

**Webinar Title: Back to Class: Behavioral Strategies for Emotional-Based School Avoidance**

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Now, let me introduce our presenters. Michelle Silverman, PhD, is a staff psychologist at the McLean Anxiety Mastery Program, where she specializes in the assessment and treatment of OCD, anxiety disorders, and related conditions in children and adolescents. She earned her PhD in school psychology from Teachers College, Columbia University, completed her pre-doctoral internship at Massachusetts General Hospital, and completed her post-doctoral fellowship at the McLean Anxiety Mastery Program and McLean School Consultation Service. In addition to her work at McLean, Dr. Silverman maintains a private practice providing evidence-based treatment for tweens, adolescents, and young adults with anxiety, as well as parent coaching.

Elan French, PhD, is a clinical psychologist who specializes in working with both youth and adults, with a particular interest in supporting LGBTQ+ youth. Dr. French has expertise in treating anxiety disorders, OCD, and eating disorders, and utilizes cognitive behavioral therapies alongside acceptance and commitment therapy, ACT, and dialectical behavior therapy skills. After completing post-doctoral training at the Klarman Eating Disorder Center, Dr. French joined the McLean Anxiety Mastery Program as a staff psychologist, where they use group-based exposure and response prevention to help youth with anxiety, OCD, and related disorders. Welcome, Dr. Silverman and Elan French.

**Dr. Elan French:** Thank you so much for this beautiful introduction, and we're really excited to present on this topic. Personally, I found clients that present with school avoidance as some of the most challenging cases to treat, so we really hope that this presentation will be helpful to you. Today, we're going to go over some background information on emotionally-based school avoidance, or EBSA, and how it presents. We'll talk about how to assess for EBSA, and we'll discuss interventions to treat EBSA, including with students, parents, and the school system. Additionally, we'll identify some common barriers to treatment and some strategies to adjust them. Next slide, please.

First, we'll start off with some background information. What is EBSA, and why is it important? In general, school absenteeism increased dramatically since the pandemic, with mental health challenges contributing significantly to school avoidance. Specifically, emotionally-based school avoidance is a consistent refusal to attend school and stay in class due to emotional distress and mental health issues. There's multiple reasons why kids might not be going to the classroom, and we're specifically going to be focused on those emotionally-based reasons.

The reason why missing school is so important is it's associated to poor outcomes, not only in academics, but also across a lot of other domains as well, including higher unemployment rates, higher rates of anxiety and depression, increased suicidality, and other outcomes across the lifespan. Addressing emotionally-based school avoidance early is really important, not just for academics, but across a lot of other domains of functioning.

Specifically, anxiety and anxiety-related key symptoms has been a key difference between students with and without school refusal. Cognitive behavioral therapy, which we'll be talking a lot about today, with a special focus on exposure and response prevention, are gold standard psychotherapy for the treatment of anxiety disorders and OCD, especially when there's avoidant component or behaviors that are being avoided because of that anxiety or OCD.

Our clinic published a study with Dr. Jacqueline Sperling as the first author about our intensive outpatient group-based treatment program called the McLean Anxiety Mastery Program, which utilizes a CBT and ERP approach to treat anxiety and OCD. We found that there was some evidence that our program, using that CBT and ERP-based approach, improved anxiety symptoms as well as addressed school avoidance due to those symptoms. Supporting this approach might be effective way to help with school avoidance. Next slide.

**Dr. Michelle Silverman:** Let's talk about what this actually looks like. EBSA can take many forms. It can look like kids dragging their feet in the morning, lots of arguments, somatic complaints, so things like tummy aches, headaches, especially in the morning or on Sunday nights. We see kids who report a lot of panic attacks before school or on the way to school, repeatedly calling or texting parents from school, or requesting that the school call home. Numerous trips to the nurse's office. Shout out to all the school nurses out there who get a lot of anxious visitors. Hiding in bathroom stalls during lunch, things like that.

In a few minutes, Elan and I will introduce a few case examples to bring this to life. Often, but not always, we see EBSA that occurs after a child who is already

predisposed to anxiety has missed several days or weeks of school due to a medical illness. They fall behind on work, they feel overwhelmed, and then they struggle to return to school after. That's a common theme that we've seen. In addition, EBSA is often accompanied by caregiver and school burnout, particularly for those kids where it's become a really chronic issue. We'll talk about burnout a little bit more towards the end. Next slide, please.

There are many mental health conditions and other environmental factors that can contribute to EBSA. For the purposes of this presentation, we're going to focus specifically on anxiety and related disorders. These are some of the most common diagnoses that we see contributing to EBSA. Social anxiety disorder is by far the most common, especially among adolescents. Other common diagnoses include separation anxiety, specific phobias, with emetophobia, or the fear of vomit, being the most common. Agoraphobia, panic disorder, and generalized anxiety disorder. We also see a lot of kids with perfectionism, which can show up as part of an OCD or a GAD diagnosis. Next slide, please.

**Dr. Elan French:** As Michelle mentioned, we wanted to talk about some case examples that we'll reference throughout our presentation in order to demonstrate how we use some of these assessment and intervention techniques and how they can be applied. One of these cases is going to be one of my past patients, whom I'll call Sam. Sam was a 10-year-old white cisgender boy in the fourth grade. He presented to our clinic with social anxiety, separation anxiety, as well as some specific phobias to heights, loud noises, and dogs.

Just beyond diagnostics, he had a lot of trouble with emotion regulation. There was some aggressive behaviors in the home setting, including light hitting of a parent, and also cursing, slamming doors, throwing objects when distressed, very anxiety-based driven. He had been pretty socially isolated for a couple months prior to treatment due to the school avoidance. Not only was he not going to school, but he wasn't really leaving the house much either.

Some notes about the family. He was raised by his mother, who was the primary caregiver. His father was involved a little bit in the picture, but did not do any of the care taking responsibilities, and he was an only child. Just to bring Sam a little bit to life, he was a really sweet kid. Prior to the anxiety, he was really adventurous. He would use the subway or in Boston, we like to call The T system to go all places by himself. He would even go on The T by himself. A couple of stops to some places that he would like.

He was interested in math, robotics, playing with Legos. This was a kid with a lot of strengths. However, anxiety really limited his life. Parent first noticed anxiety started in first grade. This was also right after the pandemic and then increased again in fourth grade. Around that time, a few days before school refusal started, patient was home alone when a pet died. We believe what he internalizes was, "Bad things happen when I'm alone at home without my mom." Then right after that, we saw school refusals start to surface.

Additionally, there was some social anxiety present that year. There wasn't any specific event that we could note that coincided with school refusal, but there was some complaints in wanting to leave home early a little bit before the actual school

refusal started. In the previous year, he had some history of bullying. He was in our program for 10 weeks. Next slide, please.

**Dr. Michelle Silverman:** I'll present an adolescent case example that I worked with at MAMP. I worked with Alice, we changed a couple of details for privacy. She was a 17-year-old girl who met criteria for primary somatic symptom disorder, as well as agoraphobia and GAD. She was with us for a total of 10 weeks in the program. She was a junior in a public high school, lots of strengths. She was a really popular girl, athletic. She played on her school soccer team, came from a close-knit family.

For Alice, the precipitating event for her school avoidance was that during her sophomore year, she was diagnosed with bronchitis, which eventually turned into mono, and she missed several weeks of school because of this. Then even as those acute symptoms improved, she continued to report symptoms like headaches, dizziness, fatigue, and nausea, which made it difficult for her to attend school and led to her eventually being placed on a medical leave of absence her junior year.

I just want to note, she did see numerous specialists. She had lots of medical workups, the results of which were all unremarkable. She was really distressed by her physical symptoms. She experienced a lot of anxiety in response. Specifically, she worried that she might pass out or vomit at school, or that some other health crisis might occur when she was in a public setting, and away from home or her parents, which she deemed like her comfort people, her comfort zone. Her symptoms led to significant impairment.

In addition to being placed on a medical leave, she stopped playing sports. She avoided going into stores or restaurants. She stopped practicing driving. She stopped seeing friends despite previously having been a really social and bubbly girl. Some of her safety behaviors, which are behaviors that help reduce anxiety in the moment but actually increase anxiety in the long run, were things like researching symptoms on the internet, excessively texting or calling parents, and frequently going to the school nurse. Next slide, please.

**Dr. Elan French:** Now we'll talk a little bit about how to assess for emotionally-based school avoidance. Similar to any clinical intake you might conduct, it's really helpful to get a diagnostic assessment as well as gather some background information, so family background, particularly academic history, social history, et cetera. Related to anxiety and OCD concerns, it's helpful to get information about the avoidance, and why school specifically might be avoided. This might include other stressors, other events that occurred around the time of school avoidance.

For example, if anxiety had previously been there before school avoidance, what changed during the time around the school avoidance? That could be really a clue in terms of what some of those fears about school, in particular, might be, and some other environmental factors contributing to school avoidance. Also, it could be helpful while you're doing this to think about this as a timeline of events about when certain anxieties started, as well as some of those environmental or stressful events.

One way you could get at what might be contributing to school avoidance, when a lot of times we have cases where kids have a lot of diagnoses, is looking at what happens on days where a kid is able to get to school and when a kid is not able to go

to school. That could really give you some information about what fears are at play, as well as maybe what is going on in the home environment. We often find that sometimes school staff, students, caregivers have different perspective and could give different types of insights. Gathering information from multiple sources, as well as, of course, other providers, healthcare workers, et cetera, could be really important. Next slide, please.

Here are just some example questions that you could ask. I won't read all of these out loud verbatim, but I could go over a couple of that I asked Sam. This first question, "I'm curious what feels hard or scary about going to school for you." Sam's answer to this question is that he specifically identified it was hard to be away from mom, and also that it was hard to be around other people. This, with follow-up questions, wound up being the two main reasons that made school hard. Then also asking, in particular, what he was afraid might happen when he's away at school. He identified he was afraid that something would happen to his mom, and then he would be all alone.

Then he was also afraid that peers would make fun of me. Confirming that separation and social anxiety disorders, again, were some of the main contributors to school avoidance. Other examples, as we mentioned in the previous slide that you could talk a little bit about, this wasn't as relevant for Sam because he was consistently missing school every day, but you could have a kid walk you through a day that they were able to get to school and really ask a lot of specific information about what the morning routine is like, what it's like at school drop-off or pickup, et cetera, to get information about what makes the school day hard. Next slide, please.

**Dr. Michelle Silverman:** Now we're going to transition into talking about some interventions, and we've broken these down into interventions that target the child, and then parents or caregivers, and finally, for schools. Just a quick disclaimer that we're going to cover what we think are the most important interventions, and how to apply them in ideal situations. Then later we'll troubleshoot some common obstacles that can arise. Next slide, please.

Starting with student-based interventions. The primary intervention that we use with kids with EBSA is exposure and response prevention, or ERP. We always start with providing psycho-ed on ERP first. We talk about anxiety, the role of avoidance, and then we get to collaboratively building an exposure hierarchy. When building the hierarchy, you want to explore any areas of avoidance relating to school. Watch out for things like avoidance raising hand in class, taking exams, specific classes the child might be avoiding, perhaps by going to the school nurse.

I once had a patient who would stall in the morning so that she missed first period. For a lot of kids with GAD and social anxiety disorder, I found that unstructured times of the school day, things like recess, lunch, the start of school before the bell rings, or in between classes is particularly anxiety-provoking for these kids because there's no script, there's more uncertainty, there's just that lack of structure, and they feel a lot more awkward. It can be helpful to get input from parents and school staff as well in terms of what are they observing, what are they seeing the child avoiding in school, to help inform exposures for the hierarchy.

Then, in addition to school-based exposures, you want to incorporate other exposures that target the underlying core fears of the anxiety, even if they don't directly involve school. For example, for kids with panic disorder, we teach them interoceptive exposures, which are exposures that stimulate the physical sensations associated with anxiety and panic. For example, shaking their head side to side quickly for 30 seconds to trigger that feeling of dizziness, breathing through a small straw to mimic shortness of breath.

The goal of these exposures is to teach patients that they can tolerate the discomfort and that the symptoms will pass. We wanted to share a few condensed versions of the exposure hierarchies for our two case examples. Next slide, please.

**Dr. Elan French:** First, I'll go through some of the school exposure hierarchy that we created for Sam. I want to just first highlight the first item on the list, or the highest in that latter, this was an item early on in treatment, which was sitting in the back of the classroom for five minutes with support of the school counselor. I highlight this because oftentimes I think schools, parents, even therapists sometimes think that just going to school for five minutes, that should be an easy first step. Actually, there might be some other exposures that you need to target even before entering the classroom.

I often find that that's the case when some of the school avoidance in the classroom might be related to social concerns, about other peers seeing them, and maybe they haven't even been to the school in a long time. There could be other items that you could do even before you go back to the classroom. For Sam, for example, we did exposures related to first him just walking up to the building and giving it a high five in the morning. He met his teachers before school started, so he could get used to seeing them outside of the classroom first.

We also set up play dates with some of his peers that were in his class, so he could get used to seeing those peers before he sees them in the classroom. Additionally, as Michelle mentioned, we also did, in addition to these exposures you see here, exposures related to social anxiety and separation anxiety fears not in the classroom as well. Some of those exposures, for example, for social anxiety involved going on a five-minute walk by himself, later going on longer walks or riding his bike places. For social anxiety, having conversations with others, ordering for himself, going to store and purchasing things, asking people questions.

We also, a lot of times, do mock school days where he would practice raising his hand in class and asking a question, practice getting things wrong to sit with that uncertainty of possible judgment when we got something wrong, which is one of his specific fears. Next slide.

**Dr. Michelle Silverman:** These are some examples of school-specific exposures that I did with Alice. Again, this is our 17-year-old with primary somatic symptom disorder. Some of the things that were really at the top of her hierarchy were eating lunch in the cafeteria and attending one of her Gen Ed classes, being outside of the therapeutic classroom, and being with more of her friends. Then some things were at the lower end. Again, this is a condensed hierarchy. We're meeting with teachers one-on-one, sitting in the car with her mom during the morning drop-off period when

there were lots of kids around, going to soccer practice, and completing some of her schoolwork for her general education classes, but not actually attending.

One thing I just want to highlight is that doing schoolwork in a library or another location can be a really effective exposure for kids who are on medical leave or are having trouble even getting into the building because it allows them to practice being in a less familiar environment outside of the home, and it can serve as a good proxy for school. Then a few examples of those non-school exposures that we had Alice do that still connected to that core fear. We had her do some interoceptive exposures. We had her run on a treadmill. She did some driving practice. Then we often had her mom leave during groups. Next slide, please.

Since the McLean Anxiety Mastery Program, where Elan and I work, is primarily a group-based program, we try to get creative with exposure so that all, or at least the majority of the patients, can participate in them together. We found that this group-based element, it makes the exposures feel more realistic to school because that's where kids are surrounded by peers. It also helps them feel less alone with their experiences. I'm biased, but I also just think it's more fun than individual ERP when the kids are all together, having done both.

These are a few of the common group exposures that we tend to do with the adolescents on our adolescent track. As Elan mentioned, we do a lot of mock classes. We might do a mock English class where the clinicians are the teachers. We've done music classes, history, science, you name it. We'll go outside and do a mock PE class, mock lunch where we all eat together, and the kids have to make conversation. We'll have them do either individual or group presentations. Group ones are especially good for social anxiety.

We'll have them do debates. We'll have them email their actual teachers, or they can practice emailing clinicians, and we can pretend to be the teachers making phone calls, doing a talent show. Social cost exposure. Things that really bring up feelings of embarrassment, awkwardness, like improv games, messing up their appearance, skipping down a street. We'll have them do imaginal scripts where they write out a worst-case anxiety scenario and then read it. Then those interoceptive exposures that I mentioned.

Then we also incorporate what we like to call secret missions, which are just adjunctive exposures that align with the child's individual goals. For example, if we have a child with separation anxiety disorder, in addition to that group-based exposure, we might also have that child's parent leave the clinic during group, so they're getting that added element. For a child with perfectionism, a really common secret mission we do is we'll have them intentionally make a typo during a group presentation to really sit with that uncertainty that other people are going to judge them. Next slide, please.

Like any good CBT therapist, we always assign exposure homework so that patients can really practice generalizing their exposures and their skills outside of session. Whenever possible, we try to set homework goals collaboratively and that align with the patient's values. I try really hard not to just say, "Okay, this is your action plan, this, and this," but we talk about it. We say, "Well, what would you like to work on this week, or what would you like to work on for tomorrow?"

For example, if I have a patient with a metaphobia who really values friendships, I might have them practice going out to eat with a friend and have them choose a trigger food or an anxiety-provoking food to eat while there. If time allows, it's helpful to identify any potential barriers that the child thinks might get in the way of doing homework, whether it's forgetting, lack of time, low motivation, those tend to be the most common, and then trying to do some problem-solving in advance and talk about, "Well, how might you deal with that? How can you help yourself remember?"

We always start groups by reviewing homework. If an item was not completed, we briefly discuss what got in the way. We try to have the patient complete it in session if possible. Then, with some kids, it can be helpful to periodically check in with their parents or school staff just to make sure that the kids actually are completing their action plans or their homework, that's what we call them at MAMP, action plans, and that they're following through with the exposure. Since we're not actually there with them to make sure. Next slide, please.

ERP is the primary intervention that we use to treat EBSA, but we also sprinkle in other evidence-based skills to help support kids with their anxiety. I'm not going to go into a ton of detail for time, but I just wanted to give a brief overview of some of these skills and how we might apply them. Cognitive restructuring, also known as Catch, Check, Change. For this one, we work with the kiddo to really identify unhelpful thoughts that might be contributing to the school avoidance. We have them check the evidence, and then we have them reframe it into a more helpful thought.

For example, a really common thought that a lot of kids share with me is that everyone's going to wonder where I am, they're going to ask me lots of questions when I go back to school. Maybe we would reframe that thought into, a few people might ask me questions, but most people are probably just focused on themselves. Then cognitive defusion, which comes from ACT, or Acceptance and Commitment Therapy. It's another helpful cognitive strategy. The goal here is to help kids notice their thoughts non-judgmentally, and then use different strategies to get some distance from those thoughts.

We try to use a lot of creative and playful defusion strategies. For example, if a child is having an unhelpful thought, like "everyone thinks I'm a loser," we might have them practice singing it to the tune of Happy Birthday. If they're worried that they're going to pass out, we might have them say it 10 times really, really fast and then 10 times really slow or in silly voices. Relaxation strategies are always helpful to review and to help manage overall stress. Things like diaphragmatic breathing, progressive muscle relaxation, guided meditation.

Then distress tolerance skills are especially helpful for kiddos who get pretty dysregulated. We teach them a lot of skills from DBT. Things like tip skills, particularly ice dives are really helpful, helping them mindfully focus on different sensations, STUN waves, like that. Then coping kits and cope ahead plans are really helpful for helping kids figure out how to proactively prepare for upcoming stressors. For the coping kits, we have them actually put together during session different items that can help them use skills. Things like disposable ice packs, they have those ones that you can crush, and then they get cold. Fidget toys, scented lotion, sour candy, or even just sticky notes with reminders of different skills that they can use.

Then for the cope ahead plans, we have them actually identify an upcoming stressor. It could be a big exam, sports game, a different parent bringing them to school than usual, and then planning ahead for what skills they can use to cope. Then having them practice visualizing themselves using those skills in that situation. Next slide, please.

**Dr. Elan French:** Next, we'll talk about strategies you could use with caregivers. Oftentimes, caregivers feel a lot of pressure to have their kids go back as soon as possible. There's obviously a lot of demands in their personal life, for example, work responsibilities. They might see their kid falling more and more behind at school. Understandably, I think there's a lot of pressure to get kids back as soon as possible. What I think we've seen is if you rush through some of these steps, it's not helpful. Oftentimes, a lot of the kids that we see have had trouble going to school for months or even years. It's going to take a while to rewire those neural pathways.

Some of the things that we could then focus on are-- One of the things I think, as Michelle highlighted a little bit earlier, is trying to change the environment to make it more school-like. That could either be making the environment at home more school-like, so for example, during the day having no electronics, no preferred activities during the day, instead maybe do school-based activities like homework, studying, attend virtual classrooms, et cetera, or going to another environment such as the library could be really effective too.

The idea, if it sounds boring to just sit there with no preferred activities at home alone on your desk all day, that's the point. We want home to not feel more reinforcing than school, so we'll also instruct parents to try to interact with their kids as little as possible during the day, to not have extended long lunch breaks together, to really build upon those independent skills that they're going to need to go back to school.

Additionally, we see a lot of accommodations related to school refusal. Some common accommodations are requests to get picked up early or reassurance seeking, responding to text, and really role-playing how to respond to these situations could be really helpful. It's one thing to say, "I'm not going to respond to those early pickup requests." I think kids know exactly what to say to their parents in order to really pull on their heartstrings, so really having some rehearsal about what they're going to say, how they're going to say it, and respond to different things that could happen could really be helpful.

At MAMP, we do use a tangible reward system. We call them stars, which are points that they could use to save up to different rewards. What we find is it's really helpful to have both some short-term rewards that they could cash in at least every week or so, if not more often than that, and then also a bigger reward to look forward to as well. Having things of very different values for the star system is really helpful.

Then, additionally, it's really helpful to teach the caregiver some emotion regulation skills. Not only so they could help their kids use it, but also for themselves too. I also find that having them have space in order to practice those skills are really helpful. For example, if during drop-off at the beginning of the morning is a really stressful time, maybe their kid becomes dysregulated, maybe you could have a plan for the parents to step out of the car for a minute, give their kid a time to work on maybe a coping skill that you planned for them to work on in the car before entering the

building. During that time where they step out of the car, they could be trying to regulate their own stress and emotions at the same time.

Additionally, I think it's fair to name that this is a pretty burnout-inducing process for all parties involved. Parents are going to get pretty burnt out, especially if they've had a kid with school avoidance for quite a while. Increasing their support system and finding other individuals who could help is really helpful when possible. This could be grandparents, this could be neighbors, this could be maybe like an after-school program if the kid is willing to go to school, and maybe that's a less stressful environment for them, but really, any way to increase their support is helpful. Next slide, please.

Some examples for Sam. One thing that Sam was doing when he was home alone is he was using a lot of screens. He was getting some attention from family members, so really reducing his access to screen and preferred activities during the school day was really helpful for motivation to go back to school. Some of the rewards that Sam was very motivated to get was Lego sets. I don't know if anyone has bought Lego sets in the last five years, but they are ridiculously expensive.

One of the ways that we broke up the Lego sets, too, is-- I don't know if anyone has used Legos in a while, but they come in little bags. There's bag one, bag two, bag three, so he could earn one bag at a time, which made this reward more financially affordable for the family. It was cool because he would be able to build his Lego set as he made progress in treatment, which was also cool. I think if there's a reward item that a kid wants and it's more expensive, you could think about ways, if it has different components, to break it down into smaller rewards.

Additionally, this was a single parent and didn't have a lot of money. We find that monthly passes were helpful, so Sam really liked going to the arcades. Mom, I think, found a monthly subscription to one of the arcades, and so he was able to cash in his stars for this trip to the arcade, which, again, having that monthly pass made it more affordable. We recruited some help of other relatives. Mom, being a single parent, was very burnt out, but there was an uncle that lived close by. Mom was actually really reluctant to ask other caregivers or other people for support, but she was willing to at least drop Sam off during less stressful times, which gave her a little bit more time for self-care. It was even helpful for Sam to go over this relative's house, even one hour a day, to give Mom a break. It was also a great separation exposure for Sam as well.

Additionally, I find that a lot of parents have beliefs about reducing accommodations, like that their kid is in really high distress, that they need their support, that it's cruel to not provide support when your kid is in such high distress. I think really going through those beliefs, challenging them, challenging those parental instincts to protect, and also giving some space to both validate and challenge them is really helpful. Next slide, please.

**Dr. Michelle Silverman:** Now we'll review some strategies to use when collaborating with school staff. At the start of treatment, you want to identify a point person from the school. Ideally, this is going to be someone with whom the child feels relatively comfortable, like a guidance counselor, a school psychologist, or an academic advisor. That individual's role is going to be to collaborate closely with you and the

family on the patient's treatment goals, to help facilitate the child's exposures at school, to communicate plans with other important key players, and to relay any challenges that come up in school.

It's important that both you and the parents have consistent communication with that individual. Then we try to provide some basic psychoeducation to that point person and any other school staff on the child's diagnosis, what ERP is, what subjective units of distress or SUDs are, that scale from 0 to 10, where we have them measure anxiety on their hierarchies. We talk about the role of avoidance and accommodation. We talk about what safety behaviors are. How to foster an approach mindset. A lot of basic psychoed about the work we're doing.

I often find it helpful to make a little cheat sheet or a glossary with key concepts that I email out to school staff so that they can reference that. One thing I really advise staff to watch out for, particularly school nurses and guidance counselors, is them becoming the skill themselves for the child. Meaning that the child is becoming reliant on going to that individual for soothing or for distraction, whether it's through games or long conversations, because that can ultimately reinforce avoidance of going to class, and it makes them dependent on others to cope.

That leads me to the next important point, which is teaching a few of the key coping skills to the school staff so that they can prompt the student to use the skill. Maybe do it together with the goal of bringing down anxiety enough just so that the student can return to class. We always emphasize that a lot of these skills are not going to take away the anxiety. They're not going to bring it down to a zero, but if you can bring that intensity down just enough to help that child go back to class. Things like box breathing, holding an ice pack to their cheeks, practicing that Catch, Check, Change, and bossing back anxious thoughts. Those are some really helpful skills that the school staff can reinforce for the child in school.

Then lastly, really being careful about what academic accommodations you're recommending or discussing with the school. This is where we want to distinguish between anxiety accommodation and academic or IEP accommodations, although they can certainly overlap in some cases. When thinking through academic accommodations for students, I really encourage schools to consider, what has the student missed academically, what do they need to receive credit for the year, and what are their specific areas of avoidance?

For example, if there's a student with social anxiety disorder, I might recommend that that student be exempt from giving presentations to the entire class, and instead is just permitted to present one-on-one with a teacher at first. For students with perfectionism, I often advocate to have them work on homework for a set amount of time. Stop when that timer goes off, and then to only be graded on what they've completed.

The big caveat with this, though, is that we want to keep these accommodations short-term, and the goal is to phase them out over time. I always try to be really transparent with the families and schools that these are things that we don't want the child to become dependent on forever, but they are meant to be short-term. Next slide, please.

These are just a couple examples of the school-based interventions that we used for Alice. We identified her therapeutic classroom coordinator as her point person. She was really close with that individual. We had weekly calls or emails with the school. I CC'd them on daily updates from our program on homework. Shared some of her favorite skills that they could reinforce in school.

Then one thing that came up for her in particular is that I really encouraged the school to be transparent about what she needed to complete academically in order to be eligible to participate in sports. She was very motivated to get back to soccer. I felt that it was important that the school really let her know that this is the bare minimum of how many classes you need to attend, how much work you need to be doing, and to be able to participate in sports. Next slide, please.

**Dr. Elan French:** Next, we're going to talk about some barriers that could happen in treatment and how to troubleshoot them. Next slide, please. For the sake of time, I actually won't list them because we're going to go through them one by one and go over how to address some of these common barriers. I will pass it over to Michelle. Next slide, please.

**Dr. Michelle Silverman:** One of the most common challenges that comes up in treating EBSA are what I lovingly refer to as the morning battles. These are all the conflicts that come up in the morning before school when anxiety and other emotions are often at their highest. This looks like the child refusing to get out of bed, difficulty executing morning routines, having a hard time getting in the car or on the bus, difficulty separating at school. As you can imagine, this can lead to a ton of arguments, a lot of burnout for other family members. These are a few strategies that can help address the morning battles.

The first is that for younger kids who have difficulty with executive functioning, we like to have them write out and post their morning routine near their bed so that they can reference it without relying on their parents for each step. I also encourage kids to prep as much as they can the night before, so packing their backpack, picking out their clothes, making lunch, et cetera.

The next one might seem obvious, setting reminders and alarms, but I am actually often shocked at how many teens are not good at being strategic about how they set alarms. Having them set multiple alarms, picking an alarm that actually has a very loud or obnoxious sound that goes off. They make alarms that emit a bright light. They have ones that vibrate. I often have them place their alarm across the room so they're not just sitting next to their phone and hitting snooze and going back to bed. I will usually have kids do this during our session so that they don't forget to do it for homework. I'll say, "Okay, let's get up. Let's go set those alarms right now."

I've also had several adolescent patients who really like the Alarmy app, which I hadn't heard of previously. It's an app that makes you solve a puzzle or some sort of problem in order to turn the alarm off. It forces your brain to wake up more. Several teens have put in a plug for that app. Then for younger kids, you can have parents set up a simple reward system so they can earn a star for completing each step of the morning routine independently. Then they can cash in those stars, let's say on Fridays, for a small treat.

For kids who have trouble separating at school, we like to come up with a plan in advance to decide what the parent's role will be, how long the parent will wait once the child gets out of the car, what skills the child can use if they're feeling anxious. That's where those cope-ahead plans can come in, how to incorporate rewards. The goal is really to be proactive about this so that no one is making decisions in the heat of the moment when emotions are high and it's easier to give in to anxiety.

Then lastly, family sessions are a great place to talk about the different challenges that can come up and to collaboratively problem-solve solutions. I find that kids are often really good at coming up with loopholes in the plan. I actually like to be pretty transparent and say, like, "What do you think is going to get in the way if anxiety is being really loud and bossy? What loopholes could you find?" Then we plan around them in a collaborative way. Next slide, please.

**Dr. Elan French:** Okay, so now we're going to talk a little bit about emotion dysregulation and behavioral challenges. I think for all teens and kids, especially I think some of the younger kids, they have not developed a lot of emotion regulation skills. As Michelle was saying, we work on building up their coping skills. I specifically find that having them write down their skills as they learn them and identify which ones are helpful to have. She usually likes an index card, something small that they could bring with them, something that's not on their phone. Oftentimes, they're not allowed to have phones in the classroom, so something that they could put in their book bag or pocket.

Oftentimes, I will divide this coping card into things to use when anxiety is low to medium and skills to use when anxiety is high because a lot of times when anxiety is really high, some of those cognitive strategies that they have, they're not going to be able to access them because their brain is not fully online when anxiety is really, really high. They might have to use some of those, for example, tip skills, ice diving, maybe going to the nurse's office and getting an ice pack on there before then they can maybe use some of those cognitive strategies.

I also often send a copy of those skills to the guidance counselor and have them print it out or keep it in their office so that when the kid comes, the guidance counselor has them and can help them identify them as well. Another thing that I like about a coping card is I find, especially actually for teens, that when a parent suggests to use a coping skills, teens automatically get defensive. Even if it's a strategy that they said that they like, all of a sudden, they are not interested in using it. Having a parent, for example, say, like, "Why don't you just refer to the coping card," and build some independence of kids to be able to use skills themselves, and also reduce this tension of caregivers or even school staff from being able to pick it out and identify it for the kid.

Another strategy that I'll briefly go over is active ignoring. This is a strategy where you are ignoring behaviors that you want to see less, intentionally. That means not giving any attention, not just verbally, but reducing eye contact, facial expression, nonverbal cues. It's called active ignoring, but the way I like to think of it is you are waiting for the right time to reinforce the behavior you want to see, so you're not accidentally reinforcing the wrong thing.

If a kid is yelling or cursing, those are behaviors that we'd want to see left. We might use active ignoring and wait for them to ask for help in a positive way, and then immediately reinforce that behavior, and then give them a lot of praise for being able to do that. Additionally, this might seem obvious to use validation, but I often find in the heat of the moment, validating a child's concerns might not seem like a priority when a parent is really busy and they just need their kid to go to school, but really taking that time and specifically doing the validation first before setting an expectation could be really helpful.

There's been a lot of research that suggests even naming how a kid is feeling. Showing that you understand and that their feelings make sense could bring down anxiety even by itself. For younger kids, timeout protocols could be really helpful, especially as you're increasing expectations to go to school. Maybe you're also making school contingent on earning screen time. There's something that we call the extinction burst, or when a behavior that we don't want to see is exhibited more before it decreases.

Having kids who have aggressive tendencies, for example, for Sam hitting his mother, his mother having a protocol that she could use when we were using unsafe hands, using a timeout protocol was really helpful. Also, communicating with school staff about what they can do when kids are dysregulated, I've also found really helpful. When relevant-- this might seem obvious, but I think especially for kids with school avoidance, having a safety plan if there's any safety concerns.

Even if there isn't safety concerns, oftentimes it could just be really distressing for kids who have avoided to go to school. If they're going more, their distress is going to increase. Having plans, making sure that everyone is aware of what safety plans are in place is really important. Next slide, please.

**Dr. Michelle Silverman:** I'm mindful of the time, so I'll move through these pretty quickly. I just want to name that with any therapeutic work, low motivation or willingness can always make it that much harder. Some of the strategies that we draw on with kids with EBSA are engaging in values or motivational work. I think if you can find out what's important to kids, talk about the kind of person they want to be, you can then help them connect those goals to their exposures.

I think trying to start with the exposures that are most closely aligned with the child's values, even if it's maybe not the parent's primary goal, can be helpful. Alternatively, you can start with more of the low-hanging fruit exposures, the ones that feel a little bit easier, but help give the kids a sense of mastery or confidence. Contingency plans are not my first go-to intervention, but they can be quite effective when needed. That usually looks like establishing new rules around screen time privileges so that they're contingent on the child doing their school-based exposures.

I will just say, make sure that if you're going to introduce that, you do it, or encourage parents to do it during a calm moment, not in the heat of the moment, warn them about extinction bursts. Then, if needed, if some kids are just totally refusing to engage, we encourage parents to do more parent-focused work, so SPACE, which is supportive parenting of anxious childhood emotions. That's an evidence-based protocol that came out of Yale, can be really helpful for parents. When kids are stuck, parent management training or PMT, we might refer them to folks who do that.

Obviously, for kids who are just really struggling in treatment and are having significant behavioral issues, emotion dysregulation, consider referring them to a higher level of care. I'm usually pretty transparent with families about that one because I find that sometimes even just having that conversation is enough to shift willingness. It really shows that all the adults are taking this seriously, that this is a crisis, and that if you're not willing to participate, this is what next steps would look like. Next slide.

**Dr. Elan French:** I'll just quickly go over the slide about difficulty following through with plans. You could have the best plan in the world, but if it's hard to implement, obviously, it's not very helpful. When a behavior plan isn't followed, really getting information about what the barriers were. Was it distress? Was it time restriction? Is it burnout? Is it a lack of buy-in? Are both parents not on the same page? Based on that, you could recommend different interventions.

A really simple thing that I found helpful is just having a printed-out copy of a plan and having caregivers go over the plan with the child every day. For example, if the plan is for them to attend one class that day, even going over that, what it's going to look like, what period they're going to-- what teacher is going to take them to the classroom if that's part of that plan that day, and really breaking it down as helpful.

Setting up smaller tangible goals. If one of the goals hasn't been reached, maybe we need to break that goal up into smaller steps. Really scheduling meetings with all parties present. Caregivers having school meetings, they are time-consuming. I find them really helpful and, in the long run, time-saving if everyone could get on the same page. Then I think also role-playing things related to behavior plans with parents, what to do in different situations, and actually role-playing it could give them some practice and confidence to implement that in the moment. Next slide.

**Dr. Michelle Silverman:** Then the last barrier, or one of the last barriers we'll talk about today, is tension between families and schools. I just want to preface this by saying this, for me, has been the exception, not the rule. I actually find most schools are really wonderful to collaborate with, and they're really eager to help support these kids. When tension does happen, it can put you in a pretty uncomfortable position. Some of my primary recommendations are to call a team meeting or a review of IEP or 504 plans, like what Elan was just saying. I usually find that this is helpful to reduce splitting, to make sure everyone's on the same page.

I usually lead those meetings, and I try to set an agenda at the start so that we stay on task. If things are really starting to get contentious, I'll recommend that parents get an educational advocate. Those folks are professionally trained in special education law. They can help clarify a family's rights, attend IEP meetings with them so that you're not becoming the middleman. Then finally, I think my biggest piece of advice here is to really clarify your role from the beginning and stay in your lane.

I let families and schools know that my primary role is to advocate for the child's mental health. I can't weigh in on services that fall outside of my area of expertise. I let families know that I can share recommendations, but it is ultimately up to the school about what they feel is reasonable, what they want to implement. I certainly always try to validate both school staff and family members when there are frustrations, but I really try to stay as neutral as possible, avoid taking sides. This

might seem obvious, but when you are feeling really burnt out, it can be an easy trap to fall into. Next slide, please.

**Dr. Elan French:** We will finally talk about clinical burnout. I'll just mention this quickly. I think it's definitely something important to name that this is hard. Getting kids to go to school who haven't been to school in a while is really challenging. Validating yourself, giving yourself space to share experience with others, whether it be your clinical team, consultation, supervision. I also find that parents understandably are very stressed, and there's a lot of reaching out to you, school systems reaching out to you for support. Maintaining boundaries of when you could reply to calls, emails, how you're going to reply to them, what times you're checking your emails, et cetera, could be really helpful to establish from the beginning.

As Michelle said earlier, if a kid needs a higher level of care, naming that as an option, thinking about what the criteria might be for you to refer to higher level of care could be helpful. Also, I think one of the biggest hacks that I found is I think there's a lot of pressure for us to be the liaison between families and schools, but encouraging parents to communicate directly to schools not only could reduce your clinical burnout, but I also think it could help foster a relationship between parents and school systems as well. Next slide.

**Dr. Michelle Silverman:** We can move through these. These are just some take-home points that you'll get when you get the slides. Maybe we can move ahead to our Q&A. We also have some resources in here, including more information about SPACE. Our reference notes. Thank you. All right. I see we have a lot of great questions in the chat. Let's see. We have a question here from Annette. "How do you manage schools that do not have the capacity or are unwilling to engage in support for a child doing this type of treatment?" I think that's a really hard one because it really is so important to collaborate with the schools and to work closely. I haven't had this come up a lot. I've certainly had some [sound cut] harder to.

In that case, I really focus on the intervention. Practice, do as much as they can with us in session. Doing schoolwork, really practicing those things in a group therapy session. We'll do those mock classes. We'll do a lot of cope-ahead plans and really scaling up the family and the child, even if the school doesn't have the capacity to provide as much hands-on support. I don't know, Elan, if there's anything you want to add to that one.

**Dr. Elan French:** No, I agree with that. I think just utilizing anything that you could take advantage of. For example, I had a parent come in during lunch to help a kid with doing an exposure. They went and did that exposure from the car and then came back to school. That was a creative way when school wasn't able to help them work with an emotion regulation school before they could re-enter the classroom. That was something that we did.

**Dr. Michelle Silverman:** We only have a minute or so left. I did see a few questions about kids who have autism spectrum disorder. I just wanted to quickly mention, obviously, this really varies on a case-by-case basis. We find that for kiddos who have comorbid ASD and anxiety, that the pace of treatment tends to go a little slower. I think we tend to give more concrete examples. Loading the distress

tolerance skills can be really helpful. Working on cognitive flexibility. There tends to be a lot of rigid or all-or-nothing thinking.

Then considering appropriate school support. Things like sensory breaks, wearing headphones in the hallway, allowing for stimming. Often, we do refer kids for neuropsych testing so that the families and schools can be given recommendations that might be helpful in an academic setting.

**[pause 00:58:24]**

**Dr. Michelle Silverman:** Do we have time for more? I know we were told to save a couple minutes at the end for the last few.

**Host:** No, we can go ahead and do our final thoughts. Thank you both so much. Thank you so much for joining us, Drs. Michelle Silverman and Elan French. Thank you to all our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

**[00:59:24] [END OF AUDIO]**