School Refusal In Australia

Addressing the growing trend of school refusal

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1st Oct 2023

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The term school refusal means that there is great difficulty in attending school and this directly relates to psychological and emotional distress (Heyne, 2006, p. 600; Sewell, 2008; p. 406). School refusal can be defined as child or adolescent motivated refusal to attend or difficulties remaining in school for the entire day. Often times, the child stays or returns home and unlike truancy, doesn't try to hide their non-attendance. School refusal is often connected to visible anxiety symptoms such as fear of separation, of tests or teachers, or of transition, with depression and sometimes with oppositional behaviour. Many children express that they would like to go to school but they simply cannot. Common somatic symptoms include headache, abdominal pain, nausea, shaking or dizziness. Symptoms that are apparent in the morning may dissipate if the child remains at home. Family dysfunction is a contributing factor, e.g. high dependency, isolation, conflict and rigid roles. Contrastingly, children who skip school are usually not anxious, hide their truancy from their parents, lack interest in schoolwork, do not abide by the school's code of conduct, and often engage in inappropriate behaviour. School refusal usually starts slowly with subtle complaints and unwillingness to attend, escalating to complete refusal to go or to remain in school (Heyne, 2006, p. 600-602; Sewell, 2008, p. 406).

Children with vague physical ailments or hesitancy to attend school without actual school refusal may also include those who don’t like school for various reasons such as delayed social or communication skills, learning issues, bullying or a poor relationship with a teacher (Sewell, 2008, p. 406). They will usually have related behaviour issues. These children can have good and bad days, and can be helped by recognition of their personal experiences of hardship, support to strengthen social skills, language or learning difficulties, and by parents working together with the school to understand the issues, develop appropriate support and monitor progress (Sewell, 2008, p. 406).

School refusal is not a medical diagnosis and is a multi-layered issue. It is helpful to think about three clinical groups with additional risk factors including learning difficulties and
family dysfunction:

- separation - anxious school refusers, usually younger
- anxious - depressed school refusers, usually older
- phobic school refusers - usually older (Dube & Orpinas, 2009, p. 87; Sewell, 2008, p. 407)

School refusal have both negative short and long term consequences.

Short term consequences include:

- Poor academic performance
- Family problems (e.g. arguments between parent and child)
- Worsening peer relationships
- Poor coping strategies (Sewell, 2008, p. 407)

Longer term consequences include:

- Academic underachievement
- Employment difficulties
- Increased risk of psychiatric illness
- Learnt maladaptive coping strategies (Sewell, 2008, p. 407)

A considerable percentage of early school refusal situations will improve spontaneously or with consistent and firm parental assistance (Sewell, 2008, p. 407). Poor prognosis is associated with longer periods of greater than 2 years of refusal, occurrence in adolescence, depression, and lower IQ are associated with a poor prognosis, which will also be affected by any serious underlying mental health disorder (Sewell, 2008, p. 407).

Assessment

Knowledge of family function is essential, as well as understanding of the family's reactions to the school refusal (Elliott & Place, 2019, p. 6; Sewell, 2008, p. 407).

Initial assessment in general practice should include:

- Consideration of predisposing, precipitating, and perpetuating factors in the child, family, and school, including an understanding of the child's emotional thinking such as:
  - fear of loss of parent.
  - needing to protect a parent.
  - intense fear of situations within the school such as bullying, exams, different teachers.
- Information from the school about the child's behaviour, social functioning, academic progress, and records of attendance. A diary of attendance and associated events, triggers and activities can be useful in recognising patterns in behaviours and emotions.
- Parent and teacher behaviour checklists and mental health scales to help differentiate issues and compare severity of behaviours at home and at school (Elliott & Place, 2019, p. 6; Sewell, 2008, p. 407).

Management

A school return strategy should be introduced as soon as possible if the period of refusal has been brief and can be introduced gradually if there has been a longer refusal period (Sewell, 2008, p. 407). This will minimise continuing issues of missed work, social isolation, low self-esteem, and avoidance behaviours. It is also important to engage the child by acknowledging the reality of feelings, working together to plan school return, and managing anxieties through problem solving, relaxation training, breathing retraining, and social skills training. Work with parents to minimise potentially harmful doubts about successful re-entry to school. Work with parents to plan calm morning routines, clear instructions, escort to school and, if required, allow the child to stay in contact with parents by phone. Provide psychosocial education to work together with the school to ensure clear understanding of the issue, arrange special supports such as modified curriculum, reduced homework or remedial tuition as required, and encourage reinforcers including access to the garden, special lunch time activities, privileges, and rewards (Sewell, 2008, p. 407).

It's important for practitioners to monitor regularly to review mental health symptoms and reinforce strategies (Sewell, 2008, p. 407). Encouraging both parents and the school to work collaboratively to recognise early concerns, think through associated factors and implement supportive management plans within the school and home settings may help differentiate reluctance about school from early school refusal, as well as stop the progression of school refusal. Utilising as many supports as possible to keep the child at school is extremely helpful. Paediatric referral may be useful for more detailed assessment and management of the underlying and associated issues. With longer term school refusal, referral to a multidisciplinary mental health team may be needed. Treatment principles include early return to school with supportive parental involvement, teacher guidance regarding support for the child in school, and individually tailored treatment plans according to the underlying psychological basis of the school refusal. This may include behaviour management, child therapy, cognitive behavioural therapy, and possible pharmacological treatment. Regular monitoring of progress and signs of relapse is crucial (Elliott & Place, 2019, p. 7-9; Sewell, 2008, p. 407).

School refusal is a common problem and has negative social, emotional, and educational consequences for the child (Ingul, Havik & Heyne, 2019, p. 46; Sewell, 2008, p. 408). Correlation with psychiatric disorders of anxiety and depression are common and may progress to adulthood. Assessment and management requires teamwork between parents, school personnel and the child. Early recognition and management may calm the distress felt by the child, the family, and the school, and diminish the long-term consequences, including the potential legal problems of nonattendance at school (Ingul, Havik & Heyne, 2019, p. 46; Sewell, 2008, p. 408).

References

Dube, S. R., & Orpinas, P. (2009). Understanding excessive school absenteeism as school refusal behavior. *Children & Schools, 31*(2), 87-95.

Elliott, J. G., & Place, M. (2019). Practitioner review: school refusal: developments in conceptualisation and treatment since 2000. Journal of Child Psychology and Psychiatry, 60(1), 4-15.

Heyne, D. (2006). School refusal. In *Practitioner's guide to evidence-based psychotherapy* (pp. 600-619). Boston, MA: Springer US.

Ingul, J. M., Havik, T., & Heyne, D. (2019). Emerging school refusal: A school-based framework for identifying early signs and risk factors. *Cognitive and behavioral practice, 26*(1), 46-62.

Kearney, C. A., Lemos, A., & Silverman, J. (2004). The functional assessment of school refusal behavior. *The Behavior Analyst Today*, 5(3), 275.

Prabhuswamy, M., Srinath, S., Girimaji, S., & Seshadri, S. (2007). Outcome of children with school refusal. *The Indian Journal of Pediatrics*, 74, 375-379.

ReachOut. (2023). *School refusal and teenagers*. https://parents.au.reachout.com/common-concerns/everyday-issues/school-refusal-and-teenagers?gclid=EAIaIQobChMIrJmWstumgQMVmx6DAx21iwsKEAAYASAAEgL14_D_BwE

Sewell, J. (2008). School refusal. *Australian family physician*, 37(6), 406.