

School Refusal Behavior:

Effective Techniques To Help Children Who Can't or Won't Go To School

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Truancy versus School Refusal

Probably from the very first day that an organized school opened, there was a child who failed to attend. Early literature labeled these children as **truant** derived from the French word “truand” meaning beggar, parasite, lazy person, naughty child, or rogue. However, in addition to those children who refused to attend school in an antisocial fashion, there was recognition of a subset of children who were absent from school whose absence was more emotionally based. In an early definition of anxiety-based absenteeism, Baldwin (1932) defined a set of behaviors that “is an attempt to obtain love, or escape from real situations to which it is difficult to adjust.”

School Phobia was identified in 1941 as a psychoneurotic disorder characterized by overlapping phobic and obsessive tendencies. In many cases it involved separation anxiety that was present before the advent of attending school and comorbid with anxiety, somatic complaints, depression, and family conflict. Early thinking identified three essential elements: 1) acute child anxiety with hypochondriacal and compulsive elements resulting from a wish for dependence, 2) increased anxiety in the child’s mother (primary caretaker) as a result of some stressor, and 3) a historically unresolved, overdependent mother-child relationship and regression to a period of mutual satisfaction. An alternative, less clinical term, **school refusal**, was later used in Great Brittan to define similar problems in children who did not attend school because of emotional distress.

A review of the literature would reveal that there appear to be two very different dynamics and characteristics that differentiate the typical truant from a school refuser. The dynamic can be readily seen in the following chart which illustrates the distinctions

School Refusal

Severe emotional stress about attending school: may include anxiety, temper tantrums, depression, or somatic issues

Parents are aware of absence or child tries to persuade parents for permission to stay home

Absence of significant behavioral or antisocial problems

During school hours, the child stays home because it is safe

A willingness to do homework and complies by completing work at home

Truancy

Lack of excessive anxiety or fear about attending school

Child often attempts to conceal absence from parents

Frequent antisocial behavior, often in the company of antisocial peers

During school hours the child is someplace other than home

Lack of willingness to do schoolwork or meet academic expectations

School Refusal is “child motivated refusal to attend school or difficulties remaining in school for an entire day.” Berg et al (1969) defined school refusal as severe difficulty attending school often resulting in a prolonged absence; severe emotional upset when faced with the prospect of attending school; staying at home with the parents’ knowledge; and an absence of anti-social characteristics. School refusal does not include absences as a result of chronic physical illnesses, absences motivated by parents, homelessness, chronic runaways, or non child initiated absences. Berg (1997) further expanded the concept as a condition characterized by reluctance or refusal to go to school by a child who: 1) seeks the comfort and security of home, preferring to remain close to parental figures; 2) displays evidence of emotional upset or unexplained physical symptoms at the prospect of going to school; 3) manifests no severe antisocial tendencies; and 4) does not attempt to conceal the problem from parents. King & Bernstein (2001) expanded the concept to include difficulty attending school associated with emotional distress, especially anxiety and depression

Kearney & Silverman (1996) defined school refusal as child motivated refusal to attend school or difficulty remaining in school for the entire day. They identify school refusal as a spectrum that includes rarely missing school, but attending under duress to consistently missing school.

School refusal includes those who

- 1) are completely absent from school
- 2) initially attend and then leave during the school day
- 3) go to school, but only after a behavioral incident (tantrum, vomiting, etc.)
- 4) display unusual distress during the school day and pleas for nonattendance

In addition, school refusal is often seen on a continuum of severity and chronicity. Many children will experience a brief period in their life where attending school is particularly difficult or emotionally overwhelming. For many this is a brief condition that spontaneously resolves itself after a few days. For others, once the problematic behavior appears, it becomes self-reinforcing and will persist for long periods of time absent significant intervention. Kearney and Silverman (1996) identified three levels of severity of school refusal:

Self-corrective school refusal refers to children whose initial absenteeism remits spontaneously within a two week period.

Acute school refusal behavior refers to children whose absenteeism lasts from 2 weeks to one calendar year.

Chronic school refusal behavior refers to children whose absenteeism lasts longer than one calendar year and overlaps two school years.

This conception of the degree of severity and the chronic nature was further expanded by Setzer and Salhauer (2001) when they outlined the varying degrees of School Refusal Behavior:

Initial School Refusal Behavior – for a brief period (less than two weeks) may resolve without intervention

Substantial School Refusal Behavior – occurs a minimum of two weeks

Acute School Refusal Behavior – two weeks to one year, being a consistent problem for a majority of the time

Chronic School Refusal Behavior – interferes with two or more academic years

Reasons for School Refusal

Children present with many different reasons for refusal to attend school. In many instances Separation Anxiety or a history of separation in the past may create an underlying anxiety about being away from home or parental figures. Many children in the foster system have experienced significant anxiety and physical and emotional separations which create an underlying anxiety that makes attending school extremely difficult.

Other children who become anxious about attending school may be struggling with the fear of losing a parent through illness, divorce, or death. In many instances the school refusal may actually begin after the parent recovers from an illness. These children may create disaster scenarios that something bad will happen to a parent if they are not there to monitor or prevent the disaster. Fear of physical and emotional abandonment may make it difficult for the child to have his or her parents out of their sight and out of their “control.” Many of these children may have experienced an unstable family situation where frequent physical moves and family changes have occurred, creating an underlying anxiety about not being able to control the home situation if they are at school. In some instances changes in the stability of the system at home and in the family such as frequent physical moves, deaths in the family, transfers to another job or community, or jealousy of new siblings can all create a generalized state of anxiety that may result in a reluctance or refusal to attend school. A family system where parents are overly anxious may actually transmit unspoken messages to the child about parents being anxious about the child attending school.

The root anxiety that the school refuser is experiencing in a school situation may vary significantly according to age. Younger children may be more anxious about being separated from caregivers, fear of a teacher, anxious about riding the bus, or fear of being picked on by older children. Frequently middle/high school refusers may have concerns about academic performance, worries about making friends, eating in the cafeteria, using the school bathroom, changing for gym, being called on for class, or being made fun of or ostracized by peers.

Behavioral symptoms are also variable but may include fearfulness, panic, crying, temper tantrums, threats of self-harm, and somatic complaints. Many children who are school refusers may utilize a variety of verbal and physical protests each morning before school. Many of their disruptive behaviors may be a “proactive” attempt to avoid going to school by being so disruptive or behaviorally out of control that parents may acquiesce and allow them to stay at home. Many school refusers may be the child who “misses the bus” or who is chronically late due to the disruptive behaviors or oversleeping.

School refusers frequently have a large number of physical symptoms including autonomic, gastrointestinal, and muscular symptoms. Dizziness, headaches, trembling, heart palpitations, chest pains, abdominal pain, nausea, vomiting, diarrhea, and, back pain, and joint pain without any organic basis may be frequently experienced by school refusers.

A variety of family characteristics have been identified as associated with school refusers. One of the more obvious dynamics is the existence of overdependence between parent and child. This lack of autonomy on the part of the child or unwillingness of the parent to allow for independent functioning may produce significant anxiety when attending school calls for separation and

autonomous functioning. The youngest child in the family is particularly vulnerable to school refusal, probably as a result of dependency or over enmeshment issues. The opposite extreme is also seen in families with extreme detachment and where a child often feels vulnerable and lacking support in dealing with the challenge of attending school. Many children who struggle with attending school come out of families where physical and social isolation is common. For these children, the social aspects of attending school are often overwhelming and escape behavior ensues. A number of other family dynamics have been identified as highly correlated with school refusal, including overprotective parents, anxious mothers and ineffective fathers, and high levels of marital tension. Kearney and Silverman (1995) identify six types of families of refusers

1. **Enmeshed** overprotective, overindulgent, dependency
2. **Conflicted** hostility, violence, coercion
3. **Detached** little involvement among members
4. **Isolated** little extra-familial contact
5. **Healthy** cohesive, expressive, problem solving
6. **Mixed** two or more traits

Demographic Characteristics of School Refusers

According to the U.S. National Center of Education Statistics, 5.5 percent of students are absent on a typical school day. Rates are higher in inner city schools as compared to rural schools, higher in public schools as compared to private schools, higher in high schools than middle and elementary schools, and higher in large schools as compared to smaller schools. Duckworth and DeJung (1989) have estimated that cutting classes is about 4 percent, 5 percent to 10 percent are late in the morning and miss part of the day, and 6 percent to 10 percent of those attending school are under anxiety based duress.

A “best guess” is that 5% to 28% of children display some aspect of school refusal behavior at some point in their life (Kearney, 2001) and prevalence rates are 2-5% for school refusal. School refusal is equally common among boys and girls, but female school refusal may be more fear based, while male school refusers are more oppositional based. School refusal can occur at all ages, but peaks at 5-7, 11, and 14 (kindergarten, 6th grade, and 9th grade). Periods of transition such as attending a new school, moves to a new home, new brother or sister, or a sick parent often increase the likelihood of school refusal. No socioeconomic or gender differences are noted. There does not appear to be a relationship to academic or intellectual ability, although prolonged school refusal will eventually impact academic achievement.

Long-term Sequelae

While school refusal is often minimized as “a phase” or a normal right of passage, it would appear that in many situations school refusal is a predictor of more lasting issues that may persist into adulthood. While school refusal may not be causative of adult problems, in many situations school refusal is predictive of later problems unless issues are addressed emphatically. A review of the literature indicates a number of studies that have found a relationship between school refusal and academic underachievement: 45 percent of high school dropouts, increased psychiatric care, autonomy issues and a reluctance to leave the physical family of origin or difficulty leaving the

emotional family of origin, and delinquency and criminal offenses have been correlated with early school refusal.

Internalizing versus Externalizing

School refusers tend to display behavior that is school avoidant utilizing an internalizing/externalizing continuum. For some children, school refusal is a way of internalizing aspects of their environment that make them feel uncomfortable or fearful.

Internalizing symptoms often includes fear (specific phobias), anxiety, somatic complaints, depression, and general negative affectivity.

- ❖ Fear (phobias) are less frequent than assumed. Approximately 10 percent of school refusing children indicate a specific fear (teacher, bullies, tests, being called on, the principal, becoming ill, etc.)
- ❖ 56 percent displayed a primary diagnosis of other anxiety disorders including Generalized Anxiety Disorder (36.5 %), Separation Anxiety (27.0 %), Social Phobia (33.6%), and Other Anxiety Disorders (PTSD, OCD, Agoraphobia, etc) (8.1%)
- ❖ Approximately 66% of all school refusing youth presented with some somatic complaints
- ❖ Macro studies indicate that 31% of school refusing youth display a diagnosable depressive disorder, and 47.6% display a number of depressive symptoms.
- ❖ The overlapping symptoms of fear, anxiety, somatic concerns, and depression create a global state or condition referred to as *negative affectivity*.

Externalizing Symptoms includes a variety of physical, verbal, active/passive, temper tantrums, etc. assumed to be triggered by internal psychological factors.

- ❖ An expression of covert symptoms (“freezing out of panic”)
- ❖ Advertising the nature of an anxiety or dramatizing the discomfort (clinging)
- ❖ method of avoiding or ameliorating an anxiety provoking situation (hiding, repeating the same question or statement, making demands)
- ❖ Behaviors that produce attention from parents or others (tantrums, suicide threats, self-harm)
- ❖ A test of parental resolve or manipulation for concrete rewards (bribes, rewards after initial non-compliance)
- ❖ Verbal or physical threats to intimidate parents into acquiescence
- ❖ Classroom misbehavior to force parent contact for reassurance

Continuum of School Refusal Behavior

As a group, school refusers are not particularly defined or described in a meaningful way through a single category or description. This particular behavior covers a wide spectrum that ranges from those who attend school under duress, those who display repeated misbehavior in the mornings to avoid school, children who are chronically late for school, those with episodic or repeated absences, to those who are completely absent for long periods of time.

As a group, school refusers are the most non-homogeneous group and the classification or designation as a “school refuser” is rendered almost meaningless. Any attempt to intervene with these children in a “one size fits all” approach is likely to be doomed from the start. The behaviors themselves, the underlying causes, and the factors that reinforce school refusal behavior vary widely from individual to individual. The variability calls for an approach different from traditional approaches to change behavior.

Most behavioral difficulties are traditionally approached from a Categorical Model geared toward separating phenomena (observed behavior) into discrete categories. This is the underlying basis of the Medical Model and the basis for the *Diagnostic and Statistical Manual of Mental Disorders – TR-IV*. The Categorical Model assumes that behavior can be viewed as relatively separate phenomena. At the core are symptoms that distinguish the presence or absence of a disorder. Unfortunately, the enormous variability in school refusers makes it difficult to derive any meaningful categories or symptoms that reflect the complexity of the phenomenon. A categorical approach to school refusal does allow us to attempt to develop descriptors of the behavior and to thereby differentiate between those who meet a criteria for school refusal, but these differentiations are not particularly meaningful. A categorical approach to school refusal also runs the risk of inappropriately classifying or diagnosing an individual as a “school refuser” when there may be much more significant issues that exist. Also a categorical approach runs the risk of the negative labeling that so often occurs once someone has been identified as “abnormal” or as differing from the group as a whole. Many times this negative labeling can lead to inappropriate functioning or a self-fulfilling prophesy.

Another typical approach for dealing with individuals whose behavior is outside the norm that attempts to avoid the negative aspects of a categorical model is a dimensional approach. Dimensional models view behavior on a continuum and are only concerned with behaviors that create dysfunction. Behavior is viewed on a continuum from adaptive to dysfunctional or absent to severe. Unfortunately with school refusal, delineating the behavior on a continuum does not particularly provide any insight as to the nature of the phenomenon or lead to reasonable interventions.

A more appropriate model for working with individuals who are school refusers might be to view the behavior through a Functional Model. A Functional model looks at the purpose the behavior serves and what motivates the behavior or what maintains the behavior. (Kearney, 2001).

A Functional Model of School Refusal Behavior (Kearney, 2001)

All human behavior is purposeful and serves a function. It is by understanding that function or purpose that we can increase the likelihood of effectively intervening. In addition, all behavior that is not reinforced extinguishes over time. For school refusal, understanding the underlying factors that maintain or reinforce the behavior will be a key in making the therapeutic changes necessary for an effective intervention. While School refusal behavior may take many different forms or varying degrees of severity, the functions or reasons behind the behaviors are relatively few and are either an attempt to avoid negative experiences or pursue positive experiences.

Avoidance of Negative Experiences

- 1. Avoidance of Stimuli that Provoke a Sense of General Negative Affect**
- 2. Escape from Aversive Social or Evaluative Situations**

Pursuit of Positive Experiences

- 1. Attention Seeking Behaviors**
- 2. Tangible Reinforcement Outside the School**

Children who are refusing school to avoid negative experiences may be attempting to avoid a particular stimuli or series of stimuli that ultimately result in a negative experience. It may be something specific like a bully, or more pervasive like the structure and discipline of the school setting. Other school refusers may be attempting to escape from the negative social or evaluative aspects of attending school. Some school refusing children may be pursuing a positive experience through refusing school such as tangible reinforcers such as staying at home, attention, or more desirable activities.

The Functional Model of school refusal recognizes these fundamental distinctions and approaches change in behavior on the basis of these different purposes and motivations. To gain a fuller understanding of these different functions, we will review each in detail.

School Refusal for Avoidance of Stimuli that Provoke a Sense of General Negative Affect (SPNA)

For many school refusers, specific stimuli or situations (bus ride, lunchroom, fire alarm, animal in classroom, restrooms, etc.) produce negative or uncomfortable feelings about school which the child feels they must avoid. For some children, they cannot identify the specific fear-related stimuli due to a lack of specificity or due to an inability to conceptualize and verbalize what is making them uncomfortable about school. What they are very clear about is they don't want to be at school and

that “being at school makes me feel yucky.” Many of these children are higher scores on measures of general anxiety and higher on symptoms of depression.

In addition, many of these children are not problematic otherwise and tend to be lower on attention problems, delinquency, or aggressive behaviors. They may also be more dependent than their peers. Many of these children have few other issues and typically come from generally healthy families. Diagnostically, many of these children are characterized as having Generalized Anxiety Disorder (GAD), Depression/Dysthymia, Separation Anxiety Disorder, Social Phobia, and Specific Phobias. In addition, this group engages in significant somatization as an attempt to avoid the negative stimuli associated with school.

School Refusal to Escape from Aversive Social or Evaluative Situations (EASE)

For another group of school refusers, school is a particularly negative and punitive experience simply for the social or the evaluative aspects. For these individuals, school is the place in their life where they experience significant embarrassment, shame, ridicule, rejection, debasement, and even abuse from their peers and the social aspects of school. For other school refusers, measuring up to the expectations for progress and learning can be something that they literally lack the capacity. For them, school is the place where they are constantly reminded that they are not good enough, smart enough, quick enough, and talented enough to achieve, let alone excel. Many of these school refusers struggle with more commonly accepted situations that naturally occur in the social and evaluative setting we call public education. Common examples might include speaking before class, walking the hallways, writing on the board, being called on in class, tests or graded situations, performance classes, i.e. physical education, music, etc..

For these youth, their school refusal might be motivated by a desire to avoid certain people (teachers or peers) due to embarrassment, shame, or ridicule. This school refuser may typically that child who struggles to perform to expectations or who has real difficulty fitting in with the other children. The youth may have higher scores on measures of general anxiety, higher on symptoms of depression, higher levels of social anxiety, and higher levels of withdrawal and somatization. Many of these school refusers come out of settings of physical or social isolation and experience significant family detachment and community detachment. This makes interacting with others in a school setting particularly troublesome, awkward, and difficult, leading to poor social interaction and greater anxiety about the social aspects of school.

Diagnostically these youth are frequently classified as having Generalized Anxiety Disorder (GAD), Social Phobia, Depression/Dysthymia, or a premorbid Avoidant Personality Disorder. General goals of intervention typically involve 1) identifying triggers of social anxiety, 2) understanding social anxiety, 3) managing excessive social anxiety, and 4) coping with normal levels of social anxiety.

School Refusal for Attention Seeking Behavior (ASB)

For some school refusers their behavior is motivated by a desire to gain something positive rather than avoid something negative. For some they may be seeking positive rewards for non-attendance including intangibles such as attention or sympathy. These youth may engage in various morning misbehaviors to get attention or stay at home (tantrums, clinging, locking self in room, exaggerated physical symptoms, noncompliance, running away, etc.). In some ways their school refusal behavior is proactive in that they understand that not going to school assists them in obtaining the positive experience of attention or staying at home. In order to get attention and sympathy these youth may exaggerate physical or emotional symptoms. Many youth who naturally experience some degree of separation anxiety about going to school may exaggerate this discomfort to manipulate, control, or solicit attention. For this group Separation Anxiety is frequently observed and is of three types:

1. Children who are truly anxious when separated from caregivers
2. Children who are more broadly seeking general attention
3. Children who are both anxious and seeking attention

These school refusers tend to be younger (mean age 9.6) and are from families with very low levels of independence (enmeshed). Frequently there is a long history of acquiescence to the child's wishes or demands (emotional terrorism or manipulation). Diagnostically these school refusers tend to struggle with Separation Anxiety Disorder, Generalized Anxiety Disorder (GAD), and Oppositional Defiant Disorder.

School Refusal for Tangible Reinforcers Outside of School (TR)

Another group of school refusers who are pursuing positives by not going to school are those who are pursuing a tangible reinforcer that they can only attain by not going to school. Often the refusal is an attempt to pursue reinforcers that are more powerful such as sleeping, TV, video games, internet, friends, day parties, the mall, etc.. These youth and their school refusal is less anxiety based and more an inability to delay gratification. Typically these youth have lower levels of anxiety, depression, or distress about going to school. "I could go to school; no big deal; but I'm not and you can't make me." These youth are generally older and display more attention problems, delinquent behaviors and aggressiveness. Families are more conflicted and have low levels of cohesion and communication between parent and child is non-functional or non-existent. Diagnostically, these youth experience Generalized Anxiety Disorder (GAD), Oppositional Defiant Disorder, Conduct Disorder, and Depression/Dysthymia.

Underlying Psychological Disorders and Co-Morbid Conditions

While a functional model of school refusal allows us to identify the purpose that the school refusal serves, we cannot simply stop there. The first analytical or diagnostic decision is to identify the purpose, but that is not sufficient to intervene. Bob and Bill are both refusing school as an attempt to avoid the social and evaluative components of school. Bob, in addition to his school refusal has an IQ of 145, is an Olympic class gymnast, has won awards for creative writing, and has very supportive and understanding parents. Bill also refuses school for the same purpose, but has an IQ of 80, has a significant reading disability, is periodically enuretic, has consistently received failing grades, and his father is in jail and his mother has a significant substance abuse problem.

A “one size fits all” approach to Bob’s and Bill’s school refusal, even one based on a thorough understanding of the purpose of the refusal behavior is unlikely to be successful without a second analytical or diagnostic decision process designed to identify any underlying psychological disorders and co-morbid conditions. In many instances it may be necessary to first address the underlying conditions before any substantive progress can be made on dealing with the school refusal issue.

Separation Anxiety Disorder

One frequently observed underlying condition is Separation Anxiety Disorder. The *DSM-IV* describes separation Anxiety Disorder as a disorder occurring prior to age 18 where the individual becomes excessively anxious when separated from parents or home for a period of at least 4 weeks. Often the child displays excessive worries, fears, distress, nightmares, and obsessive thinking about being separated from home or primary caregivers. The reaction is excessive and anticipated separation may include somatic complaints. Onset of Separation Anxiety occurs normally during preschool years and occurs in approximately 4% of all children. The disorder is more common among first-degree relatives and in children of mothers with Panic Disorder.

Separation anxiety is normal for children between 18 months and 3 years, but by 4, most children do not continue to show symptoms. Four percent of children continue beyond age 4 and only one percent continue to be symptomatic by ages 14-16. Many of these youth are excessively miserable when not with loved ones, preoccupied with fears about health and safety of parents, and avoid going places by themselves. They may be reluctant or refuse to participate in sleepovers, demand that someone stay with them at bedtime or sleep with them, and may experience recurring nightmares about being separated from parents. They may also display a number of vague somatic symptoms (dizziness, nausea, cramps, vomiting, palpitations).

Generalized Anxiety Disorder (Overanxious Disorder of Childhood)

Many youth who struggle with school refusal may also struggle with Generalized Anxiety Disorder. Although they do not experience episodes of acute panic, these individuals feel tense or anxious most of the time and find it difficult to control the worry. The condition has existed in excess of six months and the individual experiences vaguer bodily symptoms. Symptoms may involve restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbances. It includes what had formerly been called Overanxious Disorder of Childhood. For many children and adolescents, their anxieties typically involve non-specific issues around competence, performance, catastrophic events, perfectionism, and lack of approval.

Specific Phobia (formerly Simple Phobia)

Individuals with Specific Phobias fear specific objects or situations (e.g. animals, storms, closed spaces). The person recognizes that the fear is unreasonable but still avoids the specific stimuli, or endures it with intense distress. For children it must be of at least six months duration. They may not recognize their fear as excessive and it may be expressed non-verbally through crying, tantrums, freezing, or clinging. School phobia as a generic concept is frequently observed, but a differential must be made between specific phobia, social phobia, and separation anxiety. Childhood fears are developmentally appropriate and a distinction must be made based on the level with which it interferes with functioning.

Social Phobia (Social Anxiety Disorder)

Many school refusers have significant issues with social phobia or a Social Anxiety Disorder. These individuals fear embarrassment or humiliation in social or performance situations. The individual recognizes that fear is excessive and that it interferes with normal functioning. In children, there must be evidence of the capacity for age-appropriate social relationships and the anxiety must occur in peer settings, not just with adults. Children do not always recognize that their fear is excessive and the anxiety may be expressed non-verbally through crying, tantrums, and freezing or shrinking from unfamiliar people.

Panic Attacks

A Panic Attack is a brief episode where the individual feels intense dread, accompanied by a variety of physical symptoms. It begins suddenly and peaks rapidly. The onset of the attacks and the presence of “triggers” are important. Three subtypes: unexpected (e.g. Panic Disorder), situationally bound (e.g. Phobias), or situationally-predisposed (e.g. PTSD). *Panic disorders are rarely seen in children until late adolescence*, and the onset of panic disorder typically occurs in 20's to 30's.

Obsessive Compulsive Disorder

Obsessive Compulsive Disorder can create particular difficulties for some children that ultimately may result in school refusal as a way of managing their obsessive compulsive rituals and thinking. These individuals are bothered by repeated thoughts or behaviors that seem senseless, even to them, but somehow make them feel less anxious and more comfortable (this recognition of the excessiveness or unreasonableness does not always occur with children). If the school setting blocks or makes it extremely difficult for the child to engage in their anxiety reducing rituals, school may be avoided or refused. While the obsessions (thoughts or images) cause distress, the compulsions (actions) prevent, reduce, or relieve anxiety. Disorder may take the form of *either* obsessions or compulsions, but normally there are both. Washing, checking, counting, and ordering rituals are particularly common with children.

Post-traumatic Stress Disorder

Many children who are school refusers have suffered significant trauma at school or in the school context. The child who has been assaulted, the child who was humiliated, the child who was sexually abused at school, the child who was verbally or emotionally abused by a teacher all may be experiencing post-traumatic stress disorder or PTSD. Post Traumatic Stress Disorder is observed in individuals who have experienced, witnessed, or been confronted with an event that involves threat of death, serious injury, or loss of physical integrity (sexual abuse). The person's response to the event involved fear, helplessness, or horror. These individuals continue to experience the fear and anxiety in a repetitive fashion when triggered by similar stimuli or stimuli reminiscent of the original trauma. In children, it is often expressed by disorganized or agitated behavior. The youth re-experiences the trauma, avoids stimuli (or is unresponsive to stimuli) associated with the trauma, and experiences a level of increased arousal. In children, repetitive play, with themes or aspects of the trauma are expressed; there may be frightening dreams without recognizable content; or trauma specific reenactment may occur. While the school setting may be the source of the original trauma, we continue to expect the child to attend. As the trauma response becomes intensified, the child may refuse school.

Major Depressive Episode

Depression, and the accompanying loss of energy and anhedonia, may make attending school very difficult for many children. Issues of sleep difficulty, loss of appetite or increased appetite, and difficulties with concentration that are an integral part of a Major Depressive Episode may ultimately result in a child's inability to attend school. In children, a major depressive episode is more likely to occur in conjunction with other disorders than in isolation (Oppositional Defiant,

Conduct Disorder, ADHD, and Anxiety Disorders), making attending school on a regular basis extremely difficult. Major Depression is less common in children than in adults, particularly prepubertal children, but has generally been under diagnosed in children. In children, mood may be irritable, “agitated depression” rather than depressed mood or loss of interest in activities. For children, failure to gain weight at an expected rate is the equivalent of significant weight loss as a symptom of Major Depressive Episodes.

Oppositional Defiant Disorder

Oppositional Defiant Disorder may be the underlying cause of many instances of school refusal. The refusal to be compliant with the wishes and direction of adults is the hallmark of Oppositional Defiant Disorder (ODD). Refusing to attend school is a primary opportunity for the ODD child to be oppositional and resistive to the adult wishes and directives. ODD children often display multiple examples of negativistic, defiant, disobedient, and hostile behavior that has been occurring for a period of more than six months. This can often be seen in very young children, but should be diagnosed with recognition of normal developmental oppositionalism. Onset is typically gradual, occurring over the course of months or years. It is frequently observed in families with serious marital discord, substance abuse, and mothers who struggle with depression.

Conduct Disorder

Many children who refuse school initially as a product of their Oppositional Defiant Disorder often continue to develop more significant behavioral issues that may ultimately reach the level of a Conduct Disorder. In many situations, there is a fairly predictable progression from Oppositional Defiant Disorder to Conduct Disorder to Antisocial Personality Disorder. Conduct Disordered children typically violate the rights of others, particularly as it relates to aggression, destruction of property, lying, stealing, and serious rules violations. In a number of ways, Conduct Disorder bears a strong resemblance to and may be viewed as a possible precursor to Antisocial Personality Disorder (kid version of ASPD). The repetitive and persistent nature of the behavior distinguishes it from an adjustment disorder. Understandably, this disorder involves aggression, destructiveness, deceit or theft, and violation of rules and expectations. One of the specific diagnostic criteria for a Conduct Disorder is a failure to attend school “often truant from school, beginning before age 13 years.” (DSM-TR-IV). Almost all cases which meet the criteria for Conduct Disorder would also meet criteria for Oppositional Defiant Disorder, however, the converse is not necessarily true.

Encopresis and Enuresis

For a child who struggles with enuresis and encopresis, the thought of attending school and having an “accident” in a public setting can create sufficient anxiety to make attending school very difficult. Many children may refuse to attend school as a safe way of avoiding embarrassment, shame, and ridicule. The anticipatory anxiety that may come with even the thought of attending school and not

being able to successfully regulate bowel and bladder control may actually increase the possibility of the loss of control. School refusers may be opting out of school rather than run the risk of an embarrassing event.

Attention Deficit/ Hyperactivity Disorder

For a child with ADHD, the thought of going to school is the equivalent of Dante's tenth level of hell. For an entire day, the child will be asked to comply in ways that they find difficult if not impossible. They will be subject to ongoing correction, criticism, and negative messages about them and their behavior or performance. It would stand to reason that some of these children may "opt out" and either refuse to attend school completely or be unable or unwilling to participate in the educational processes.

Attention Deficit/Hyperactivity Disorder has had a variety of names and descriptions since it was first described in 1902 and is one of the most commonly diagnosed disorders of childhood. It is a composite disorder that includes two major symptoms: inattention and impulsivity/hyperactivity. It is especially difficult to establish this diagnosis in children younger than four, although symptoms can be observed. Younger children typically experience few demands for sustained attention until the school setting. Criteria call for symptoms to have occurred prior to age seven and mothers report higher intrauterine activity, excessive crying, less sleep and increased irritability.

Developmental milestones occur early and these children "hit the ground running." They appear to be "motor-driven" and often engaged in dare-devil and risky activities. They may perform poorly in school though IQ is typically in the normal range. There is a significant correlation between first-degree family members and individuals diagnosed with ADHD. A family history of mood disorders, learning disabilities, substance abuse, and anti-social behavior is observed. *DSM-IV-TR* identifies four specific types of ADHD: **Attention-Deficit/Hyperactivity Disorder, Combined Type** where the criteria for both inattention and hyperactivity/impulsivity are met; **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type** where the criteria for inattention but not hyperactivity/impulsivity are met **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type** where the criteria for hyperactivity/impulsivity but not inattention are met; and **Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified** where there are prominent symptoms of inattention or hyperactivity-impulsivity.

Learning Disorders

A significant co-morbid condition that directly impacts school refusal behavior is the presence of a Learning Disorder. Learning disorders are characterized by inadequate development of academic skills that are not due to demonstrable physical or neurological disorders.

Specific academic achievement is *substantially* below what would be expected given the person's age, IQ, and educational level. Estimates are that between 2 to 10 percent of the population meet the criteria and approximately 5 percent of students in public schools are identified as having a

learning disorder. Many of these children may avoid the negative experiences of school that are almost inevitable for a learning disabled child by refusing to attend or other negative and self-defeating coping strategies.

Assessment of School Refusers

In addition to those diagnosable co-morbid conditions that have been discussed earlier, many school refusers have a variety of underlying conditions that may cause, exacerbate, or reinforce refusal to attend school. In order to successfully intervene, these individual, environmental, or extenuating factors must be identified and successfully addressed in order for an intervention to be successful. Absent a clear identification of all underlying conditions, many interventions with a school refusing population are doomed to have limited success.

Several aspects of an accurate assessment become even more critical for school refusers. Due to the significant somatization that many of these children display, obtaining a complete medical history and a thorough physical examination are essential. It is also critical to conduct separate interviews with parents and the child. Many of these children come from extremely enmeshed families and often there exists a version of “unispeak” where the parent speaks for the child or the child speaks for the parents. Conducting a separate interview allows for greater insight into the behavior that is actually taking place.

Part of the assessment process will attempt to identify the purpose of the school refusal (functional model), but in addition, there must be a clear understanding and Evaluation of factors maintaining school refusal behaviors. In order for the behavior to continue to persist, there must be a reinforcing contingency at work and any intervention strategy must address the reinforcers for inappropriate behavior.

For many school refusing children, a strong underlying force is anxiety and depression. School refusal may be an extended symptom of dysfunctional underlying anxiety or depression. Depression and anxiety must always be considered when assessing a school refusing child. In addition, for many school refusers, a pattern of family dysfunction may be creating or exacerbating the behavior. It would be faulty to assume that all school refusers come from dysfunctional families. Many school refusers have families that are perfectly healthy and functional, but there may be specific stimuli about the school experience that produces inappropriate coping strategies.

In assessing school refusers it is important to review the pattern of school absence. For the child who only or fairly consistently misses school on Thursdays, the child may be communicating that some event or person is only experienced on that day. It could be gym class, or contact with a bully that only occurs on Thursday. A careful review, may provide information about the exact intervention that is required. In addition it would also be important to carefully review the time period at the first onset of the problem. Answers to the proverbial “Why here? Why now?” may provide significant information that is required for a successful intervention.

Obtaining collateral information from other people who are aware of the child may also provide a direction as to the purpose of the school refusal and the factors that reinforce or support the behavior. Standardized measures that assess functioning levels and underlying conditions may also be key. Standardized measures that evaluate the level of anxiety or level of depression that a child is experiencing will put any intervention plan on much firmer footing and guarantee a higher success rate when intervening with school refusers. Some of the more commonly used standardized measures might include:

Social Anxiety Scale for Children/Adolescents assesses fear of negative evaluation and social avoidance and distress

Child Behavior Checklist (Achenbach) Children who refuse school to escape aversive social or evaluative situations show significantly higher scores on Withdrawn and Somatic Complaints Scales, as well as the overall Internalizing Scale.

Behavioral Assessment System for Children (BASC) – Internalizing vs. Externalizing problems as they relate to school refusal

State-Trait Anxiety Inventory for Children – a 40 item inventory that distinguishes situationally based anxiety from characterological anxiety

Manifest Anxiety Scale – 37 item, yes-no inventory that targets physiological anxiety, worry, and concentration difficulties. It is useful for children who refuse school for negative reinforcement (escape behaviors)

Reynolds Child/Adolescent Depression Scale – useful for children who refuse school to avoid general negative affectivity or to escape evaluative situations

School Refusal Assessment Scale – Parent and Child Questionnaires to determine the function of the school refusal behavior (Graywind Publications). *School Refusal Assessment Scale* contains 16 items designed to assess the maintaining variables or motivations for school refusal.

Strategic Intervention Planning

Strategic Intervention with School Refusers must be based on decisions and information arrived at during the assessment and diagnostic process.

Intervention plans should describe outcomes you wish to achieve and the interventions you plan to use to reduce, relieve, ameliorate, or change the symptoms (distress) or impairment (loss of functioning).

By asking yourself “What” questions about the individual, the goals of the intervention can be determined. (e.g. What is the most distressing aspect of the disorder? What physical factors may contribute to the situation or exacerbate the disorder? What stressors is the individual experiencing? Etc.)

The objectives of the intervention plan specify the “How” goals are to be addressed and the interventions that will be attempted (e.g. How will range of affect be expanded? How will self-esteem be increased? How will the client learn to express anger effectively? How will marital tension be reduced? How will family and teachers monitor change? Etc.)

Sample Treatment Plan for a School Refusing Child Diagnosed with Separation Anxiety

Type of School Refusal: *School Refusal for Attention Seeking (AS)*

Underlying or Co-morbid Conditions *309.21 Separation Anxiety, Early Onset,
Possible Gastro-intestinal Concerns, and Parental Conflict*

Goal I: Decrease Excessive Anxiety Concerning Separation

Objective A: Explore precipitating events such as losses, stressors, and changes through individual therapy.

Objective B: Deal with issues related to rational fears through problem solving and teaching coping skills.

Objective C: Confront irrational fears and beliefs through cognitive therapy.

Objective D: Minimize the psychological impact of anxiety by teaching relaxation training and self-talk strategies.

Goal II: Increase School Attendance and Achievement

Objective A: Increase school and parent consistency through conducting joint meeting with parents, school personnel, and child.

Objective B: Develop a “morning routine” that will be followed by the parents without regard to the child’s behavior

Objective C: Develop a consistent and predictable strategy for assisting the child from the car to the classroom.

Objective D: Develop a system of “anxiety strategies” that can be deployed in the classroom to prevent withdrawal through access to support personnel or “worry time”

Goal III: Explore Physical Symptoms

Objective A: Conduct a complete physical to rule out any organic basis for vomiting or headaches.

Goal IV: Reduce Parental Conflict

Objective A: Parents will participate in marital therapy to learn effective strategies for conflict resolution.

Objective B: Educate parents regarding age-appropriate emotional separation through parenting classes.

Goal V: Increase Overall Level of Functioning

Objective A: Increase, through systematic desensitization, the amount of time the child can tolerate being away from the parent.

Objective B: Develop a list of coping strategies that the child can employ to avoid feeling anxious when separated through a family brainstorming process.

Goal VI: Involve Other Family Members as Supports

Objective A: Increase anxiety free time away from parents by utilizing his favorite Uncle to serve as a security object.

Objective B: Increase capacity to be away from parents through sleepovers at cousin's house

Intervention Approaches

Generally, the number one factor that increases the likelihood of success with children who can't or won't go to school is an early return to school. Quickly returning to attending some portion of the school day is the treatment of choice in almost all situations. The longer the child successfully remains outside the school and outside a normal school day routine, the more difficult it will be to return to school. Identifying particular classes that the child can attend, identifying a limited time period where the child is required to be in the building, or identifying certain days that the child must attend are all legitimate strategies to employ and legitimate intervention goals and objectives. Mutual agreement on the part of both parents as well as mutual agreement with school officials on a strategy of partial return is critical to prevent the child from "splitting" parents or "splitting" parents and school personnel.

The following discussion of intervention strategies looks first at some general approaches or interventions that are frequently employed with this population and then looks at specific interventions that work most effectively with the four different purposes that school refusal might be serving.

General Approaches

Systematic Desensitization

The process of systematic desensitization is a long-standing behavioral strategy for dealing with and anxiety based fear response that is out of proportion to the actual stimuli. For many school refusers, their anxiety about attending school is often far in excess of what even they identify as reasonable. Systematic desensitization is the process of developing fear-producing stimulus hierarchy that establishes the feared aspects of attending school and then systematically pairing the items on the hierarchy with deep muscle progressive relaxation training that is incompatible with an anxiety based response. Gradually working the child through her hierarchy of fears related to school and giving her the ability to regulate her response to the feared situation may allow the child to return to school.

Exposure Therapy

Exposure Therapy has at its core the idea of habituation will occur with continued or prolonged exposure to an anxiety provoking stimuli. With a school refuser, the goal is to extinguish or diminish the fear response to attending school through exposure. The exposure to the feared object (hallways, teacher, gym class, bathrooms, etc.) can be *In Vivo* with the idea of a gradual reentry to school and easing the child back into a classroom situation with longer periods of exposure. Another exposure therapy approach is the idea of Implosion or Flooding. This is a rapid reentry or exposure with the idea that if the person is subjected to prolonged exposure to the feared object or situation they will eventually habituate.

Modeling Therapy

Modeling for school refusers has been particularly effective for those youth who struggle with the social aspects of the school experience. Based on social learning theory, the premise is that by demonstrating or showing the child non-fearful behavior in anxiety provoking situations, they may be able to copy behaviors and develop a repertoire of responses that will allow them to function in an anxiety provoking situation. The modeling opportunity can be presented in a number of formats including, video modeling, live modeling, and participant modeling where the child observes another child modeling non-anxious behaviors and then performs the behaviors with the aid of the therapist. This “seeing and doing” approach has been most effective (Terry, 1998). In a less formal or structured way, simply engaging in role playing activities and receiving immediate feedback can also have a very positive effect.

Cognitive Therapy

Cognitive therapy assumes that the child perceives some aspect of school attendance as threatening (to the child, caregiver, or family) and feels incapable of managing the situation. By remaining at home, the problem is avoided, anxiety is reduced, and school refusal is reinforced. Cognitive Behavior Therapy CBT has been shown to be effective in treating school refusal. Wimmer (2003) reports that 83% of children treated with cognitive therapy were attending school at one-year follow up. A large part of doing cognitive therapy with this population is likely to involve Cognitive Restructuring (RET). Assisting the child to identify self-statements that result in anxiety and then providing them with a counter, contrasting anxiety-provoking statements with alternative positive statements is a way of effectively changing many of the cognitive distortions that are at the root of anxiety. The new cognitions may take the form of a mantra that can be repeated subauditorially to decrease anxiety. Having the child keep a daily Behavioral and Thought Diary can provide some insight into the cognitive distortions that produce the anxious feelings.

Social Skills Training

Providing the child who struggles with the social aspects of school with concrete skills and techniques to increase their ability to function in a social context may be a key to eliminating school refusal. Social skills can be taught in a variety of concrete ways and utilizing a variety of formats. Social Skills Groups of age level peers where a child can receive feedback about her social behavior are very effective. Having a trusted adult who serves as a social “coach” is also effective at encouraging a child to engage in a more socially accepted way and to have an experience of a positive social encounter at school. Verbal skills and strategies that increase social effectiveness can be taught and encouraged. In addition, teaching school refusing children to be aware of and accurately read non-verbal cues and signs will increase social effectiveness.

Parent Training

For the group of school refusers whose purpose is attention seeking behavior, the bulk of the intervention may be assisting the parent and school personnel in changing their patterns of

interaction with the child. School refusal behavior is often a polarizing experience for parents who may have very different ideas and approaches for handling the problem. Parental involvement is a key indicator for success, because as long as the parents do not present a united front and a consistent approach to the issue, the child will continue to divide and receive enormous attention, sympathy, and involvement of his parents. Parent training often provides parents with a broader range of parenting options and behavioral management strategies. Parent training may also have the benefit of a reduction in parent's own anxiety which will make them considerably more effective in intervening with their child.

Educational/Supportive Therapy

Providing children and their parents with information about the nature of anxiety can be an effective intervention for some. For a child, just understanding what is happening to them and normalizing anxiety as a part of life can provide them the opportunity to make a different response to attending school. Helping a child to talk about fears and distinguish between fear, anxiety, and phobias can alleviate some of the panicky feeling that they feel in school. For some older children journaling about fears, thoughts, and coping strategies is an effective tool.

Pharmacological Treatments

In many situations the pediatrician and a medication approach to the problem is the first line of defense. Sometimes this is the only intervention or medications are used in conjunction with behavioral and psychotherapy interventions. Some authors (myself included) have strong feelings that medication has no place in the treatment of school refusal. Some of the more typical medications that are utilized include:

- **Tricyclics** – Tofranil (Controlled studies have shown minimal effectiveness) Use is considered off label.
- **SSRIs** – Prozac (only SSRI approved for use with children under 12). Paxil, Zoloft, Luvox, (Black Labeled) (Approved for Obsessive Compulsive Disorder in Children) Not recommended for children with a family history of Bi-Polar Disorder.
- **Beta Blockers** – Inderal (Propranolol). Abrupt cessation may trigger hypertensive crisis.
- **Benzodiazepines** – Ativan, Valium, Xanax Possible physical and/or psychological addiction. (Sedation or irritability) Not first-line treatment because of concerns about dependence, withdrawal, and drug tolerance.

Family Therapy

Family therapy with school refusers is often a very effective intervention in that typical family therapy allows for an exploration of the purpose that the school refusal serves for the family as well as the ways that the family might be inadvertently or unknowingly rewarding or reinforcing school

refusal. There are many different forms of family therapy, but most have some dimension of examining the roles that each family member plays, responsibilities that the family member carries, the power dynamic within the family, and family communication patterns. In addition typical family therapy explores the family routines, the unwritten family rules, and who in the family has the power to reward or regulate behavior. Many times a change in family dynamics or family functioning will extinguish school refusal behavior in a family member.

Alternative Instruction

In some situations, the use of alternatives to traditional school based instruction may need to be employed. These situations should be viewed as temporary and transitional and not as a resolution to the problem as the primary treatment goal is an early return to school. Homebound instruction or other alternative instruction processes will not resolve the issue. In some cases, the extra attention may make staying at home more attractive and be reinforcing the school refusal behavior. Home schooling may mask the anxiety, but does not deal with the underlying anxiety, and may actually socially isolate the child.

The following information attempts to look at the phenomenon of school refusal and the specific interventions that work most effectively with the four different purposes that school refusal might be serving. Interventions that address the specific purpose of school refusal in one type may be ineffective in others. The following is a chart compiled by Kearney and Albano (2000) that identifies a number of intervention strategies for each of the four types of school refusers.

Treatment of School Refusal

Kearney and Albano (2000)

Function

To avoid stimuli that provoke general negative affect (crying, nausea, distress, sadness, and various phobias, i.e. bathrooms, cafeteria, teachers, bullies, etc.)

To escape aversive social and evaluative situations (social phobia, test anxiety, shyness, lack of social skills)

To get attention (tantrums, crying, clinging, separation anxiety)

For positive tangible reinforcement (lack of structure or rules, free access to reinforcement, avoidance of limits)

Treatment Components

Somatic control exercises such as breathing retraining and muscle relaxation
Gradual re-exposure to school
Reduce physical symptoms and anticipatory anxiety
Self-reinforcement, self-talk, self-esteem

Role play
Cognitive restructuring of negative self-talk
Gradual exposure to real life situations
Social skills training and reduction of social anxiety
Coping strategies templates

Parent training in contingency management
Clear parental messages
Evening and morning routines
Use of consequences for compliance/noncompliance
Forced Attendance

Family contingency contracting to increase rewards for attending school and decrease rewards for missing school
Curtail social and other activities for nonattendance
Alternative problem solving strategies to reduce conflict
Increase family communication skills

School Refusal for Avoidance of Stimuli that Provoke a Sense of General Negative Affect (SPNA)

Treatment Components for Youth with Anxiety Based Avoidance of Stimuli That Provoke Negative Affectivity: (SPNA) School Refusal

Pharmacotherapy

- Early treatments involved using antidepressants and anxiolytics
- 70's and 80's showed some promise for imipramine (tofranil)
- Recent use of Alprazolam (Xanax) shows promise but raises significant dependency/abuse issues
- Use of new SSRI's shows some promise with this group
- Combination of medication and therapy is far superior to medication alone
- Use of medication is probably best avoided unless
 1. extremely high anxiety levels
 2. school refusal is comorbid with major psychological disorders (OCD, ODD, MDD)
 3. child is unresponsive to psychological treatment

Cognitive-Behavioral Therapy

- **Cognitive elements have typically involved**
 1. Recognizing and identifying anxious feelings and somatic indicators
 2. Clarifying unrealistic or negative expectations or anxious thoughts
 3. Developing coping strategies (self-talk, breathing, relaxation, distractions, etc.)
 4. Evaluating coping behavior and self-reinforcement
- **Behavioral elements**
 1. Imaginal and *in vivo* exposure
 2. Role play and modeling
 3. Relaxation training

Psychoeducation

- Educate the youth regarding the nature of feelings, negative thoughts, and negative behaviors that comprise anxiety
- Teach the child to self-monitor and distinguish nature and severity of anxiety
- Introduce the concept of gradual exposure with the goal of full attendance

Build a Negative Affective-Avoidance Hierarchy

- Sorting process of feeling and avoidance (fear thermometer). Some aspects of school attendance may involve strong affect and fear, while other produce an avoidance response
- Establish the level of distress and level of avoidance

Somatic Control Exercises

- Tension release techniques
- Diaphragmatic breathing

Desensitization

- Begin with imaginal and move to *in vivo* techniques
- Imaginal
 1. Use guided imagery (sights, sounds, smells, feelings, places, and thoughts)
 2. Rate the level of discomfort
 3. When reaching discomfort level (above 50%) introduce breathing, relaxation or pleasurable scene to return to comfort level
 4. Process what happened with the child
- *In Vivo*
 1. Gradual exposure to school building with similar rating and intervention
 2. Gradual exposure to elements of real school setting (bus, office, classroom, teacher, etc.
 3. Gradual removal of *safety objects* or signals

Self-Reinforcement

- Recognize the child's success and have him say encouraging things aloud

Maintaining a School Schedule

- When the child does not attend, maintain a regular schedule, e.g. awake at regular time, lunch at regular time, work until school dismissal
- Even on weekends and holidays maintain a schedule
- Rewards for compliance, consequences for non-compliance

School Refusal to Escape from Aversive Social or Evaluative Situations (EASE)

Treatment Components for Youth Who Escape Aversive Social or Evaluative Situations: (EASE) School Refusal

Cognitive-Behavioral Therapy

- **Cognitive elements have typically involved**
 1. Training in social problem solving
 2. Social perception and decoding skills
 3. Communication skills
 4. Evaluating coping behavior and self-reinforcement
- **Behavioral Elements**
 1. In session practice of managing social anxiety
 2. Role play and modeling
 3. Relaxation training
 4. Reading facial expression, body language, and non-verbal content

Psychoeducation

- Educate the youth regarding the nature of feelings, negative thoughts, and negative behaviors that comprise social anxiety
- Teach the child to distinguish between “normal” social anxiety and severe social anxiety
- Introduce the concept of gradual exposure to social anxiety provoking situations
- Regression to the mean, habituation, and “fading” as a result of acclimation

Build a Social/Evaluative Anxiety-Avoidance Hierarchy

- Sorting process of feeling and avoidance (social fear thermometer)
- Establish the level of distress and level of avoidance for a variety of social or evaluative situations

Cognitive Restructuring

- Catastrophizing
- Negative thinking leading to poor performance. If you think you are socially incompetent you will be socially incompetent
- Restructure thinking with FEAR (Kendall, et. al., 1992) or STOP (Silverman & Kurtines, 1996)

- **FEAR** - **F** what am I *feeling*, **E** what do I *expect*, **A** what *actions* and *attitudes* will help, and **R** what might be the *results* or *rewards*
- **STOP** - **S** are you *scared*, **T** what are you *thinking*, **O** what *other* thoughts and behaviors can you think of, and **P** *praise* yourself and *plan* for the future
- With older children you can use more traditional cognitive-behavior therapy (Beck, 1979) and focus on automatic thoughts, all-or-none thinking, catastrophizing, negative labeling, *can't's*, *shoulds*, and *won'ts*, and mind-reading

Behavioral Exposures

- Identify lower level situations in Social Anxiety-Social Avoidance Hierarchy
- Break situation down into smaller steps
- Using relaxation and self-talk techniques while attempting lower level steps until comfortable and then progress to the next step.
- STIC (show that I can) social tasks that are specific, concrete, time limited, and measurable

School Refusal for Attention Seeking Behavior (AS)

Treatment Components for Youth Who Refuse School for Attention: (AS) School Refusal

Restructuring Parent Commands

- Transform long debates/discussions/pleadings into short commands and simple child responses
- Identify key errors in parental commands:
 1. Questionlike
 2. Vague
 3. Incomplete
 4. Multi-step or excessively long
 5. Someone else might complete the task if they ignore or delay
- Eliminate criticism, sarcasm, and lecturing
- Do not complete the task, but be involved in a parallel activity
- Design appropriate rewards and consequences
- If you alter the attention patterns, it will get worse before it gets better
- Have an option to deal with non-compliance

Ignoring Simple Inappropriate Behaviors

- Lecturing, yelling, negotiating, trying to calm, or physical force is inappropriate for intervening with attention seekers
- Teach parents to avoid reinforcing inappropriate behavior
 1. Ignoring
 2. Averting eye contact
 3. Time out
 4. Attending to siblings or others
- Ignore physical complaints unless child has a fever
- If the child is legitimately sick, show little physical or verbal attention and the child must remain in bed during school hours

Establish Fixed Routines

- Restructure chaotic morning and evening routines
- Have the child awaken 90 – 120 minutes before the start of school
- Don't be overly concerned about lateness, the message is that you will eventually be required to go to school
- Issue the command to go to school hourly with appropriate rewards or consequences
- Daytime contact with the child should be limited
- After an incident of school refusal, the evening should focus on completing homework and "serving time for missing school"

Punishment for School Refusal

- Compile a punishment hierarchy and rate it's effectiveness
- Assess for consistency, trigger points for punishment, differences between parents, and openness for new methods of discipline
- Identify and target five specific behavioral components of school refusal i.e. refusal to move, crying, complaining, aggression, assurance seeking behaviors
- Assign punishments to each target behavior

Rewards for School Attendance

- Assess the use of rewards in the past and their effectiveness
- Initially link rewards to the absence of school refusal behaviors (crying or screaming)
- Eventually link rewards to school attendance for all or part of day

- Move to a point system where points are awarded for absence of refusal behaviors and load heavily on actual attendance.

Excessive Reassurance-Seeking Behavior

- Frequently the child may ask the same question, or make the same plea, over and over
- Answer the question once; on the second attempt remind the child that she knows the answer; ignore all subsequent attempts to ask another version of the question
- Calls home to seek reassurance should be placed on a diminishing reinforcement schedule. Calls in excess are grounds for punishment that night.

School Refusal for Tangible Reinforcers Outside of School (TR)

Treatment Components for Youth Who Refuse School for Tangible Reinforcement Outside School: (TR) School Refusal

Because antagonism and poor problem-solving are common to many of these families, the treatment goals are to enhance the family's ability to resolve conflict effectively

The components of functionally based treatment for this group of school refusers includes: contracting, escorting the child to school, communication skills training, peer refusal skills training.

Contracting for Attendance

- Due to the level of conflict in these families, initial and subsequent contract negotiation must take place under therapist supervision
- The first contract may involve an easily defined problem that has little to do with school attendance (chores, etc.)
- For the first contract, simplicity is the key, don't tackle convoluted or volatile situations
- Generate 5-10 possible solutions and try to have all parties arrive at a consensus
- Define rewards for compliance and consequences for non-compliance

The first contract should be:

1. Simple and straightforward
2. Last no longer than 2-3 weeks
3. Close all loopholes or excuses
4. Exact definitions should be made regarding timelines and responsibilities
5. Criteria should be established for successful completion

The school attendance contract

1. Should only be attempted after a successful first contract and there is not severe conflict existing between parent and child
2. Involves elements of a precursor to full attendance
3. Set routines and behaviors for eventual return to school (waking, dressing, etc.)
4. Require completion of school work at home and chores during school hours
5. Lasts no longer than 3-5 days
6. No loopholes, exact definition, specific criteria

The second school attendance contract

1. Link attendance at school with the most powerful positive reinforcer (extension of curfew, sleepovers, additional time with friends, shopping, video games, phone, computer, rides for friends, tattoos, use of family car, etc.)
2. Link attendance with the right to earn money or additional privileges by completion of chores
3. Can gradually increase criteria of performance to attendance for whole days

Communication Skills Training

- Many of these children are from families where poor communication is a major issue
- Initial efforts may focus on basic interaction problems such as, interrupting, poor listening, silence, refusal to communicate, and arguing
- A family therapist can help establish communication rules: no insults, no sarcasm, volume, etc.
- Practice communication in various dyads and triads with the goal of total family communication

Peer Refusal Training

- Peer influence may be more motivating than any reinforcers in a school attendance contract
- Peer refusal training is most useful for those who intend to stay in school, but succumb to pressure to leave early
- Obtain a description of what others are saying or doing to entice non-attendance
- Practice rebuttal statements (modeling and role playing)
- Develop a workable strategy to respond to peer pressure without social ridicule or rejection

Sample School Attendance Contract

Privileges

Responsibilities

General

In exchange for decreased family tension and a resolution to the school problem, all family members agree to

Try as hard as possible to honor the contract

Specific

In exchange for the privilege of being paid \$25 for cutting the grass and feeding the dog, Bobby agrees to

attend school each day from 10 to 2

Should he not complete his responsibility

he will cut the grass and feed the dog without being paid

Should he not complete these chores

game cube will be removed for 1 week

In exchange for the privilege of playing football Bobby agrees

to attend school each day from 10 to 2 **and** be ready to leave for School by 9:30 (dressed, hair combed, teeth brushed, and backpack with all homework)

Should he not complete his responsibility

he will be required to attend School "as is" and not attend football practice or play on Saturday

In the event that all terms of the contract are honored from Monday 9:30 am to Friday 6:00 pm Bobby will be transported To Blockbuster and allowed to rent any non-M game of his choice

Bobby and his parents agree to uphold the conditions of the contract and read and initial it each night before going to bed and each morning before going to school.

Date: _____

Date: _____

Date: _____

Techniques for School Personnel and Parents

Forced School Attendance

Kennedy (1965) reported 100% success for first episode of school refusal

Rapid Treatment Procedure included:

1. Good therapist school relationship
2. Downplay or ignore somatic complaints
3. Require the child to attend “by any force necessary”
4. Fathers were encouraged to take the child to school
5. School personnel were encouraged to “keep the child there” by whatever means necessary
6. Viewed as a “flooding” procedure with eventual habituation

Forced School Attendance requires some caution with anxiety based (SPNA and ASE) school refusal, but is more effective for attention based (AS) school refusal

Kearney and Albano, 2000 developed guidelines for the use of Forced Attendance

- The child is refusing school the majority of the time
- Child is refusing school for attention (AS) and has little distress or anxiety
- Parents must be willing to take the child to school and school officials must be willing to serve as “escorts” and even supervise classroom behavior
- Two parents or one parent and another trusted adult take the child to school to manage misbehavior (and then leave)
- The child is clear about the consequences of what happens if he or she refuses school
- The child must be under 11 years of age

Steps for Forced School Attendance

1. Parents prepare the child for school – physically, if necessary
2. Issue a command for the child to go to the car to be taken to school
3. If the child refuses, issue a warning

4. If refusal persists, parents physically carry the child to the car, one drives, one manages misbehavior in the back seat, no physical or emotional abuse
5. Ignore inappropriate behavior, work through tantrums, maintain a neutral demeanor
6. Upon arrival at school, issue the command to leave the car and go to school
7. If refusal persists, parents and school personnel physically take the child into the building.

Escort Services

- Is a process where a parent actually accompanies the child to school and remains with them for the entire day. The escort accompanies the child to school and to and from each class
- Requires cooperation with school officials
- Works best for child seeking tangible reinforcers, not attention seekers
- Occasionally the threat of escorting and accompanying social embarrassment is enough to attain school attendance
- Ideally the “escort” should be a non-parent, Aunt/Uncle, Grandparent, or the parent least emotionally involved
- The escort service allows the child to attain rewards for attendance

Suggestions for Parents

- Believe that your child will get over the problem and let them know that you believe they can handle it.
- Listen to your child and encourage them to talk about their fears
- Be understanding, use reflective listening don't use shame,
- Maintain good contact with school and teacher
- Make sure that the child knows you will return
- Prepare them with gradual separations
- Inform them that you will be returning and they are to stay
- Leave quickly (don't look back or hover)
- Do not reinforce their distress by rescuing them from separation
- Tell the child you will be doing something boring at home
- Be reliable and on time when picking up your child
- Have the other parent, a relative, or a neighbor take the child to school
- Let the child have something of yours to keep in her pocket
- Give the child as much control as possible
- Prolonged goodbyes don't help the situation. A firm, caring, and quick separation is best for all concerned.

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CASE STUDIES

The following three case studies provide you with an opportunity to develop an individualized intervention plan. After each case description, there is a template that will facilitate the development of an intervention plan based on 1) identifying the purpose that the school refusal serves, 2) identifying and underlying or co-morbid conditions, 3) establishing intervention goals, and 4) developing tentative objectives to achieve those goals.

“Can’t I Stay at Home and Have You Teach Me”

Rebecca Rigatoni, an eight year old girl, has always had difficulty attending school, but has attended with much coaxing and encouragement until she started the third grade. Since then the problem has worsened significantly. She begs to stay home from school and when her pleading does not work she resorts to screaming, being oppositional, and resisting getting dressed which often results in her missing the bus. Rebecca insists that she doesn’t want to go to school because it makes her feel sad and afraid. She cannot identify anything or anyone at school that makes her fearful and insists that her teacher and the other students are “nice.” Her mom is frequently required to bring her to school in the family car and Rebecca has piled up a number of tardies. Rebecca knows that her mother is a former teacher and she wants to stay home and have her mother teach her what she needs to know.

Upon arriving at school, Rebecca frequently begins complaining that she is sick and asks to go to the office. She is on a first name basis with the office staff and attempts to get them to call her mother to pick her up. Sometimes simply talking to her mother will allow her to return to class. If she is sent back to her classroom, she frequently returns to the office during the next period. Her mother usually resorts to picking her up at least twice a week. When she gets home she usually spends the time in the presence of her mother playing quietly or watching TV. Rebecca’s solution to the problem is for her mother to get her a cell phone that she can take to school, which violates school policy, and use it to call her mother during recess and lunch to make sure that nothing has happened. Her teacher indicates that Rebecca is a good student, and somehow manages to keep up academically, despite her frequent absences. She is cooperative and pleasant unless the teacher refuses to let Rebecca go to the office and then she can become quite difficult and tearful.

Mrs. Rigatoni reports that Rebecca often tells her that she would rather be at home than go to school and that when she is at school all she can think about is her mother and baby brother. Mrs. Rigatoni had taught school prior to the birth of her children and Rebecca has often insisted that she could teach Rebecca at home. Rebecca has a number of friends in the neighborhood, but gets into moods where she won’t leave the house and follows her mother from room to room.

Type of School Refusal _____

Underlying or Co-morbid Conditions _____

Goal 1 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 2 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 3 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 4 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

“Everybody There Hates Me”

Nicholas Nacho is fourteen and has just started his freshman year at a large county consolidated high school. The elementary and junior high he attended was in a small rural mining town. Since the beginning of school he has missed twenty-three days in the first quarter. Nicholas states that he hates the school, hates the kids, and hates the teachers, but cannot provide any concrete examples or reasons as to why he has such negative feelings. “Everybody there hates me.” He says the kids there are not like him and go out of their way to make remarks or make fun of him and his accent. He wishes the “old high school” had never been closed and consolidated with the school in the city.

When Nicholas is at school he often shows up late for first period which enables him to avoid hanging out in the halls with the other kids. He is often found eating his lunch by himself in the library rather than going to the cafeteria. Given a choice, he sits quietly in the back of class, never raises his hand to answer a question, goes mute when called on for an answer, and has real difficulty working in small groups. He often is “sick” on days where a test is scheduled and refuses to make up the test at school and would rather take a zero. Nicholas reports that he doesn’t know any of the names of his new classmates and he has not made any friends since the start of school. If he talks to anyone it is the few kids who are from his old junior high school, but even with them he often just stands on the edge of the group and does not participate in the conversation.

When he stays home from school, he spends most of the day watching TV or playing video games. He is willing to do the make up work or homework, which he completes quickly and accurately. He takes the initiative to go on line and download the class work and homework assignments and they are always completed by the time his parents get home. To everyone’s surprise, Nicholas “cut” school, hitch-hiked home, and spent the day doing his class work and homework. Despite being punished, he has continued to leave the school without permission, but always goes straight home, despite the five mile walk. Other than cutting school, his parents report that Nicholas is not a problem and they describe him as a quiet, respectful, and compliant child. He seldom gets in trouble at home and is generally very helpful with the younger siblings. His parents are exploring the option of homebound instruction or allowing him to complete his classes on-line.

Type of School Refusal _____

Underlying or Co-morbid Conditions _____

Goal 1 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 2 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 3 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 4 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

“School Makes Me Want to Throw Up”

Eric Eggplant is an eight year old boy who had recently transferred to a new school. For the first three weeks of third grade he had spent only part of the day at school either curled up in a ball on his classroom floor or trying to run from the school building. His mother reports that the behavior started at the end of last year and attributed it to his teacher being a witch and she allowed him to come home. At the end of the year she sought to have him transferred out of that school that had “no feelings.” Eric would awaken each morning with a stomach ache and then proceed to vomit. On days when he did not vomit or his mother made him go to school he would fight her in the car or vomit in the parking lot. When asked what the teacher did that was so mean, Eric could not give any examples. He stated that his teacher this year is not mean, the kids are not mean, and he can think of no reasons why he can’t stay at school all day, other than school “makes me want to be sick.”

Eric’s mother acknowledged that there had been some difficulty getting him to go to school in kindergarten, but it quickly faded. She attributed much of this to the teacher “who was an angel.” His mother has tried talking to him, “bribing” him, and punishing him, and refusing to come to school when Eric called complaining about being sick. The last episode where he ran from the building caused a great deal of alarm among his mother and the school administration.

This year has been particularly difficult for Eric in that his parents have separated and divorce papers were filed but ultimately withdrawn as his parents try to work things out. Eric still wants his father to come home and live with them and doesn’t understand why he won’t just move back in. He has been experiencing frequent nightmares and has suddenly developed an extreme fear of thunder and lightning. He will no longer sleep in a dark room and many nights, ends up in bed with his mother simply “because it’s easier.” He has also regressed to wetting the bed and refuses to do things by himself that his mother knows he can do.

Type of School Refusal _____

Underlying or Co-morbid Conditions _____

Goal 1 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 2 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 3 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Goal 4 _____

Objective 1 _____

Objective 2 _____

Objective 3 _____

Registration Form:

**Heisel and Associates Inc.
7413 Miami Ave.
Cincinnati, Ohio 45243
513-271-3923/800-388-2267
513-271-5383 fax**

CEU Hours: 5 COST: \$61

School Refusal

Please Print Clearly or Type:

Name: _____

License #: (Psychologists only) _____

Address: _____

City/State: _____ **Zip:** _____

Phone: Work: _____ **Home:** _____

Email Address: _____

To register by credit card (Master Card or Visa) please call 800-388-2267 or Fax to 513-271-5383, or send your name, card number and expiration date to the above address. You can also register via e-mail at jheisel@heiselandassoc.com.

Name: _____

MasterCard ___ **Visa** ___ **Expiration Date:** _____

Card Number _____

Billing Address: _____



Post Test School Refusal

- 1. True or False** **The oldest or only child is the most vulnerable to displaying school refusing behaviors.**

- 2. True or False** **The term “school phobia” is a relatively recent concept and only identified in the last ten years.**

- 3. True or False** **Kearney and Silverman limited the concept of school refusal to include only those children who are not physically present in the school building.**

- 4. True or False** **School refusers’ families are almost always pathological in some fashion.**

- 5. True or False** **The distinction between acute school refusal and chronic school refusal is based on time absent from school.**

- 6. True or False** **The functional model is concerned with the severity of behavior and is not interested in the purpose of the behavior.**

- 7. True or False** **Kearney’s Functional Model views all school refusal behavior as pursuing positive experiences or avoiding negative experiences.**

- 8. True or False** **The onset of school refusing behavior is generally irrelevant to developing and effective approach to the problem.**

- 9. True or False** **It is always important to consider anxiety and depression in any school refusing child.**

- 10. True or False** **With school refusers, it is important to interview both the child and parents separately.**

- 11. True or False** **In order to diagnose ADHD, symptoms must be observed in multiple settings and not just at school.**

- 12. True or False** **Children who are willfully disobedient and create problems in the classroom should be diagnosed as having a Conduct Disorder.**

- 13. True or False** **Oppositional Defiant Disorder is frequently observed in children from families with marital discord, substance abuse, and depression.**

14. True or False **Homebound instruction may often socially isolate the child.**
15. True or False **One aspect of cognitive restructuring is to contrast anxiety provoking statements with alternative positive statements**
16. True or False **Almost all professionals agree that the only way to effectively treat school refusal behavior is through psychopharmacology.**
17. True or False **It has been conclusively demonstrated that there is no increased suicide risk using SSRI's with children and adolescents.**
18. True or False **Social skills training can be an effective intervention for some school refusers.**
19. True or False **In developing an attendance contract for a truant (TR), it is best to start with contracting for school attendance**
20. True or False **Treatment/intervention for a child who refuses to attend school for attention does not require working to change parenting styles.**
21. True or False **A reward schedule for attendance at school should not be used as that is "bribing" the child to attend**
22. True or False **Some children who refuse school as a result of avoiding negative affect cannot identify a specific fear-related stimuli (non-phobic)**
23. True or False **Lecturing, yelling, negotiating, trying to calm, or physical force work with school refusers who are attention seekers**
24. True or False **Recognizing and identifying anxious feelings and somatic signs is unimportant in developing an intervention**
25. True or False **Peer influence may be more motivating than any reinforcers in a school attendance contract**

I, _____ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.

Signature: _____

