Understanding and managing school refusal in children and adolescents

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Introduction

School refusal is a common problem observed in children in India and elsewhere. It is a serious problem because it usually poses significant and adverse consequences. Unfortunately, it is not often seen as such. Short-term consequences include poor academic performance, family difficulties, and peer relationship problems.[1,2] The long-term consequences are obvious: reduced opportunities to attend higher education, employment problems, social difficulties, and increased risk for later psychiatric illness.[3]

Definition

School refusal can be defined as difficulty attending school associated with emotional distress.[4] Children may have a variety of problems associated in school refusal. These may include completely absence from school, partial attendance, behaviour difficulties such as morning tantrums or psychosomatic complaints prior to going to school, or pleading with their caregivers to allow them to remain home from school.[5]

Epidemiology

School refusal occurs in approximately 5% of all school-age children. It tends to be equally common in boys and girls and is more common at transition points e g entry into school (age 5-6) and entry into high school (age 11-12). It is not associated with socioeconomic status.[4]

Concept issues

The following are noted as key points in understanding school refusal as a concept:

1. Severe difficulty in attending school.
2. Severe emotional upset.
3. During school hours, the child remains at home with the knowledge of the parents.
4. Absence of significant antisocial disorders such as juvenile delinquency, disruptiveness, and sexual activity.

Clinical Picture

The difficulty in attending school may range from partial absence (e.g. attending 2 classes a day, returning home after a period at school), irregular attendance or complete absence. The emotional symptoms are predominantly in the anxiety and fear dimension. The child would repeatedly complain of being fearful of the school itself and gradually to other articles or situations associated with the school. For example, the fear could potentially involve clothing such as school uniform, socks, or material e.g. home work sheets, text books or people e.g. school friends or teachers. Attempts by the parents to get the child to school result in behavioural symptoms include avoidance, temper tantrums, misery, or complaints of feeling ill without obvious organic cause when faced with the prospect of going to school e.g. headaches, abdomen pain. Often the child begs or pleads with the parents that he will start going to school the next day. It is important to be aware that during school refusal, the child *wants* to go to school, but *cannot* due to the extreme anxiety/ fear he experiences. As a result, the teachers see the child as "anxious" as opposed to "naughty".

The parents are fully aware that the child is at home when he does not go to school. At times, since the parents themselves are working, they have to make appropriate arrangements for the child to stay. It is common for grandparents to look after the child or for the parents to take the child to work with them. During this time, the child is usually quite happy to comply. School refusal places a significant burden on key relationships within the family. The parents often try various methods to get the school. For example, they may try cajoling or pleading, which the child stubbornly refuses to comply with. At times anger and threats are made, which result in crying or tantrums. At times the parents may physically force (flooding) the child to go to school. This often results in severe tantrums, or even aggression. The condition may impact the parental relationship e.g. the parents may blame each other or feel helpless or guilty of being "bad parents"- a sentiment that is often reinforced by well meaning relatives.

It is important to distinguish school refusal from truancy. Truant children, are unlikely to be excessively anxious or fearful about attending school. Their absence is more likely to indicate a lack of interest in schoolwork or an unwillingness to conform to the school's expectations or codes of behaviour. The truant child often attempts to conceal his or her absence from parents and engages in delinquent and disruptive acts in the company of other antisocial peers. In contrast, parents are well aware of their children's whereabouts in school refusal. While school refusing children may come across as oppositional, this is usually in the context of school attendance and not in other circumstances.

Diagnostic issues

School refusal is not a diagnostic category in the DSM or the ICD classificatory systems. It is seen more commonly as a symptom of related disorders. Research has identified 3 common groups of diagnoses in patients with school refusal. These include phobic disorders, separation-anxiety disorder and mixed anxiety-depressive disorder.[6] The characteristics of these 3 categories appear slightly different. The separation anxiety group tend to have earlier age of onset. This was 8.7 years in one study.[1] Parents of school refusing children with separation anxiety disorder had increased prevalence rates of panic disorder and panic disorder and/or agoraphobia. Parents of school refusing children with phobic disorders had increased prevalence rates of simple phobia or social phobias.[7]

It is important to rule out other possible causes of a school non-attendance. These include social causes e.g. poverty, bullying at school, physical problems e.g. common childhood infections, or other mental disorders e.g. conduct disorder.

Case Example

The following case vignette illustrates the common presentations with school refusal:

Parvathi is a 7 year old girl who presented to the clinic with school refusal after finishing her kindergarten and before moving to 1st class. She lived in a city, with her parents, Ravi and Radhika. She was cared for at her grandparent's house by her grandparents while both parents went to work. The fear of school started when her parents had talked about 1st class in a casual way, discussing the punishments they had been given in school, years ago. These had included being hit on the palms and knuckles with a ruler and being sent out of class. Parvathi had cried on hearing this and was calmed down by her parents. This fear was heightened, when on a visit to the school prior to start of the school year, a teacher had said jokingly, that '"bad children in 1st class" were often punished by being locked up in the bathroom with cockroaches. On the first day of school, Parvathi and Radhika went together, but Parvathi cried so loudly that the anxious mother took her back home. This pattern was repeated over the next few days. A week later, the school suggested that Radhika leave her at school and just go to work. They told her that crying is common initially but that most children settled when the parents left. The tearful mother did so. However, the school called her an hour later that Parvathi's crying had still not stopped and advised her to be taken home. Parvathi cried all the way back home and clung to her mother all day. Ravi was angry that she was at home when he returned. Now Parvathi would constantly cling to Radhika in the mornings and would cry for long time after her mother left for work. Her mother spent increasingly longer times at home trying to settle Parvathi down, but her clinginess worsened. As a result, Radhika found that she could no longer reach work on time. Ravi got more frustrated and angry with both Radhika and Parvathi, saying that Parvathi was being spoilt by Radhika. As time passed, Radhika started complaining of significant abdominal pain in the morning. This resulted in several trips to specialists to identify the cause of the pain and treat it, to no avail. However, Ravi was more concerned when she complained of abdominal pain. The pain would often disappear when the family decided they would stop trying to send her to school for that day. All attempts to get her to school resulted in severe screaming and "tantrums". She would pass her time at home by watching TV and playing video games. However, at night, her clinginess to her mother worsened and she started complaining of repeated dreams of a monster taking away her mother, and could no longer sleep in her own bed. This fear of something happening to mother extended to all situations and the mother found that she could neither work, nor socialise. The parental relationship worsened further. Parvathi would often cling to Radhika when Ravi was angry and when refusing school would say "she preferred to be with mummy as she is scared of her daddy". Her grandmother would give her chocolates to calm her down sometimes. Well meaning relatives suggested she was "anxious child" and said "anxiety is common around getting to school" and advised the parents to "give her time". However, no change was noted. Another suggested that the parents were being "too soft" on her, and that "tough love" was needed. Features of other anxiety disorders or depression were not noted.

In this case, careful assessment and application of proper criteria revealed that she fulfilled several criteria of separation anxiety disorder including: developmentally inappropriate and excessive anxiety concerning separation from a key figure (in this case the mother), excessive distress, school refusal, nightmares around separation, difficulty sleeping and repeated complaints of physical symptoms. Significant dysfunction included loss of education for Parvathi, loss of work for Radhika and marital discord between the parents.

Developmental and family history: On further assessment, Parvathi was anxious by temperament. Both her parents had social phobia. The parents described themselves as anxious by nature as well. A related feature was that they tended to have constantly anxious interactions with Parvathi (e.g. "Don't go to there, an insect might bite you"). Both described her as otherwise intelligent, gifted player of Veena.

Therefore, the diagnosis would be:
Axis I: Separation anxiety disorder
Axis II: nil
Axis III: nil
Axis IV: nil

Axis V: School refusal, Family history of anxiety, anxious interactions between parents and child, marital discord, loss of education and work opportunities
Axis VI: CGAS score of 60

Making the diagnosis does not necessarily lead to proper management. A formulation, specific to the case is needed. Formulations are of several types: these include a diagnostic formulation, which incorporates key diagnostic criteria, a psychodynamic formulation, which explains symptoms in a psychodynamic way[8] or a clinical formulation which incorporates a biopsychosocial model.[9] A clinical formulation incorporates vulnerability and precipitating factors and links these to maintaining factors. A useful way to do a formulation is to list out the influencing factors in a grid as below.

Table 1: Formulation grid

	Biological	Psychological	social
Predisposing factor	Family history	Anxious temperament Anxious interactions in the family system	nil
Precipitating factors	Nil	Fear based discussions around school by parents and teacher	
Perpetuating factors		Increased fear due to flooding. Anxiety around parental emotions e.g. anger (father), parental modelling of anxiety e.g. mother crying in anxiety which child noticed, modelled helplessness by parents, presence of avoidance based pleasurable factors e.g. computer games, grandparents offering chocolates when child refusing school	Inconsistent parenting
Protective factors		Absence of abuse, presence of talent	Presence of social network/ extended family

General issues during assessment

In general, it is important for the psychiatrist to be aware that the patient is the child not the parent. Therefore, attempts to establish a rapport with the child independent of the parent must be made e.g. use of age appropriate toys, getting the child to draw pictures, drawing the family tree on a white board and labelling each person etc. The psychiatrist must strive to reduce blame and maintain the focus that the child *has* a problem and no individual is to blame for the problem.

Management of school refusal

The first step to management is an initial assessment and diagnosis as above. Medical conditions should be assessed for and ruled out. Common conditions associated with anxiety in children are anaemia and thyroid problems. It is important to involve all the key stake-holders in the case. These most commonly include the family and school systems. Often, school based assessment is not possible in a busy clinic. However, communication with the school is absolutely essential. Ideally, the doctor should speak directly to the school and come up with an agreed plan. However, if this is not possible, other means of communication such as letters or relaying messages through the family may be used.

Key components of the management include:

Psychoeducation: The first step is to present the formulation to the family. Education reduces anxiety in all systems including the family and school systems and serves to empower the parties involves. It has a direct effect on reducing helplessness felt in this situation. By modelling confidence instead of helplessness, significant gains are often made at the assessment itself.

Medical management: In younger children, medication is rarely indicated. Presence of other anxiety disorders such as panic disorder or Generalised anxiety may require treatment independently by agents such as SSRIs. Benzodiazepines should be avoided, given their propensity to cause addiction or cognitive side effects. In general, if pharmacological treatment is indicated, SSRIs are preferred. Antipsychotics have no documented efficacy in school refusal.

Cognitive Behavioural Therapy: A variety of trials support CBT approaches in school refusal. CBT for school refusal is primarily based on exposure techniques to increase school attendance and reducing avoidance.

Family interventions: These focus on ensuring consistency across various family members and

providing support to them. Independent disorders in the family members are treated appropriately.

Psychodynamic therapies have not demonstrated efficacy in managing school refusal.

Based on the formulation, the following management was done.

Parvathi and her family were seen by a psychiatrist. After the above diagnosis and formulation were made, the psychiatrist spent a long time in educating the parents and grandparents regarding the illness. Medical illness such as hypothyroidism and anaemia were ruled out.

The agreed upon goal was to get Parvathi back to school. The Psychiatrist insisted on having Parvathi attend family sessions. Parvathi was enthusiastic about it when her anxiety had reduced and she was relieved that she was getting help and not being forced. She also realised that all the family members were working together and would not stop trying to get her back to school no matter what. The psychiatrist worked to ensure that the parents and grandparents were united in this goal. The family was advised that Parvathi should not have any fun based activity when not at school. The grandmother agreed to stop chocolates and computer games. The parents agreed to take her to work with them when possible, where she would sit on at a table drawing but no other fun activity. It was stressed that flooding (forced exposure to school in the presence of high anxiety) should be avoided and that return to school would take time. The parents agreed to have an assessment for their own anxiety and Ravi agreed he would take medicine for the same. They stopped discussing school refusal in her presence and focussed on positives such as her talent at playing music. They further stopped discussing her medical symptoms or tantrums in her presence. The parents worked out a gradual return program with the school after the psychiatrists sent a letter of support.

The psychiatrist formed a good therapeutic relationship with Parvathi. Initial individual sessions with her focussed only on rapport building (e.g. play sessions) to ensure she was not scared of seeing the doctor.

The first step of exposure was to teach progressive muscle relaxation. As part of fun, the psychiatrist taught Parvathi and her family this. These were done by the family together as part of family building activity. A useful guide to progressive relaxation exercises is included in the appendix of this chapter.

The next step was to build up a hierarchy of anxiety provoking situations. Again Parvathi was an enthusiastic participant in this activity when it was explained.

Table 2: A sample hierarchy of exposure

	Severity of distress (0= no distress, 100= severe distress)	**Severity after 3 months**
Reading books relating to school	10 able to do it but will avoid it when possible	0 able to do this with no distress
Wearing school uniform at home	10	0
Wearing school uniform and carrying school bag and lunch box at home	20	0
Driving past school in morning	30	10
Stopping in front of school gate in morning	40	10 achieved after 1 month of therapy
Entering the school	50	10
Entering the class room	60	20
Staying for one class	70	20
Staying for 2 classes	85	30
staying in the class room all day	100	30. Still has some anxiety e.g. when asked a question by a teacher but able to be in class all day

The third step was to couple the hierarchy with relaxation. The family did relaxation twice a day for 10 minutes in the morning and evening. During the day at a specific time, Parvathi did relaxation again and then started the exposure task e.g. reading a book about school. After a few sessions of this at home, she reported that the anxiety had reduced from 10 to zero. Gradually she was able to work down the way through the program. The psychiatrist asked them to move to the next step in the hierarchy when the distress reduced by 50% for each step.

Four months later, Parvathi was well integrated at school, but continued to be anxious at times. The mother was able to return to work. Spin off benefits included better functioning of the family and improved relationship between the parents.

Follow up

Various studies have demonstrated good results with CBT interventions. Prabhuswamy et al[10] (2007) followed thirty-three children aged 8 to 16 years presenting with school refusal at baseline and after 3 months. Twenty of the thirty subjects (66.6%) who could be followed-up had returned to school. Psychiatric diagnosis persisted in 16 subjects. Younger age, being last-born, no or one diagnosis, and good baseline functioning predicted a favourable outcome.

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Conclusion

School refusal is a common condition. It is often not recognised and its severity is underestimated. It is easily treatable and outcomes of treatment are generally good.

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