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***Commentary***

# Preparing for return to in-person school instruction in pediatric chronic pain populations

Lauren E. Oddo and Laura S. Gray

Summer typically provides a welcome reprieve from school-related stressors and functional demands that burden our patients. This summer will be different, given the need to prepare many patients for return to in-person instruction after prolonged disruptions in school attendance pursuant to the coronavirus pandemic. In the current report, we focus on select challenges associated with return to in-person instruction in pediatric pain populations. We draw from our ongoing clinical work within a multidisciplinary pediatric pain clinic in a large metropolitan area, and highlight clinical strategies designed to support patients' adaptive coping and decrease functional disability during this time. It is our hope to contribute to an ongoing dialog surrounding optimal delivery of services for this vulnerable population.

## Implementation of accommodations

### Challenges

There is consensus that youth experiencing chronic pain should engage in school, as focusing on functioning decreases pain-related disability (Logan & Simons, 2010; Simons et al., 2010). Some patients require reasonable accommodations (i.e. formal or informal alterations of environment, curricula, and/or equipment to allow students with disabilities and/or functional limitations an equal opportunity to benefit from the educational process; e.g. Harrison et al., 2013; Conroy et al., 2020) to optimize functioning and decrease the likelihood of chronic boom and bust cycles leading to increased pain, deconditioning, and functional disability (Carter & Threlkeld, 2012). Barriers to implementing accommodations may exist within the school building itself due to pandemic safety precautions. For some students, in-person instruction requires remaining in a single classroom, limited/specified break times, wearing masks (requiring pull-down to hydrate and eat), and food restricted from classrooms. Schools may require students who report feeling unwell (e.g. headache) to return home. Several of our patients have been reluctant to deploy coping skills in the classroom (e.g. drinking water, taking movement breaks) for fear of breaking school rules. Certainly, the increasing availability of vaccine for some populations may continue to change the school landscape and decrease anxiety associated with return to school, whereas prolonged wait for vaccine approval for others, such as younger age groups, may lead to continued pandemic modifications in the schools. Our goal is to help patients use behavioral pain management strategies within the school building while maximizing health and safety.

### Clinical strategies

***Selecting appropriate accommodations.*** Implementing formal and/or informal accommodations in this context requires forethought, flexibility, and creativity among providers, families, and school personnel. Several clinical indicators can help guide decision making, including current level of functioning, physical deconditioning, anxiety

symptoms, and history of school refusal. Sometimes the best option for reducing functional disability is not to offer too extensive a set of accommodations, or to ensure accommodations are only a temporary and scaffolded support. Certain accommodations can perpetuate a focus on pain and functional disability (see Clinical example 1).

***Collaborating with third parties.*** We work with patients, their families, and schools to understand the rationale for certain accommodations versus others, to problem solve any barriers, and to effectively communicate. We often select discrete coping skills that students feel comfortable deploying within the classroom, which can maximize adherence. Common strategies include getting up from the desk to sharpen pencils or to throw something away, eating a peppermint (i.e. simulating mindful eating), and using deep breathing exercises. Coping cards depicting these options often encourage follow-through. We also help families to partner with schools by streamlining communication, identifying school advocates, and selecting top problems.

Partnering with schools is also an essential step in developing and implementing accommodations to support student success. We establish open dialog with partners from patients' schools who are abreast of school policies and capabilities. Written letters detailing accommodations help ensure that schools understand students' needs. Early and ongoing communication helps to develop reasonable accommodations before students return to the building. See Table 1 for additional communication tips.

Table 1
Tips for successful partnerships with schools

| Key Ingredient | Clinical Strategies |
|---|---|
| Identify an advocate or point person<br><br>*This helps to minimize response time and ensures someone at the school is coordinating* | · Ask family who in the school knows their child best<br>· Consider 504 Plan or IEP coordinators, as these people are familiar with the system and available accommodations<br>· Check with any family-identified advocate to ensure that this person is willing and able to fill this role<br>· Identify an informal support person (e.g. favorite teacher) who sees the student regularly; inquire if this person is willing to provide updates on child's school functioning |
| Understand school parameters<br><br>*This helps to ensure appropriate and feasible recommendations* | · Seek guidance from school personnel on instructional methods, space, and safety precautions<br>· Elicit feedback from school personnel on proposed recommendations<br>· Modify accommodations to meet pandemic restrictions |
| Get to the point<br><br>*This helps to optimize communication for busy people* | · Develop clear and concise requests<br>· Offer to speak to school personnel by phone or their preferred method of contact<br>· Ensure email communication is brief and limited<br>· Ask yourself "can this email be answered in 1 minute?"; if no, consider a phone call instead |
| Keep communication lines open<br><br>*This allows for flexible and prompt adjustments to recommendations* | · Encourage school personnel to contact with updates<br>· Share that you will check-in with personnel throughout the semester to ensure recommendations remain feasible and benefit the student |
| Avoid the expert role<br><br>*This helps to encourage collaboration and problem solving* | · Acknowledge that school personnel have valuable insights and are necessary partners in supporting student functioning<br>· Thank collaborators for their time and effort<br>· Use collaborative language (e.g. "I'm curious what you think about [insert accommodation]"; "What are some barriers that you encounter when implementing [insert accommodation]?"; "How can I make [insert accommodation] more feasible given [stated constraints]?") |

***Clinical example 1.*** One family asked school personnel to provide several breaks for their child ("Aaron") out of the classroom. Aaron and his family presented to our clinic feeling frustrated that their efforts were ineffective. We soon learned that these breaks involved Aaron standing in the open hallway while others passed him by, as the school had limited space options due to physical distancing precautions. Aaron reported feeling spotlighted and quite uncomfortable in these breaks, resulting in increased stress, physiological arousal, and attention to pain. Additionally, Aaron frequently reported to the school nurse with requests to take exams during the mornings, in anticipation of headaches in the afternoons interfering with performance. It appeared that these accommodations were inadvertently reinforcing pain behaviors and functional disability. Indeed, an important step in developing reasonable school supports was first aligning with Aaron and his family to better understand their concerns.

## Resistance to in-person instruction and anticipatory anxiety

### Challenges

Patients with chronic pain often develop school avoidance cycles (Smith & Bryant, 2020) and anxiety predicts poorer school functioning in this population (Khan et al., 2015). Prolonged time in virtual schooling may exacerbate anticipatory fear and complicate return to school. Some students might experience intense fear of crowds, developed after prolonged social distancing. Others may struggle to adjust to new schedules, physical demands, and social expectations. Indeed, many patients with chronic pain are likely to prefer virtual learning, but key features of this context can interfere with their functional goals. The virtual environment generally limits social/physical demands, provides students with the ability to attend class from the comfort of their beds, and sleep in. Any change, perhaps especially during this time, is likely to be difficult for our patients and prompt fear, anxiety, and stress, which could exacerbate pain and symptoms.

### Clinical strategies

***Psychoeducation.*** We encourage clinicians to support patients and families in understanding the benefits of in-person instruction from a chronic pain perspective (Logan et al., 2008; Logan & Simons, 2010). For example, discussion that in-person instruction reduces self-regulation and executive functioning demands, in contrast to virtual format, which typically requires significant caregiver monitoring as youth are tasked with structuring days and self-regulating towards goals, often with limited school-based support. Our patients report that enhanced social interactions, changes in settings, and more engaging classes characteristic of in-person instruction provide them with distractions from pain. The in-person context can allow for easier access to extracurricular activities, socialization, and supports belongingness – encouraging school attendance on bad pain days. In-person instruction also provides natural limits on daytime sleeping and helps to regulate sleep schedules. Patients who are ambivalent about return to in-person instruction, despite clear need, may benefit from motivational interviewing using personalized feedback to support adaptive decision-making (Miller & Rollnick, 2009).

***Exposure.*** Gradual exposures can help to address school-related anxiety. Clinicians will need to implement exposures as creatively and flexibly as possible, conditional on school protocol and safety precautions. For example, some families practice their school commute. Others meet teachers/ counselors in person. If permitted, students can view their lockers and practice walking to classes. If these in-person exposures are not feasible, consider imaginal exposures or virtual options. Social skills practice via role plays and virtual and in-person conversations may be indicated. Non-school activities out of the home can support social exposure goals. Families often implement reward schedules and/or token economies to support motivation. Families also help with extensive problem solving, particularly with exposures involving younger children. As with any exposure, deploying relaxation and cognitive strategies may be useful (Southam-Gerow, 2019).

***Structured return to in-person instruction.*** Developing a structured and time-bound gradual return to school plan can encourage approach behaviors and minimize school avoidance. These plans are quite prescriptive, and families are encouraged to share the plan with the school (see Text Box). In developing these plans, we emphasize the importance of not going backwards; for example, once a child participates in full days, they agree to not drop back to half days. Patients and their families often agree on no matter what criteria, which provide them with concrete circumstances permitting absence (e.g. profuse bleeding or fever). Clear, predictable, and mutually agreed upon expectations for patients and families can help to decrease parent-child conflict. Note that some schools may offer hybrid virtual options, which could be indicated in a return to school plan. Providers should carefully consider risks/benefits of virtual options within return to school plans, contingent on school, family, and patient factors (e.g. avoidance).

***Clinical Example 2.*** A recent patient ("Jade") presented to our clinic with a significant history of school refusal and generalized anxiety. She was advised by a primary care provider to return to in-person school, and she had attended a single in-person day. However, the school soon transitioned to a temporary virtual instruction due to a possible coronavirus case within the community. Following this disruption, Jade had not returned to in-person instruction and her parents reported being unable to motivate return. They experienced significant parent-child conflict. We implemented a time-bound gradual return to instruction plan, with a contingency management protocol (see Text Box). Jade and her parents contributed to and agreed upon the plan.

## Sleep considerations

### Challenges

Many children and families report sleep dysregulation and limited routines during the pandemic (Bates et al., 2020; Gilic et al., 2020; Yang et al., 2020; Becker et al., 2021). A challenge for our patients is deploying planning, organizational, and time management skills to structure and self-regulate a daily routine with intentional breaks from screens as well as opportunities for walking and physical movement. These circumstances increase risk for deconditioning in pediatric pain populations.

### Clinical strategies

Given impending sleep and lifestyle adjustments associated with return to in-person instruction and the likelihood of deconditioning among our patients, we recommend starting sleep and lifestyle changes promptly. Standard CBT-insomnia protocols (Lewin & Huntley, 2017; Palermo et al., 2017) are well suited. We also coach patients and families to gradually move bedtime and waketime earlier over time by 15- to 30-minute increments (e.g. facilitated by use of phone reminders in the evening and an alarm in the morning) until the desired bedtime/waketime is reached. Indeed, a consistent bedtime routine can also help facilitate sleep onset during this gradual shift. Increased daytime activity is also useful in regulating sleep/wake patterns.

***Clinical Example 3***. One patient described wanting to maintain a better balance between their schoolwork and other enjoyable activities. Another patient created a non-negotiables list of must-do activities the night before in-person instruction days, including gathering school materials, laying out school clothes, and packing lunch, water bottle (extra water if fountains are turned off), and snacks. These activities were routinized prior to the pandemic, but likely require forethought and practice after more than a year of virtual instruction.

## Cultural considerations

Patients and families express various beliefs about pain, privacy, and disclosure (Batista et al., 2012; Khin Hla et al., 2014; Sieberg et al., 2017). For example, some families may view clinicians and/or school personnel as experts, and appear reticent to express their concerns about treatment plans. Indeed, careful attention to these and other factors is essential in optimizing care, particularly with differing family concerns related to the pandemic and return to in-person school. Clinical frameworks, such as the multidimensional ecological comparative approach (MECA), can help to optimize care by supporting culturally attuned

**Example time-bound gradual return to instruction plan, with contingency management**

Example script for introducing gradual return to school plan: *"We believe it is in Jade's best interest to implement a gradual return to school plan over the course of 2-3 weeks. We have found that a supportive plan between school staff, caregivers, and the youth can significantly help attendance and academic functioning. Specifically, since Jade is already attending half days, we recommend that Jade begins with half school days and increases attendance for 1 hour (or 1-2 classes) every 2-3 days, until reaching full days."* See below for an example plan:

½ day Monday
Maintain Tuesday
+ 1 hour Wednesday
Maintain Thursday
+ 1 hour Friday

Maintain Monday
+ 1 hour Tuesday
Maintain Wednesday
+ 1 hour Thursday (full day)
Maintain full day Friday

**Contingency Management Protocol (Parent Tips)**

1. Remove reinforcers in the home environment. For example, ensure child accesses only school materials during school hours. Simulate school environment at home, including removing access to videogames and enabling firewalls.

2. Maintain consistent, predictable, and reasonable expectations that are mutually agreed upon. For example, if child is unable to access video games during school hours, this rule is consistently implemented regardless of pain or symptoms. Consistent and predictable parent follow-through on expectations and consequences can reduce inadvertent reinforcement.

3. Develop a list of privileges earned via specific, adaptive coping behaviors. Help parents to reflect on differences between basic rights, gifts, and privileges (see Barkley & Robin, 2008, for operative definitions of these terms). For example, have parents and child develop a set of specific coping behaviors and privileges. Emphasize with caregivers that they must reliably implement contingencies in order to be effective. Adjustment of privileges contingent on behaviors is advised, for example child can earn more of a privilege for completion of more difficult tasks. See below for an example privileges plan.

   Consume 3 x 32 oz. water bottles in a day = 5 minutes of videogames
   Attend school = 10 minutes of videogames
   Exercise (i.e. selected from a pre-determined menu of agreed upon exercise options, including a specific weights routine; walk; running around with dog; mowing the lawn) = 10 minutes of videogames
   20 belly breaths (or following along with a relaxation video) = 5 minutes of videogames

4. Encourage families to have daily special time (e.g. approximately 5 minutes of child-directed play) that is not conditional upon child pain, symptoms, coping, or functioning. This special time should be predictable and reliably implemented and is necessary to support warm parent-child relationships.

and empowering encounters between clinicians, patients, and schools (Falender et al., 2014).

## Conclusion

Our patients will likely encounter novel challenges in the transition to in-person instruction after prolonged in-person absence and new opportunities to deploy coping skills and strategies. Many clinicians anticipate an uptick in school-related anxiety and refusal. In this brief review, we hope to contribute to an important dialog surrounding clinical care during this time. Please see Appendices for additional resources and clinician guides for return to school and managing anxiety.

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**Appendix A: Questions for clinicians to consider in anticipation of return to in-person instruction**

1. What are the benefits of in-person schooling vs. virtual schooling?
    a. Increased daytime movement, social interaction, access to teachers for support, more engaging environment, change of scenery, easier to track work/assignments, decreased screen time, decreased parental monitoring, etc.

2. How will in-school will be different in the upcoming school year?
    a. Will teachers be simultaneously teaching virtual students?
    b. Will student use computers for learning the whole day?

3. What is the school's lunch plan?
    a. Are there opportunities for socialization?
    *Note*. Many schools currently have hybrid plan, so students may not be in school on the same days as their friends. Some schools are not changing classes as often, keeping lunch in small pods, or limiting interactions outside of pods.

4. What are social considerations?
    a. Does virtual format offer increased or decreased social opportunities vs. in-person?
    b. If students will have less in-school socialization, what are other social options?

5. What are any social anxiety triggers?
    a. Does return to in-person school mean stopping other sports/bands/clubs (due to COVID-19 rules or available time)?
    b. Will the student have access to supportive friends during the day? Can lunch/classes be scheduled with friends?

6. Who are supports within the school?
    a. Who are in-school advocates/safe people?
    b. How can child access these people?
    c. How can the child ask teachers for help? Role play raising hand, etc.

7. What are contextual factors in the home?
    a. Do caregivers have the bandwidth to provide oversight and monitoring of child during virtual school hours?
    b. What is the child's capacity for self-regulated behavior (e.g. refraining from off-task behavior during school hours; completing work independently and reliably)?
    c. Who is at home during virtual instruction?
    d. What, if any, distractions exist in the home setting? How do these differ from in-school distractions?
    e. What does the child's workspace look like in virtual schooling (e.g. bed versus desk in quiet, removed spot)?
    f. How reliable is the family's internet access?

8. What are family-level factors that could support, or interfere with, return to school plans?
    a. In what way, if any, do caregivers' concerns (e.g. fear of child's pain, guilt about implementing contingency management) interfere with successful implementation of goals (e.g. exposure)?
    b. What are parental attributions of child behavior, both at home and in the classroom?
    c. How comfortable and proficient are caregivers in implementing predictable and consistent rewards and discipline?
    d. In what way is parental attention inadvertently reinforcing withdrawal/avoidance vs. approach behaviors? Consider role playing with parents on adaptive responses to child pain behaviors and avoidance, including scripting possible parental response options for high-stress times.

9. How are grades and work tracked?
    a. How will child track their workload?
    b. How will child turn in their work (virtually vs. in class)?
    c. What will child do in the event of falling behind in school? Back-up planning.
    d. How can parents support, for example pre-set check-ins, grade reviews in the first few weeks to smooth transition?

    *Note.* Some schools may require virtual check-ins.

**Appendix B: Tips for managing anxiety and stress**

1. Enhance self-awareness of stress response
    a. How does stress impact their body?
    b. What symptoms may increase with stress, if any?

2. Develop an in-school stress reduction plan
    a. What are relaxation strategies they can do in the classroom vs. out of the classroom?
        i. Consider strategies at desk given physical distancing and space restrictions
    b. How can they access rewarding social connection?
    c. What demands/stressors during transition can be minimized?
        i. Consider reducing both school and non-school demands during acute transition
    d. What enjoyable activities can they add to their day?
    e. Identify comfort strategies

3. Create gradual exposure to school setting, as indicated
    a. Visit school in person, if possible (or virtual tour)
        i. Positive recall: review positive memories from school
    b. Visit the outside of the school
    c. Practice driving to parking lot and walking to the front door
    d. Walk around the school, perhaps to locker, classrooms, etc.
    e. Meet the teachers, counselors, school advocates

4. Increase daytime movement and activity to mimic the school day
    a. Practice walking 5-10 minutes around the house every hour to prepare for changing classes
    b. Increase overall physical activity/stamina
    c. Gradually increase reading, math, and writing exercises over summer

5. Assign dry runs
    a. Wake up, get dressed and keep the in-person school schedule including travel time (i.e. practice the morning commute if possible)
    b. Establish sleep schedule prior to start of school

6. Know the school plan/routine
    a. Review the school's COVID-19 safety plan
    b. Discuss how this may change the patient's prior school pain coping
    c. Identify any worries with new school plan/routine
    d. Review benefits of vaccinations (by teachers, other students, etc.)
    e. Create new daily schedule
    f. Schedule time for school, homework, exercise, social connection, activity, etc.
    g. Consider reducing the demands while adjusting to new routine

    *Note.* For students doing hybrid learning, they may need a separate plan for virtual & in-person days. Things to include for both plans are sleep, exercise, homework completion, social support, relaxation, diet, hydration, scheduling enjoyable activities, routine.

7. Plan ahead for possible disruptions
    a. If sudden return to virtual, how do you need to be prepared?

**Appendix C: Sources for references**

National Association of School Psychologists – COVID-19 Resources: www.nasponline.org/resources-and-publications/resources-and-podcasts/covid-19-resource-center

CDC Guidelines: www.cdc.gov/coronavirus/2019-ncov/index.html

CDC Guidelines - School related: www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/schools.html

American Academy of Pediatrics Guidelines - Return to school: https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools

American Psychological Association: www.apa.org/topics/covid-19

Check with local public health department recommendations.