

Dealing with school refusal behavior

A primer for family physicians

Workable solutions for unhappy youth and frustrated parents

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Practice recommendations

- You can help assess forms of a child's school refusal behavior as well as reinforcers that maintain the problem (B).
- All youths with school refusal behavior should be assessed for severe anxiety and depression (C).
- You can treat medical conditions associated with school refusal behavior, provide pharmacotherapy for severe anxiety and depression, and work with school-based personnel and a clinical child psychologist to gradually reintroduce a child to school and address comorbid educational, psychological, and familial problems (A).

Nathan is a 13-year-old boy referred by his parents to a family physician for recent school refusal behavior. Nathan has had difficulty adjusting to middle school and has already been marked absent one-third of school days this academic year. These absences have come in the form of tardiness, skipped classes, and full-day absences. Nathan complains of headaches and stomachaches and says he feels upset and nervous while in school. His parents, however, complain that Nathan seems fine on weekends and holidays and seems to be embellishing symptoms to miss school. Nathan's parents are concerned that their son may have some physical or mental condition that is

preventing his school attendance and that might be remediated with medication.

Child-motivated refusal to attend school or to remain in classes for an entire day is not that uncommon. The problem affects 5% to 28% of youths at some time during their lives and is often referred first by parents to the attention of a family physician.¹⁻²

The behavior may be viewed along a spectrum of absenteeism (**FIGURE**), and a child may exhibit all forms of absenteeism at one time or another. In Nathan's case, for example, he could be anxious during school on Monday, arrive late to school on Tuesday, skip afternoon classes on Wednesday, and fail to attend school completely on Thursday and Friday.

In this article you will learn characteristics of school refusal behavior to watch for and assess, and treatment strategies for youths aged 5 to 17 years. You will also find advice and techniques to offer parents.

■ Characteristics of youths with school refusal behavior

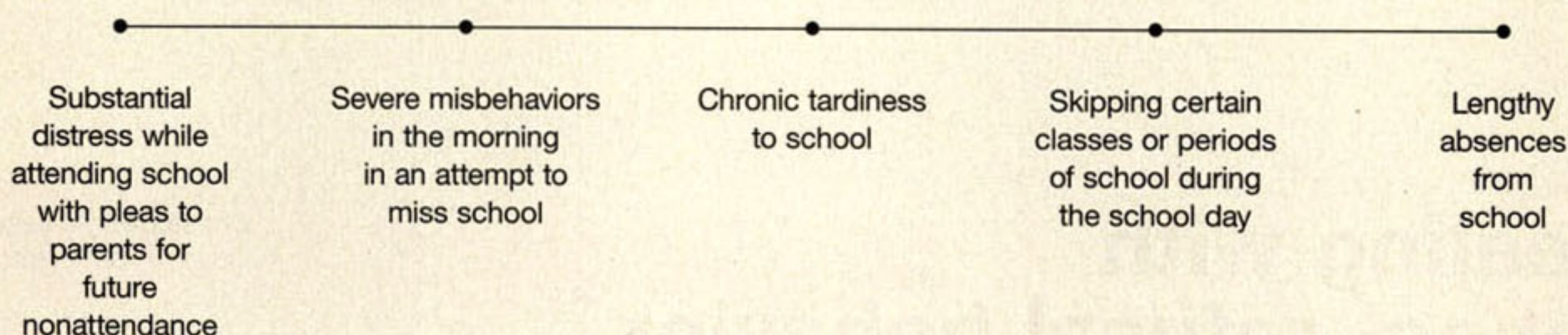
School refusal behavior is a term that encompasses all subsets of problematic absenteeism, such as truancy, school phobia, and separation anxiety.³ Children and adolescents of all ages, and boys and girls alike, can exhibit school refusal behavior. The most common age of onset, however,

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FIGURE

A child may exhibit each behavior on this spectrum at different times



is 10 to 13 years. In addition, youths who are entering a school building for the first time, especially elementary and middle school (as was the case for Nathan), are at particular risk for school refusal behavior. Little information is available regarding ethnic differences, although school dropout rates for Hispanics are often considerably elevated compared with other ethnic groups.⁴⁻⁵

School refusal behavior covers a range of symptoms, diagnoses, somatic complaints, and medical conditions (**TABLES 1-3**).⁶⁻¹² Longitudinal studies indicate that, if left unaddressed, school refusal behavior can lead to serious short-term problems such as distress, academic decline, alienation from peers, family conflict, and financial and legal consequences. Common long-term problems include school dropout, delinquent behaviors, economic deprivation, social isolation, marital problems, and difficulty maintaining employment. Approximately 52% of adolescents with school refusal behavior meet criteria for an anxiety, depressive, conduct-personality, or other psychiatric disorder later in life.¹³⁻¹⁶

■ Getting to the bottom of school refusal behavior

If a child has somatic complaints, you can expect to find that the child is (1) suffering from a true physical malady, (2) embellishing low-grade physical symptoms from stress or attention-seeking behavior, or (3) reporting physical problems that have no

medical basis. A full medical examination is always recommended to rule out organic problems or to properly treat true medical conditions.

If no medical condition is found, explore the reasons a particular child refuses school. A common model of conceptualizing school refusal behavior involves reinforcers¹⁻²:

- To avoid school-based stimuli that provoke a sense of negative affectivity, or combined anxiety and depression; examples of key stimuli include teachers, peers, bus, cafeteria, classroom, and transitions between classes
- To escape aversive social or evaluative situations such as conversing or otherwise interacting with others or performing before others as in class presentations
- To pursue attention from significant others, such as wanting to stay home or go to work with parents
- To pursue tangible reinforcers outside of school, such as sleeping late, watching television, playing with friends, or engaging in delinquent behavior or substance use.

The first 2 functions are maintained by negative reinforcement, or a desire to leave anxiety-provoking stimuli. The latter 2 functions are maintained by positive reinforcement, or a desire to pursue rewards outside of school. Youths may also refuse school for a combination of these reasons.¹⁷ In Nathan's case, he was initially anxious about school in general (function 1) but,

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The School Refusal Assessment Scale—Revised (Table 4) enables evaluation of negative and positive behavior reinforcers

after his parents allowed him to stay home for a few days, was refusing school as well to enjoy fun activities (eg, video games) at home (function 4).

One method for quickly assessing the role of these 4 functions is the School Refusal Assessment Scale–Revised.^{18,19} This scale poses 24 questions, the answers to which measure the relative strength of each of the 4 functions. Versions are available for children and parents, who complete their respective scales separately (**TABLES 4 AND 5**). Item means are calculated across the measures to help determine the primary reason for a child's school refusal.

In addition to using the School Refusal Assessment Scale–Revised, you may ask interview questions regarding the form and function of school refusal behavior (**TABLE 6**). Take care to assess attendance history and patterns, comorbid conditions, instances of legitimate absenteeism, family disruption, and a child's social and academic status. Specific questions about function can help narrow the reason for school refusal.

Assess specific school-related stimuli that provoke absenteeism (eg, social and evaluative situations), whether a child could attend school with a parent (evidence of attention-seeking), and what tangible rewards a child receives for absenteeism throughout the school day. Information about the form and function of school refusal behavior may also be evident during in-office observations of the family. Data from the School Refusal Assessment Scale–Revised, interviews, and observations can then be used to recommend particular treatment options.

■ Treating youths with school refusal behavior

Should you choose to address more than a diagnosed physical condition contributing to school refusal behavior, various resources are available to you. Medications have proven useful in alleviating severe cases of anxiety and depression. And cognitive management techniques can

TABLE 1

Common symptoms that could signal school refusal behavior

| INTERNALIZING/ COVERT SYMPTOM | EXTERNALIZING/ OVERT SYMPTOM |
|----------------------------------|--|
| Depression | Aggression |
| Fatigue/tiredness | Clinging to an adult |
| Fear and panic | Excessive reassurance-seeking behavior |
| General and social anxiety | Noncompliance and defiance |
| Self-consciousness | Refusal to move in the morning |
| Somatization | Running away from school or home |
| Worry | Temper tantrums and crying |

TABLE 2

Primary psychiatric disorders among youths with school refusal behavior

| DIAGNOSIS | PERCENTAGE |
|--|------------|
| No diagnosis | 32.9 |
| Separation anxiety disorder | 22.4 |
| Generalized anxiety disorder | 10.5 |
| Oppositional defiant disorder | 8.4 |
| Major depression | 4.9 |
| Specific phobia | 4.2 |
| Social anxiety disorder | 3.5 |
| Conduct disorder | 2.8 |
| Attention deficit/hyperactivity disorder | 1.4 |
| Panic disorder | 1.4 |
| Enuresis | 0.7 |
| Posttraumatic stress disorder | 0.7 |

Source: Adapted from Kearney and Albano (2004).

be applied to the child, the parents, and the family together.

Treatment success will be better assured, too, if you work closely with

TABLE 3

**Rule out these somatic complaints
and medical conditions commonly associated
with school refusal behavior**

| SOMATIC COMPLAINT | MEDICAL CONDITION |
|---|--|
| Diarrhea/irritable bowel | Allergic rhinitis |
| Fatigue | Asthma and respiratory illness |
| Headache and stomachache | Chronic pain and illness (notably cancer, Crohn's disease, dyspepsia, hemophilia, chronic fatigue syndrome) |
| Nausea and vomiting | Diabetes |
| Palpitations and perspiration | Dysmenorrhea |
| Recurrent abdominal pain or other pain | Head louse infestation |
| Shaking or trembling | Influenza |
| Sleep problems | Orofacial disease |

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**Cognitive
management
techniques are
available for the
child, the parents,
and the family**

school personnel and a clinical child psychologist to gather and share information, coordinate a plan for returning a child to school, and address familial and comorbid psychological problems that impact attendance.

**When to consider anxiolytics
or antidepressants**

Pharmacotherapy research for school refusal behavior is in its infancy. However, some investigators have found that tricyclic antidepressant such as imipramine may be useful in some cases²⁰⁻²¹—generally for children with better attendance records and fewer symptoms of social avoidance and separation anxiety.²²

With respect to substantial child anxiety and depression without school refusal behavior, researchers have focused on selective serotonin reuptake inhibitors. In particular, fluoxetine, fluvoxamine, sertraline, and paroxetine have been useful for youths with symptoms of general and social anxiety and depression.^{23,24} However, youths often do not respond to these medications as well as adults

because of the fluid and amorphous nature of anxious and depressive symptomatology in children and adolescents.

Useful psychological techniques

Sophisticated Level 1 clinical controlled studies on treatment of diverse youths with school refusal behavior have appeared in recent literature.²⁵⁻²⁸ Options for this population may be generally arranged according to function or the set of reinforcers primarily maintaining absenteeism:

- Child-based techniques to manage anxiety in a school setting
- Parent-based techniques to manage contingencies for school attendance and nonattendance
- Family-based techniques to manage incentives and disincentives for school attendance and nonattendance.

Child-based anxiety management techniques include relaxation training, breathing retraining, cognitive therapy (generally for youths aged 9–17 years), and exposure-based practices to gradually reintroduce a child to school. These techniques have been strongly supported by randomized controlled trials specific to school refusal behavior (see above) and are useful for treating general anxiety and depression in these youths as well.

Parent-based contingency management techniques include establishing morning and evening routines, modifying parental commands toward brevity and clarity, providing attention-based consequences for school nonattendance (eg, early bedtime, limited time with a parent at night), reducing excessive child questioning or reassurance-seeking behavior, and engaging in forced school attendance under strict conditions. Parent-based techniques have received strong support in the literature in general, but have been applied specifically to youths with school refusal behavior less frequently than child-based techniques.

Family-based techniques include developing written contracts to increase incentives for school attendance and decrease

CONTINUED

TABLE 4**Child version of the School Refusal Assessment Scale–Revised**

- | | |
|--|---|
| 1. How often do you have bad feelings about going to school because you are afraid of something related to school (for example, tests, school bus, teacher, fire alarm)? (1) | 13. How often do you have bad feelings about school (for example, scared, nervous, or sad) when you think about school on Saturday and Sunday? (1) |
| 2. How often do you stay away from school because it is hard to speak with the other kids at school? (2) | 14. How often do you stay away from certain places in school (eg, hallways, places where certain groups of people are) where you would have to talk to someone? (2) |
| 3. How often do you feel you would rather be with your parents than go to school? (3) | 15. How much would you rather be taught by your parents at home than by your teacher at school? (3) |
| 4. When you are not in school during the week (Monday to Friday), how often do you leave the house and do something fun? (4) | 16. How often do you refuse to go to school because you want to have fun outside of school? (4) |
| 5. How often do you stay away from school because you will feel sad or depressed if you go? (1) | 17. If you had less bad feelings (for example, scared, nervous, sad) about school, would it be easier for you to go to school? (1) |
| 6. How often do you stay away from school because you feel embarrassed in front of other people at school? (2) | 18. If it were easier for you to make new friends, would it be easier for you to go to school? (2) |
| 7. How often do you think about your parents or family when in school? (3) | 19. Would it be easier for you to go to school if your parents went with you? (3) |
| 8. When you are not in school during the week (Monday to Friday), how often do you talk to or see other people (other than your family)? (4) | 20. Would it be easier for you to go to school if you could do more things you like to do after school hours (for example, being with friends)? (4) |
| 9. How often do you feel worse at school (for example, scared, nervous, or sad) compared to how you feel at home with friends? (1) | 21. How much more do you have bad feelings about school (for example, scared, nervous, or sad) compared to other kids your age? (1) |
| 10. How often do you stay away from school because you do not have many friends there? (2) | 22. How often do you stay away from people at school compared to other kids your age? (2) |
| 11. How much would you rather be with your family than go to school? (3) | 23. Would you like to be home with your parents more than other kids your age would? (3) |
| 12. When you are not in school during the week (Monday to Friday), how much do you enjoy doing different things (for example, being with friends, going places)? (4) | 24. Would you rather be doing fun things outside of school more than most kids your age? (4) |

NOTE: (1) = avoidance of school-related stimuli that provoke a sense of negative affectivity, (2) = escape aversive social and/or evaluative situations, (3) pursuit of attention from significant others, (4) pursuit of tangible reinforcers outside of school.

NOTE: Items are scored on a 0–6 scale where 0=never, 1=seldom, 2=sometimes, 3=half the time, 4=usually, 5=almost always, and 6=always.

incentives for nonattendance, escorting a child to school and classes, and teaching youths to refuse offers from peers to miss school.²⁹ As with parent-based techniques, family-based techniques have received strong support in the literature in general, but have been applied specifically to youths with school refusal behavior less frequently than child-based techniques.

Gradual reintroduction to school

A preferred approach to resolve school refusal behavior usually involves gradual reintroduction to school and classes. This may include initial attendance at lunchtime, 1 or 2 favorite classes, or in an alternative classroom setting such as a guidance counselor's office or school library. Gradual reintegration into a regular classroom setting may then proceed.

TABLE 5

Parent version of the School Refusal Assessment Scale—Revised

- | | |
|---|---|
| 1. How often does your child have bad feelings about going to school because he/she is afraid of something related to school (for example, tests, school bus, teacher, fire alarm)? (1) | things (for example, being with friends, going places)? (4) |
| 2. How often does your child stay away from school because it is hard for him/her to speak with the other kids at school? (2) | 13. How often does your child have bad feelings about school (for example, scared, nervous, or sad) when he/she thinks about school on Saturday and Sunday? (1) |
| 3. How often does your child feel he/she would rather be with you or your spouse than go to school? (3) | 14. How often does your child stay away from certain places in school (eg, hallways, places where certain groups of people are) where he/she would have to talk to someone? (2) |
| 4. When your child is not in school during the week (Monday to Friday), how often does he/she leave the house and do something fun? (4) | 15. How much would your child rather be taught by you or your spouse at home than by his/her teacher at school? (3) |
| 5. How often does your child stay away from school because he/she will feel sad or depressed if he/she goes? (1) | 16. How often does your child refuse to go to school because he/she wants to have fun outside of school? (4) |
| 6. How often does your child stay away from school because he/she feels embarrassed in front of other people at school? (2) | 17. If your child had less bad feelings (for example, scared, nervous, sad) about school, would it be easier for him/her to go to school? (1) |
| 7. How often does your child think about you or your spouse or family when in school? (3) | 18. If it were easier for your child to make new friends, would it be easier for him/her to go to school? (2) |
| 8. When your child is not in school during the week (Monday to Friday), how often does he/she talk to or see other people (other than his/her family)? (4) | 19. Would it be easier for your child to go to school if you or your spouse went with him/her? (3) |
| 9. How often does your child feel worse at school (for example, scared, nervous, or sad) compared to how he/she feels at home with friends? (1) | 20. Would it be easier for your child to go to school if he/she could do more things he/she likes to do after school hours (for example, being with friends)? (4) |
| 10. How often does your child stay away from school because he/she does not have many friends there? (2) | 21. How much more does your child have bad feelings about school (for example, scared, nervous, or sad) compared to other kids his/her age? (1) |
| 11. How much would your child rather be with his/her family than go to school? (3) | 22. How often does your child stay away from people at school compared to other kids his/her age? (2) |
| 12. When your child is not in school during the week (Monday to Friday), how much does he/she enjoy doing different | 23. Would your child like to be home with you or your spouse more than other kids his/her age would? (3) |
| | 24. Would your child rather be doing fun things outside of school more than most kids his/her age? (4) |

NOTE: (1) = avoidance of school-related stimuli that provoke a sense of negative affectivity, (2) = escape aversive social and/or evaluative situations, (3) pursuit of attention from significant others, (4) pursuit of tangible reinforcers outside of school.

NOTE: Items are scored on a 0-6 scale where 0=never, 1=seldom, 2=sometimes, 3=half the time, 4=usually, 5=almost always, and 6=always.

If possible, a child should remain in the school setting during the day and not be sent home unless intense medical symptoms are present.³⁰ A recommended list regarding the latter includes frequent vomiting, bleeding, temperature greater than

100°F, severe diarrhea, lice, acute flu-like symptoms, or an extreme medical condition such as intense pain.

The outcome for Nathan

Using a structured diagnostic interview

TABLE 6**Sample questions and targets of assessment regarding the forms of school refusal behavior****QUESTIONS RELATED TO THE FORM OF SCHOOL REFUSAL BEHAVIOR**

What are the child's specific forms of absenteeism, and how do these forms change daily?

Is a child's school refusal behavior relatively acute or chronic in nature (in related fashion, how did the child's school refusal behavior develop over time)?

What comorbid conditions occur with a child's school refusal behavior (see **TABLE 3**), including substance abuse?

What is the child's degree of anxiety or misbehavior upon entering school, and what specific misbehaviors are present in the morning before school (see **TABLES 2 AND 4**)?

What specific school-related stimuli are provoking the child's concern about going to school?

Is the child's refusal to attend school legitimate or understandable in some way (eg, school-based threat, bullying, inadequate school climate)?

What family disruption or conflict has occurred as a result of a child's school refusal behavior?

What is the child's academic and social status (this should include a review of academic records, formal evaluation reports, attendance records, and individualized education plans or 504 plans as applicable)?

QUESTIONS RELATED TO THE FUNCTION OF SCHOOL REFUSAL BEHAVIOR

Have recent or traumatic home or school events occurred to influence a child's school refusal behavior?

Are symptoms of school refusal behavior evident on weekends and holidays?

Are there any non-school situations where anxiety or attention-seeking behavior occurs?

What specific social and/or evaluative situations at school are avoided?

Is the child willing to attend school if a parent accompanied him or her?

What specific tangible rewards does the child pursue outside of school that causes him or her to miss school?

Is the child willing to attend school if incentives were provided for attendance?

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A tricyclic antidepressant may be useful for children with better attendance records and fewer symptoms of social avoidance and separation anxiety

and other behavioral assessment measures, Nathan's psychologist concluded that the teenager met criteria for generalized anxiety disorder. He worried excessively about his social and academic performance at school and displayed several somatic complaints related to anxiety. His treatment thus involved a two-pronged approach.

Nathan's physician placed him on a regimen of sertraline, 50 mg/d, which has been found to significantly reduce symp-

toms of generalized anxiety disorder in youths aged 5 to 17 years. In addition, Nathan's psychologist implemented child-based anxiety management techniques as well as family therapy to increase incentives for school attendance and limit fun activities during a school day spent at home. The physician and psychologist collaborated with school personnel as well to gradually reintroduce Nathan to a full-time academic schedule.

Final comments

School refusal behavior sometimes is severe and intransigent, and requires a multidisciplinary approach. Cooperation and communication among parents, physicians, mental health professionals, and school officials is often crucial for resolving any particular case of school refusal behavior. The references at the end of this article provide more detailed information and note advances in the field. ■

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Success has been seen with relaxation training, breathing retraining, and exposure-based practices to gradually reintroduce a child to school