



# Riegler, Shienvold & Associates

## Mental Health Quick Notes

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### School Refusal

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#### School Refusal in Children and Adolescents

Holiday ornaments are put away and a new calendar year begins. It is once again a prime time for schools and families to see the beginning (or resurfacing) of the problem of school refusal in children and teens. After being away from school for illness or school holidays, it is often more difficult for a child with anxiety associated either with school or with absence from home to return. In some cases discomfort and avoidance behaviors are severe and the label of school refusal is given.

**School Refusal- What it is-**School refusal is a description rather than a formal diagnosis. It is often a symptom of other underlying problems. School refusal happens when a child or teen will not go to school at all or frequently experiences severe distress at going to school or is unable to concentrate on learning while in school because of distress about being there. Presenting complaints may include somatic symptoms (that improve if the child is permitted to stay home or leave school early); fear and intense anxiety (sometimes reaching the level of a panic attack); temper tantrums; and crying spells and depressed mood (sometimes with the threat of self harm).

Refusing to go to school can happen at any age, but is most common at ages 5-7 years and 11-14 years. At these ages, children are typically coping with the developmental challenge of starting school or making the transition from elementary to middle school and then from middle to high school. Kearney and Albano (2000) report that as many as 28% of school age children refuse to attend at some point in their school career (Therapist's guide for the prospective treatment of school refusal behavior. San Antonio, TX: The Psychological Corporation).

Possible co-morbid psychiatric problems are separation anxiety, social phobia, panic disorder, depression, and generalized anxiety disorder. These problems may complicate school refusal and make a team approach to intervention even more imperative.

**School Refusal- What it is not—**As previously described, school refusal is associated with distress about going to and/or being in school. This distinguishes the school refuser from the truant student. Truancy is typically associated with conduct disorders or delinquent behavior. Skipping or "cutting" school is bragged about to peers by the truant child, but missing school is associated with embarrassment

and shame by the child who feels unable to attend school. Time spent out of school by the school refuser is usually spent in quiet activities at a caretaker's home. The truant child, in contrast, is often hanging out with other peers who have also skipped school and may be engaged in illegal activities like drinking or drug use. The school refuser is usually compliant in completing missed work at home, but the truant child is usually defiant or avoidant about school work. There can be some overlap and some differences are correlated with age, but treatment of school refusal and truancy are different.

**Triggers-** School refusal may have multiple causes and the school refuser may have one or more psychiatric diagnoses. Often, however, triggers for the onset of the problem can be identified. These may include:

- \* *Illness in child or parent*
- \* *Death in the family's family*
- \* *Jealousy after the birth or adoption of a sibling*
- \* *Change of school because of moving or grade changing*
- \* *Separation, divorce or serious family conflict.*
- \* *Aversive experiences at school, such as being bullied*
- \* *Hearing about traumatic events at their own or another school, such as a school shooting.*

**Prevention-** Not every trigger situation leads to problems with school attendance and initial problems can sometimes be prevented from growing into those requiring treatment. The following can often help:

- \* *Willingness to listen to and take the child or teen's fears seriously, while maintaining a calm confidence that he/she will be able to attend successfully with the help of adults.*
- \* *A transition period of half-day attendance if the child is returning to school following a serious illness.*
- \* *Familiarization visits to a new school or new classroom to meet the teacher(s) and learn where the homeroom, bathrooms and lunchroom are.*
- \* *Pairing a returning or new child with a peer buddy or group of friendly peers to ease the transition.*
- \* *Planned phone call to the home during the school day if a parent is sick or home with a new baby.*
- \* *School-based plan to reassure children (and parents) it is safe to be in school.*

#### Clinical Features of School Refusal

The beginning of school refusal is often, but not always, gradual. Children with school refusal often present with anxiety symptoms and adolescents with anxiety and depression. Separation anxiety is most common in younger children and approximately three of four children diagnosed with Separation Anxiety Disorder have at least one episode of school refusal. The problem is as common in girls as boys. A family history of depression or anxiety is often, but not always found in school refusers.

What the parent sees is severe distress going to school. This distress may include more oppositional behaviors like extreme temper tantrums, defiance about getting dressed, and hiding in the house or yard. The distress in another child maybe shown in more internalizing behaviors like severe somatic complaints, crying, clinging, and begging. The anxiety can reach the level of a full-blown panic attack that is frightening to both the child/teen and parents. If the child reaches school despite the problems, the same distress can recur in trying to get the child in the building or the classroom. Once in the classroom, the distress subsides for some children. Others refuse to participate or ask to go to the nurse's office or even try to escape the school building.

Children and adolescents differ in the length of time they show their distress. Some parents report "having my normal child back" the whole evening or weekend before it's time for school (including doing homework). The child is confident attendance will not be a problem; the somatic complaints and distress then escalate quickly on waking. Other school refusers start to express anxiety about going the next day from the time they get home and may have difficulty falling asleep, especially after a weekend or holiday break. The complaints then increase dramatically in intensity in the morning.



## School Refusal Cont.

### Helping the Child or Adolescent with School Refusal

Early identification and intervention is key in treating school refusal and successful treatment may involve helpers in a variety of roles.

**School staff.** As stated earlier, school staff can help with prevention. In addition, early recognition of school refusal often happens in the school. Excessive absences, especially after school breaks, frequent trips to the nurse's office for headaches, stomachaches and other somatic complaints; and once there, requests to go home early are noticed.

Following the identification of the problem, school staff are integral in treating school refusal. Typically school administrative staff, the guidance counselor, the school nurse, and the classroom teacher have a key role to play in developing and carrying out the treatment plan developed with outside professionals and the family.

School refusal is multiply determined and school staff are critical to assessing and developing a school-based plan for learning delays or disabilities, the boredom of a gifted child not challenged by school, or the child with problems with peers. The child or teen may also have specific phobias or strong fears related to school requirements. School involvement is needed for fear of giving speeches, fear of eating in the lunchroom, fear of using a public bathroom, test anxiety, or anxiety about being hurt or teased on the playground.

#### **Pediatrician or family doctor.**

Because of the common association of school refusal with complaints about physical problems, the doctor's office is often a first and important stop in assessing and treating school refusal. For example, children and teens can insist attendance is impossible because of headaches, stomachaches, vomiting, diarrhea, dizziness, fainting and weakness in the limbs. When possible, necessary screening for medical problems should take place while the child is attending school. When physical illnesses are ruled out and the decision made that school refusal is the problem, the physician's authoritative reassurance that the child is healthy and just needs help with the emotional concerns sets the framework for a treatment plan.

It is imperative that the physician not request homebound instruction for the child or adolescent school refuser. Longer absence from school is associated with greater severity and prolonging of the symptoms. Absence makes the child temporarily "feel better" and the association between school attendance and pain and discomfort is therefore strengthened.

**Parents.** Parents are sometimes blamed for children and teenagers refusing to attend school. Occasionally an anxious or depressed parent feels lonely without the child and is part of the problem. Usually, however, parents are themselves frustrated and helpless and alone in dealing with school refusal. Single parents or parents who both must work are obviously affected immediately. Sending a child to school who looks and sounds like he/she is being shipped to Siberia is tough for most parents. Prompt assessment and a treatment plan outlining their roles helps the parent feel supported, educating about how to help their child, and in control of the helping process.

A plan to get the child regularly to school on time will help. If fears about riding the school bus are an important feature, a transition plan of having the more authoritative parent, extended family, or a family friend drive the child to school may help. The child is less likely to escalate their distress symptoms if goodbyes to the primary attachment figure are said at home. It is also important that the child stay in school unless the nurse determines that he/she is physically ill. The parent must calmly support this--despite anguished or angry calls from the child. On the other hand, planned phone contact, as at lunch time, may help reassure the child as part of a comprehensive treatment plan.

Parents also have a role in helping develop and then implementing a program of positive reinforcements or rewards for school attendance and longer periods spent in the classroom. If school refusal is associated with learning problems or problems getting along with peers, the parents can collaborate with the school in addressing these complications. If mental health treatment is required, the parents can secure this help.

**Mental Health Professionals.** Mandatory school attendance laws and the emotional and educational sequelae of chronic school absence lead most school refusers to be referred for mental health assessment and treatment.

Just as medical problems had to be ruled out, an assessment to rule out contributing comorbid psychiatric disorders such as depression, separation anxiety disorder, a panic attack history, specific phobias, or post-traumatic distress disorder is typically done in an outpatient mental health practice. This is usually done in the interest of time even when the school has qualified mental health staff. Parent, child, and teacher checklists and child/teen and family interviews provide history about the onset and course of the school refusal symptoms, any triggers associated with the onset, psychiatric history if any, school history including attendance, report cards and any psychoeducational testing done, relationships with peers, and family functioning.

The outpatient therapist collaborates with the family, the school, and the family doctor to develop a plan for regular attendance and support as soon as possible. The more chronic missing school becomes, the more difficult it is to break the cycle. It is important that the need for the child or adolescent to attend is calmly supported by all authority figures and that whatever supports are necessary to help the family and school staff carry out the plan effectively are in place. At times a plan with accommodations that provide for gradually increasing the time in the school or in the classroom may be recommended. Parents are typically helped to establish morning routines, change parent-child communication about the problem, and use a system of rewards and consequences for school attendance and refusal.

The evaluation results may suggest longer-term interventions that are needed to help improve the child's school and emotional adjustment. The anxious child may need to learn coping skills such as relaxation training, deep breathing, and problem solving training to help manage their emotions in anxiety-provoking situations. The child who avoids evaluation situations like speeches or tests may need roleplay practice, gradual exposure and cognitive restructuring of negative self-talk to build confidence. The child with peer difficulties may need social skills and problem-solving training at school and/or in group therapy. The depressed child or adolescent may need a medication evaluation by a psychiatrist as well as outpatient therapy.

In a minority of cases, the causes or complications of school refusal may be so overwhelming to the child or adolescent and their family that short-term intensive treatment in a day hospital program may be necessary to start the transition to school. With successful reentry to school and discharge from the day hospital program, the outpatient therapist then helps coordinate and carry out the discharge plan.

#### **The Good News**

School refusal is a complex, multiply determined problem that often challenges the patience and resources of all those trying to help. Describing in this newsletter even some of the triggers and symptoms and the multiple system responses needed may sound negative, complicated, and even overwhelming. The good news though is that most cases are successfully treated. Early intervention, involvement and support of family, and a team approach do work.

#### **Recommended Readings:**