Problematic school absenteeism includes school-aged youths who display complete absences from school, skipped classes, tardiness, morning misbehaviors in an attempt to miss school, and/or substantial distress at school that precipitates pleas for future nonattendance. A recent national study revealed that the rate of chronic absenteeism (i.e., missing 10+% of the school year) among American youth may be 10-15%. Chronic absenteeism is higher among low-income students and school dropout rates are highest among Hispanics.

Some youth are referred to treatment specifically because of absentee problems but such problems can also be an integral part of broader anxiety, mood, or disruptive behavior disorders. Key concomitants of problematic school absenteeism include substance abuse, violence, suicide attempt, risky sexual behavior, pregnancy, delinquency-related behaviors, injury, illness, and school dropout. Longitudinal studies reveal severe consequences of problematic school absenteeism into adulthood, including economic deprivation and psychiatric, social, marital, and occupational problems.

Treatments for problematic absenteeism involve Tier 1 (preventative), Tier 2 (early intervention), and Tier 3 (complex intervention) approaches. Tier 1 interventions involve school-wide efforts to maintain attendance as well as regular monitoring to identify students with emerging attendance problems. Tier 1 interventions are broad-based in nature and include strategies to improve school climate and safety as well as student health and social-emotional development. Tier 2 interventions include (1) cognitive-behavioral procedures to address anxiety- and non-anxiety-based cases of absenteeism, and (2) those implemented more systemically to boost student engagement and to provide peer and teacher mentoring. Tier 3 interventions include expanded Tier 2 interventions, alternative educational programs, and legal strategies.
Selective mutism is a persistent and debilitating condition in which a child fails to speak in public situations where speaking is expected. Selective mutism affects 0.2-2.0% of children, with girls slightly more affected than boys. The disorder commonly begins during preschool years but treatment is often delayed by parents or others who believe the problem is temporary. Selective mutism may have a chronic course for some children and can produce significant problems with respect to peer rejection, incomplete verbal academic tasks or standardized tests, or inadequate language or social skills.

A primary goal of treatment for selective mutism is to increase the audibility and frequency of speech, especially in public situations such as school. The most common and empirically supported treatment components for selective mutism are behavioral in nature. These components include exposure-based practices that are integrated with stimulus fading, self-modeling, and shaping and prompting. Supplementary procedures include negative reinforcement/escape, social skills and language training, family therapy, and anxiety management techniques. Parent-based contingency management procedures are also important to facilitate a child’s more audible and frequent speech and reduce nonverbal compensatory behaviors. These treatment components are typically used in conjunction with one another in various settings and with various people such as parents, school officials, and peers.
Problematic School Absenteeism and Selective Mutism

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Thursday, 21 March 2013 15:42 -

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