School Refusal: behavioural and diagnostic profiles of a clinical sample

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Background

School refusal is characterized by severe difficulty in attending school with associated anxiety. Based on the primary symptoms, the affected child may be categorised within a range of diagnoses. Although the subject has been widely studied, no data is available on the characteristics of Sri Lankan children with school refusal.

Aims

1. To study the behavioural and diagnostic characteristics of children presenting to a specialist child mental health outpatient setting with school refusal
2. To assess the associated environmental influences and the outcome of intervention.

Methods

The study sample consisted of children who presented to an outpatient mental health service (Jan 2004-April 2005) with school refusal for 2 weeks or more. Data on presenting symptoms, behavioural profiles and diagnosis was obtained retrospectively from clinical documents. All children attended mainstream education.

Results

Data was available on 79 children. Mean age was 9.6 years. Majority were male. Mean duration of school non-attendance was 11.5 months. Somatic complaints (59.6%) and anxiety (50.6%) were the main clinical presentations. Low academic performance based on parents' reports and school records was reported in 48.1%. The commonest diagnoses were anxiety disorder (31.6%) and Attention Deficit Hyperactivity Disorder (ADHD) (16.4%). Possible precipitants for school refusal were conflicts with peers (33%) and bullying (30.4%). A socially inhibited temperament was identified in 40.5% and aggressive tendencies in 29% of children. Statistically significant associations were not found between variables except between the gender and diagnosis ($p < 0.05$).

Conclusions

This study identifies clinical issues that need to be addressed in the assessment, early identification and management of children with school refusal.

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Introduction

The term school refusal typically describes a condition with certain characteristic features that also differentiate it from truancy. These are severe difficulty in attending school resulting in prolonged absence; associated severe emotional upset (which may involve such symptoms as excessive fearfulness, temper tantrums, misery and somatic complaints without an obvious organic cause when faced with the prospect of going to school) and the child remaining at home with the knowledge of the parents during school hours (1-4). In contrast, school absenteeism has been categorized into (i) pure anxious school refusal with separation anxiety and depression, (ii) pure truancy with oppositional defiant disorder and conduct disorder and (iii) mixed school refusal with features of both anxiety and truancy (5-7). A high percentage of children with school refusal are recognized to have a psychiatric diagnosis (3). Such diagnoses include separation anxiety disorder, social phobia, simple phobia, panic disorder, post-traumatic stress disorder, major depressive disorder, dysthymia and adjustment disorder. Presentation of school refusal as somatic complaints in the absence of organic disease is well recognized and is considered as a common expression of underlying anxiety and depression (8, 9). Also, school refusal in adolescence can be the presenting symptom of an underlying psychiatric disorder such as an anxiety disorder or a mood disorder (10).

There is no data available on the characteristics of Sri Lankan children with school refusal. This study attempts to study the emotional and behavioural characteristics of children presenting with school refusal in a Sri Lankan setting. It also assesses the environmental influences and the outcome of interventions in children who presented with school refusal to a specialist child mental health outpatient setting.

Method

The setting for the study was a specialist mental health outpatient service in a tertiary care children's hospital. School refusal for this study was defined as continuous or intermittent refusal by the child to attend school lasting two weeks or more, where this was one of the main presenting complaints for seeking consultation. Retrospective data was gathered from the clinical records of children who were newly referred to the service over a sixteen month period and fulfilled the inclusion criteria. Data was recorded on a structured format to include demography, the nature and duration of school refusal, associated psychosocial information, developmental history including academic functioning, main diagnosis and co-morbid disorders. The level of academic performance was assessed from parent estimation and school reports and classified as high, average, or low. All diagnoses were based on DSM IV-TR criteria. Children whose school non-attendance

was due to truancy and related antisocial behaviour, and those who kept away from school with parental consent were excluded from the study. All the children in the sample attended mainstream education. Data was analysed using SPSS software. The frequency distribution was calculated for demographic and school refusal related data. Cross tabulation and the chi square test was used to calculate association between relevant variables with statistical significance set at $p \leq 0.05$.

Results

Data of 79 children who fulfilled the inclusion criteria was available for analysis. The majority 44 (55.7%) were male. The mean age of the sample was 9.6 years (SD 2.06 years; range 5 to 15 years). The age distribution of the sample is shown in Table 1. The peak age group for school refusal was 9-12 years. The age with the highest proportion of school refusal was 11 years with 18 (22.8%) children belonging to this age group. The correlation coefficient between the duration of school absenteeism and the age of the child was low ($r=0.18$). There was no significant association between the duration of school refusal and the sex of the child ($p>0.5$).

The mean duration of school refusal for the study sample was 9.8 months (SD=8.81 months; range 1 to 39 months). During the previous month, 13 (16.5%) had continuous non-attendance and 50 (63.3%) had attended school intermittently. Adequate data was not available in 16 (20.2%) children. School refusal had been present for up to 13 months before seeking help in 49 (81.7%). Table 2 gives the distribution of the duration of school refusal.

Associated symptoms and signs

These symptoms and signs were observed in the sample in the following frequencies: recurrent somatic complaints (without an organic basis) 47 (59.6%), anxiety about school setting 40 (50.6%), low academic performance 38 (48.1%), aggressive or disruptive behaviour 32 (40.5%), phobic avoidance 25 (31.6%), obsessions and rituals 15 (19.0%), depressive symptoms 11 (13.9%), separation anxiety 8 (10.1%), psychotic symptoms 3 (3.8%) and antisocial conduct 2 (2.5%). Suicidal threats were made by 4 children (5.1%) when asked to attend school.

Diagnoses and Comorbid disorders

A diagnosis of phobic anxiety disorder was recorded in 25 (31.6%) and separation anxiety disorder in 11 (13.9%) children. Other diagnoses were attention deficit hyperactivity disorder (ADHD) 13 (16.4%),

depression 3 (3.8%) and autism/Asperger's disorder 2 (2.6%). No children met criteria for a psychotic disorder. Males were represented in a higher proportion in all diagnostic categories except in phobic anxiety disorder and depression, which had a higher percentage of females. The association between gender and diagnosis was statistically significant (chi square 1.406, $p<0.001$). The association between age and diagnosis was not significant ($p>0.05$).

Precipitating causes and related stressful experiences

Several possible precipitants for the onset of school refusal were reported in the study sample. Some children had multiple such experiences. Interpersonal problems in the school environment were the leading cause which included conflict with peers 26 (33.0%), being a victim of bullying 24 (30.4%) and feeling intimidated by the teacher 19 (24.1%). Other reasons recorded as possible precipitants were feeling socially excluded 10 (12.7%) and an allegedly false complaints made against the child to the teacher 2 (2.5%). The inability to cope with school activities was reported in 12 (15.2%) and the experience of an upsetting event at school (other than those already mentioned) in 11 (13.9%) children. In 11 children (13.9%), a change of school immediately preceded the onset of school refusal and 4 (5.1%) had left home to stay at a boarding place or school hostel. Family related precipitants were an illness in a parent 16 (21.5%), conflict between parents 10 (12.7%) and an upsetting event at home 8 (10.1%). Bullying was reported by 24 (30.4%) children and behaviours associated with bullying were being called names 13 (16.5%), extortion of money by older peers 3 (3.8%), isolating the child in the school transport vehicle 5 (6.3%), and having personal belongings stolen or destroyed by others 2 (2.5%).

Temperament of the child with school refusal

Several temperamental traits of children in the study sample were recognised from information provided by parents. These included timidity and inhibition in school and other social contexts 32 (40.5%), the tendency to be easily emotionally distressed 25 (31.6%), the tendency to experience temper outbursts 23 (29.1%), impulsiveness 5 (6.5%) and over-conscientiousness and over-sensitivity to comments from others 6 (7.6%).

Outcome of the study sample

At one month follow up after intervention, 26 (32.9%) had returned to school, 5 (6.3%) had not returned and 48 (60.7%) were lost to follow up. There was no statistically significant association between the diagnosis and the outcome ($p>0.05$).

Table 1 – Age distribution of the sample

Age of presentation (years)	N(%)
5-8	22 (27.8)
9-12	52 (65.8)
13-15	5 (6.3)
Total	79

Table 2 – Duration of school refusal

Duration of school refusal	N(%)
1-2 months	20 (25.3)
3-6 months	16 (20.3)
7-13 months	29 (36.6)
Over 14 months	14 (17.8)
Total	79

Discussion

A highlight of this study was that low academic functioning was a prominent complaint in almost half (48%) of the children in the sample. This may have played a role as a predisposing factor as well as a precipitant to school refusal. This study is a first to have identified low academic functioning as a possible association for school refusal. However, in the absence of a control group, it is not possible to establish whether the level of school functioning could be a risk factor that predisposes children to school refusal. Reviews on school refusal also have not identified an association between learning difficulty and school refusal.

Somatic complaints and anxiety were presenting features in over 50% of the study sample and is compatible with the anxious temperament identified in 40% of the sample. This finding is recognized in other studies as well (10-13). While most studies have considered disruptive behaviour in association with truancy rather than school refusal, our sample showed a 40% prevalence of such behaviour and an aggressive temperament in 29%.

The demography of our sample is similar to some clinical and community studies but different from others. For instance, school refusal occurs in all ages and is noted to peak during key periods of transition. Accordingly, refusal become more prevalent at school entry (5 and 6 years) and entry into secondary school (10 and 11 years) (2,3,14). The single age with highest prevalence was 11 years (22.8%) in this study, which coincides with the transition to secondary school. However, there was no peak at school entry. Other Asian studies have found the peak age to be older at 13-14 yrs (15). Also, boys were slightly over represented in this study sample although general opinion is that school refusal is equally prevalent in both sexes (16). Another Asian study has however found in a clinical sample a higher prevalence of school refusal in boys (17).

Other findings of this study worthy of note are that 40% of children were reported by parents to be timid and inhibited, a third of the sample reported conflict with peers, and 30% were victims of bullying.

It is not possible to comment further on the possible association between temperamental qualities and negative psychosocial experiences associated with school refusal behaviour in the absence of a control group. However, other authors have commented on the positive association between temperament and school refusal (2,6).

The mean duration of absence from school, continuous or intermittent was 9.8 months and the duration of school refusal in 36.6% was 7 to 13 months, which indicates that the study population was late in seeking help for the problem. The possible reasons for the long duration of persistence of school refusal cannot be determined on the available data and needs further investigation. The fact that 60% were lost to follow up may or may not mean that these children have returned to school. However, studies on outcomes and long term sequelae show 45% school dropout rate and an overall lower quality of life in 41% (3,9,18).

Limitations

Parental mental health has been recognised as a possible contributory factor, but this study did not explore that aspect (4,19). Similarly, socioeconomic factors that are known to contribute school related problems were not assessed. Although an objectively structured questionnaire was used in gathering data, the use of a standardized schedule such as the "School Refusal Assessment Scale" may have helped to classify different psycho-behavioural reasons for school refusal (20).

Clinical Relevance

Nearly a third of the clinical sample studied was diagnosed with an anxiety disorder and another third had experienced bullying. A majority of children in the sample presented with somatic complaints and symptoms of anxiety and 48% reported learning difficulties. All these findings are relevant clinical issues to address in the assessment, early identification and management of children with school absenteeism especially in the context of the delays in seeking help.

Declaration of interest

None

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