Current Practice

School refusal in children and adolescents

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Introduction

School refusal is a pattern of behaviour with multi-factorial origins. Kearney and Silverman[1] defined school refusal behaviour as 'child motivated refusal to attend or difficulties remaining in school for the entire day'. It is important to remember that school refusal is not a formal psychiatric diagnosis; it is a presenting complaint that reflects a variety of problems.

There is usually a gradual onset of school refusal symptoms in youth. The above definition includes a continuum of school refusal behaviour in children who display marked distress on school days and plead with their caregivers to allow them to remain at home, those who go to school after having behavioural problems such as morning tantrums or psychosomatic complaints, children who initially attend school but then leave during the school day and those who are completely absent from school.

School refusal behaviour is a serious problem because it usually causes significant and adverse consequences. This is often associated with short-term sequelae including poor academic performance, family difficulties and peer relationship problems and it leads to many long term dysfunctions.

The longer the child stays out of school, the more difficult it is to return. Psychiatric conditions related to school refusal primarily include anxiety, depression and disruptive behaviour disorders. As such, school absenteeism remains an important public health issue for mental health professionals, paediatricians and educators.

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Epidemiology

School refusal occurs in approximately 5% of all school-age children[2]. Most studies suggest that school refusal tends to be equally common among both sexes. School refusal may occur throughout the entire range of school years, but it peaks at three stages: on starting school, after changing school and in the early teens.

Causes

School refusal can be the presenting complaint for children with a variety of underlying psychiatric conditions. Separation anxiety is the commonest diagnosis particularly among younger children. School refusal can also result from a specific phobia related to school such as fear of bullies, of one particular teacher or to the journey to and from the school. Depression is important as a cause of school refusal in teenagers. Psychosis is a rare cause. School refusal behaviour is highly co-morbid with a number of different mental health disorders such as separation anxiety disorder, generalized anxiety disorder, oppositional defiant disorder and depression[3]. Developmental learning or language disorders cause significant frustration in the school setting and may predispose the vulnerable child or youth to school avoidance.

Triggers

Although some cases of school refusal behaviour are not triggered by any clear stimuli, many are often triggered by specific stimuli. Specific stimuli include academic underachievement, family and marital conflict and transitions, illness, school-based challenges and threats and traumatic experiences[4].

Maladaptive parent-child relationships are of particular interest in the school refusal behaviour of the child. Family factors reflect a combination of three family processes:

a. Ineffective home organization and discipline.

b. Emotional over-involvement of family members with the child.

c. Difficulty negotiating with outside agencies.

The work of Kearney and Silverman[5] identified five familial relationship subtypes that are descriptive of children and adolescents with school refusal behaviour. These are:

1. *The enmeshed family*: (over involved parent-child relationship) Children in this family tend to exhibit dependency and overindulgence.

2. *The conflictive family:* Two of the key characteristics of the conflictive family type include hostility and conflict among families with youngsters who display school refusal behaviour. Additional characteristics include high levels of coercion, noncompliance and aggression.

3. *The isolated family:* in which there is little extra familial contact on the part of its members.

4. *The detached family:* As defined by Foster and Robin (1989) a detached family is one whose constituents are not well involved with one another's activities or attentive to one another's thoughts and needs. Typically, parents within this family subtype are not heedful when it comes to their child's activities or problems until these reach a severe level.

5. The healthy family

Kearney and colleagues designed a system of school refusal behaviour based on function or reasons why youths refuse school[6]. These functions are linked to specific reinforcements youths often receive for school refusal behaviour. Those are:

1. Avoidance of school-related stimuli that provoke negative affectivity or general anxiety and depression e.g. difficulty with transitions between classes or time periods. This function is commonly associated with generalized anxiety disorder, somatic complaints, tardiness and constant pleas for nonattendance.

2. Escape from aversive social and/or evaluative situations at school e.g. difficulty with evaluative situations such as examinations. This function is commonly associated with generalized and social anxiety disorder as well as shyness and withdrawn behaviour.

3. Pursuit of attention from significant others. This function typically applies to younger children who refuse school to remain at home with parents or others. Common misbehaviours include tantrums, running away from school and noncompliance. This is commonly associated with separation anxiety disorder and oppositional defiant disorder.

4. Pursuit of tangible reinforcers outside the school setting e.g. to pursue more alluring activities outside of school such as watching television. This function is commonly associated with oppositional defiant and conduct disorder

However, the diagnostic studies also convey that many youths with school refusal behaviour demonstrate no psychiatric condition. Many youths display problematic absenteeism as their sole behaviour problem without co-morbidity.

Assessment

School-refusing youths vary widely regarding their clinical presentation, family dynamics, and school situation. To meet this challenge it is recommended that assessment be multi-method and multi-informant. In addition to a clinical interview, comprehensive evaluation of factors maintaining the school refusal behaviours, ratings of severity of anxiety and depression from self-report, parent, clinician, and teacher perspectives, assessment of family functioning, assessment of temperament of the child and language assessment and review of school attendance are important aspects in the assessment. Addressing true medical conditions related to school refusal behaviour is obviously imperative as well[7].

Management

The primary goal of treatment is early return to school fulltime except in the most severe cases. A 'rapid return' strategy may be useful if the period of absence is brief or can be introduced gradually if there has been a longer refusal period. This will minimize continuing problems of missed work, social isolation, low self esteem and avoidance behaviours. In the management of school refusal, consideration should be given to the following components:

education and consultation, behavioural (exposure/return to school) or cognitive-behavioural strategies, family interventions and pharmacological interventions if warranted by severity of symptoms[8]. Research on treatment efficacy over the past decade has been mainly confined to cognitive behavioural therapy (CBT) and pharmacotherapy.

Using a multidimensional approach[9];

- ***Child-based strategies***
    - Educating children about the nature of their anxieties and school refusal behaviours.
    - Somatic control exercises such as relaxation training in order to control the physical anxiety symptoms.
    - Cognitive restructuring to help children modify their irrational thoughts and to think more realistically.
    - Exposure-based techniques should gradually reintroduce children to school as they practise methods of controlling their anxieties.
    - Social skills training, problem solving skills and training of assertiveness skills.
    - Training of peer refusal skills.
- **Parent and family based strategies**
    - Establishment of schedules, including regular morning, daytime and evening routines for the school-refusing child.
    - Training in the implementation of contingency management procedures to reward attendance and to punish non-attendance.
    - Empowering parents to use brief and clear commands and to establish school going behaviour.
    - Reducing excessive reassurance-seeking behaviour.
    - Escort the child to school and, if necessary, allow the child to stay in contact with the parents.
    - Forced school attendance in special circumstances.
- **School based strategies**
    - Work with the school to ensure clear understanding of the problem and arrange special support.
    - School consultation involving specific recommendations to school staff to prepare for the child's return, use of positive reinforcement and academic, social and emotional accommodations.
    - Anti-bullying measures.
    - Reducing violence.
    - Increasing positive school climate and making transitions easy for students.
    - Planning curriculum to meet diverse student needs.

In-patient treatment is sometimes considered when the child's problems are so severe that there is no response to other forms of treatment and when the family environment blocks effective treatment.

Cognitive behavioural therapy

CBT is a highly structured approach that includes specific instructions for children to help gradually increase their exposure to the school environment. In CBT, children are encouraged to confront their fears and are taught how to modify negative thoughts.

Highly anxious school-avoidant children profit quite remarkably from such intervention in terms of anxiety-reduction, increased self-efficacy, and improvement in school attendance[10].

Medical and pharmacological treatment

Generally, medications are considered as part of a multimodal treatment plan for children and adolescents with anxiety disorders and are not prescribed alone as a sole intervention without concurrent therapy[8]. The selective serotonin reuptake inhibitors (SSRIs) are emerging as the initial choice for treating anxiety disorders in children and adolescents[11].

SSRIs have now replaced tricyclic antidepressants as the first-line of pharmacological treatment for anxiety disorders in children and adolescents[12].

Benzodiazepines can be used on a short-term basis, alone or in combination with an SSRI, for a child with severe school refusal. In as much as it may take several weeks to appreciate the benefits of an antidepressant, a benzodiazepine can be started simultaneously to alleviate acute anxiety symptoms until the effects of the antidepressant are apparent.

Prognosis

The success rate for return to school in children and adolescents is generally 70% or better. Although outcome was satisfactory for 70–76% of adolescents, about one-third of youth treated for school attendance difficulties continue to have serious adjustment problems in later life[13].

Conclusions

School refusal is an important public health and social problem which needs to be tackled by multi-agency working and strategic partnership between health and education and between young people, their parents/care-givers and professionals.

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