childpsych PSYCHOLOGY PRACTICE

childpsych:psychology practice

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# childPSYCH News

A newsletter for professionals and parents

Inside this issue:

| | |
|---|---|
| When Children Refuse To Go To School | 1 |
| How Should AD/HD Be Diagnosed? | 2 |
| How Much Sleep Do Children Need? | 2 |

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Special points of interest:

- childPSYCH News is published quarterly free of charge.
- If you would like more copies or do not wish to receive this newsletter please phone or email us.
- Unless otherwise indicated, all articles are written by P. Gosschalk, Principal Psychologist of *childpsych: psychology practice*

## When Children Refuse To Go To School

**Feature article**

This is the time of the year when going to school can be distressing for some children. Between 1 and 5 percent of school age children will refuse to attend school and some because of debilitating anxiety. This is called anxiety-based school refusal.

While "school refusal" is not a psychiatric diagnosis, many children who refuse school will meet the criteria for a formal psychiatric disorder. The most common being separation anxiety, fear of social situations (social phobia), a fear of something in the school such as the toilets (simple phobia), overwhelming anxiety-like attacks (panic disorder) and coping with a traumatic experience (post-traumatic stress disorder). Other psychiatric diagnoses which cause school refusal are depression and adjusting to a stressful life change (adjustment disorder). Younger children tend to school refuse because of anxiety whereas adolescent children tend to be suffering from depression.

### Common Symptoms

Younger children will complain of feeling sick, pains in their stomach etc, on the day of school or the night before. Older children may engage in truancy instead. As a psychologist who worked in schools, I have had to assist children who at the age of 12 were so distressed by attending school that they have cowered in the passenger's seat of the family car.

### Assessment

A careful evaluation is necessary by an experienced clinician who will need to look for what caused the anxiety to begin, what is keeping it going and what needs to be done so that once the anxiety is treated the problem should not re-surface again. It is also very important to evaluate the family environment. For example, some school refusing children will have developed separation anxiety when the mother is experiencing domestic violence. Being overly dependent on a parent and coming from a family where there is a lot of conflict has also been associated with school refusal. Such children either feel they cannot cope alone in the world or that they feel they must remain with their family because something terrible might happen. Any effective intervention plan must also support the family with any problems.

***Going to school can be distressing for some children***

### Treatment

Treatment of anxiety-based school refusal is mainly divided into behavioural, cognitive-behavioural and pharmacological (medication) approaches. Pharmacological treatment is used when there is severe anxiety or depression and/or when the child has been school refusing for a while and has not responded to non-drug treatments. Cognitive-behavioural and behavioural interventions have been used very successfully to treat anxiety-based school refusal. Both approaches are usually successful within 3 to 6 weeks and seem to prevent the problem from reoccurring for at least 5 years.

Cognitive-behavioural approaches use strategies such as positive self talk but are not very useful with young children. Behavioural approaches are simpler treatments and are done by either forcing the child to return to school or by gradually returning the child to school. Forced returns, where the child is dragged kicking and screaming and handed over to the teacher, is actually quite successful with children who have developed anxiety-based school refusal *suddenly*. However, for those children who have had anxiety about attending school for some time a gradual return is favoured. Forced returns seem to produce the quickest success (2.5 weeks on average) compared to gradual returns (4 weeks on average), though I personally would rather return the child to school gradually giving them a sense of control. It is also important for children to learn skills such as relaxation for managing their school refusal problems.

*Continue over...*

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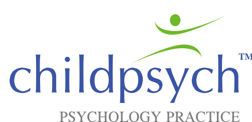
“ The Australian Psychological Society and American Academy of Pediatrics have put forward guidelines for the diagnosis of AD/HD.”




helping families and children to move forward

*anxiety-based school refusal con't*

Making parents co-therapists helps prevent reoccurrence of the problem.

### What Can Parents Do?

Parents can assist their child with returning to school by asking for professional help and reading one of the books recommended below. Parents can ensure that when children are dropped off at school, they are dropped off as soon as the bell goes. This ensures that an anxious wait till school starts is minimised. It is also a good idea to practice saying goodbye appropriately with a quick hug, kiss and “see you this afternoon”. It may also comfort the child to hear about the parents own fears as a child and how they overcame them. Finally, some younger children are comforted from having an item of their parents to bring to school, such as a brooch.

### Further Reading

*For professionals*

Gosschalk, P. (2004). Behavioral treatment of school refusal in a 5-year old girl with separation anxiety disorder. *Education & Treatment of Children, 27, 2,* 150-160.

Wanda, F. (2003). School refusal in children and adolescents. *American Family Physician. 68, 8,* 1555-1561.

*For parents*

Hall, Janet, "Confident Kids", Lothian, 1993.

Wever, Chris “ The school wobblies”, Shrink Rap Press.

## How Should AD/HD Be Diagnosed?

In 2003/2004 a West Australian Parliamentary Committee reported that in that state, AD/HD was mis-diagnosed in up to 75% of cases.

There is much controversy about whether AD/HD is over-diagnosed in Australia and the United States of America. One thing is certain, AD/HD is a real neurobiological disorder which should be diagnosed only after a full evaluation. There is no test for AD/HD despite what some may claim. However, several influential organisations such as The Australian Psychological Society and American Academy of Pediatrics have put forward guidelines for diagnosing AD/HD. These guidelines emphasise the importance of obtaining information from a variety of sources such as teachers and parents. The guidelines also caution against making a diagnosis based on how the child presents in the consulting room. AD/HD children can be quite restrained in such environments. The use of questionnaires which measure not only AD/HD symptoms but also other areas of the child's functioning is also recommended. These rating scales compare the observations of the child by various adults and determine just how different the child's behaviour is from those children without AD/HD. In other words, is the child just “over active” or “hyperactive”.

In addition, an evaluation of cognitive (brain) performance is useful in differentiating between the types of AD/HD. For those of you unfamiliar with the types of AD/HD, there are three types - hyperactive/impulsive types, inattentive/distractible types and those that are both inattentive and hyperactive. A cognitive evaluation assists with determining what “type” the child is because children with the inattentive type of AD/HD usually perform poorly on tests of memory and planning skills and have learning problems, compared to those who are mainly hyperactive.

It is also important to interview parents and teachers to get a full background history and detect other areas of concern. For example, about 25 percent of children with AD/HD will have an anxiety disorder and 12-60 percent will have a learning disorder. A medical evaluation is also important in ruling out hypothyroidism, lead poisoning and other medical causes.

***an evaluation of cognitive performance is useful***

In short, a full paediatric and psychological evaluation is needed. This takes hours of work but thoroughness should be the standard.

## How Much Sleep Do Children Need?

Sleep is paramount for children. Poor sleep can lead to problems such as hallucinations, impaired cognitive performance and depressed mood. In fact sleep problems are under diagnosed in children and some children are mis diagnosed with a psychiatric disorder when the reason is an undiagnosed sleep problem.

Good sleeping behaviours for school aged children refer to such things as:

* a set bed time,
* no caffeine drinks (such as Coke) after 4pm or four hours before bed,
* daily exercise,
  a good diet,
* and engaging in relaxing activities before bed time.

It is important to make decisions about children's bed time based on their developmental needs.

### Sleep Guide

1-4 Weeks Old: 15 ½ - 16 ½ hours per day
1-4 Months Old: 14 ½ - 15 ½ hours per day
4-12 Months Old: 14 - 15 hours per day
1-3 Years Old: 12 - 14 hours per day
3-6 Years Old: 10 ¾ - 12 hours per day
7-12 Years Old: 10 - 11 hours per day
12-18 Years Old: 8 ¼ - 9 ½ hours per day