Four Reinforcers Predict School Refusal Behavior

BY BRUCE K. DIXON
Chicago Bureau

ST. LOUIS — Problematic family functioning merges with children's perceptions of positive and negative reinforcements to produce school refusal behavior, according to research presented at the annual conference of the Anxiety Disorders Association of America.

"It's important that we be aware of the relationship between family environment and school refusal behavior," said Gillian Chapman, of the University of Nevada, Las Vegas.

"This awareness is an essential step toward our ability to structure appropriate clinical assessment criteria and, ultimately, devise applied and appropriate therapy for children and families with school refusal behavior," she said.

Ms. Chapman is part of a team of UNLV researchers, led by Christopher A. Kearney, Ph.D., that is investigating the often complicated circumstances that lead to a child's desire to avoid school.

School refusal behavior is an umbrella term that covers many hypothesized subtypes of youths with problematic absenteeism, including truancy, school phobia, and anxiety-based school refusal, explained Dr. Kearney, professor of psychology and director of clinical training at the university.

"Refusal to attend school is a common and urgent problem, and it would benefit clinicians if they had a cookbook reference to help them identify and treat the various forms of this behavior," he said in an interview.

Through his previous research, Dr. Kearney has concluded that there are four primary functions, or reinforcements, that are the best predictors of absenteeism:

► Avoidance of school-related stimuli that provoke negative affectivity. Differential diagnoses or problems include panic disorder and agoraphobia; generalized anxiety disorder; specific phobia; and depression and suicidal behavior.

► Desire to escape aversive social and/or evaluative situations. Differential diagnoses or problems include social anxiety disorder, depression, and suicidal behavior.

► Pursuit of attention from significant others, usually the parents. Differential diagnoses or problems include separation anxiety disorder, oppositional defiant disorder, and noncompliance in response to most parental commands.

► Seeking of tangible reinforcers outside of school (or, it's "more fun" to be outside of school). Differential diagnoses or problems include conduct-disordered behavior such as stealing, setting fires, or aggression; substance abuse; and lack of motivation in many situations.

Avoidance of school-related stimuli that provoke negative affectivity is just one reinforcer.

DR. KEARNEY

These reinforcers maintain or reward school refusal behavior. The first two are negative reinforcements (avoidance behavior), and the second two constitute positive reinforcement, Dr. Kearney noted.

The goal of Ms. Chapman's research was to clarify the clinical distinctions among these four functions. She examined the roles of such contributing factors as family cohesion, communication, expressiveness, independence, enmeshment, achievement, and control.

It turned out that family conflict was significantly more common in children who sought reinforcements outside of school and that family enmeshment was more common in attention-seeking children.

Children in well-adjusted, healthy families may exhibit school refusal behavior merely because they're anxious, added Dr. Kearney. "They have good problem-solving and communication skills, but they just don't know how to solve the high anxiety."

Ms. Chapman also found that children who refuse school to get attention come from more dependent families than do those who refuse school for positive tangible reinforcement, and children who refuse school to avoid stimuli-provoked negative affectivity come from more cohesive families than do those who refuse school for positive tangible reinforcement.

As a group, the 182 families in the study scored below average for independence (that is, they had higher parent-child dependence and overindulgence), she said.

Mean family scores on the cohesion, achievement, intellectual-cultural orientation, active-recreational orientation, and organization subscales were also below normative levels. ■

Build on Basic Strategies to Treat Trauma-Exposed Kids

BY ROBERT FINN
San Francisco Bureau

HOLLYWOOD, CALIF. — In treating children exposed to trauma, think about the DEFs once the ABCs are taken care of. That's the message Nancy Kassam-Adams, Ph.D., delivered at the annual meeting of the International Society for Traumatic Stress Studies.

"After Airway, Breathing, and Circulation, think about Distress, Emotional support, and Family," said Dr. Kassam-Adams of Children's Hospital of Philadelphia.

A large percentage of children experience a serious injury or other trauma at some time during their childhood, and according to at least one study, 16% have posttraumatic stress symptoms months later, she said.

Parents are more likely to turn to their family doctor than to anyone else when seeking psychosocial assistance for children with acute stress, and in the 6 months after a serious injury 80% of families pay a median of three visits to their primary care physicians. These are golden opportunities to intervene and perhaps to prevent serious cases of posttraumatic stress disorder, Dr. Kassam-Adams said.

A child may experience distress from physical pain, anxiety, and grief or loss. One way to help is by assessing all of these factors, listening carefully to how the child understands the situation, correcting any misconceptions, and treating the child's physical ailments in a way that maximizes his or her control over the situation.

Reassurance and realistic hope can also be provided, and bereavement resources can be mobilized when necessary.

In assessing emotional support, ask both parent and child what works to help the child cope with difficult or scary things. Remember that the injured child is part of a family system, and other members of the family may have suffered injury or trauma as well.

Try to determine whether the family is coping well with the trauma and whether they will need outside help. ■

After the ABCs: DEFs of Traumatic Stress

D	**Distress**	Assess and manage pain. Ask about fears and worries. Consider grief and loss.
E	**Emotional support**	Ask who and what the patient needs now. Determine whether there are barriers to mobilizing existing supports.
F	**Family**	Assess distress in parents, siblings, and others. Gauge family stressors and resources. Address other needs, possibly beyond the medical.

Source: Dr. Kassam-Adams

Suicide Attempts Linked to Dating Violence, Sexual Assault

BY MARY ANN MOON
Contributing Writer

Urban adolescent girls who have been hit or physically hurt by a boyfriend in the past year are 60% more likely to attempt suicide than those who have not, reported Dr. Elyse Olshen of Columbia University, New York, and her associates.

For urban adolescent boys, date violence does not raise the risk of attempted suicide, but a history of being sexually assaulted does. And for both boys and girls, those who say they are gay, lesbian, bisexual, or unsure of their sexual orientation are more likely to attempt suicide than are those who identify themselves as heterosexual.

Clinicians "should have a low threshold for referring these at-risk teenagers for mental health services," the researchers said. One way to avoid these problems is to routinely screen urban youths for these risk factors, they said.

Dr. Olshen and her associates examined the relationships among dating violence, sexual assault, and suicide attempts using data from the 2005 National Youth Risk Behavior Survey, a biennial survey of public high school students conducted in states and localities across the United States and supported by the Centers for Disease Control and Prevention. They analyzed the results from a New York City sample that was predominantly African American and Hispanic—representative of that city's general high school population and generalizable to urban youth populations throughout the United States.

A total of 8,080 students from 87 New York City schools answered the anonymous and voluntary 99-item questionnaire. A total of 40% of girls and 24% of boys reported persistent sadness during the preceding year, and about 20% of girls and 10% of boys reported suicidal ideation.

Nearly 12% of girls and more than 7% of boys reported one or more serious suicide attempts in the preceding year, the investigators said (Arch. Pediatr. Adolesc. Med. 2007;161:539-45).

Nearly 10% of girls and more than 5% of boys reported a lifetime history of sexual assault. The prevalence of dating violence in the preceding year was nearly 11% among girls and nearly 10% among boys.

Recent dating violence was associated with a 60% higher risk of attempted suicide among girls. "This association is similar in magnitude to that reported among predominantly white adolescent girls" in studies from two New England states, which suggests that there are no major racial or ethnic differences in the relationship between violent or sexual victimization and suicide attempts, Dr. Olshen and her associates said.

For adolescent boys, recent dating violence was not associated with suicide attempts, but a history of sexual victimization was. "These marked differences between adolescent boys and girls are striking and bear further investigation," the researchers noted. ■