School Refusal in Children and Adolescents

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Disclosures

Neither I nor my spouse have a relevant financial relationship with a commercial interest to disclose.
SCHOOL REFUSAL CASE STUDY

HPI

• T.R. is a 11 y.o. with a history of asthma, allergies and anxiety, who began to have more anxiety symptoms last year when she entered middle school.

• She developed stomachaches, which caused her to miss school. She was referred to a gastroenterologist. Medical workup was negative.

• Her anxiety increased, and she had more difficulties going to school. She refused to get on the school bus, and her father drove her to school. When he dropped her off she cried and clung to father, not wanting to leave his side. She developed panic attacks when he left her.

• At school she avoided eating lunch in the classroom.
SCHOOL REFUSAL CASE STUDY

Social History

• Dad works at Wegmans and missed multiple days from work to stay home with his daughter when she did not go to school. He filed for FMLA due to missed days.
• TR lives with her biological parents, and younger 7 year old brother
• She has friends, and enjoys spending time with them and going to sleepovers.
SCHOOL REFUSAL CASE STUDY

Family History

• Dad has anxiety and history of panic attacks and is prescribed Prozac. An uncle had schizophrenia, drug use and committed suicide. T.R.’s paternal grandfather and several other members of Dad’s family have anxiety.
SCHOOL REFUSAL CASE STUDY

Past Medical History

• Asthma, Allergies and Atopic Dermatitis resulting in several ER visits and followed by a Pulmonologist.
• Tonsillectomy/Adenoidectomy age 5
• Severe croup episode requiring ambulance trip to the ER and epinephrine injection age 6

Medications: Albuterol Inhaler prn
SCHOOL REFUSAL CASE STUDY

• TR began to miss school. Initially she missed a few days of school a month, but she then began missing one or two days a week of school. She continued to complain of stomach aches and headaches, and had crying spells and panic attacks on school days.

• T.R. was referred to a therapist, and began to meet regularly with her. However, she continued to struggle with anxiety, and to miss school frequently.

• TR’s parents met with her physician to discuss the possibility of her staying out of school for a month to decrease her stress. They asked her physician for a letter to excuse her from school for medical reasons.
SCHOOL REFUSAL CASE STUDY

• TR’s
  • T.R. saw met with the social worker regularly at school and began individual and family therapy in June 2012. Since then, T.R. has continued with some symptoms of anxiety but has attended school regularly, done well academically and transitioned to 2 new schools. She has never been treated with medication.

• Some of her symptoms were helped by getting on the school bus with her dog, eating her lunch at a special table outside the lunchroom, being met by the school nurse at school drop off and being assigned to a kindergartener to walk to her classroom as a job.

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Epidemiology

- Prevalence: 1-5%
- Boys = Girls
- Most common ages: ages 5, 6, ages 10, 11
- No socioeconomic differences
### School Refusal vs Truancy

#### Criteria for Differential Diagnosis of School Refusal and Truancy

<table>
<thead>
<tr>
<th>School Refusal</th>
<th>Truancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe emotional distress about attending school: may include anxiety, temper tantrums, depression or somatic complaints</td>
<td>Lack of excessive anxiety or fear about attending school</td>
</tr>
<tr>
<td>Parents are aware of absence; child often tries to persuade parents to allow him or her to stay home</td>
<td>Child often attempts to conceal school absence from parents</td>
</tr>
</tbody>
</table>
School Refusal vs Truancy (con’t)

<table>
<thead>
<tr>
<th>Criteria for Differential Diagnosis of School Refusal and Truancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Refusal</strong></td>
</tr>
<tr>
<td>Absence of significant antisocial behaviors such as juvenile</td>
</tr>
<tr>
<td>delinquency.</td>
</tr>
<tr>
<td>During school hours child usually stays home because it is</td>
</tr>
<tr>
<td>considered to be a safe and secure environment</td>
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### School Refusal vs Truancy (con’t)

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<tr>
<td><strong>School Refusal</strong></td>
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<tr>
<td>Child expresses willingness to do schoolwork and complies with completing work at home</td>
</tr>
</tbody>
</table>
Clinical Considerations

• Presentation: physical and/or psychological symptoms
• Symptoms frequently change over time
Clinical Features

• Gradual onset
• Symptoms may begin after a holiday, illness
• Weekends, vacations exacerbate symptoms
• Stressful events – home, school, peers may cause refusal
Clinical Features (con’t)

• Some children leave home, then have difficulties as they get closer to school
• Some children make no effort to leave home
• Fear, panic symptoms, crying episodes, temper tantrums, threats of self-harm, somatic symptoms
# Somatic Symptoms

## Somatic Complaints in School Refusing Children

<table>
<thead>
<tr>
<th>Autonomic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
</tr>
<tr>
<td>Diaphoresis</td>
</tr>
<tr>
<td>Headaches</td>
</tr>
<tr>
<td>Shakiness/trembling</td>
</tr>
<tr>
<td>Palpitations</td>
</tr>
<tr>
<td>Chest Pains</td>
</tr>
</tbody>
</table>
# Somatic Symptoms (con’t)

## Somatic Complaints in School Refusing Children

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Nausea</td>
</tr>
<tr>
<td>Vomiting</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Muscular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back pain</td>
</tr>
<tr>
<td>Joint pain</td>
</tr>
</tbody>
</table>
Clinical Symptoms (con’t)

Symptoms present in morning, and improve if child is allowed to stay home
“I can play with pain, Ma, I just can’t work with pain.”
Clinical Symptoms

THE LONGER THE CHILD IS OUT OF SCHOOL, THE MORE DIFFICULT IT IS TO RETURN
Short-term Sequelae

• Poor academic performance
• Family difficulties
• Problems with peer relationships
Long-term Consequences

• Academic underachievement
• Employment difficulties
• Increased risk for psychiatric illness
Long-Term Sequelae

Long-Term Sequelae of School Refusing Children
(Flakierska-Praquin et al. 1997)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interrupted compulsory school</td>
<td>18%</td>
</tr>
<tr>
<td>Did not complete high school</td>
<td>45%</td>
</tr>
<tr>
<td>Adult psychiatric outpatient care</td>
<td>43%</td>
</tr>
<tr>
<td>Adult psychiatric inpatient care</td>
<td>6%</td>
</tr>
<tr>
<td>Criminal offense</td>
<td>6%</td>
</tr>
</tbody>
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### Long-Term Sequelae of School Refusing Children

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<th>Outcome</th>
<th>Prevalence (%)</th>
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<tbody>
<tr>
<td>Still living with parents after 20-year follow-up</td>
<td>14%</td>
</tr>
<tr>
<td>Married at 20-year follow-up</td>
<td>41%</td>
</tr>
<tr>
<td>Number of children at 20-year follow-up</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>59%</td>
</tr>
<tr>
<td>One or more</td>
<td>41%</td>
</tr>
</tbody>
</table>
Associated Psychiatric Disorders

- School refusal is not a psychiatric diagnosis
- Emotional distress is significant
- Anxiety and depression most common
- Children: anxiety symptoms
- Adolescents: anxiety and mood disorders
Psychiatric Disorders in Children with School Refusal (Bernstein et al 1991)

<table>
<thead>
<tr>
<th><strong>Diagnosis</strong></th>
<th><strong>Percentage</strong></th>
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<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>54%</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>20%</td>
</tr>
<tr>
<td>Anxiety Disorder, NOS</td>
<td>12%</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>8%</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>6%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>4.5%</td>
</tr>
<tr>
<td>Panic Disorder with Agoraphobia</td>
<td>3%</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>.5%</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>52%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>30%</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>22%</td>
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Psychiatric Disorders in Children with School Refusal  
(Bernstein et al.1991)

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<tr>
<td>Other disorders</td>
<td></td>
</tr>
<tr>
<td>Adjustment Disorder with mood/anxiety</td>
<td>26%</td>
</tr>
<tr>
<td>Learning Disorder</td>
<td>5.5%</td>
</tr>
<tr>
<td>ADHD</td>
<td>6.5%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
Etiology

• Heterogeneous and multi-casual
• Serves different functions depending on the child
• Avoidance of specific fears provoked by the school environment
  • Test-taking situations
  • Bathrooms
  • Cafeterias
Family Functioning

• Problems with family functioning contribute to school refusal, however, few studies have systematically evaluated and measured these problems
• Parents of children with school refusal have an increased rate of panic disorder, agoraphobia and depression
Assessment

• Comprehensive evaluation
• Allocate sufficient amount of time
• More than one appointment may be needed
• Information from school, other health care providers
• Rule out underlying medical conditions
Assessment (cont.)

- Clinical Interview
  - Family (child and parents together)
  - Child
  - Parents
- Complete physical examination
Assessment (cont.)

• Complete medical history
• History of onset and development of symptoms
• Associated stressors
• Sleep history
• School history
• Family psychiatric history
Assessment (cont.)

• Mental status examination including evaluation of psychiatric problems and substance abuse
• Assessment of family dynamics and functioning
Assessment (cont.)

• Collaboration with school staff

• Review of school attendance records, report cards, and psycho-educational evaluations
Treatment (cont.)

• Primary goal – early return to school
• Avoid writing excuses unless a medical condition makes it necessary
• Treatment should focus on co-morbid psychiatric conditions, family dysfunction, and other contributing factors
Treatment (con’t)

MULTIMODAL, COLLABORATIVE TEAM APPROACH
Primary Care Provider
Child
Parents
School Staff
Mental Health Professional
Treatment

• Most effective:
  Parent involvement  
  Exposure to school  

• Must take into account:
  Severity of symptoms  
  Co-morbid diagnosis  
  Family dysfunction  
  Parental psychopathology  

• Few controlled studies have evaluated the efficacy of most treatments
Behavior Interventions (con’t)

• Systematic desensitization (graded exposure to the school environment)
• Relaxation training
• Positive reinforcement
• Social skills training
Pharmacologic Treatment

• Very few double-blind, placebo-controlled studies
• Use of SSRIs for anxiety and depression
• Duloxetine (SNRI) approved for Generalized Anxiety Disorder
• Fluoxetine (Prozac), Sertraline (Zoloft), and Fluvoxamine (Luvox), approved for OCD
• Fluoxetine (Prozac) and Escitalopram (Lexapro) approved for depression
Pharmacologic Treatment (cont.)

• Treat underlying psychiatric disorder
• Multimodal treatment – always with psychotherapy interventions
• Psycho-education (child, parent, school personnel)
• Start low, go slow
Pharmacologic Treatment (con’t)

• Benzodiazepines used for short-term basis (few weeks max) for children with severe school refusal

• Benzodiazepine may be initially prescribed with an SSRI to target acute symptoms of anxiety. Once the SSRI has had time to produce beneficial effects, the benzodiazepine should be discontinued
School Refusal Case Study T.R.

• T.R. and her family continued to meet with her therapist regularly. Her therapist worked closely with her parents, school staff, and her physician to collaborate care. Her physician did not write a letter to excuse her from school.

• Some of her symptoms were helped by getting on the school bus with her dog, eating her lunch at a special table outside the lunchroom, being met by the school nurse at school drop off and being assigned to a kindergartener to walk to her classroom as a job.

• T.R. has continued with some symptoms of anxiety but has attended school regularly.

• She has done well academically. She has never been treated with medication.
Summary

• School Refusal vs Truancy
• History and physical to r/o underlying medical condition
• Evaluate and treat psychiatric conditions
• Goal: early return to school
• Parents participation crucial
• Collaborative approach: family, PCP, teachers, mental health professional
Websites

www.childanxiety.org
www.aacap.org
www.mentalhealth.samhsa.gov
QUESTIONS?