Solutions to school refusal for parents and kids

Pinpoint and address reinforcers of the child’s behavior

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Nathan, age 13, is referred by his parents for recent school refusal behavior. He has had difficulty adjusting to middle school and has been marked absent one-third of school days this academic year. These absences come in the form of tardiness, skipped classes, and full-day absences.

Nathan complains of headaches and stomachaches and says he feels upset and nervous while in school. His parents, however, complain that Nathan seems fine on weekends and holidays and seems to be embellishing symptoms to miss school. Nathan’s parents are concerned that their son may have some physical or mental condition that is preventing his school attendance and that might be remediated with medication.

Child-motivated refusal to attend school or remain in class an entire day is not uncommon, affecting 5% to 28% of youths at some time in their lives.¹²

The behavior may be viewed along a spectrum of absenteeism (Figure, page 68), and a child may
School refusal

**Figure**

A child might exhibit each behavior on this spectrum at different times

| Substantial distress while attending school with pleas to parents for future nonattendance | Severe misbehaviors in the morning in an attempt to miss school | Chronic tardiness to school | Skipping certain classes or periods of school during the school day | Lengthy absences from school |

exhibit all forms of absenteeism at one time or another. In Nathan’s case, for example, he could be anxious during school on Monday, arrive late to school on Tuesday, skip afternoon classes on Wednesday, and fail to attend school completely on Thursday and Friday.

In this article you will learn characteristics of school refusal behavior to watch for and assess, and treatment strategies for youths ages 5 to 17. You will also find advice and techniques to offer parents.

**REFUSAL BEHAVIOR CHARACTERISTICS**

School refusal behavior encompasses all subsets of problematic absenteeism, such as truancy, school phobia, and separation anxiety. Children and adolescents of all ages, boys and girls alike, can exhibit school refusal behavior. The most common age of onset is 10 to 13 years. Youths such as Nathan who are entering a school building for the first time—especially elementary and middle school—are at particular risk for school refusal behavior. Little information is available regarding ethnic differences, although school dropout rates for Hispanics are often considerably elevated compared with other ethnic groups.

School refusal behavior covers a range of symptoms, diagnoses, somatic complaints, and behaviors, economic deprivation, social isolation, marital problems, and difficulty maintaining employment. Approximately 52% of adolescents with school refusal behavior meet criteria for an anxiety, depressive, conduct-personality, or other psychiatric disorder later in life.

**FINDING A REASON FOR SCHOOL REFUSAL**

If a child has somatic complaints, you can expect to find that the child is:

- suffering from a true physical malady
- embellishing low-grade physical symptoms from stress or attention-seeking behavior
- reporting physical problems that have no medical basis

A full medical examination is always recommended to rule out organic problems or to properly treat true medical conditions.

**Four functions.** If no medical condition is found, explore the reasons a particular child refuses school. A common model of conceptualizing school refusal behavior involves reinforcers:

- to avoid school-based stimuli that provoke a sense of negative affectivity, or combined anxiety and depression; examples of key stimuli include teachers, peers, bus, cafeteria, classroom, and transitions between classes
- to escape aversive social or evaluative situations such as conversing or otherwise interacting
Box

Is there a link between school violence and absenteeism?

Violence on school campuses across the country naturally makes many parents skittish about possible copycat incidents. In fact, some parents acquiesce to their children’s pleas to remain home on school shooting anniversaries—particularly the Columbine tragedy of April 20, 1999.

Student and parental fears likely are exacerbated by new episodes of violence, such as three school shootings in 2006:
- On September 27, a 53-year-old man entered a high school in Bailey, Colorado, and shot one girl before killing himself.
- On September 29, a high school student near Madison, Wisconsin, killed his principal after being disciplined for carrying tobacco.
- On October 2, a heavily armed man barricaded himself in a one-room Amish schoolhouse in Paradise, Pennsylvania. He bound and shot 11 girls before killing himself, and five of the girls died.

Compared with highly publicized school violence, however, personal victimization is a much stronger factor in absenteeism. Specifically, school violence is related to school absenteeism especially for youths who have been previously victimized. The literature shows:
- Students who have been bullied are 2.1 times more likely than other students to feel unsafe at school.
- 20% of elementary school children report they would skip school to avoid being bullied.
- High school students’ fear of attending classes because of violence is directly associated with victimization by teachers or other students.
- Missing school because of feeling unsafe is a strong risk factor for asthma and, potentially, being sent home early from school.

with others or performing before others as in class presentations
- to pursue attention from significant others, such as wanting to stay home or go to work with parents
- to pursue tangible reinforcers outside of school, such as sleeping late, watching television, playing with friends, or engaging in delinquent behavior or substance use.

The first 2 functions are maintained by negative reinforcement or a desire to leave anxiety-provoking stimuli. The latter 2 functions are maintained by positive reinforcement, or a desire to pursue rewards outside of school. Youths may also refuse school for a combination of these reasons.

In Nathan’s case, he was initially anxious about school in general (the first function). After his parents allowed him to stay home for a few days, however, he was refusing school to enjoy fun activities such as video games at home (the last function).

Assessment scale. One method for quickly assessing the role of these functions is the School Refusal Assessment Scale-Revised. This scale poses 24 questions, the answers to which measure the relative strength of each of the 4 functions.Versions are available for children and parents, who complete their respective scales separately (see Related resources). Item means are calculated across the measures to help determine the primary reason for a child’s school refusal.

In addition to using the assessment scale, you may ask interview questions regarding the form
identified differences in responses between elderly and younger patients. In general, a lower starting dose is recommended for an elderly patient, reflecting a decreased pharmacological clearance in the elderly, as well as a greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy (see CLINICAL PHARMACOLOGY AND DOSAGE AND ADMINISTRATION in full PD). Monitoring of orthostatic vital signs should be considered in patients for whom this is of concern. This drug is substantially excreted by the kidneys, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (see DOSAGE AND ADMINISTRATION in full PD). Concomitant use with Fursecin in Elderly Patients with Dementia-Related Psychosis: In placebo-controlled trials in elderly patients with dementia-related psychosis, a higher incidence of mortality was observed in patients treated with fursecin plus risperidone when compared to patients treated with risperidone alone or with placebo plus fursecin. No pathological mechanism has been identified to explain this finding, and no consistent pattern for cause of death was observed. An increase of mortality in elderly patients with dementia-related psychosis was seen with the use of Risperidone*, regardless of concomitant use with fursecin. Risperidone* is not approved for the treatment of patients with dementia-related psychosis. (See BOXED WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis.)

ADVERSE REACTIONS: Dose Dependency of Adverse Events: Data from two fixed-dose trials provided evidence of dose-relatedness for extrapyramidal symptoms associated with risperidone treatment. These symptoms include: sleepiness, increased drowsiness of sleep, accommodation disturbances, orthostatic hypotension, palpitations, weight gain, erectile dysfunction, ejaculatory dysfunction, organic dysfunction, asthma/asthmatic increased fatigueability, and increased pigmentation. Vital Sign Changes: Risperidone* is associated with orthostatic hypotension and tachycardia (see PRECAUTIONS). Weight Changes: A statistically significant greater incidence of weight gain for Risperidone* (16%) compared to placebo (9%). Laboratory Changes: A between-group comparison of laboratory changes revealed no statistically significant differences in the proportions of patients experiencing potentially important changes in routine serum chemistry, hematology, or urinalysis parameters. Similarly, rare were the Risperidone*/placebo differences in the incidence of discontinuations for changes in serum chemistry, hematology, or urinalysis. However, Risperidone* administration was associated in increased levels of prolactin (see PRECAUTIONS). ECG Changes: Between-group comparisons for paced placebo-controlled trials revealed no statistically significant differences between risperidone and placebo in mean changes from baseline in ECG measurements, including QT, QTc, and PR intervals. When all Risperidone* dosages were pooled and randomized controlled trials in several indications, there was a mean increase in heart rate of 1 beat per minute compared to no change for placebo patients. Adverse Events and Other Safety Measures in Pediatric Patients With Autistic Disorder: In the 2-8-week, placebo-controlled trials in pediatric patients treated for irritability associated with autistic disorder (N=186), two patients (one treated with Risperidone* and one treated with placebo) discontinued treatment due to an adverse event. Incidence of Treatment Emergent Adverse Events in Two 5-Week Placebo-Controlled Trials in Pediatric Patients with Autistic Disorder: Body System Preferred Term: Psychiatric Somnolence, Appetite increased, Confusion Gastrointestinal: Saliva increased, Constipation, Dry mouth Body as a whole: general: Fatigue Central and peripheral nervous system: Tremor, Dizziness, Autonomic Dysfunction, Parkinsonism Respiratory: Upper respiratory tract infection (Metabolic and nutritional): Weight increase Heart and cardiovascular: Tachycardia Other Events Observed During the Premarketing Evaluation of Risperidone*: During its premarketing assessment, multiple doses of Risperidone* were administered to 2607 adult patients with schizophrenia and 1923 pediatric patients in Phase 2 and 3 studies and the following reactions were reported: a) frequent adverse events are those occurring in at least 1/100 patients; infrequent adverse events are those occurring in 1/100 to 1/1000 patients. It is important to emphasize that, although the events reported occurred during treatment with Risperidone*, they were not necessarily caused by it. Serious adverse reactions experienced by the pediatric population were similar to those seen in the adult population (see WARNINGS, PRECAUTIONS). Other Adverse Reactions: Psychiatric Disorders: Frequent: Increased anxiety, decreased self-esteem, decreased sexual desire, decreased sexual function, impaired concentration, depression, apathy, cataleptic reaction, somnolence, increased irritability, increased weight. Other Disorders: Incidence (one patient): Adverse Events: Those that occurred in more than 1/100 patients are listed below:

**Table 1**

<table>
<thead>
<tr>
<th>Common symptoms that could signal school refusal behavior</th>
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<tbody>
<tr>
<td><strong>Internalizing/covert symptoms</strong></td>
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<tr>
<td>Depression</td>
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<tr>
<td>Fatigue/tiredness</td>
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<tr>
<td>Fear and panic</td>
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<tr>
<td>General and social anxiety</td>
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<tr>
<td>Self-consciousness</td>
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<tr>
<td>Somatization</td>
</tr>
<tr>
<td>Worry</td>
</tr>
<tr>
<td><strong>Externalizing/overt symptoms</strong></td>
</tr>
<tr>
<td>Aggression</td>
</tr>
<tr>
<td>Noncompliance and defiance</td>
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<tr>
<td>Refusal to move in the morning</td>
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<tr>
<td>Running away from school or home</td>
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<tr>
<td>Temper tantrums and crying</td>
</tr>
</tbody>
</table>

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research for school refusal behavior is in its infancy. Some investigators have found, however, that a tricyclic antidepressant (TCA) such as imipramine, 3 mg/kg/d, may be useful in some cases—generally for youths ages 10 to 17 years with better attendance records and fewer symptoms of social avoidance and separation anxiety. Researchers speculate that TCAs, which are not always effective in children, may influence symptoms such as anhedonia or sleep problems that contribute to school refusal behavior.

With respect to substantial child anxiety and depression without school refusal behavior, researchers have focused on selective serotonin reuptake inhibitors (SSRIs). In particular, fluoxetine, 10 to 20 mg/d, fluvoxamine, 50 to 250 mg/d, sertraline, 85 to 160 mg/d, and paroxetine, 10 to 50 mg/d, have been useful for youths with symptoms of general and social anxiety and depression.

Youths often do not respond to these medications as well as adults do, however, because of the fluid and amorphous nature of anxious and depressive symptomatology in children and adolescents. Careful monitoring is required when treating youth with SSRIs, which have been associated with an increased risk of suicidal behavior.

**Psychological techniques.** Sophisticated clinical controlled studies have addressed the treatment of diverse youths with school refusal behavior. Options for this population may be arranged according to function or the primary reinforcers maintaining absenteeism:

- child-based techniques to manage anxiety in a school setting

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### Table 2

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>None</td>
<td>32.9%</td>
</tr>
<tr>
<td>Separation anxiety disorder</td>
<td>22.4%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>10.5%</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>8.4%</td>
</tr>
<tr>
<td>Major depression</td>
<td>4.9%</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>4.2%</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>3.5%</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>2.8%</td>
</tr>
<tr>
<td>Attention deficit/hyperactivity disorder</td>
<td>1.4%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1.4%</td>
</tr>
<tr>
<td>Enuresis</td>
<td>0.7%</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Source: Reference 7
Child-based anxiety management techniques include relaxation training, breathing retraining, cognitive therapy (generally for youths ages 9 to 17), and exposure-based practices to gradually reintroduce a child to school. These techniques have been strongly supported by randomized controlled trials specific to school refusal behavior\(^2\) and are useful for treating general anxiety and depression as well.

Parent-based contingency management techniques include establishing morning and evening routines, modifying parental commands toward brevity and clarity, providing attention-based consequences for school nonattendance (such as early bedtime, limited time with a parent at night), reducing excessive child questioning or reassurance-seeking behavior, and engaging in forced school attendance under strict conditions. Parent-based techniques have received strong support in the literature in general\(^29\) but have been applied less frequently than child-based techniques to youths with school refusal behavior.

Family-based techniques include developing written contracts to increase incentives for school attendance and decrease incentives for nonattendance, escorting a child to school and classes, and teaching youths to refuse offers from peers to miss school.\(^8\) As with parent-based techniques, family-based techniques have received strong support in the literature in general, but have been applied less frequently than child-based techniques to youths with school refusal behavior.

School refusal behavior sometimes is severe and intransigent and requires a multidisciplinary approach. This might include psychotherapy and medication. Cooperation and communication among parents, physicians, school officials, and mental health professionals is often crucial for resolving this difficult behavior.
GRADUAL REINTRODUCTION TO SCHOOL
A preferred approach to resolve school refusal behavior usually involves gradual reintegration to school and classes. This may include initial attendance at lunchtime, 1 or 2 favorite classes, or in an alternative classroom setting such as a guidance counselor’s office or school library. Gradual reintegration into regular classrooms may then proceed.

Questions related to \textit{forms} of school refusal behavior

\begin{tabular}{|p{20cm}|p{20cm}|}
\hline
\textbf{What are} the child’s specific forms of absenteeism, and how do these forms change daily? & \textbf{What specific} school-related stimuli are provoking the child’s concern about going to school? \\
\hline
\textbf{Is a child’s} school refusal behavior relatively acute or chronic in nature (in related fashion, how did the child’s school refusal behavior develop over time)? & \textbf{Is the child’s} refusal to attend school legitimate or understandable in some way (eg, school-based threat, bullying, inadequate school climate)? \\
\hline
\textbf{What comorbid conditions} occur with a child’s school refusal behavior \textit{(Table 3)}, including substance abuse? & \textbf{What family} disruption or conflict has occurred as a result of a child’s school refusal behavior? \\
\hline
\textbf{What is} the child’s degree of anxiety or misbehavior upon entering school, and what specific misbehaviors are present in the morning before school \textit{(Table 2)}? & \textbf{What is the child’s} academic and social status? \textit{(This should include a review of academic records, formal evaluation reports, attendance records, and individualized education plans or 504 plans as applicable.)} \\
\hline
\end{tabular}

Questions related to \textit{functions} of school refusal behavior

\begin{tabular}{|p{20cm}|p{20cm}|}
\hline
\textbf{Have recent} or traumatic home or school events influenced a child’s school refusal behavior? & \textbf{Is the child} willing to attend school if a parent accompanies him or her? \\
\hline
\textbf{Are symptoms} of school refusal behavior evident on weekends and holidays? & \textbf{What specific} tangible rewards does the child pursue outside of school that cause him or her to miss school? \\
\hline
\textbf{Are there} any nonschool situations where anxiety or attention-seeking behavior occurs? & \textbf{Is the child} willing to attend school if incentives are provided for attendance? \\
\hline
\textbf{What specific} social and/or evaluative situations at school are avoided? & \\
\hline
\end{tabular}
If possible, a child should remain in school during the day and not be sent home unless intense medical symptoms are present. A recommended list of intense symptoms includes:

- frequent vomiting
- bleeding
- temperature >100°F
- severe diarrhea
- lice
- acute flu-like symptoms
- extreme medical conditions such as intense pain.

**CASE CONTINUED: A FULL-TIME STUDENT**

A structured diagnostic interview and other behavioral assessment measures show that Nathan meets criteria for generalized anxiety disorder. He worries excessively about his social and academic performance at school and displays several somatic complaints related to anxiety. His treatment thus involves a two-pronged approach:

- sertraline, 50 mg/d, which has been found to significantly reduce symptoms of generalized anxiety disorder in youths ages 5 to 17.
- child-based anxiety management techniques and family therapy to increase incentives for school attendance and limit fun activities during a school day spent at home.

His therapist and family physician collaborate with school personnel to gradually reintroduce Nathan to a full-time academic schedule.

**References**

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