Treatment for school refusal in Dutch youth with MBID and their families: Adapting the *@school program*

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Treatment for school refusal in Dutch youth with MBID and their families: Adapting the *@school program*

- MBID youth and school attendance problems
- The *@school program* for adolescent school refusal
- Adaptions to the *@school program* for MBID youth
  - Assessment
  - Process
  - Content
- Experiences until now…and implications for research and practice?

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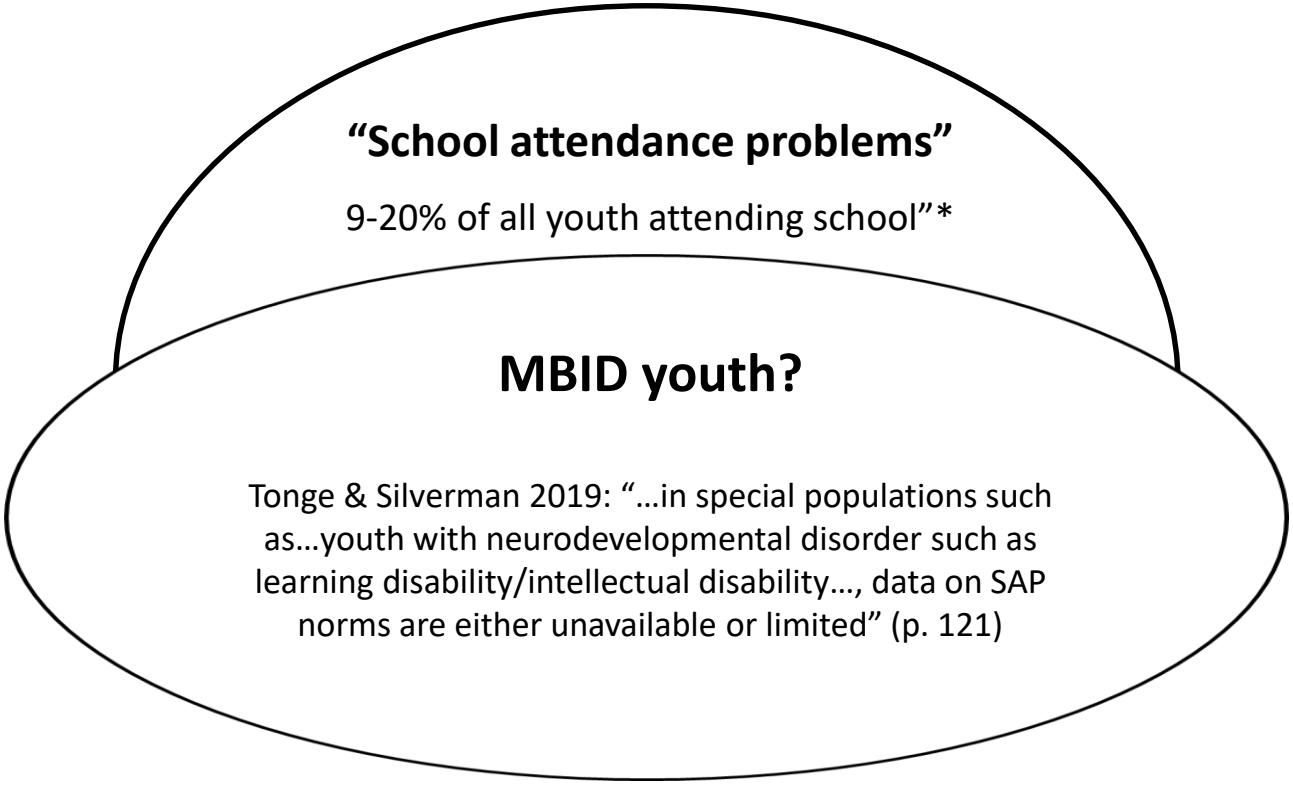
What do we mean by ‘MBID’?

- Mild Intellectual Disability (MID) is characterized by significant limitations both in intellectual functioning (i.e., an IQ-score that falls between 50/55-70) and in adaptive behaviour *(AAIDD; Schalock et al., 2010)*

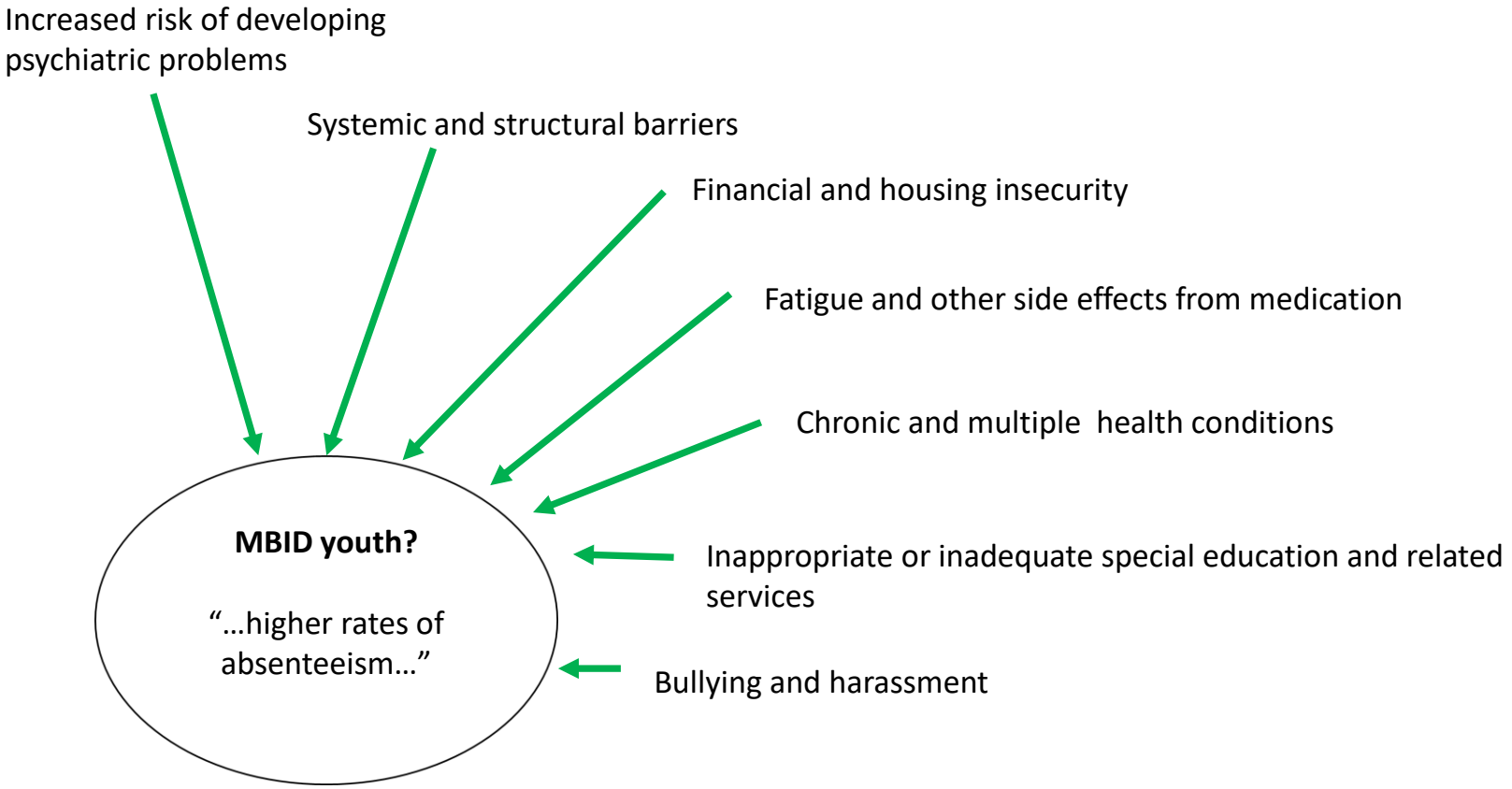
- IQ-score between 70 and 85 = similar or even more problems and often need more support than youngsters with an IQ-score between 50 and 70

- = Mild-to-Borderline ID (MBID) *(de Wit, Moonen & Douma, 2012)*

School attendance problems



School attendance problems and MBID youth



(Cortiella & Boundy, 2018; Melvin et al., submitted)

School attendance problems

School Refusal

Focus of today's presentation

Truancy

School Withdrawal

School Exclusion

(Heyne at al., 2019)

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School refusal… and MBID YP

Above-average rates of internalizing problems among youth with MID (Dekker et al., 2002)

Anxiety = most prevalent emotional disorder in YP with ID (Emerson, 2003)

More rumination and distress from worries in YP with MBID (Forte et al., 2011)

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School refusal… and MBID YP

- Given the negative ST and LT consequences of SR, effective treatment is needed
- But…no evidence-based treatments available for YP with MBID and SR
- And: very few available for MBID YP in general

- Why?

- **CBT for SR (recommended) might not be suited to MBID?**

Why tailor treatment for MBID YP?

- “Cognitive and social-emotional development, and contextual factors may facilitate or limit a young person’s participation in treatment such as CBT”

(Sauter et al., 2009)

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Why tailor treatment for MBID YP?

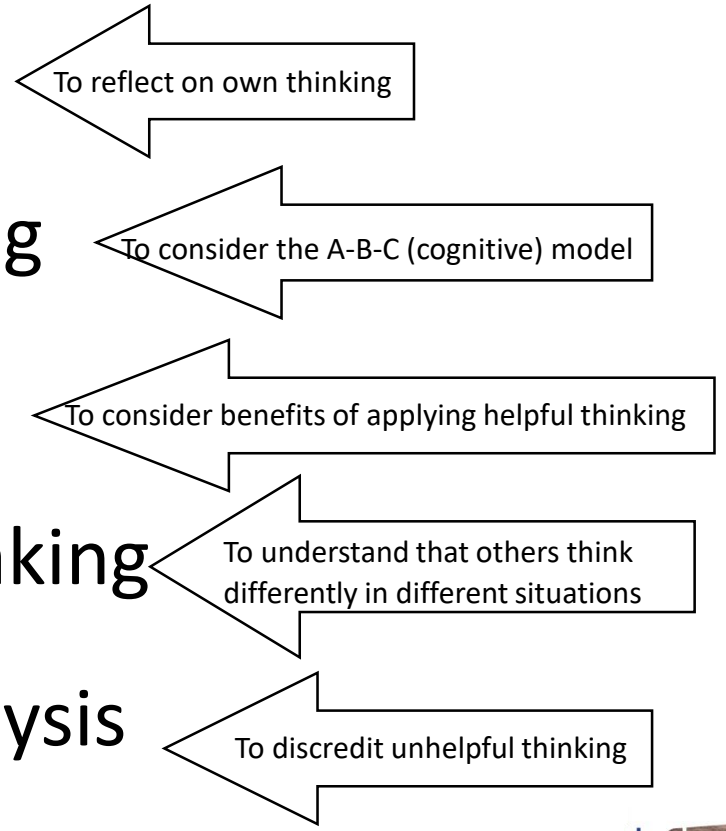
- **Large individual differences between MBID YP, but in general:**

- Deficits in information processing (memory; attention)
- Limited self-regulation skills and metacognition (planning; inhibition; executive functioning)
- Limited social-cognitive skills (emotion recognition; social problem solving)

(De Wit, Moonen & Douma, 2012; Hronis et al., 2017)

Which cognitive capacities are needed for CBT?

- Self-reflection
- Consequential thinking
- Hypothetical thinking
- (Social) perspective taking
- Logical thinking / analysis



Why tailor treatment for MBID YP?

- **Large individual differences, but in general:**
- Delays and deficits in information processing / cognitive functioning

- **Plus a higher chance of:**
- Less than optimal parenting (sensitivity; responsiveness)
- Abuse, neglect and attachment problems
- Parents with high stress, poor health and relationship problems
- Neighbourhoods with high unemployment, low incomes, poor housing, high crime levels

> Practical and contextual barriers to participation in/benefiting from treatment!

(De Wit et al., 2012)

BUT…(or and)…

- Adults with (MB)ID = can identify, distinguish between, and link thoughts, feelings and behaviours…
- CBT is effective in treating mental health problems (e.g., anxiety, depression) in adults with (MB)ID…
- Why not YP too?

(e.g. Oathamshaw & Haddock, 2006; Willner & Lindsay, 2016)

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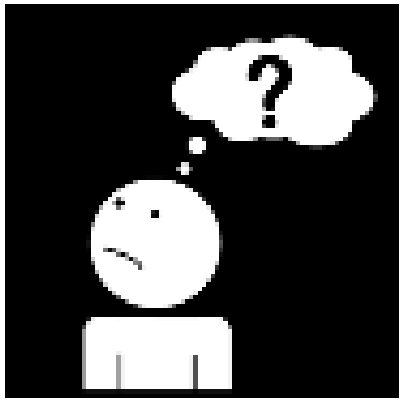
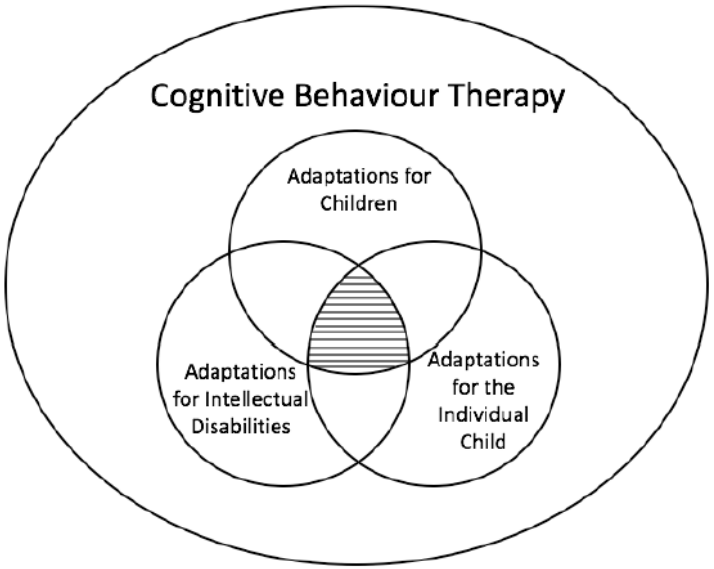
Why tailor treatment for MBID YP?

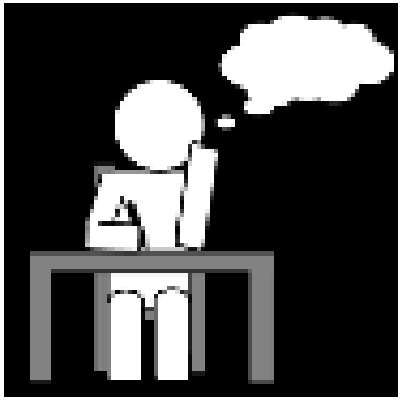
- "There are multiple cognitive, executive and communication factors which need to be considered before engaging in CBT with children who have ID, in order to **maximize the effectiveness of therapy**" *(Hronis, Roberts & Kneebone, 2017)*

Why tailor treatment for MBID YP?

- It is important to consider these factors in *assessment, treatment process and content* when treating MBID YP







(Hronis et al., 2017)

How tailor treatment for MBID YP?

- Extensive assessment: multi method, multi source
- Individualized treatment (case formulation-based vs protocols)
- Adapt to the level of language and communication
- Adjust tempo and treatment length, more breaks in session
- Use a mix of modalities(face-to-face; online)
- Practical, hands-on exercises and roleplay
- Make materials concrete (visual support)
- Increase structure and repetition
- Engage the social network

(De Wit et al., 2012; Hronis et al., 2017)

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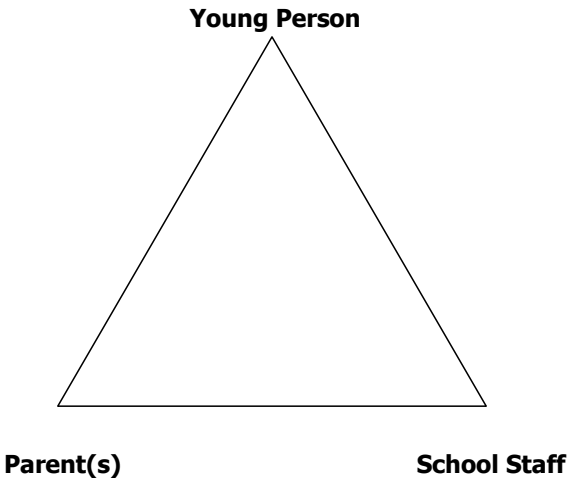
How tailor treatment for MBID YP?

This presentation: tailoring CBT for SR:

The '@school program' for YP with MBID

The @school program: CBT for adolescent school refusal

- Modular CBT for adolescents with school refusal: CT and BT strategies
- Aim: increase school attendance, decrease anxious avoidance / anxiety / depression , increase self-efficacy (parents and youth)
- Treatment strategies = modules (standard & optional)
- Treatment is manual-based AND individualized
- Parallel parent-adolescent treatment; 2 à 3 family sessions; school consultation
- Developmentally-appropriate design and delivery



Adapting assessment

Recommended adaptations	@school √	Further adaptations
Extensive assessment: multi method, multi source	- YP, parents and school are involved - cognitive, social-emotional and systemic factors assessed - assessment informs case formulation, which informs individualized treatment plan*	- measures valid/reliable for MBID?* - adaptations to items/length of measures - reduced assessment battery

* Case formulation-based treatment

dynamic interaction between the individual child and his/her environment. The four "Ps" of case formulation (predisposing, precipitating, perpetuating, and protective factors) also provide a useful framework for organizing the factors that may contribute to the development of anticipatory distress (Barker, 1988; Carr, 1999; Winters, Hanson, & Stoyanova, 2007). Predisposing factors are those that put a child at risk of developing a problem (in this case, high anticipatory distress). These may include genetics, life events, or temperament. Precipitating factors refer to a specific event or trigger to the onset of the current problem. Perpetuating factors are those that maintain the problem once it has become established. Finally, protective factors are strengths of the child or reduce the severity of problems and promote healthy

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Systematic Review

OXFORD

Systematic Review: Predisposing, Precipitating, Perpetuating, and Present Factors Predicting Anticipatory Distress to Painful Medical Procedures in Children

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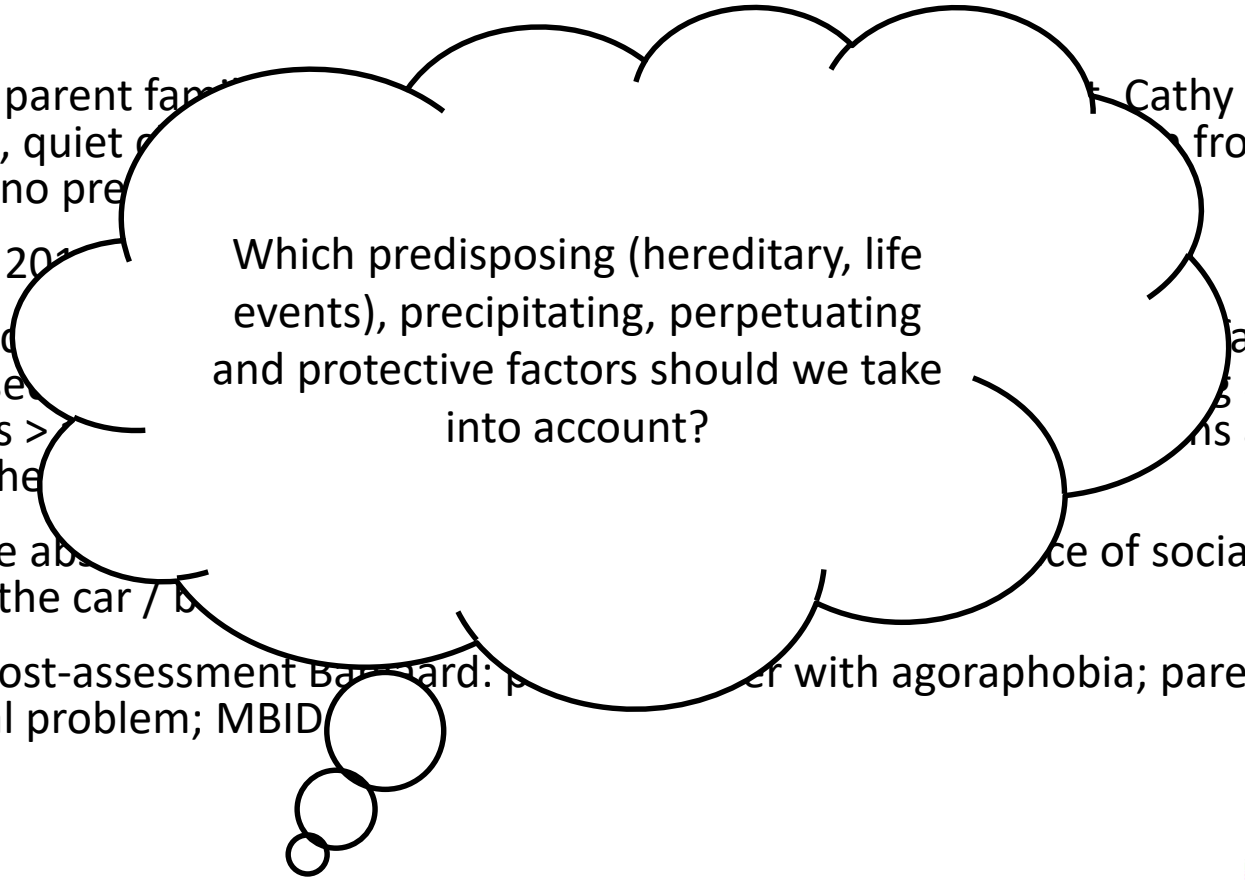
* Case formulation-based treatment

- *Case example, Cathy (16)*



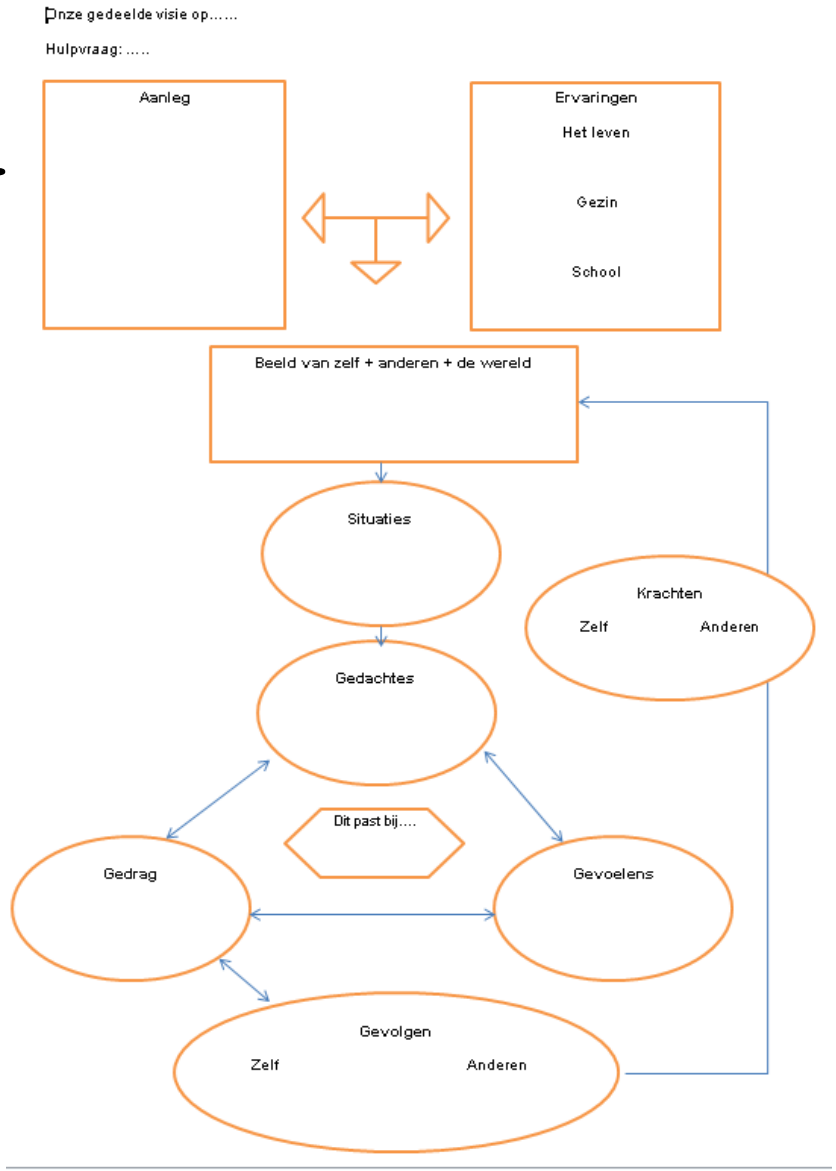
- Dutch, 2 parent fa… Cathy was a sensitive, quiet … from parents in grade 1; no pre…
- WISC-III 20…
- No atten… family grade 8 = increase… and social problems > … about (mental)he…
- Complete ab… ce of social situations / being in the car / b…
- DSM-5 post-assessment Ba…ard: p… with agoraphobia; parent-child relational problem; MBID…

* Case formulation-based treatment

Predisposing factors: MBID; trauma, bullying; overestimation of (cognitive) abilities

Precipitating factors: changes in schooling; life events, complex situations

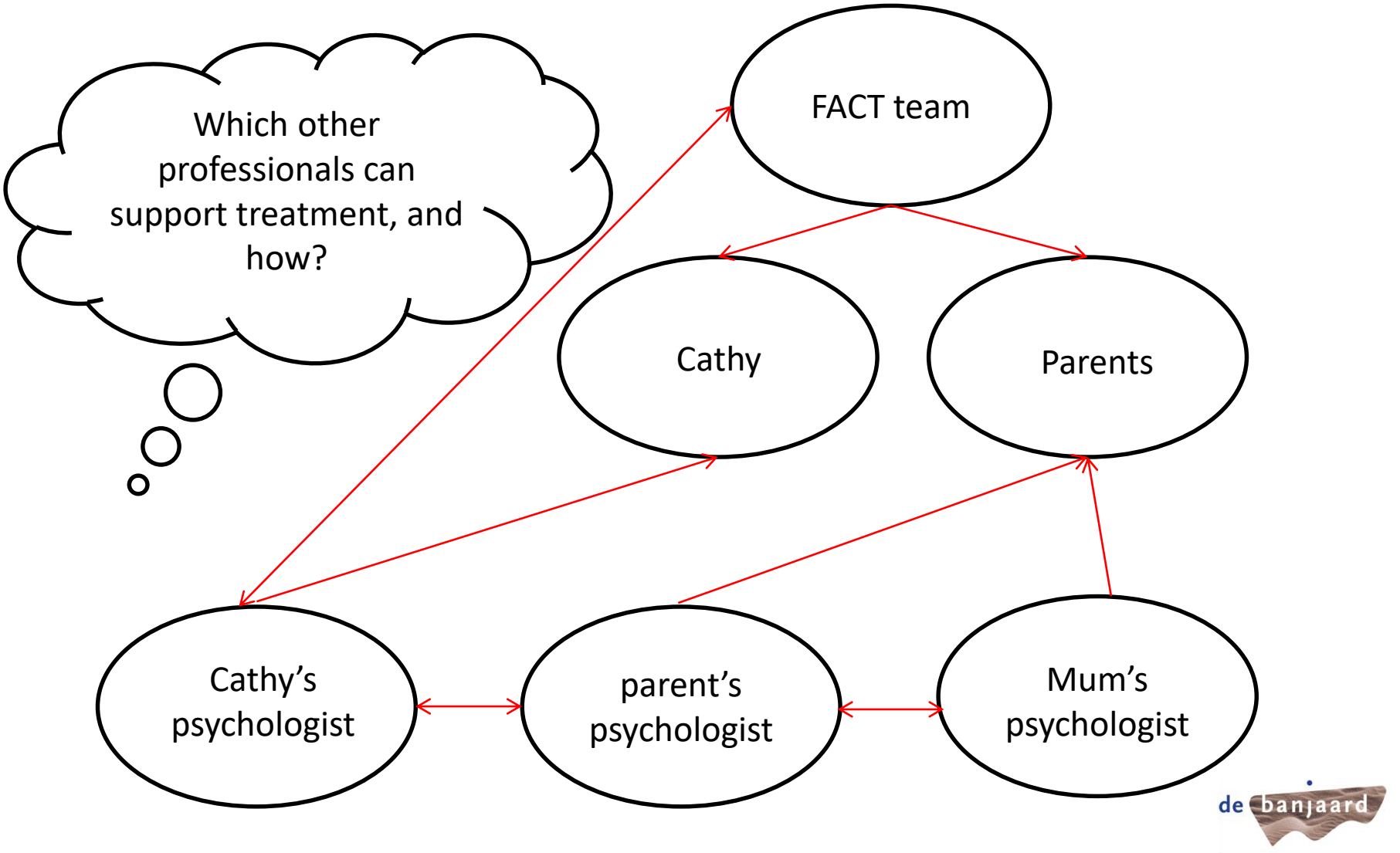
Perpetuating factors: unhelpful thoughts-feelings-behaviours; ; reactions of parents and teachers



Adapting treatment process

Recommended adaptations	@school √	Further adaptations
Engage the social network + increase generalization	- involvement of YP, parents and school in treatment - flexible dosage of modules allows for repetition - varying role of parents in facilitating attendance	- other professionals to support parents / YP (incl. at home)* - taking therapy to the 'problematic environment' (sessions at school) - longer treatment duration
Create a safe learning environment (motivation, positive reinforcement)	- individualized treatment planning - goal setting = module - psychoeducation = module	- add psychoeducation about MBID

*Other professionals to support parents / YP



Cathy's exposure / attendance plan: A collaborative approach

Parents, school and professionals all share a' 'firm but kind' attitude:

A balance between giving clear messages about attendance (directive) and giving Cathy choices and listening to her (supportive)

Cathy's exposure / attendance plan: A collaborative approach

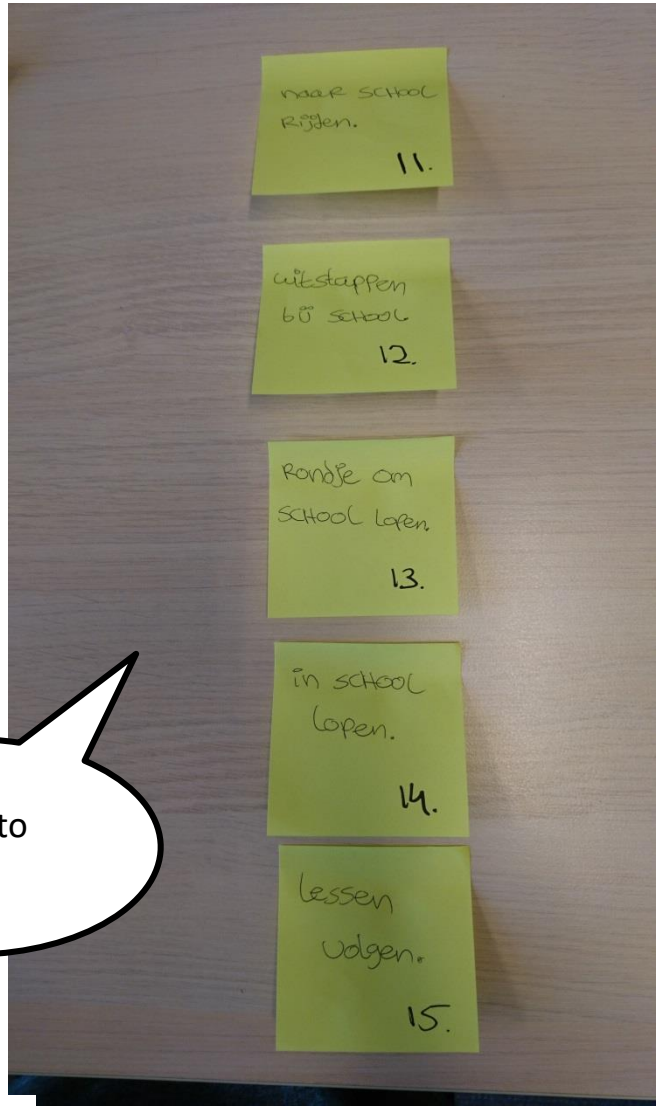
3 graded exposure attendance plans were made with Cathy and her parents:

1) Getting to school (by car)

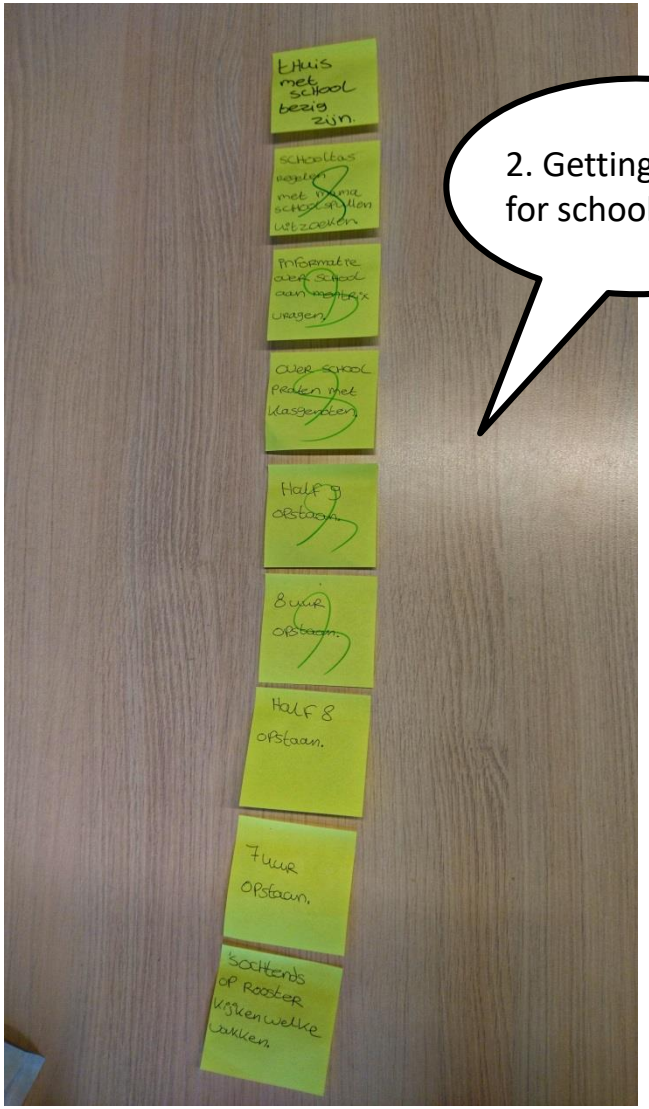
2) Getting ready for school (e.g., meeting with mentor, checking school website and class schedule, buying textbook, morning-evening routine, etc.).

3) Increasing regular attendance (e.g, how many hours a day, which classes, which time frame, etc)

Cathy's exposure / attendance plan



1. Getting to school



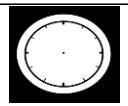
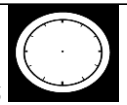
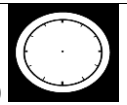
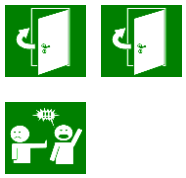
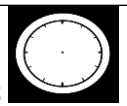
2. Getting ready for school

Adapting treatment content

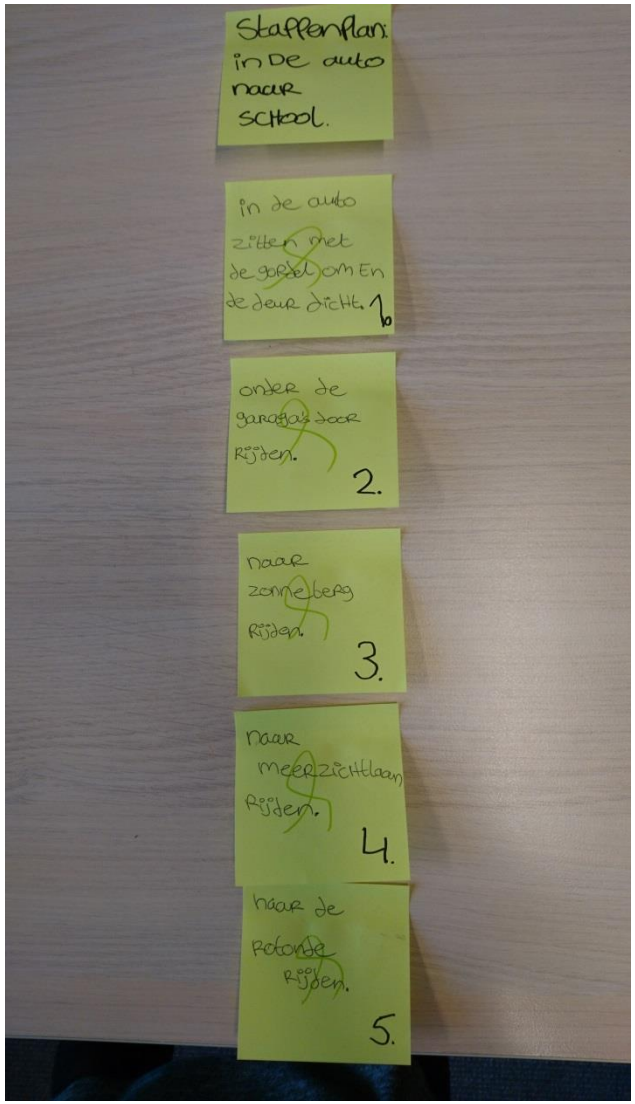
Recommended adaptations	@school √	Further adaptations
Adapt to the level of communication	- use of visual resources in the form of handouts for young people and parents*	- simplifying language in manual and handouts - more use of visual material
Make materials concrete	- visual resources (handouts) - relevant [personal] examples > in ABC-schemas - learn through experience > exposure, behavioural experiments	- use of video material? - more use of role play and active learning (modelling, writing on the board) - optional focus on BT vs CT

* Use of visual resources

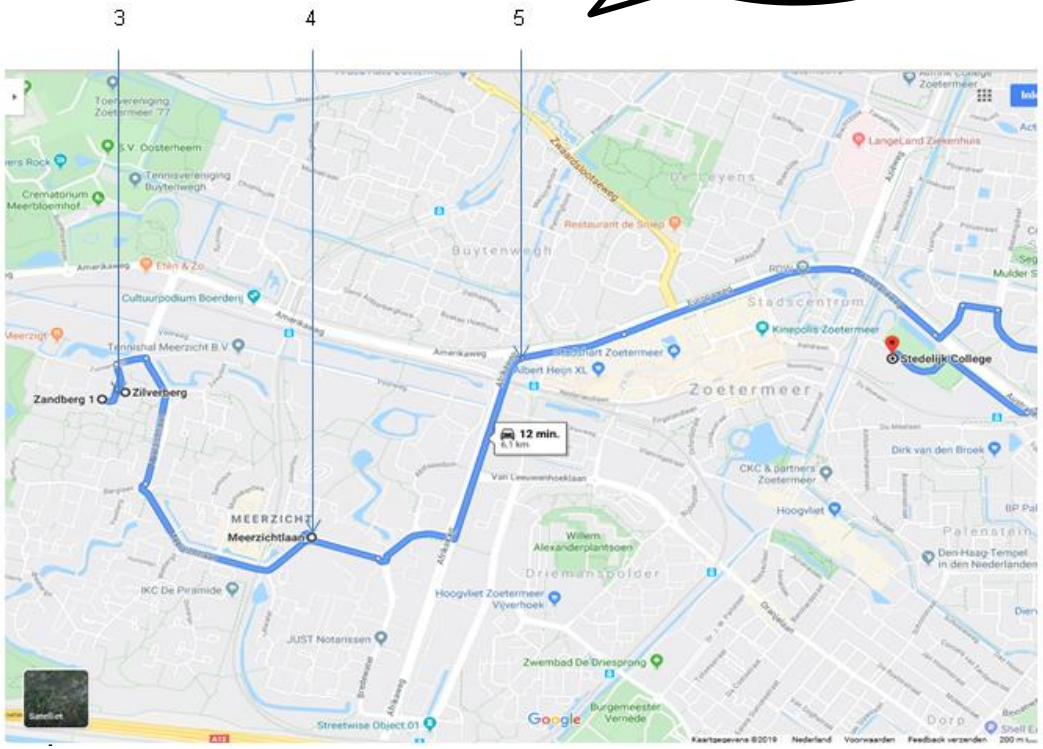
Getting out of bed action plan

When?		What?
7.00 		Mum calls C. "Time to wake up" at the door to her bedroom 2x
7.10 		Mum opens the door Mum says "Come, get out of bed now please" in a sterner voice
7.15 		C. has a shower and gets ready in the bathroom
7.30 		C gets dressed.
7.30 		Sister leaves C. alone and stay in her room. C. ignores sister if she provokes her and stays in her own room. If they fight: Mum goes upstairs and says, "Stop fighting. Go back to your own room please". Mum doesn't get involved in a discussion.
8.00 		C. goes downstairs C. eats breakfast C. gets schoolbag (is packed the evening before)
8.15 		Boyfriend A. will bring C. by car in the first week From week 2: C will take the tram by her self Back up plan: parents will take her by car if tram is too difficult

* Use of visual resources

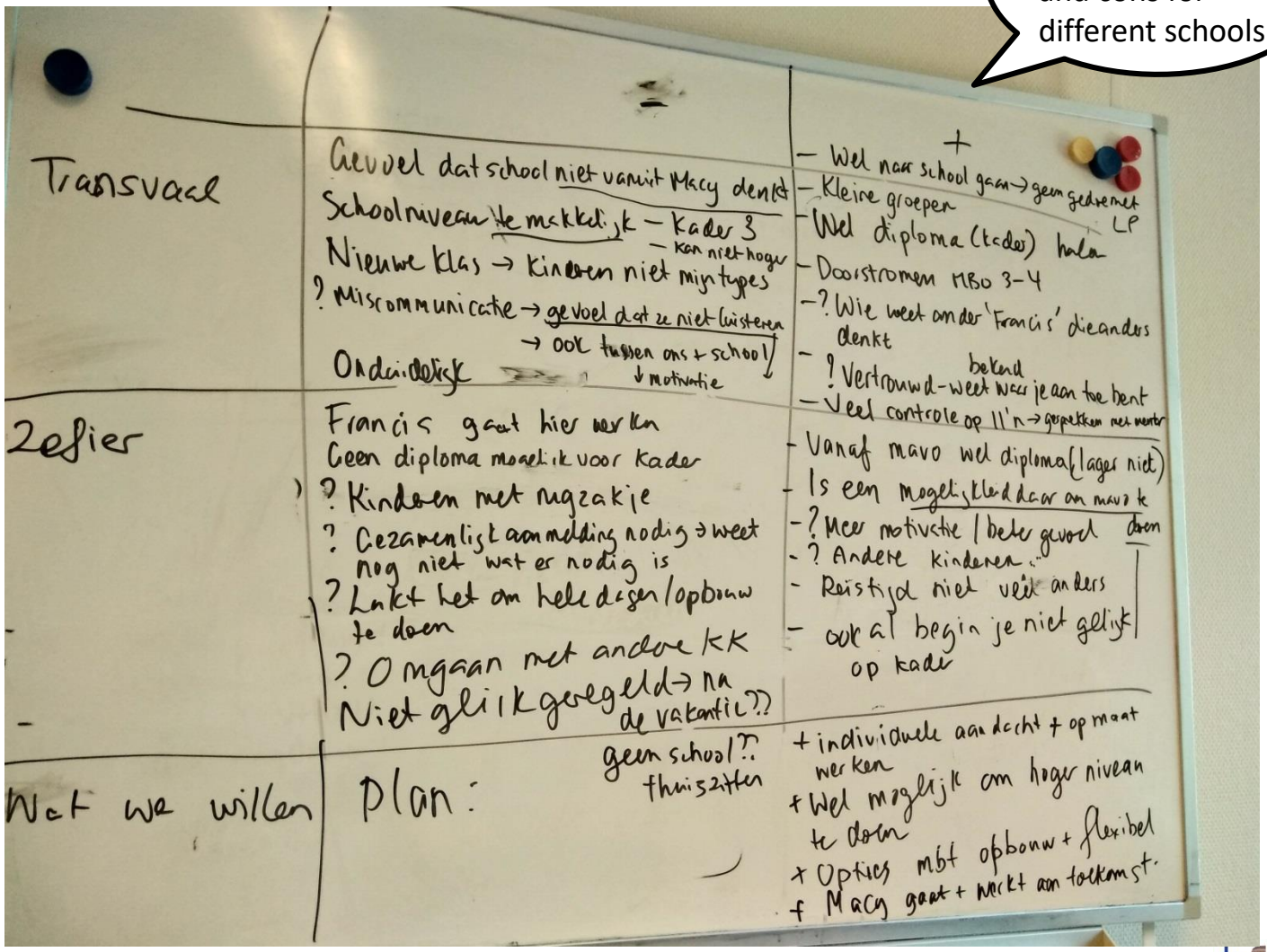


Visualizing and mapping the steps in the fear hierarchy



* Use of visual resources

Weighing up pro's and cons for different schools



CBT-specific adaptations

Recommended adaptations	@school √	Further adaptations
Assessment of CBT-relevant cognitive capacities	- inclusion of informal and formal measures as part of treatment planning	- measures valid/reliable for (M)ID?
Priming CBT-relevant cognitive capacities	- optional affective education prior to CT module	- development of 'CT preparation module'*
Different 'levels' of CBT available; teaching in steps	- in CT module, 'more-' or 'less-cognitively demanding' techniques are differentiated	- increased use of concrete/visual materials in CT module to reduce cognitive demands
More BT and BT-based activities	- BT vs CT is explicitly considered in treatment planning	- explicit suggestions for more BT and BT-based activities in manual
Extra guidance and practice	- many sorts of handouts and suggestions for activities available	- explicit suggestions for active therapist role and more practice-based learning in manual

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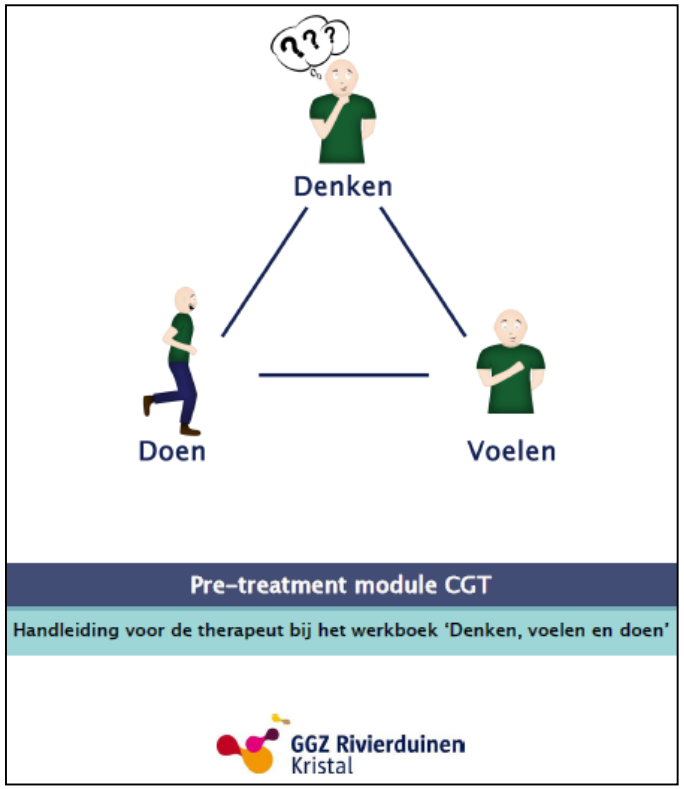
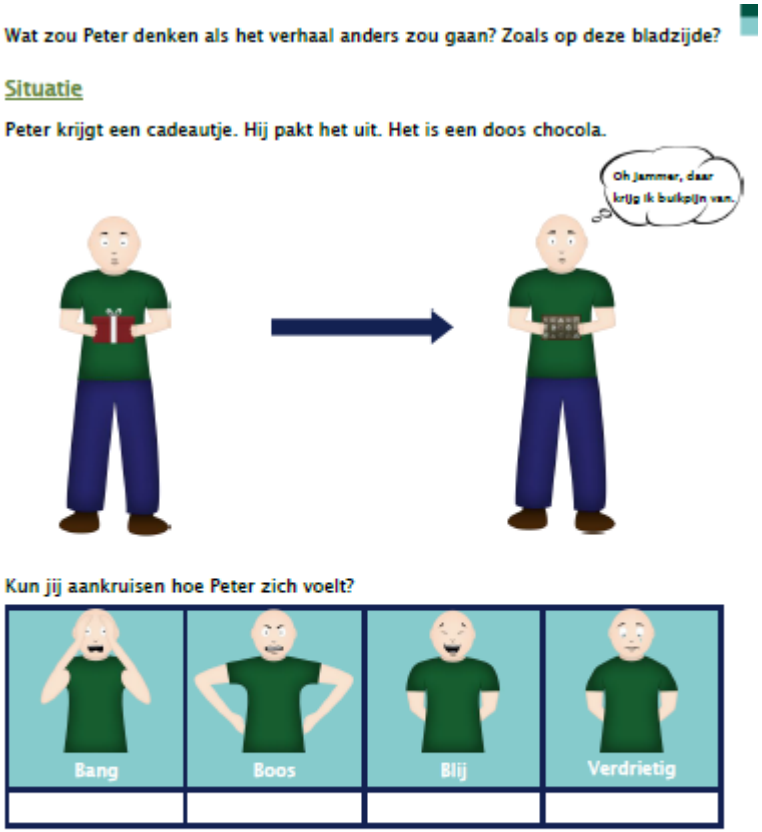
* Preparing for CT-module





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For more CBT-specific adaptations…

Table 1. Key adaptations relating to each cognitive domain

Domain	Therapy adaptations
Attention	• Shorter, more frequent sessions • Include breaks • Reduce task length by dividing into smaller units • Engage children with a variety of modalities, colours, and pictures • Positively reinforce attention • Minimal distractions in therapy room • Begin with 'person-oriented' tasks before moving to 'task-oriented' exercises
Working Memory	• Use short, simple, subject–verb–object sentences • Present material verbally and visually • Use memory aids such as visual prompts • Present one task/activity at a time • Present information numerous times/repeat tasks
Learning and Memory	• Engage in implicit learning processes (e.g., role-play, hands-on activities) • Reality-based teaching: learn via 'doing' • Teach via modelling, using 'thinking out loud' when modelling • Frequently check understanding • Master skills before moving on • Practise and repeat skills • Provide immediate feedback • Record sessions or provide written summaries to the child and caregiver • Children encouraged to write events from the week to facilitate recall • Involve carers/parents to facilitate memory and recall
Executive Functions	• Therapist should plan and structure the sessions • Try to maintain a set structure to sessions • Use a visual schedule outlining session structure • Minimize switching between tasks • Target mental flexibility problem-solving and decision-making throughout therapy • Redirect uninhibited responses • Establish rules for therapy
Language and Reading	• Child should be facing therapist • Visual aids can assist communication • Use pictures/drawings to facilitate understanding, placed next to text with a clear link between text and image • Use 'Easy Reading' format for text • High-frequency connectives are more effective for ID (e.g., 'and') • Divide text into bullet points • Bold to emphasize main points • Avoid jargon • Define new terms where necessary • Sentences as short as possible (maximum 15 words) • Good contrast between colour of text and page • Sentences consisting a single concept • Words fewer than three syllables

See Hronis et al., 2017

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Experience until now…and research and practice implications

- Common P's factors (negative experiences at school; traumas; overestimation of abilities; parents' own MBID; etc)
  - Need for assessment of other risk and protective factors? Impact on treatment?
- Co-morbidity (e.g., ASS; PTSS):
  - Need for other treatment modules (e.g., EMDR)?
- Impact of (acceptation of) MBID on school placement / suitability of school:
  - Need for alternative education setting/programs?
- Role of parents: their participation is especially neccessary for this population, but can also be challenging both practically and emotionally
  - Need for other support network (family, professionals)?
- Cognitive delays/deficits such as planning- and language expression problems:
  - Need to take into account when considering choice of treatment strategies?

Questions welcome!

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