

Anxiety Disorders and School Refusal

Julio was terrified that he was about to lose consciousness and die. His heart was pounding, his hands were sweaty, and he felt like he had to call 911 to get help. When his teacher tried to stop him from leaving the classroom, he shoved the teacher out of the way, raced out of the classroom and the building, and ran down the city streets to get home to his mother to get help. The school suspended him from school for shoving his teacher, but Julio had no intention of returning to school anyway, as he was terrified he would have another panic attack there and that they would not help him. Julio's mother took him to see a therapist to get help for him.

Preview

Many students diagnosed with other conditions described in this book often have prominent features of anxiety but are seldom diagnosed as having an anxiety disorder. As a consequence, teachers and school personnel often focus on other aspects of the student's functioning without specifically addressing the anxiety that may be significantly impairing the student academically, behaviorally, and socially.

Anxiety is the most common form of childhood psychopathology. However, precise rates for having any one type of anxiety disorder in childhood or pre-adolescence are unknown, with estimated rates ranging from 2.6% up to 41.2% (Cartwright-Hatton, McNicol, and Doubleday 2006). Anxiety problems typically emerge before adolescence, and are relatively common in adolescents, with estimated rates of at least 10% (Garland 2001). Some estimates suggest that anxiety disorders may affect about 20% of all youth at some point in their development.

Specific anxiety disorders are more common at particular stages of development. Separation Anxiety Disorder (SAD) and specific phobias are more common in younger children aged six to nine. Generalized Anxiety Disorder (GAD) and Social Anxiety Disorder (Social Phobia) are more common in middle childhood and adolescence. Panic Disorder can occur in adolescence as well. Other anxiety disorders, described below, include anxious school refusal, School Phobia, Post-Traumatic Stress Disorder, specific phobias, and Selective Mutism.

Children and adolescents with anxiety disorders typically experience intense fear, worry, or uneasiness that is out of proportion to the situation. The anxiety usually has two components: (1) physical sensations such as headache, stomach pain, nausea, sweating, racing heart, tingling, weakness, and shortness of breath, and (2) emotions of nervousness and fear.

Types of Anxiety Disorders

Separation Anxiety Disorder (SAD)

Separation Anxiety Disorder is the most common anxiety disorder in young children. The hallmark of SAD is significant difficulty separating from parents or from home. Just the idea of going to school often provokes extreme anxiety for the student. SAD symptom severity fluctuates. In some cases, the condition persists for years or is a precursor to Panic Disorder with agoraphobia (irrational fear of going out in public places from which escape might be difficult). The average age of onset of SAD is 7.5 years. The prevalence of SAD ranges from ap-

proximately 4-5% for children aged seven to eleven years and drops to slightly over 1% for teenagers aged fourteen to sixteen years.

SAD is strongly related to school refusal, discussed later in this chapter. Up to 80% of students with school refusal report a history or presence of SAD (Masi, Mucci, and Millepiedi 2001). Childhood SAD may be a risk factor for other anxiety disorders, although what it predicts is still uncertain. Cognitive-behavior treatment (CBT), including school-based CBT to treat SAD and SAD-related school refusal, has been demonstrated to be effective.

Panic Disorder

Students with Panic Disorder experience feelings of utter terror that strike suddenly and repeatedly with no warning. The students often cannot predict when an attack will occur, and the sense of not knowing when the next attack will strike may lead them to periods of intense worry or anxiety between panic attacks.

Students having panic attacks may report that their heart is pounding, that they feel sweaty, weak, faint, or dizzy. Their hands may tingle or feel numb, and they may feel flushed or chilled. As irrational as it sounds to others, the student—like Julio in the example at the beginning of this chapter—may genuinely feel that he is having a heart attack or is going to die. The student may feel that he has to escape the premises. A panic attack or episode usually peaks within ten minutes and generally subsides within twenty to thirty minutes.

Not all students who experience a panic attack develop Panic Disorder, but a subset does. About one third of people with Panic Disorder develop agoraphobia. For teens with Panic Disorder who have experienced a panic attack in school, school avoidance or even school refusal may result because they are excessively worried about when and where the next episode will occur and their ability to easily escape.

Can you think clearly or access knowledge or skills when you are in a panicked state? Neither can your student. But even between panic attacks, the student may have difficulty concentrating or working due to interference from worry about when the next attack might occur.

Social Anxiety or Social Phobia

In the early days of middle school, Shakir was invited to hang with the guys after school near the fast food restaurant across the street, but he always made an excuse why he could not. After a month, the kids felt rejected and turned on him, teasing him at school. This pattern continued until there were no groups left that were interested in befriending Shakir. When he was referred to the school's counselor, she learned that every time he had started to cross the street, he had had an anxiety attack at the thought of having to socialize with that many kids at once. The excuses he gave the boys were a smokescreen to hide his embarrassment at being unable to handle being around that many people.

Social Anxiety Disorder is also known as Social Phobia. Social Phobia usually begins in childhood or early adolescence and has a lifetime prevalence ranging from 3-13%. Students with Social Phobia have a persistent fear of being embarrassed in social situations such as during a performance, when they have to speak in class in front of their peers, or during conversation with others. The fear is apparent in any situation where others might observe them or judge them. Social Phobia is accompanied by physical manifestations of anxiety that include palpitations, tremors, sweating, diarrhea, blushing, and increased muscle tension.

Social Phobia is not just shyness. Shyness may produce discomfort, but it generally does not produce avoidance of situations. Many children who appear shy and inhibited do not develop social anxiety disorder. Social Phobia disrupts the student's life, interfering with school or social relationships. Whereas their peers may look forward to performing in a school concert or play with a mixture of excitement and a bit of nervousness, students with Social Phobia live in utter dread for weeks before the event. To complicate their anxiety, they also worry that others will notice their extreme reactions and consider them babyish, immature, or odd.

Unlike Separation Anxiety Disorder, which has a fairly high remission rate, Social Phobia may be a lifelong challenge, although it may become less severe over time. In some cases, Social Phobia (like Separation Anxiety Disorder) may lead to Panic Disorder.

Research on social anxiety in students indicates that:

- Middle school girls' sense of self-worth is diminished by anxiety due to peer victimization (Grills and Ollendick 2002).

- High school girls experience social anxiety and loneliness because of school-related victimization by peers (Storch and Masia-Warner 2004).
- High school girls are more likely to suffer severe social anxiety than high school boys (Dell'Osso et al. 2003).
- High school students with even moderate levels of social anxiety may have school difficulties and avoid social situations (Dell'Osso et al. 2003).

Although the pathways to Social Phobia are not well understood, they appear to include genetic vulnerability and family/parenting variables as well as negative peer experiences. Early disabilities may also be a risk factor for developing social anxiety as children with a history of early language impairment are 2.7 times as likely to have social phobia by age nineteen as peers without a history of early language impairment (Voci et al. 2006).

School Phobia

School phobia, a condition characterized by excessive and intense anxiety about going to school, affects up to 5% of elementary and middle school students. Young children who are school phobic may report headaches, stomachaches, or fatigue. Assuming that a physical examination reveals no underlying health problems, further assessment is indicated. Because symptoms of school phobia overlap symptoms of depression, referral to the school psychologist may be helpful. If left untreated, school phobia has potentially significant and negative long-term consequences including academic failure, impaired peer relationships, and other psychiatric or anxiety-related issues.

School phobia may sometimes be a medication side effect. Do not neglect to consult with the child's physician if a student is on medication and develops school phobia.

School phobia may also be a result of harassment or bullying at school. Do not neglect to find out whether the student is being bullied.

School Refusal

School refusal refers to student-initiated refusal to attend school as distinct from just fear or anxiety about going to school. The average age of onset of school refusal is 10.3 years. School refusal is reported to affect approximately 1% of school children across the primary and secondary school levels if a narrower definition of school refusal is used. It may affect 5-28% of students at some point in their lives if the definition is expanded to include those who attend school but have trouble staying in school.

In a number of situations, anxiety or depression may be factors in school refusal (Bernstein et al. 2001). The most common diagnoses for youth with school refusal (Kearney and Albano 2004) are:

- Separation Anxiety Disorder (22.4%)
- Generalized Anxiety Disorder (10.5%)
- Oppositional Defiant Disorder (8.4%),
- Depression (4.9%),
- Specific phobia (4.2%),
- Social Anxiety Disorder (3.5%), and
- Conduct Disorder (2.8%)

As noted by Kearney, the issue of school refusal is a complex one. Children who were classified as “anxious school refusers” were more likely to have depression and Separation Anxiety Disorder, whereas those who were “purely truant refusers” were more likely to be diagnosed with Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), and depression. Other studies find that “anxious school refusers” escape anxiety by avoiding school, while ODD and CD predict pursuit of external and tangible reinforcers outside of school (Kearney and Albano 2004).^{*} The assessment and management of school refusal requires a functional behavioral analysis (Chapter 26).

In a 2003 study, almost 90% of children and adolescents who had features of both “anxious school refusal” and “truant school refusal” had at least one psychiatric disorder (Egger, Costello, and Angold 2003). In our experience, school refusal is frequently associated with severe OCD, severe depression, bullying, and school failure.

^{*} As discussed in Chapter 8 on ADHD, teachers and school personnel really need to incorporate lavish and tangible external or extrinsic reinforcers to motivate students with ADHD. The Kearney and Albano findings come as no surprise to us: When school is not a reinforcing place, the students will go/seek reinforcement elsewhere.

Specific Phobias

A specific phobia is an extremely intense and irrational fear of something that really poses little or no actual danger. Specific phobias usually first appear during childhood or adolescence and often persist into adulthood. Some common specific phobias are: closed-in places (e.g., tunnels, elevators), weather (e.g., thunderstorms, tornadoes), animals (e.g., snakes, dogs), insects (e.g., bees, spiders), blood, needles, heights, dark, driving, water, and flying.

These symptoms can cause social embarrassment, disruptive behavior, and an inability to follow the class routine, e.g., the student refuses to go outside for PE due to a phobia of bees. Sadly, most people do not know how painful this is and think of it as strange or willful misbehavior. Specific phobias exhibited in the home can also impair school functioning, e.g., a student who has difficulty falling asleep because of a phobic fear of the dark may be tired and unable to concentrate in school the next day.

Generalized Anxiety Disorder (GAD)

Generalized Anxiety Disorder is chronic anxiety that lasts six months or more and that pervades all aspects of the student's day. Students with GAD worry about everything, and their worry persists even when past performance indicates that there is no real basis for worry. In young children, GAD is also referred to as Overanxious Disorder of Childhood.

Symptoms of children with GAD may look like those of children with Obsessive-Compulsive Disorder (Chapter 5) in that these kids may be perfectionists, frequently doubt themselves, and seek frequent approval and constant reassurance. For some children, however, there is just a general and pervasive sense of anxiety or worry (that is, not a specific worry). GAD is accompanied by physical symptoms such as fatigue, headache, muscle tension, or aches. Students with GAD may report difficulty swallowing, have hot flashes, or feel lightheaded. They may experience nausea, trembling, restlessness, or edginess. Some children with GAD may be irritable, sweat excessively, feel dizzy, or have an acute startle reflex. GAD interferes with concentration and the ability to relax. It also interferes with the student getting a good night's sleep (Alfano et al. 2006).

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder may develop when a child or adolescent is exposed to a traumatic event that involves the actual or perceived threat of death or serious bodily injury, and their response involves intense fear, helplessness, or horror. Symptoms of PTSD usually emerge within three months of the original trauma and include: persisting signs of physiologic arousal (such as difficulty falling asleep or staying asleep), irritability or anger outbursts, difficulty concentrating, excessive vigilance, and an exaggerated startle response. Occasionally, symptoms of PTSD do not emerge until years after the traumatic event. Whenever the child or adolescent is exposed to some situation or event that is reminiscent of the original trauma, the student may experience intense anxiety and distress accompanied by bodily reactivity. The student with PTSD is likely to avoid situations associated with, or which remind her of, the traumatic event. This can lead to a markedly restricted range of activities and settings, impairing social and school activities. The course of PTSD varies, and in some cases, the condition may become chronic.

Following the terrorist attacks on September 11, 2001, a survey was conducted of pediatricians to assess the impact on children. Almost two thirds of the pediatricians who responded to the survey identified behavioral problems in children directly affected by 9/11 (Laraque et al. 2004).*

Selective Mutism

Selective Mutism is an anxiety disorder characterized by a persistent failure to speak in social situations despite speaking in other situations. The term "specific mutism" is used to indicate a situation in which the student does not speak to school personnel, but may speak to peers and parents, both at home and in school. "Generalized mutism" refers to those situations in which the child only speaks in the home and not outside the home.

Because the child is capable of speaking and interacting in some situations, selective mutism is

* Immediately after 9/11, Leslie expected her young patients to have a worsening of their anxiety symptoms because every school in her area (New York) had someone who had lost a family member or was affected. Surprisingly, there was no significant increase in anxiety in her patients, which she attributes to the outstanding job that the schools and parents did in counseling the students and supporting them.

not due to a primary language deficit, psychosis, or lack of knowledge of social language. Selective Mutism is often maintained by well-intentioned family, friends, and teachers or other school personnel who readily interpret the nonverbal gestures and behavior. Not surprisingly, children with specific or generalized mutism display high levels of social phobia and significant deficits in verbal and nonverbal social skills at home and in school (Cunningham, McHolm, and Boyle 2006).

The symptoms of selective mutism tend to improve over time, but, like other anxiety diagnoses, the presence of selective mutism predicts higher future rates for phobic disorders and other psychiatric disorders (Steinhausen et al. 2006). Treating anxiety improves academic performance and school functioning during the course of treatment (Wood, 2006).



School Impact

As suggested by the descriptions of the disorders, anxiety disorders may have significant negative impact:

- High anxiety can impair academic performance (Muris and Meesters 2002).
- High anxiety is a risk factor for substance abuse, depression, and adjustment problems post-school. Substance abuse and a history of anxiety disorders predicts early school withdrawal (Van Ameringen, Mancini, and Farvolden 2003).
- Teenagers with high anxiety express higher levels of stress, anger, sadness, fatigue, and an urge to eat. They also experience stronger smoking urges and more tobacco use, although the relationship between anxiety, depression, and smoking is different for adolescent boys than it is for girls (Dudas, Hans, and Barabas 2005).
- Anxiety can lead to school attendance problems including school avoidance, school refusal, and/or withdrawing from school early. The more anxiety diagnoses the student has, the greater the risk of leaving school early.
- Social phobia is associated with reduced visual memory scores (Vasa et al. 2006).
- Anxiety disorders may be associated with lowered linguistic abilities and reduced cognitive flexibility (Toren et al. 2000).
- High anxiety can impair self-esteem.

- High anxiety can impair peer relations as well as limit the student's ability to form or maintain close personal relationships.
- Severe anxiety can negatively affect a child's thinking, decision-making ability, and perception of the environment.
- Anxiety can significantly interfere with concentration and learning.



Tips and Tricks for Helping Students with Anxiety Disorders

The following tips and strategies can help students with anxiety disorders:

- Do not force, but positively reinforce the student for staying in an anxiety-provoking situation. If the student's anxiety is so intense that she really cannot tolerate the situation, allow her to leave the situation and go to a designated "safe person" or a "safe place." The safe place may be another part of the classroom or another designated location in the building.
- For students who leave the classroom too frequently, gradually introduce some limits on how often or when the student may go to the "safe person" or "safe location," but only do so after consulting with the parents, student, and any treating professionals.
- For students with panic attacks, provide a permanent pass so that the student can make a graceful exit from the classroom without being conspicuous. The ability to make a graceful exit is important to the student's self-esteem and peer relationships. (See Chapter 31 for more on graceful exits.)
- Provide lecture notes and copies of board work as an accommodation for material missed while the student is out of the room or for impaired concentration due to interference from anxious thoughts.
- Extend time on classwork and homework as well as on tests.
- Accommodate late arrival to school due to sleep problems or separation anxiety. Do not punish a student for being late to school if she has separation anxiety, school avoidance, school phobia, or school refusal.
- If the student has Separation Anxiety Disorder:

- Have a “check-in” ritual for the child when she arrives at school (counselor, nurse, office). Having the responsibility to report to a particular individual and being greeted warmly by school personnel for showing up may increase the student’s likelihood of entering the school building.
- Try to have a motivating activity for the student to do after the check-in procedure (such as feeding the class pet, helping the teacher set up the classroom, playing with a friend before class, computer time, etc.)
- Provide positive reinforcement for compliance with the check-in procedure.
- At the start of any program to help the student reduce anxiety, encourage the student to bring in a “transitional object” from home (something that makes her feel safer, like a favorite stuffed animal) and encourage her to take a favorite book or drawing or object from school back home (school-to-home transitional object).
- Pre-plan with the student when she will be allowed to call home, e.g., “Finish this worksheet and then you can call home and tell Mom that you got your work done.” Dealing with separation anxiety by allowing the student to call home to report success tends to be more effective than a “cold turkey” approach of “You cannot call home at all.” As an alternative plan, have the parent and student pre-determine what time the student may call home.
- Encourage parents to tuck into their child’s lunch bag or notebooks cheery notes like “I’m so proud of you for making it through to lunch today. Have a great time with your friends!” or “When you come home today, I hope you’ll tell me about something exciting you learned in school today!” Positively reinforce time spent in school or time spent on tasks. Use in-school reinforcers such as the opportunity for more time on the computer, lunch in the classroom with a special friend, extra recess time, or time to read or draw.
- Encourage parents to systematically increase the amount of time that the stu-

dent is separated from them in the home or outside of school.

- Suggest to the parents that someone other than the parent takes the child to school. This sometimes makes it easier for the child to separate and enter school.
- Provide in-school counseling to support cognitive interventions that can help the student replace anxious thoughts with more positive ones; collaborate with treating therapist if student is getting cognitive-behavior therapy.

Before the child calls parents from school, coach parents how to respond if the student calls crying, and begs to be taken home. One strategy we have used is to teach parents to say, “I understand that you are having a rough time right now. I’d like you to call me back in one hour to let me know how you’re doing.” If the child persists, crying, “Take me home NOW!” the parent might then say, “I know that you’re upset, so please call me in an hour. Please put your teacher on the phone now and I will tell her that I want you to call me in an hour.”

- If the student exhibits school refusal:
 - Expose the student to school gradually—starting with a few hours.
 - Have a “check-in” ritual for the child when they arrive at school (counselor, nurse, office), as described above.
 - Set up an engaging activity for the student to do after the check-in procedure, such as feeding the class pet, helping set up the classroom, playing with a friend for a few minutes before class, or providing some computer time. This provides positive reinforcement for completing the check-in.
 - Provide in-school counseling to support cognitive interventions that can help the student replace anxious thoughts with more positive ones; collaborate with therapist if student is getting cognitive-behavior therapy.
- Provide test accommodations:
 - Have someone the student knows test the student in a separate location.
 - Extend time.
 - For students that have trouble retrieving language, provide a word bank.

- School personnel can teach students simple relaxation techniques that can be used in school, e.g., yoga or breathing techniques (see Appendix G and the accompanying CD-ROM).
- If school avoidance is the result of academic difficulties leading to anxiety, address any learning disabilities and provide added academic support.

If the student's plan calls for a check-in ritual, ensure that there is an alternative person available to support the check-in ritual in case the assigned staff person is absent!

- For students with social anxiety (social phobia):
 - Provide added adult support during interactions with peers.
 - Allow the student to eat lunch in the classroom with a few friends.
 - Provide added adult support during transitions, for example, changing classes.
 - Provide the student with specific instructions as to what to do in a novel situation such as “When we go on the field trip tomorrow, you can help by checking off each student’s name as they get on the bus.”
 - Allow the student to observe others giving their oral presentations or engaging in an activity before asking the student to give her presentation, etc.
 - Carefully match the student with other students for small-group instruction and activities.
 - Use coaching and “Instant Replay” (Chapter 31) to teach the student what to do in social situations. For example, “Look at the bridge of the other person’s nose when she is talking to you” or “Take turns talking.”
 - Include peer interactions as part of academic assignments, e.g., “Think-Pair-Share” activities (see “Decreasing Hyperactivity” section in Chapter 8) or working on tasks with peers.
 - Provide social skills training in a small group. Many students with social anxiety do not need social skills training, but the small-group experience can build their confidence and enable them to feel more comfortable with peers.

- Plan and prepare staff to respond in an agreed upon fashion to phobic reactions and incorporate accommodations or interventions into a plan.
- When the student is calm, talk about what to do when the student feels panicky or highly anxious, e.g., use diaphragmatic breathing for ten breaths, think about how your friend would handle this situation, go for a walk in the hall, come back and resume work.
 - Use coaching or direct instruction and “Instant Replay” (Chapter 31) to teach the student how to respond to anxiety-producing situations, e.g., “If you cannot find your pencil, raise your hand and I will give you one,” “If you make a mistake, make an X through it and I will know not to read it.” With younger students, role-playing with puppets may be helpful.
 - Use coaching, “Cooperative Problem Solving,” and “Instant Replay” (Chapter 31) to help the student implement anxiety-reducing strategies.
- Reduce unnecessary exposure to anxiety-producing situations until the student is better prepared to handle those situations, e.g., if a student experiences significant anxiety about public speaking, allow the student to tape record the presentation or to present it only to the teacher, etc.
- Incorporate stories or books that deal with anxiety into the student’s reading.

If a student is frequently using the “graceful exit” pass to leave one—and only one—class, initiate a Functional Behavioral Assessment (Chapter 26) to determine if curricular modifications or special education services are required. It is important to determine if something is going on in the class that is leading to social anxiety or avoidance.

Other School-Based Interventions or Supports

The Role of the School Nurse

For students whose school anxiety or avoidance might increase their asthma symptoms or is a consequence of their asthma or any other medical

condition, including the school nurse in the planning and supports can make a positive difference. School nurses play an important role in conducting groups, educating students and their parents, and coordinating with the student's physicians.

School-Based Therapy

If school psychologists are well trained in cognitive-behavior therapy (CBT), suggest that the student meet with the school psychologist. This is an effective individual or group-based intervention for anxious students on its own or used in conjunction with other supports and interventions. Providing parent education and training can boost the clinical anxiety-reducing benefit for the students (Bernstein et al. 2005).

The "Worry Hill" program by Aureen Wagner, Ph.D. provides a clear explanation of anxiety and how parents and school personnel can help a child overcome anxiety (Wagner 2005).

For school refusers, school-based CBT may have to wait until other interventions have been successful in getting the student back into school. When a student is not attending school due to school refusal, the first step is to conduct a Functional Behavioral Assessment (Chapter 26) to determine the function that the refusal serves and so that meaningful interventions can be developed. Even if the school refusal is thought to be anxiety-related, a more refined analysis of the type of anxiety is required. For example, if a student is socially anxious, then the plan will need to deal with peer issues, whereas if a student is avoiding school due to a specific phobia, a different approach will be required.

Some students who have been absent from school for long periods of time (due to hospitalization or other factors) may also experience significant anxiety upon returning to school and may need to be slowly exposed again to the school setting. For such students, asking the student to attend school for a specific class or a small amount of time each day may be an effective approach. As the student becomes more comfortable, the amount of time can be gradually increased. To prevent additional stress that can increase the student's anxiety, provide 1:1 tutoring in the school setting for work missed. This way, the student can catch up and feel less anxious about attending classes while increasing the amount of time they spend in the building. If the

student cannot tolerate spending that much time in the building, provide 1:1 tutoring in another setting (such as the public library) each day to supplement time spent in class. This way, the student is not in the home and is still getting instruction. In extreme cases, the school may need to provide the supplemental 1:1 tutoring in the home.

For students with whom cognitive-behavioral interventions may be particularly challenging, consider starting with a more behavioral approach. For example, the school psychologist or counselor can teach the student relaxation techniques (Appendix G), and then teach the student to use the techniques when she encounters an anxiety-provoking situation. The student practices acting as if she were not anxious ("make believe" or "be an actor"), e.g., "Act as if you were your best friend, Julie. How would she handle this?"



Associated or Comorbid Conditions

Approximately half of anxious adolescents have other disorders. The most common comorbid condition is depression, with anxiety emerging first developmentally and depression emerging later. The following conditions tend to occur at higher rates in children and adolescents with anxiety disorders:

- Other anxiety disorders (e.g., social phobia)
- OCD
- Mood Disorders (e.g., depression or BP)
- Memory problems
- ADHD
- School refusal
- Unexplained headaches, stomachaches, muscle/joint pains, nausea or gastrointestinal symptoms, etc.
- Substance abuse or alcohol abuse
- Eating Disorders
- Sleep problems
- Executive Dysfunction (EDF)
- Pragmatic (Social) Language Disorder (Social language deficits caused by verbal EDF)
- Sensory dysregulation
- Learning Disabilities
- Processing speed deficits (may be secondary to interference)

School-Based Assessments

A number of clinical scales can be used by the school psychologist to assess anxiety, e.g.:

- Spence Children's Anxiety Scale for children ages eight through twelve
- Revised Children's Manifest Anxiety Scale for ages six to nineteen
- Beck Anxiety Inventory for Youth for ages seven to fourteen.

Parents who are concerned about their child's anxiety issues may ask the school to assess the student to determine if any accommodations or school-based interventions are needed. In some cases, the school's assessment may trigger a referral to an outside mental health professional for evaluation and treatment.

Assessments for anxiety disorders are more helpful if they include both timed and untimed measures of performance, review of attendance records, review of how often the student might be leaving classes and/or going to the nurse's office, and screening the student for sleep and homework issues (see Appendix F and Figure 23.2).

Summary

Anxiety disorders are the most common childhood psychiatric disorder. Students may experience any of a number of different types of anxiety disorders, but all impair a student's ability to concentrate, enjoy school, and socialize with peers. Students with anxiety disorders may need accommodations in class, for tests and homework, and support for transitions and social situations. In more severe cases, they may require Behavior Intervention Plans, in-school clinical services such as counseling, and for students who are social phobic, social skills training in small groups. The school psychologist, counselor, or special education teacher can coordinate in-school services.

Julio's school team asked his therapist to advise them about what to do when Julio had panic attacks. She recommended arranging for Julio to go see a "safe person" when he felt panicky and that school personnel cue Julio to use certain techniques she had taught him in therapy. In her first meeting with Julio, the therapist had talked with him about panic attacks, instructed him in a simple breathing relaxation technique that she encouraged him to practice daily, and suggested an alternate thought

to concentrate on when he started to have his next panic attack. They spent the remainder of the session practicing what he would think and do if he felt he was going to have another panic attack, and how he would practice the skills at home each day. His mother was taught the techniques and was asked to help her son with "practice panic drills." Somewhat to everyone's surprise (including the therapist's), Julio did not have any more panic attacks in school or at home, and at last follow-up, two years later, he was still panic free.

