of:
  A particular location/setting or being away from a safe place or a safe person
Signs for Getting Some Help

• Frequent visits to the ER or cardiologist
• Feeling the need to have a safe person around or to stay in a safe place
• Use of medications to get through situations
• Fears of bodily sensations or changes

Obsessive Compulsive Disorder

• Either Obsessions or Compulsions or both
• Obsessions:
  – Recurrent thoughts, impulses, or images experienced as intrusive and that cause anxiety or distress
• Compulsions:
  – Repetitive behaviors or mental acts that a person feels compelled to perform in response to an obsession or according to rigid rules with the goal of neutralizing the obsession

Signs for Getting Some Help

• Rituals are taking up more than an hour a day
• Other people are used for reassurance and completing rituals
• You would be embarrassed if others knew what you were doing
• It amazes you that others do things so quickly
Social Phobia

- Marked and persistent fear of one or more social or performance situations in which a person is exposed to unfamiliar people or to the possible scrutiny of others. They fear they will act in a way that is humiliating or embarrassing.
- Exposure to the feared situation provokes anxiety

Signs for Getting Some Help

- It is hard to even write your name in front of others
- You cannot use a urinal or toilet if others are around
- Speeches make you change your major
- You are always worried about what everyone else will think about you

Specific Phobia

- Persistent excessive fear cued by the presence or anticipation of an object or event
- Exposure to the object or event brings about immediate significant anxiety or panic
- Recognition that the fear is excessive
- The feared object or event is avoided or endured with great difficulty
Signs for Getting Some Help

• Driving, which is more dangerous than flying, is preferred
• A picture of a snake sends you fleeing
• Blood or needles cause you to pass out
• All tall buildings are avoided, even if a relative lives in one

Post-Traumatic Stress Disorder and Acute Stress Disorder

• Person has been exposed to a traumatic event in which both of the following were present:
  – Actual or threatened death or serious injury was witnessed or experienced
  – The response to that event was intense fear, helplessness, or horror

PTSD and ASD continued

• Re-experiencing of the event
• Avoidance of stimuli that trigger memories of the event
• High levels of anxiety and arousal
• PTSD if the symptoms last over one month
• ASD if the symptoms last under one month
Signs for Getting Some Help

- Events from years ago still haunt you
- Startle response is above what is helpful for most situations
- You take a very long way to get to places to avoid passing a place where you witnessed a traumatic event
- Constant nightmares
- Person becomes withdrawn

Generalized Anxiety Disorder

- Excessive anxiety and worry for more than 6 months about a number of events or activities
- It is difficult to control the worry
- 3 or more of the following are present
  - Restlessness, fatigue, mind going blank
  - Irritability, muscle tension, sleep difficulty

Signs for Getting Some Help

- Difficulties in making even small decisions
- Constantly worrying about minor events
- Procrastination – it’s easier to wait until the last minute and just get it done than to do it early and have to think about it and revise it
- Restricting other’s behaviors so that you do not have to worry about them
Possibilities for Treatment

- Set up home to be just like a school.
- Consider truancy or short-term stay.
- Intensive Therapy.
- Consider a teacher change if the refusal is linked to one specific class or teacher.
- Lighten the expectations a bit – reduce class load and then work up to a full load.
- If a child has missed days, there has to be leniency with make-up work.

School Refusal

- Allow a phone call or two a day at set times, and then slowly increase the distance in time, then reduce to one call, and again increase the distance in time from arrival at school.
- Keep a worry log that contains all of the students worries and have them write answers in it – they can refer to it throughout the day.
- Daily free pass to the school counselor for a decreasing amount of minutes each few days.

Mistake Practice

- Great for Social Phobia and Perfectionism.
- Go out and purposely make mistakes:
  - Order a Whopper at McDonalds.
  - Go into Sears and ask where Sears is.
  - Drop a handful of pennies at the mall.
  - Call a person the wrong name.
  - Sneeze very loudly at a movie.
Mistake Practice Goals

- Learn that the feared consequences typically do not happen.
- Even if it is a negative experience, they can handle it.
- They get a realistic idea of how people will respond to them, not just what their worst case scenarios tell them.

Exercises continued

- Practice making mistakes - both you and your student
  - I point out my mistakes in therapy to my clients. I laugh at myself for pronouncing words wrong and tell them stories of failures. I show them that it’s human to make mistakes.

Exercises continued

- Confront extreme statements:
  - This always happens...
  - I am horrible because...
  - I can’t do that...
  - They make me so crazy...
  - It just has to be that way...
  - No one will ever understand...
Exercises continued

• Role Play
  – Criticisms; both giving them and receiving them.
  – Compliments; both giving them and receiving them.
  – Future events; allows for practice before confronting a fear.
  – Beware doing past events - approach it in a “how to try again” mode, not “how you failed.”

Examples

• Why didn’t I finish that assignment today? “I don’t think I am good enough.”
• THEMES: “I have to be the first one done to be accepted and I have to be perfect.”
• RESTATEMENT: “Others that are not the first ones done are still good people, and no one in this class has a perfect grade on everything.”

More Examples

• Or, instead of a RESTATEMENT, have the student say to themselves:
  • “This is just an anxiety thought and I do not need to answer it or give it power.”
  • “While it may feel good to talk through this thought now, it will just increase the chances of doing it more in the future.”
The Student Buzzword

- FAIR/UNFAIR
  - The only judges of fair and unfair in interpersonal activities are the people that are talking right there in the room (and both are giving their opinions). But, so many people want to just blame others with being unfair. This is not productive.
  - Whether or not people are being fair or unfair (whatever that means to them) matters little. What matters is the reaction to a situation.

Don’t Try Harder, Try Different

- “Should” is not a helpful word.
- “Can’t” versus “won’t”.
- Practice does not make perfect, it makes routine.
- Control is an illusion.
- Specialness.
- Everything in the world is neutral.
- All that there really is is perception or interpretation.
- Avoidance/Reassurance seeking maintains and increases anxiety.
- Short-term versus long-term.

Correction of a Potential Anxiety Disorder

<table>
<thead>
<tr>
<th>Fear Stimulus</th>
<th>Misappraisal of Threat</th>
<th>Anxiety</th>
<th>Adaptive Coping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Corrective Experience</td>
<td>Accuracy Threat Appraisal</td>
<td>Adaptive Emotional Response</td>
</tr>
<tr>
<td>Next Presentation of Fear Stimulus</td>
<td></td>
<td>Adaptive Behavior</td>
<td></td>
</tr>
</tbody>
</table>
Creating Exposures

• Almost anything can be made into an exposure.
• Therapists need to decide what they are comfortable doing:
  – Looks, 45 Degree angles, Garbage cans
  – Bar soap, Mistakes, Toilets, Religion
  – Trains, Bridges

Exposures continued…

• I try to do the exposure with the student the first time.
• Have them do it over and over – goal is habituation.
• Continue to expose over days and weeks – beware of spontaneous recovery. There is very little symptom substitution.

Worry Exposure

• Worries are often an attempt to think of all of the negative events that may occur and then prepare for them.
• Worries are also a cognitive experience, which is easier to deal with than a visual experience – prepare for the worst.
• Worries are often used to control negative potential outcomes.
Worry Exposure

• Procrastination is a way to avoid having to think about what you have to do – if you wait until it is just about due, then you just do it and get it over with – no thinking about it before or after (as in how to revise it).
• Example of how worries do not control anything.
• Truth versus Belief exercises.
• The meteor exercise.

More Behavioral Approaches

• Self-control therapy: Monitor and evaluate actions positively & reward self.

Our Colleagues

• What if a colleague is a “client”?
  – “I have tried this already, it does not work.”
  – “This kid just needs some good parenting.”
  – “I see them more than you do each day – I know what needs to be done.”
  – “I have been teaching for _____ years and I think that I know what I am doing.”
  – “I just want to pass him and then he will be out of my hair.”
Handling Our Colleagues

• Ask them for their suggestions first and try to incorporate a few into the plan that you will be designing.
• Let them know that you will be there to assist them and to model the new methods.

Colleagues continued…

• Create a friendly competition among a group of teachers – they can even self select the teams. Have each team come up with a method that they will utilize and have a standardized tool to evaluate across teams. This way the people that are on teams are invested in their method, and will not fear favoritism. Results may be accepted more this way.

Colleagues continued…

• Encourage a Behavioral View:
  The student is acting in such a way to get something – for some reason the behavior is rewarding to the student.
  – What is the class or the teacher possibly contributing to the maintenance of the student’s behavior?
  – Is it only in her/his class?
  – Does it increase or decrease when attention is given?
### School-Based Interventions

**Intervene Quickly**

**Approach**
- Understanding and Reassuring but Firm
- Unified Collaborative Approach
  - Parents
  - School Staff
- Encourage Comprehensive Physical Exam to Rule Out Organic Basis for Symptoms

### School-Based Interventions

**“The Toolbox”**
- Pre- and Post-Referral
  - Coordinate efforts with Therapist
- Behavioral Interventions
  - Coping Skills List
  - Anxiety Graph/Thermometer
  - Check-ins (1-5 Scale)
  - Breaks
  - Buddy System

### Books by Dr. McGrath

[Image of books]
References


References


Recommended Readings

- Don’t Try Harder, Try Different (McGrath)
- An End to Panic – or – Panic Attacks Workbook. Treatment of Panic and Agoraphobia.
- When Once is not Enough. Treatment for OCD.
- Feeling Good. Basic CBT for Depression
Contact

- School Anxiety / School Refusal
- Cece Horan, Psy.D.
- ABBHH
- 847 755 8145
- Anxiety and OCD Program
- Patrick B. McGrath, Ph.D.
- 847 755 8531
- Patrick.McGrath@alexian.net